West Berkshire Safer Communities Partnership

Domestic Homicide Review Overview Report

Co-Chairs

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March 2016

CONTENTS **Page**

Foreword - Family tributes to SH

As part of the review, the co-chairs and the panel met with members of SH's family. Throughout the process the panel sought to ensure that their voices were heard and that through them, SH was at the centre of our thinking. With this in mind, it was agreed that members of the family would have the opportunity to provide a written statement about SH as a foreward to the Overview Report. Those tributes are set out here in full and without editing by the panel or the author.

The report uses the initials SH to denote the victim in this case. The initials represent her first name and maiden name. The decision to adopt this approach was taken after discussion with family members and their advocate. It was taken to maintain confidentiality but also to be more personal to her rather than using random initials or other forms of anonymisation.

A tribute to SH from her sister W

SH was my big sister and much to her disgust I would follow her around. But as we got older, we became closer. She talked to me and tried to explain about the atomic bomb when it was first in the news. She took me to my first grown up dance and gradually as our families began to grow, she became a big part of my everyday life. We ran a group together that is not the same any more.

She was a happy, larger than life person who was always up for a party or a bit of fun. On our shopping trips she would use her mobility scooter and if any young men got in her way she would tell them she will take them home in her basket. She would always make them smile. She was the best sister anyone could have and she leaves a big hole in all of our family's lives, she will be greatly missed and there is now a big hole that no one can fill. Now at each family gathering or party, her laughter and sense of fun will be missing.

A tribute to SH from her sister P

I can still remember as if it were yesterday. I was at work, I checked my phone on my break and noticed I had missed several calls from unknown numbers and from my sister W. I called W back and all she said was 'Adult B has killed SH', 4 words that sent our lives into utter chaos, disbelief and shock.

SH was my big sis, as she called herself, but not only that, she was also my friend. SH was a rock to so many people, always helping others, she listened to people and always found a way of sorting any problem out.

SH rarely complained about her own problems or disabilities and very often would make fun of herself for this and would laugh it all off. At any family party she would always be the first one up dancing and the last to sit down, whereas many of us would need a little stiff drink to enable them to get up, but SH didn't. She loved life and grabbed it with both hands.
I still remember her doing her own rendition over some railings of the theme from the film Titanic, 'My heart will go on', at one of my brother's birthday parties. This is just one of my fond memories of SH.

I think about SH every single day and miss her so much that even now I still have a tear in my eye, when I organise a night out to bingo, a place SH loved. I still find myself grabbing my phone and wanting to text her to see if she wants to come. Then it all comes flooding back again – she's not here.

SH came on our family holiday to Florida and had a fantastic time. One night we stayed out really late at Disney World to see the fireworks. When we were making our way back to the car I looked at her and remarked that she looked exhausted. SH replied 'I know but it was bloody worth it.' Another time, SH was on the Little Mermaid ride which continually rolls. She couldn't get off it in time and had to go round again. She thought this was hysterical and couldn't stop laughing. These are a few of the memories I have which are fond, and as I write this it makes me smile, something I haven't done in a while whilst thinking of SH. When I go to sleep at night it races through my mind about the way she died; fighting for her life whilst being strangled – a vision no-one should go to sleep on.

I will always miss my big sis and I know if she was here she would say 'Come on Pen pull yourself together, because shit happens'.

I am hoping that in time we can come to terms with this but I still find more questions than answers. I do hope that also in time I can think about SH not only in the horrific way she died but more about the wonderful person she was when she was here, how she made us laugh, when sometimes we just wanted to cry, her words of inspiration and equally her determination to not let anything stand in her way. We will always miss her every day.

A tribute to SH from her mother

SH is my eldest daughter and from the word go she was a 'daddy's girl'. She went everywhere with her Dad and grew up doing everything with him. Unfortunately my husband died in August 2013 and SH was very upset as she missed him so much. I was devastated to lose him and then a year later to lose SH, but I find comfort in knowing that they are together again as I know they will be looking after each other.

A tribute from SH's sons

Our Mum

It has been almost two years since you were tragically taken away and we did not get the chance to say goodbye. Your absence has left a hole in our hearts which will never be filled until we meet again.

Mum, you were our guardian angel, you were so calm, caring, kind, patient, humorous, non-judgemental and had a unique personality. We could turn to you no matter what problem we had and your smile would always see us through the good and bad times.

We three boys are thankful as we have learnt so much of your ways. Throughout the years you have showed us how to love, to be honest, to care and be the best we could be no matter what.
For that, you were more than just our mother; you were our friend, our rock, our guidance and most of all our everything. Now you are gone nothing will ever be the same, but you have installed some rare qualities in us which will continue in our hearts.

Even though lymphoma, undergoing many surgical procedures and sessions of chemotherapy haunted your life, at no point did you let on how bad your illness was and you never burdened us with all your medical problems. Still you never gave in, never made a fuss and always smiled no matter what difficult times lay ahead. More importantly you were strong minded, a fighter and whole hearted, which see you through all your pain and suffering over the years.

With all this happening you still found time to be a fantastic grandmother to all twelve grandchildren. They were all loved and cherished, supported, encouraged and entertained equally. These are memories all the grandchildren will all cherish and never let go.

Mum, I know your presence in our minds is soothing, but we can never say farewell to you, because we could never endure the pain. Instead mum, we say, we love you until we meet again.

Your three boys!

Section One

Introduction and background

1.1 Introduction

This Domestic Homicide Review (DHR) examines the circumstances surrounding the unexpected death of SH in Newbury, Berkshire in August 2014. The DHR was commissioned by the Community Safety Partnership of West Berkshire District Council.

1.2 Purpose of the Domestic Homicide Review

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

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

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

The purpose of a DHR is to:

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

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

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

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

1.3 Process of the review

A DHR was recommended and commissioned by the Community Safety Partnership in September 2014 in line with the expectations of the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews 2011. This guidance is issued as statutory guidance under section 9(3) of the Domestic Violence, Crime and Adults Act 2004.

A panel met for the first time on 5 November 2014 following the appointment of an independent Chair and at that meeting the independent author was appointed. That meeting also agreed the Terms of Reference and agreed that the DHR would also serve as a Mental Health Homicide Review. It was also agreed that the DHR would seek to satisfy the standards and requirements of a Vulnerable Adult Serious Case Review.

The panel has met on five occasions.

In May 2015, in response to representations from a family member and their advocate, and following a series of email exchanges and conversations between the Community Safety Partnership (CSP) Chair and the Home Office, the CSP, confirmed its confidence in the DHR Panel Chair. Although the chairing arrangements had been made in accordance with Home Office guidance, the family member was concerned about the degree of independence, given that the Chair was employed by an agency represented on the Community Safety Partnership.

Following the representations made by family members and their advocate, a discussion took place with the Home Office to set out the CSP position in relation to interpretation of the guidance. Following that discussion and to provide the family with increased assurance about independence and in agreement with NHS England it was agreed (in liaison with NHS England) that the independent author would take up the role of co-chair in addition to his role as author.

In conducting this DHR, the panel has experienced the conflicting demands of the need to ensure confidentiality which are in contrast to the responsibilities for NHS organisations to ensure they comply with the requirements of the Duty of Candour. In this case, this was apparent in the IMR provided by Berkshire Healthcare NHS Trust (BHT) also being a Serious Incident Report for the NHS. As such its findings, which the DHR panel wished to consider more fully, had already been shared with family members. Although this was resolved locally, it highlights the potential tensions between different processes and organsiations and requires further thought and work nationally to avoid becoming a more regular issue for such joint reviews

Panel Membership

Name	Title	Organisation
Andy Fry	Co-chair – Chief Executive	Royal Berkshire Fire & Rescue Service
Steve Appleton	Co-chair and Independent author of the Overview Report	Contact Consulting (Oxford) Ltd
Susan Powell	Safer Communities Partnership Team Manager	West Berkshire District Council
Jon Muller	Interim Shared Services Manager	West Berkshire District Council – Adult Social Care
Linda York	DCI Berkshire Protecting Vulnerable Persons Unit	Thames Valley Police
Nicole Sharp/ Matthew Hensby	Regional Manager	Sovereign Housing
Jim Boden	Domestic Abuse Reduction Coordinator	West Berkshire District Council
Jenny Selim	Designated Nurse Safeguarding	Berkshire West Clinical Commissioning Group
Helen McKenzie	Director of Nursing & Governance	Berkshire Healthcare NHS Foundation Trust
Tandra Forster	Head of Adult Social Care	West Berkshire District Council
Will Smith/Christopher Gill/Lucien Champion	Mental Health Homicide Investigation Manager	NHS England
Judith Colby	Voluntary Sector Representative	West Berkshire Voluntary Sector
Debbie Johnson	Domestic Abuse Specialist	Thames Valley Probation Service
Tony Heselton	Named Professional for Safeguarding and Prevent Lead	South Central Ambulance NHS Foundation Trust

Co-chair – Andy Fry

Andy is the Chief Fire Officer and Chief Executive of Royal Berkshire Fire and Rescue Service. In a public sector career spanning 29-years, he has worked in three fire and rescue services and also spent 5-years with Suffolk County Council. For the last 11-years he has operated in various posts at Director and Chief Executive level and, in undertaking these roles, has been involved in conducting and overseeing numerous reviews and investigations.

During his time with Suffolk County Council as a Corporate Director, Andy's portfolio of responsibilities included leading the Domestic Violence Unit, the Drug and Alcohol Action Team, the Hate Crime Unit, and the 'Make a Change' Team – a multi-agency team established as part of the response to the murder of five sex workers in Ipswich at the hands of Steve Wright. The experience he gained in this role exposed Andy to a broad range of issues associated with domestic abuse, and left him with a firm personal belief that public sector agencies have a critical role to play in preventing it – a belief central to the decision he took to accept an invitation to Chair this Domestic Homicide Review.

Co-chair and Overview Report Author – Steve Appleton

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

Steve has had no previous involvement with the subjects of the review or the case. He has considerable experience in health and social care, and has worked with a wide range of NHS organisations, local authorities and third sector agencies. He is a managing director of his own limited company, a specialist health and social care consultancy.

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

1.4 Subjects of the review

SH
White British female
Date of Birth 25th November 1951
Date of Death 17th August 2014
Deceased was wife of Adult B

Adult B
White British male
Date of Birth 9th April 1954
Adult B was husband SH

1.5 Time Period

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

1.6 Terms of reference

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

1. Review the care and treatment provided, including risk assessment and risk management.

2. Review the communication between agencies, services, friends and family including the transfer of relevant information to inform risk assessment and management.

3. Examine the events leading up to the incident, including a chronology of the events in question.

4. Identify any care or service delivery issues, alongside factors that might have contributed to the incident.

5. Examine how organisations adhere to their own local policies and procedures and ensure adherence to national good practice.

6. Review documentation and recording of key information, including assessments, risk assessments, care plans and management plans.

7. Review communication, case management and care and service delivery of all the agencies involved.

8. Review if the Berkshire Healthcare NHS Foundation Trust fully appreciated the risks and safeguarding issues - particularly in connection with the safety of the victim.

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

10. Assess whether the suspect received the right level of care and support from Berkshire Healthcare NHS Foundation Trust, and the extent to which the care and support in question met appropriate standards.

11. Review communication between the GP and Berkshire Healthcare NHS Foundation Trust, and the extent to which the Trust responded to any concerns raised.

12. Review documentation and record keeping of key information by the Improving Access to Psychological Therapies and Crisis Teams against best practice and national standards, and assess whether Berkshire Healthcare NHS Foundation Trust's record keeping was appropriate.

13. Review Berkshire Healthcare NHS Foundation Trust's internal investigation report and assess the adequacy of its findings, recommendations and implementation of the associated action plan.

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

15. To assess and review Berkshire Healthcare NHS Foundation Trust's engagement with the victim's family, before and after the incident - including information sharing and involvement in the internal investigation, measured against best practice and national standards.

1.7 Post-Implementation Audit

In order to ensure that the recommendations confirmed as being necessary through the DHR have been implemented, and that they are achieving the positive impact intended, the Panel agreed that a post-implementation audit would be undertaken 12-months after publication of the Overview Report. It was further agreed that the audit will be undertaken by the DHR Co-Chair and Overview Report Author, Steve Appleton, in conjunction with the other Co-Chair, Andy Fry. The findings of this audit will be presented to the West Berkshire Safer Communities Partnership.

1.8 Individual Management Reviews (IMRs)

IMRs were requested from a range of agencies that had been in contact with or providing services to both SH and Adult B. IMRs were also requested from other agencies with which SH and Adult B may have had contact with.

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

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

This Overview Report is based on IMRs commissioned from those agencies that had involvement with SH and Adult B as well as summary reports, scoping information and interviews with SH's two sisters and brother in law, Adult B's daughter and ex-wife, SH's son and daughter-in-law, Adult B's employer and Adult B himself.

The IMRs have been signed off by a responsible officer in each organisation. Although there are some elements of the IMRs with which the panel disagreed in terms of factual accuracy and a number of the conclusions that were drawn, the panel was content to approve them following discussion with IMR authors and the input of further independent expertise to review those areas where panel members had concerns about the conclusions drawn. Where differences of opinion remain, these are highlighted in the report.

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

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

Organisation	Author(s)	Title
Berkshire Healthcare NHS Foundation Trust	Tony Drew	Independent Investigator
Berkshire West Clinical Commissioning Group	Angus Tallini	GP
Thames Valley Police	DCS Andy Murray	
West Berkshire Council	Tandra Forster	Head of Adult Social Care
South Central Ambulance NHS Foundation Trust	Paul Cooke	Named Safeguarding Lead
Sovereign Housing Association	Nicole Sharp	Regional Director
West Berkshire Domestic Abuse Service (A2Dominion)	Karen Diver	Service Manager

In addition information was requested from:

- West Berkshire Council – Emergency Duty Service
- Citizens Advice Bureau
- Victim Support
- Samaritans

The panel also commissioned two independent reports, one from a mental health nurse and the other from a Consultant Psychiatrist. The nursing report focused on matters of nursing/clinical practice in relation to Berkshire Healthcare NHS Foundation Trust's (BHT) mental health services. The report from the Consultant Psychiatrist focused on the matter of Adult B's diagnosis and the reasons for the different diagnoses applied to him over time.

1.8.1 Issues relating to IMR gathering

An IMR was requested from South Central Ambulance Service NHS Trust (SCAS). This request was originally made in a letter from the panel chair to SCAS, dated 17 November 2014. It was the assessment of the DHR panel that information initially supplied by SCAS did not meet the necessary standard that would be expected of an IMR. The report, which was in fact an Excel spreadsheet of contact did not adhere to an agreed IMR template and contained limited information. The limited narrative contained no meaningful analysis and omitted information on a number of issues that the panel was aware of from other IMRs and contact with family members.

The IMR author met with one of the co-chairs in May 2015 to discuss the issues relating to the IMR and it was agreed that a revised version would be submitted by 29th May 2015. A report was received, albeit after the agreed deadline, but it was the view of the panel that this updated version still did not sufficiently address the areas of concern the panel had about content and structure. In addition, despite being invited to panel meetings no representative of SCAS attended those meetings or sent apologies.

Further dialogue took place with SCAS via the IMR author and assurances were given about the production of a revised IMR that would reflect the issues that had been highlighted both in conversations and in a marked-up copy of the second IMR submission.

At the panel meeting in July 2015, the panel were still not in receipt of a revised IMR from SCAS. The co-chair wrote to the IMR author requesting that the IMR be provided no later than the 21st August and made clear that if this did not happen a formal complaint outlining the concerns of the panel would be put to the Chief Executive of SCAS.

This email, sent on 21st July 2015, was not acknowledged by the SCAS IMR author. Following further conversations between the co-chair and SCAS, it was agreed that another representative from SCAS would take over the production of the IMR to the agreed deadline. This deadline was met.

In setting out this chain of events, the panel seeks to highlight the obstacles that have been faced in obtaining an IMR from SCAS that not only was of sufficient quality, but that included an appropriate degree of analysis, addressed areas and issues of concern and that could be produced to a reasonable timescale.

The delays in obtaining the IMR have caused delay in producing the Overview Report. In addition, they have required the expenditure of a significant amount of management time from the co-chairs and the panel co-ordinator.

This is not an isolated occurrence and the panel are aware of at least one other DHR in Berkshire that has experienced similar difficulties in obtaining an IMR of an adequate standard and within a reasonable timescale.

These issues have been highlighted with NHS England locally in the hope that they may be able to provide clearer direction to SCAS. The co-chairs have also written to and engaged with the SCAS Chief Executive to reinforce the need for a more appropriate level of response to IMR requests.

1.8.2 Scoping

Scoping work was conducted with a number of additional agencies to establish whether or not SH or Adult B had been in contact with them or received services from them. The agencies were as follows:

West Berkshire Council Adult Social Care Emergency Duty Service

- Confirmed no contact

Citizens Advice Bureau

- No contact since 2007

Victim Support

- Confirmed no contact prior to the incident

Samaritans

- Following discussion with the Samaritans and a review of their information retention and confidentiality policy, no further enquiries were required or undertaken.

1.9 Diversity

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

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

[1] Paragraph taken from Home Office Domestic Homicide Review Training; Information Sheet 14. P47

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

Consideration of the impact of disability in relation to domestic abuse is et out in Section 1.13.

1.10 Confidentiality

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

1.11 Involvement with the family

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

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

In relation to Adult B, the views of his ex-wife and his daughter were gathered through face-to-face meeting with the co-chairs and they have been kept informed of progress with the DHR.

In relation to SH, the views of her two sisters were gathered through a face-to-face meeting with the co-chairs and they have been kept informed of progress with the DHR.

SH's eldest son, SW has met face-to-face with the co-chairs and the panel co-ordinator once and with one of the co-chairs and the panel co-ordinator once. There were some delays in enabling these meetings to take place, as outlined in Section 1.3. Extensive email exchange took place between the Community Safety Partnership Chairman and SW, as well as with his advocate from Advocacy After Fatal Domestic Abuse (AAFDA) in relation to concerns the SW had about the chairing arrangements for this DHR. Following the appointment of the co-chair and further exchanges, SW was willing to meet with the co-chairs and his advocate.

[2] Gender Equality Duty 2007. www.equalityhumanrights.com/.../1_overview_of_the_gender_duty

1.12 Involvement with the perpetrator

The co-chairs wrote to Adult B to inform him about this DHR and to seek his views about engaging with the DHR process. Adult B was willing to be interviewed as part of the process and the co-chairs met with him in prison in May 2015. Adult B has been kept informed of the progress of the review.

In addition to meeting with Adult B the co-chairs also met with his former employer, specifically, his line manager from the Environment Agency and a representative of the Human Resources Department.

1.13 Disability and domestic abuse

In England approximately one in five of the population are disabled.[3] It is now recognised that disabled people experience disproportionately higher rates of domestic abuse, often for longer periods than those people who are non-disabled. It is also known that the domestic abuse directed towards people with a disability can often be more severe in its manifestation and be more frequent.[4] 50% of disabled women have experienced domestic abuse compared with 25% of non - disabled women.[5]

Studies have identified that there are a number disability specific types of physical, sexual, emotional and financial abuse that are not experienced by non-disabled women.[6] Disabled people also encounter differing dynamics of domestic abuse, which may include more severe coercion, control or abuse from carers.[7] Examples given include, but are not limited to, 'the misuse of medication, isolating individuals from family and friends, removing the battery from the woman's power wheelchair'.[8]

Reliance on care is known to increase situational vulnerability to other people's controlling behaviour and can exacerbate difficulties in leaving an abusive situation.[9]

Disabled women are significantly more likely to experience domestic abuse than disabled men and experience more frequent and more severe domestic abuse than disabled men.[10]

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[3] Family Resources Survey: United Kingdom 2009-2010 Department for Work and Pensions, 2011
[4] Disability & domestic abuse Public Health England November 2015
[5] http://www.domesticviolencelondon.nhs.uk/1-what-is-domestic-violence-/21-domestic-abuse-perpetrated-against-people-with-disabilities.html
[6] Vulnerabilities for abuse among women with disabilities' Nosek, MA, C. Clubb Foley, R.B Hughes and C A Howland 2001 in Sexuality and Disability September 2001, Volume 19, Issue 3, pp 177-189
[7] Disability & domestic abuse Public Health England November 2015
[8] CF Shah et al, op cit
[9] Disability & domestic abuse Public Health England November 2015
[10] Adding insult to injury: intimate partner violence among women and men reporting activity limitations. Cohen, M. et al. 2006, Annals of Epidemiology, Vol. 16, pp. 644-651

There is some limited international evidence to indicate that women with a disability could be up to 40% more likely to be victims of domestic violence than women without disability.[11]

In its work the DHR panel has been mindful of the impact of SH's physical disability and the reliance that was placed on Adult B as a carer. In considering the factors that contributed to the incident, the panel is clear that SH's physical disability should be considered as one that increased her vulnerability to and risk of domestic abuse.

[11] Preventing violence against women and girls with disabilities Frohmader, C et al University of New South Wales January 2015

Section Two

Domestic Homicide Review Panel Report

2.1 Summary facts of the case

This overview report is an anthology of information and facts from agencies that had contact with, had provided or were providing support for SH and Adult B. The report examines agency responses to and support given to SH and Adult B prior to the incident on 17th August 2014. The report necessarily provides particular focus on the facts relating to the interactions and interventions of services with Adult B. This should be viewed in any way as a diminution of the victim, SH, who the report has striven to represent appropriately and clearly throughout.

SH was a 62 year old woman who lived with a number of long term physical health conditions. She and her husband had been together for over 20 years and married some ten years after they began their relationship.

SH and Adult B lived in Newbury in a one bedroom flat rented from Sovereign Housing Association. SH has three adult children from a previous marriage and Adult B has an adult child from his previous marriage.

Adult B had recently taken part retirement from his job at the Environment Agency where he had worked for 34 years.

In the months leading up to the incident, SH and Adult B had been on a family holiday to Florida with one of SH's sisters, her brother in law and a number of other family members. Whilst away in the USA, Adult B had experienced difficulty sleeping and was reportedly very anxious. He returned home early leaving SH with her relatives in Florida.

On SH's return from the USA, Adult B continued to experience anxiety and his behavior was a cause of concern to SH. She spoke to her sisters about this and as is detailed later in this report, spoke with professionals who were in contact with Adult B about her concerns about him and about her situation.

Adult B had been in regular contact with NHS services, through his GP and through Berkshire Healthcare NHS Foundation Trust. He was complaining of lack of sleep, anxiety, depression and had expressed some suicidal ideation. He was especially anxious about money, or the perceived lack of it, and had begun withholding food and money from SH.

On 15th August 2015, Adult B presented himself at Newbury Police Station and told officers there that he believed he had defrauded his elderly mother of several thousand pounds over a prolonged period of time. (This was later found to be a false claim).

During the 16th August 2014 there were contacts between SH and Adult B with South Central Ambulance Service (SCAS). The first was a call from Adult B where he related his concern that SH was having a diabetic hypo. The call handler asks if SH had been aggressive or violent and Adult B states she had not. When asked if he can assess SH's temperature by touching her skin but he tells them that SH is concerned that he will be violent towards her. SH can be heard faintly in the background saying "*that's because you are*." `An ambulance crew attended and found that SH was not having a hypo. They did however have some concerns about Adult B's mental state and identified safeguarding concerns for SH.

The ambulance crew decided that specialist input might be needed and with this in mind contacted the mental health Crisis Team. They also sent information about their safeguarding concerns for SH to West Berkshire Council, but this information was not passed to the Crisis Team.

SH contacted the mental health Crisis Team after the ambulance crew left to enquire about when a home visit might take place, though no time was given to her.

Later on 16th August 2014, Adult B contacted SCAS, on this occasion he was complaining of rectal pain. He was advised to seek advice from primary care services, but in fact following a further call with the out of hours GP service, he attended West Berkshire Community Hospital later that day.

The Crisis Team attended in the early afternoon. During this visit SH expressed her concerns about Adult B's mental health and that sometimes she felt that he was going to hit her. Following the visit the Crisis Team made arrangements (following a call with the out of hours GP service) to collect medication for Adult B from the pharmacy and to deliver it to him later that evening.

On 16th August 2014, SH went out for a meal with her sister. Throughout the evening she spoke with professionals from the mental health Crisis Team on the telephone as she was concerned that Adult B's mental health was deteriorating. She also expressed concern for her own welfare and safety.

After the meal, SH returned to her home. On the morning of 17th August 2014, at 07.28 Adult B phoned Thames Valley Police, using the 999 number and told them he had killed SH by means of strangulation. This prompted an 'immediate response'[12]

[12] Immediate response is a response type used for an emergency which requires immediate officer intervention. The response time should be 15 minutes from incident create to resource on scene. (TVP IMR)

An ambulance was also called and the police attended the address at 07.36. Adult B was arrested at the scene at 07.38. Paramedics then entered the address and confirmed that SH was deceased at 07.40

On 20th February 2015 at Reading Crown Court, Adult B was found guilty of manslaughter on the grounds of diminished responsibility and sentenced to six years in prison.

Domestic Abuse Contact

There was no contact with the Domestic Abuse Service delivered by A2Dominion under contract to West Berkshire District Council.

2.2 Analysis of individual management reviews

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

In doing so the panel have been mindful of the guidance relating to the application of hindsight in DHRs and have attempted to reduce it where possible. This is in accordance with the Pemberton Homicide Review conducted in 2008: "*We have attempted to view the case and its circumstances as it would have been seen by the individuals at the time. It would be foolhardy not to recognise that a review of this type will undoubtedly lend itself to the application of hindsight and also that looking back to learn lessons often benefits from that very practice*."[13]

The panel has also borne in mind the helpful statements contained in the Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, led by Robert Francis QC:

"It is of course inappropriate to criticise individuals or organisations for failing to apply fully the lessons to be learned from the knowledge that is now available, and accepting in the light of that knowledge, not possessed at the relevant time, that more or earlier intervention should have occurred. It must be accepted that it is easier to recognise what should have been done at the time… There is, however, a difference between a judgment which is hindered by understandable ignorance of particular information and a judgment clouded or hindered by a failure to accord an appropriate weight to facts which were known."[14]

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

[13] A domestic homicide review into the deaths of Julia and William Pemberton. Walker,M. McGlade, M Gamble, J. November 2008

[14] Report of the Mid-Staffordshire NHS Foundation Trust Public Inquiry Executive Summary pp23 Francis QC, Robert February 2013.

2.2.1 Thames Valley Police

Thames Valley Police (TVP) is the police service covering Buckinghamshire, Berkshire, Oxfordshire and Milton Keynes. It is the largest non-metropolitan force in England.

The Thames Valley Police Investigation Review Team was set up in April 2010 to deal with all IMR requests relating to vulnerable people. The selected team of officers are all accredited detectives with a background or knowledge in at least one strand of the Protecting Vulnerable People disciplines of Child Abuse, Domestic Abuse, Serious Sexual Assault and Vulnerable Adult investigations. The team is dedicated to IMR investigations. The team is entirely independent of any investigation or Police action for which IMRs are requested.

TVP's first contact with Adult B within the scope of this DHR was on 15th August 2014 when he presented himself at Newbury Police Station and told an officer that he thought he had defrauded his mother of several thousand pounds over a period of 20 years. He also told the officer that he was suffering from depression, but gave no impression that he was risk to himself or to others.

TVP's second contact with Adult B was on 17th August 2014 when he telephoned 999 and reported that he had killed SH. The focus of the TVP IMR is on the second incident.

TVP had had limited previous contact with Adult B and SH. The first of these was on 14th September 2009 when SH reported having her kitchen window damaged by what she thought was a pellet from an air gun. There were no witnesses to this incident and the person responsible was not identified. The incident was appropriately recorded on CEDAR.[15]

On 8th August 2005 SH reported a robbery one of her sons who had his mobile phone, credit cards, cash and keys stolen from him. SH was the reporter of the incident and the IMR shows there was no further involvement from her.

On 15th September 2006 SH was recorded as 'Other' on a CEDAR record. In this incident the aggrieved had an argument with a work colleague and the father of the work colleague was seen in a car park next to the victims car. The father was seen driving away and after this damage was seen on the aggrieved persons car. It was later established that the father was not implicated in the damage to the vehicle and that SH had not in fact witnessed the actual incident.

[15] CEDAR is the Crime Evaluation Data Analysis & Recording Database that records all crimes or cime related incidents

On 15th August 2014 Adult B presented himself at Newbury Police Station. He told an officer that he believed he had committed a fraud against his mother, specifically defrauding her of £X over a period of 20 years. He explained that he was suffering from depression. Adult B stated that he had collected cheques from his mother at her home address which she thought were being deposited into a savings account but Adult B believed he had spent this money himself. He believed this had all happened in West Sussex where his mother lived.

The IMR states that the officer who spoke with Adult B recalled that the only reference that Adult B made to SH during their conversation was that she was upset with him as he had told her about what he believed he had done before he visited the police station. Adult B told the officer that his depression had been worsening and the officer advised him to visit his GP practice. The officer also asked Adult B if he had talked to his GP about the reasons for his depression and asked if he was receiving any counseling. Adult B told the officer that he was expecting his first counseling session the following week (18th August 2014) and that he had not told his GP about the reasons for his depression. The officer again reinforced the importance of Adult B seeing his GP.

The IMR states that the officer involved said that Adult B was visibly upset but that this appeared to be in the context of the offence he believed he had committed. Adult B said that he had as much money in savings as he thought he had taken from his mother and the officer advised him not to spend this money. He also stated that it was important to conduct a check on Adult B's mother. It was recorded that this check did not take place immediately but in fact took place after SH's death as part of the investigation into that offence.

The officer told Adult B that the details of their conversation would be passed onto Sussex Police and if it found an offence had been committed then he would be contacted and the offence would be investigated. Adult B asked the officer about the possible outcomes and he was told that this could not be predicted but there were a number of outcomes, including no further action, a caution or court proceedings. Adult B also told the officer that he thought he may be defrauding his employer by being off work sick. The officer thought that Adult B might not be looking after himself but did not believe there was any immediate cause for concern. The officer stated that when Adult B left the police station he appeared more relaxed. Adult B told the officer he was planning to get some food and then arrange to see his GP. The officer did not believe there was anything to indicate that Adult B was likely to commit any criminal offences.

TVP recorded this event on Niche[16] as an Adult Protection matter following consultation between the officer and a Sergeant. This was to be forwarded to Sussex Police via the PVP Referral Centre. The referral classified Adult B's mother as being at risk given her status as an older person and the alleged domestic fraud. The officers took the decision to take this route rather than a fraud crime report because the officer was not certain that an offence had been committed and felt it would be best dealt with through an approach by Sussex Police via a welfare check. The officer did not make any referral directly to Sussex Police or to any Safeguarding Agencies.

The IMR finds that it would not have been reasonable for the officer concerned to arrest Adult B based on the limited information that he had. The incident was flagged with the Protecting Vulnerable People (PVP) Referral Centre and that as this was believed to be a domestic incident between Adult B and his mother, a domestic abuse risk assessment was conducted on 18th August 2014 and Adult B's mother was assessed as standard risk, in part because she was in another county and that at the time of the assessment Adult B was in custody following SH's death. This was an interim risk assessment completed by a risk assessor in the PVP Referral Centre and was completed a day after SH had been killed by Adult B.

The IMR states that if SH had not been killed and Adult B held in custody, then consideration would have been given as to whether Adult B would have been likely to visit his mother and if so, what risk factors, if any would have existed. This may have resulted in referrals to other agencies. The IMR finds that such action would have impacted on the information passed to Sussex Police.

On 19th August 2014 a sergeant's review asked that the officer in the case check to see if Sussex Police had been made aware and to check on the existence of Adult B's mother, given Adult B's mental health issues.

On 19th August 2014 there was an Adult Protection Review which stated that Major Crime Unit detectives would be visiting Adult B's mother at home and would update the PVP Referral Centre to any referrals being made to any other agencies. On the same day there was an update from the Major Crime Detective Inspector to say that Adult B's mother had been visited by detectives. She had told them that she had given money to Adult B but did not expect it back so no fraud had been committed.

[16] Niche is a system that can hold information about people, places and crimes and since 2012 has been used as a record of a person's time in police custody. Niche is now taking over as the main system for TVP and existing databases such as CEDAR are being combined and will be accessed via Niche.

It was determined that there was no requirement to share information with any other agencies as there was no significant risk to Adult B's mother. The Niche record was closed on 27th August 2014 and there was no further action in relation to the matter of perceived fraud.

At 07.28 on 17th August 2014 Adult B telephoned TVP via the 999 service and told the call handler that he had murdered SH by strangling her. He informed the call handler that he had been on medication for depression and that he did not have any weapons in his possession and that SH had stopped breathing in the previous 30 minutes. Adult B told the call handler that his GP had become worried about him self-harming. At 07.29 an ambulance was called but was instructed to 'hold off' until the police arrived. Adult B had told the call handler that the back door to his flat was unlocked. Adult B was noted to be "obviously distressed but calm on the phone". Officers arrived at the scene at 07.36 and paramedics were with SH at 07.37.

Adult B was arrested at the scene and escorted away.

Analysis of involvement and lessons learned

TVP had minimal involvement prior to the incident. The main contact was on 15th August 2014 when Adult B presented to Newbury Police Station. During this contact the appropriate processes and procedures were followed.

There was nothing in Adult B's presentation to the officer on that day that indicated any risk of violence towards SH, or to Adult B's mother. Equally there was no indication that Adult B was presenting any risk to himself. The raising of the Adult Protection report appropriately referenced the mental health problems that Adult B had described to the officer and the PVP referral was, as the IMR states, a proportionate response.

Adult B was given appropriate advice by the officer concerned on 15th August 2014.

On the day of SH's death, the police responded swiftly to the 999 call made by Adult B. The times of response fell well within those expected by TVP. The IMR indicates that SH was deceased before officers and the paramedics arrived at the scene.

Given the nature and degree of contact between SH, Adult B and TVP, there are no lessons to be learned from the IMR and no recommendations for action have been made.

2.2.2 West Berkshire District Council – Adult Social Care

West Berkshire District Council is the local authority of West Berkshire in Berkshire, England. It is a unitary authority, having the powers of a non-metropolitan county and district council combined. Adult Social Care (ASC) is part of West Berkshire Council. It offers services for adults (aged 18 or over) who need support in their daily lives to help them to live independently. They also provide a range of information, help and advice including signposting to other local organisations.

SH had been known to ASC since June 2003. She had been provided with a range of aids for daily living (ADL) to meet her mobility and personal care needs due to spinal stenosis.[17]

Occupational Therapists (OT) had been involved in her care periodically, to offer assessments and ADL. Her last contact was with the Access for All (AFA) team in April 2014 to request a bathing assessment. In August 2014, at the time of her death, the bathing assessment had not taken place and she was on the Physical Disability OT waiting list for assessment. During ASC involvement with SH, OT assessment timeframes varied between one week and 13 months.

The primary reason for SH's contact with ASC was to provide her with practical ways to improve the quality of her life. The IMR states that case notes indicate that, in the main, these supports were provided, although the time frame from assessment request to actual provision was lengthy. As part of the assessment, the needs of her primary carer (Adult B) were mentioned, but the response from SH was that as a couple they were fine. This was repeated in numerous assessments and case notes.

The IMR states that there was no evidence of a carers assessment or a comment attributed to Adult B about his caring role. There is reference in 2011 to a carers self-assessment being completed, but lost in transit. This was not pursued directly with Adult B. Subsequent contacts in 2011 and 2012 with SH noted that she said the couple were fine. The IMR states that it is not clear from the case file whether this was the view of both SH and Adult B.

The last contact was an Information and Advice Specialist (IASS), HK in the AFA in April 2014, following SH's internet enquiry regarding a bathing assessment. HK said that she checked to see if the case was open on RAISE, the electronic recording system used by the council. It was closed. The IMR states that HK

[17] Spinal stenosis is a condition where the space around the spinal cord (the spinal column) narrows, compressing a section of nerve tissue. The main symptoms of spinal stenosis include pain, numbness, weakness and a tingling sensation in one or both legs. This can make walking difficult and painful, although sitting down or leaning forward can offer relief in some cases. (NHS Choices website)

cannot recollect whether she had read RAISE notes prior to calling SH, but thinks it unlikely.

Case notes are usually read in situations where, for example, the caller is following up a previous referral, there is an associated safeguarding matter, or the caller is asking about an existing service.

HK remembered that the presenting problem concerned SH's mobility and sensory difficulties. SH had said that Adult B helped with the cooking and the couple had cleaners to assist with the housework.

HK did not pursue Adult B's caring role further, as SH gave no prompt that there were any other issues. The IMR states that HK would not have been aware that a carers assessment had been lost previously, or that SH had always responded that the couple were fine, which they may have been at the time of assessment.

The Information Gathering Document was completed and passed to the Senior Social Worker (KW) for decision. SH was placed on the waiting list to see a Surgery Link Worker (SLW) who could advise on bathing aids. This was viewed as a short-term measure pending a possible recommendation by an OT for a major adaptation, which can take up to a year to progress.

After three months on the SLW waiting list, SH was transferred to the Physical Disability Team, where after screening she was placed as a priority four for OT assessment. This is a low priority status, and would normally mean that the assessment would be completed within six months.

The IMR finds that transfer out of AFA if an assessment or service cannot be provided within three months appears to be normal practice. AFA would have been aware that SH's assessment would likely have been accorded low priority, but nonetheless, transferred the case. The IMR finds that the practice of transferring a client to another waiting list should the case not be allocated for assessment in AFA is purely an administrative issue and is not effective practice that is in the interests of the client.

The IMR states that the AFA Team Manager (MA) advised that IASS staff should gather appropriate and proportionate information, and this may or may not include detailed information on a carer depending on the nature of the referral, and what the referrer says. The IMR states that IASS staff will not always look back at information available from previous contacts, as the volume of work is high. However, staff, such as SLWs who go out to assess, would familiarise themselves with the case. The request in this case was relatively simple. The SLW would assess to see if there is easily accessible equipment to provide a temporary or longer-term solution, preventing the need for a major adaptation.

Analysis of involvement and lessons learned

The WBC ASC IMR shows that the contact between the service and SH was primarily focused on the impact of her physical health, and the resulting lack of mobility that she experienced, alongside the consequent challenges she faced in conducting every day tasks. This focused on the practical rather than emotional or relational matters facing SH.

The IMR reveals that ASC had lengthy, if at times, sporadic contact with SH. There is no indication from the IMR that the professional conduct or interaction with SH was anything other that what would normally be expected. It does suggest that ASC experienced challenges in responding to particular identified needs and that waits for services such as adaptation were lengthy. This is not unique within local authorities by any means, and the times described are reflective of other areas in England.

Information about SH was not routinely reviewed to inform workers who were new to her circumstances. Had this been the case, those workers or teams who were engaging in new contact would have had a more detailed view of her circumstances and tailored their input and responses more effectively. Despite this, there is no evidence from the IMR that this omission had any deleterious impact on the interaction between ASC and SH.

The IMR also highlights the need to ensure that the prompts for other teams, specifically in this case for IASS, to gather information about the needs of carers and that professionals should proactively seek to identify and respond to the needs of cares.

The IMR details the issue of the ‘lost’ carers assessment from 2011. It is not clear exactly how this was mislaid but it appears to have been a self-assessment that Adult B reported to have hand delivered to an office of WBC. It appears that the form did not reach ASC and may have been taken to the wrong office. This highlights the need for accurate information to be provided to individuals about where forms should be sent.

The lack of an up to date carers assessment for Adult B appears to represent a missed opportunity to provide him with the means to express confidentially any concerns he had about his caring role or to have his needs as a carer formally identified and responded to by ASC, particularly in a period when his mental health was deteriorating

The IMR highlights need for swift handling of requests and the need to more proactively update referrers with the status and progress of the referral and any subsequent action. Although this does not appear to have happened in this case it is not believed that this had any negative impact and did not have any direct link to the eventual incident. It is however a point of learning for ASC to which they are responding.

2.2.3 Newbury & District Clinical Commissioning Group (NDCCG)

The NDCCG is a clinically-led membership organisation and a fully authorised statutory public body which has a constitution and is run by a governing body. CCGs are overseen by NHS England (including Regional Offices and Local Area Teams) who manage primary care commissioning, including holding the NHS Contracts for GP practices. CCGs are responsible for commissioning the vast majority of NHS services within the areas they serve and every GP practice within the United Kingdom is required to be a member of a CCG.

It is important to remember that GPs are not directly employed by the NHS. Rather, they are independent contractors commissioned by the Local Area Team of NHS England.

The General Practitioner (GP) service is a universal service that provides primary medical care to families 24 hours a day both at the local practice where a family is registered and through the Out of Hours service. It provides holistic medical care (to include physical and psychological health care) for families from birth to death.[18]

The IMR provided by the CCG relates to contacts between SH and Adult B via their registered practice, Falkland Surgery, which is a member practice of NDCCG. It provides primary care services to a population of approximately 14,300 people in the Newbury area.

In respect to SH the IMR finds that the contact between her and the surgery was routine. They provided care and treatment in respect of SH's long-term conditions, including her diabetes for many years. The IMR finds that there were no clinical contacts with SH which indicated any form of domestic abuse, physical or otherwise.

In relation to Adult B, the IMR states that he accessed primary care services both through the surgery and via the out of hours service (Westcall). In the period covered by the IMR these contacts were principally related to insomnia and anxiety. The first of these was on 14th June 2014. The IMR states that Adult B had been in frequent contact with the surgery over the following two months, both by telephone and face-to-face. He had 16 consultations between 14th June 2014 and the time of his arrest. Five of these were telephone consultations, 11 were face-to-face.

[18] Sheffield DHR Overview Report, Cantrill, Prof. Pat December 2011

The IMR states that Adult B's anxiety initially centred on concern for his wife because she had remained in Florida, where they had gone on holiday, while his mother had become ill, requiring his urgent return home. (This illness is now known to have been a fabrication).

It appeared to GP1 that the problem was insomnia that reportedly started while Adult B was in Florida, but which was then compounding significant anxiety, and as a result anti-anxiety medication was initiated. Amitriptyline[19] 10-30mg at night was commenced on 16th June 2014 to help with both sleep and anxiety.

On the 18th June 2014 Adult B was referred to Talking Therapies by GP1. It was on this day that Adult B contacted the NHS 111 services and stated he had suicidal ideation. Following ambulance attendance Adult B was taken to Accident & Emergency (A&E) at Basingstoke Hospital. The IMR states that Adult B was assessed by an A&E doctor and the Mental Health Team attached to the A&E department. Records received from Basingstoke by the GP surgery on the 23rd July 2014confirm that a full mental health assessment was made on the 19th June 2014 after this presentation, with a diagnosis of anxiety/depression and low risk of suicide.

Although this represented a delay in receipt of this information, the action plan agreed was in line with the plan already underway at the time, with no new actions required. Part of the assessment included direct questioning about any forensic history, which was answered in the negative.

When the Amytripyline was not effective, Lorazepam[20] 1mg (standard dose) together with Zopiclone[21] 7.5mg (standard dose) were started on the 20th June 2014. On 23rd June 2014, because of inadequate symptom control of Adult B's anxiety symptoms, GP2 prescribed Propranolol[22] 40mg three times a day.

[19] Amitriptyline hydrochloride is used to treat depression. It is thought that Amitriptyline hydrochloride increases the activity and levels of certain chemicals in the brain. This can improve symptoms of depression. Source: NHS Choices

[20] Lorazepam belongs to a class of medicines called benzodiazepines. It is a medicine which is used to treat anxiety or anxiety due to sleeping problems or other psychiatric problems. Source: NHS Choices

[21] Zopiclone is a medicine which is used to treat sleeping problems. Zopiclone should only be used at the lowest possible dose and for a maximum of up to four weeks. Source: NHS Choices

[22] Propranolol hydrochloride blocks the effects of certain chemicals in the body. It can be used to reduce heart rate, to help the heart beat more regularly, to reduce the heart's work and to lower blood pressure. It can also reduce the frequency and severity of angina attacks. Propranolol hydrochloride can also help to reduce some of the symptoms of anxiety and stress such as a rapid heart rate or sweating. Source: NHS Choices

On 27th June 2014, when this latest medication failed to control Adult B's anxiety symptoms, another medication was initiated. Mirtazapine[23] 15mg (an anti-anxiety medication commonly used because of a helpful drowsiness side effect to assist sleep when taken at nighttime, but also with longer acting anti-anxiety properties.) This was instead of Amitriptyline, Zopiclone or Lorazepam but together with Propranolol, which can be taken alongside.

The IMR finds that at no time during any of the GP assessments were any psychotic thoughts or evidence of psychotic behaviour identified.

Because of the failure of the anxiety symptoms to resolve despite usual intervention both pharmaceutical and psychological, GP2 referred Adult B for blood and urine tests to investigate for physical causes of anxiety. Though rare GP2 felt it must be considered in the context of Adult B's failure to respond to the usual treatment. The results of these tests were all normal in June 2014.

Given that his anxiety symptoms persisted, in early July 2014 Adult B was referred to Berkshire Healthcare NHS Foundation Trust (BHT) mental health services via the Common Point of Entry (who assess all mental health referrals first to decide on subsequent action required) for assessment and assistance. Adult B was already known to the Common Point of Entry team following a self referral via the emergency mental health contact number which had been provided by GP1.

The referral resulted in an assessment on 7th July 2014, as per documentation received on the 10th July. This assessment was repeated on the 8th July 2014 when Adult B contacted the mental health Crisis Team because of distressing symptoms. From documentation received by the GP surgery on the 14th July 2014 the conclusion was that Adult B had responded well to brief input from the Crisis Team and that he should wait for further intervention from the Talking Therapies service, while also continuing with the medication regime already in place.

Both these assessments concluded that the principal problem for Adult B was anxiety with some suicidal thoughts from which he was protected from acting on because of factors such as his wife and family. The Common Point of Entry and the Crisis Teams both recommended Talking Therapies for psychological support to manage his anxiety and insomnia symptoms, to which Adult B had already been referred and was awaiting assessment and treatment.

[23] Mirtazapine is used to treat depression. It is thought that Mirtazapine increases the activity and levels of certain chemicals in the brain. This can improve symptoms of depression. Some people who take Mirtazapine may find that it intensifies depression and suicidal feelings in the early stages of treatment. These people have an increased risk of self-harm or suicide in the early stages of taking Mirtazapine. As Mirtazapine starts to work these risks decrease. Source: NHS Choices

The IMR draws upon the chronology of presentations to primary care services and A&E, including secondary care mental health services in both Hampshire and Berkshire, as well as the assessments recorded in Adult B's clinical notes.

The IMR finds no gaps in the service provision or the communication between services which would account for any possible prevention of the incident. It concludes that there was no indication during any of the multiple assessments of any anger, impulsivity, or thoughts or actions relating to violence towards SH, Adult B himself, or others. The IMR concludes that the GP surgery responded in a timely and appropriate way. It also states Adult B's symptoms were difficult to control, but that over the course of the two and a half months, there was no indication that his presentation was changing from the original diagnosis of severe anxiety.

Analysis of involvement and lessons learned

Both GP1 and GP2 acknowledge that Adult B's symptoms were hard to control, but that there was little change in his overall presentation. Both of them conducted assessments with Adult B during their consultations with him and neither identified any psychotic thinking.

The experience of the GP's in being able to access advice from secondary care mental health services via BHT was positive and timley.

Neither GP1 nor GP2 found any evidence in their consultations with Adult B that would have indicated a propensity for violence, nor of any form of domestic abuse or violence. However, it is not clear to what degree they questioned Adult B about his relationship with SH either in her absence or when she was attending the consultations with him, which she did on three occasions.

There were numerous changes in Adult B's medication over period between June and August 2014. This was not usual practice but both GP1 and GP2 have stated that Adult B's symptoms were not controlled. This is evidenced in his continuing anxiety during this period. This lack of symptom control was a key factor in the addition of other medications. The IMR rightly states that is not uncommon for people not to respond to certain medications and that some of this lack of response can be due to the period of time it takes for medications to begin acting, in some cases between 4-6 weeks. The guidance issued by the National Institute for Health and Care Excellence (NICE) in relation to treatment for anxiety suggests the use of medication only where necessary and to avoid benzodiazepines such as Lorazepam or anti-psychotics. Given his resistant symptoms the GP approach was to try medications, with appropriate caution, with Adult B. He was never prescribed anti-psychotics.

The IMR makes the point that the current NICE guidance does not provide more detailed assistance for practitioners about treatment resistant cases or a scale of treatment escalation.

Adult B was appropriately referred for Talking Therapies by the GP. He was also advised to make contact with the service himself which would enable an assessment within 10 days of the self-referral. Talking Therapies are usually able to see patients within four weeks of referral and sooner in an urgent case. Adult B was also referred to the service by the Mental Health Crisis Team.

A number of GP's had contact with Adult B, this was in part due to his use of the out of hours service (Westcall) or as a result of his requesting urgent, same day appointments with the duty GP. All GP's who had contact with Adult B were able to access his notes using the electronic record system, which had details of his symptoms, treatment plan, the frequency of appointments and other referrals made. This approach is routinely in place.

Although SH attended three of Adult B's face-to-face GP consultations, it is not clear from the IMR what opportunities she was given to discuss her concerns about Adult B's health, or her own circumstances. It does not appear that SH was given the chance to discuss these matters confidentially, without Adult B being present. This represents a missed opportunity to have gathered SH's views about her home situation and relationship in the context of Adult B's anxiety and changing behaviour.

There is a re-emphasising of the need for GP's and other professionals to ensure detailed assessments of individuals and that factors such as social circumstances, family relationships and their impact of symptomatology should routinely be explored. Providing health and social care professionals with the skills to ask questions about domestic abuse and about violence is a key learning point. The need to be professionally curious, to probe and be able to ask difficult questions are key skills that can and should be developed and encouraged. This would assist in equipping professionals with the skills to make appropriate enquiries of individuals, particularly in relation to domestic abuse, violence and social circumstances so that risks can be identified and appropriate action/treatment plans put in place.

The NDCCG IMR makes three recommendations which are set out in Section Four.

2.2.4 Berkshire Healthcare NHS Foundation Trust

Berkshire Healthcare NHS Foundation Trust (BHT) is a secondary care provider organisation that delivers specialist mental health and community health services across Berkshire to a population of approximately 900,000 people. It has 171 mental health inpatient beds but provides of range of community based mental health services. Services are organised through six localities that align with local authority boundaries.

The IMR provided by BHT also served as the Trust's internal incident review report. This work was commissioned by BHT and was led by an independent external investigator. The investigator had access to all relevant BHT records, records of contact with Westcall (the GP out of hours service) and voice recordings of telephone calls involving the mental health crisis team and Westcall. He also conducted interviews with all BHT staff involved in Adult B's care. The BHT review was commissioned on 20th August 2014 and provided to BHT on 2nd October 2014. The DHR panel reviewed the report and following receipt of queries from the DHR panel on 3rd March 2014, the independent investigator revised the report and provided clarifications on issues raised.

The DHR panel has also had access to voice recordings of SH's contact with the mental health crisis team in the period immediately prior to her death, during the afternoon and evening of 16th August 2014.

BHT contact

The BHT IMR sets out the contact between Adult B and its services along with those of the GP and the Westcall service. This summary commences at the point of Adult B's early return from Florida on 12th June 2014. On 15th June 2014 Adult B phoned the NHS 111 service and was called back by a Westcall doctor. He said he had returned home early from holiday because of an emergency relating to his mother, and had not slept for three nights. He was advised to attend Newbury Community Hospital (NCH) where he was seen and diagnosed with insomnia. He was prescribed Zopiclone 7.5mg. The following day Adult B visited his GP at Falkland Surgery and was presecribed Amytripline (upto 30mg). This was followed by a further GP visit on 18th June 2014 when he was prescribed Lorazepam.

On 18th June 2014 Adult B made contact with BHT through the Common Point of Entry (CPE) about his feelings of stress and anxiety as well as his lack of sleep. He was given contact numbers and advice about managing anxiety and advised to take his medication and was encouraged to have a physical health check with his GP.

Later that same day Adult B and his ex-wife contacted the South Central Ambulance NHS Foundation Trust and he was taken to Basingstoke Hospital. He was assessed by the mental health liaison service who concluded that there was no indication of the need for referral to secondary care mental health services and Adult B was referred back to his GP. BHT were not made aware of this contact.

SH returned from Florida on 22nd June 2014. Following a call to NHS 111, a Westcall doctor phoned SH who relayed her concern that Adult B had become stressed, couldn't sleep and was having panic attacks. The doctor spoke with Adult B who said medication had so far not helped him and he denied any psychosocial stressors. Although the doctor did offer to see Adult B at Newbury Community Hospital, it was left that Adult B would see his GP the following morning for blood tests. Adult B saw his GP on 23rd June 2014 for this purpose and then again on 27th June 2014 when he was prescribed Mirtazapine.

On 29th June 2014 Adult B telephoned the mental health Crisis Team and spoke to a nurse identified in the IMR as W7. He was said to be quite distressed which seemed to stem from financial decisions he had made. He referred to early retirement as '*a big mistake'*. He described poor sleep and appetite, lack of energy and motivation, irritability and agitation. Distraction techniques were suggested but he said he had tried this and it had not helped. He was given advice about medication. '*Currently he has no suicidal thoughts and intent or thoughts to harm others*. *Plan: offer support when rings; referral to CPE for full assessment and OPA with a psychiatrist*.'

On 6th July 2014 Adult B telephoned the Crisis Team about continuing difficulties sleeping despite medication. He was given advice which he indicated was 'good'. An agreed plan was recorded for him to contact the Talking Therapies service on Monday 7th July 2014, and to contact the Crisis Team again if needed.

On 7th July 2014 Adult B telephoned the Crisis Team and reported panic attacks which he rated as 8-9/10. He reported thoughts of '*not wanting to be here which he attributes now to the increased frequency of his anxiety*. *He has no plans to end his life. CPE have been informed and will follow up with an assessment as he has no history of mental illness.*' The CPE worker, W1, conducted a telephone based assessment. Adult B related his sleep problems and anxiety and denied previous mental health issues. He referred to his recent part-retirement and financial concerns as well worries he had about his mother's health and a concern about constipation for which he had contacted his GP on 1st July 2014. Worker W1 recorded that Adult B presented no signs of thought disorder and that his risk to himself and others was "nil evident". The plan agreed was for him to be referred to Talking Therapies and he was advised to consult his GP for regular review of his medication and was also given the Crisis Team number for future contact if needed.

The referral to the Talking Therapies service was logged on 8th July 2014. On the same day SH contacted the Crisis Team. She spoke with Worker W8 and was noted to be tearful and "at the end of her tether". She was concerned about Adult B's behaviour and mood. W8 spoke to Adult B who was calmer during the conversation. Input from the Crisis Team was discussed but he preferred to wait for the Talking Therapies team. A plan was agreed that Adult B would contact his GP to discuss further options and W8 noted that there was no indication of high-level risk.

On 9th July 2014 Adult B saw his GP and the following day, 10th July 2014 the GP sent a faxed referral marked urgent to the CPE. The referral noted that medication was not helping and that Adult B was calling the surgery every day. The referral stated that the GP was unable to suggest any other intervention than Talking Therapies and asked if Adult B could "be seen in clinic". The CPE team leader, W9 contacted the Talking Therapies team and confirmed that Adult B had responded positively to an 'opt-in' invitation and was awaiting assessment. A letter was sent from CPE to the GP surgery to advise of the 7th July 2014 assessment and that Adult B was willing to wait for the Talking Therapies service assessment.

On 11th July 2014 Adult B saw his GP and was advised he could increase his medication. On 16th July 2014 Adult B was provided with telephone triage by the Talking Therapies service daily supervisor, W2. The outcome of this contact was that Adult B was deemed suitable to receive Cognitive Behavioural Therapy, which would include work on panic and sleep hygiene.[24]

Adult B had two further GP appointments on 24th and 25th July 2014.

Adult B had a face-to-face assessment with the Talking Therapies service on 4th August 2014. During this assessment Adult B denied any suicidal or self-harming thoughts or plans. He indicated he simply wanted the feelings of anxiety and lack of sleep to stop and identified SH and his daughter as 'protective factors" and denied any risk to others. In relation to neglect to others he indicated he had to continue to care for SH. He was reluctant to contact the Crisis Team and CPE as he had not found this to be helpful previously. The IMR records that Adult B specifically denied any domestic abuse. This is the first recording of a direct reference to domestic abuse. Adult B was also signposted to the Citizens Advice Bureau in relation to his concerns about finances and was given a leaflet on support for carers.

[24] Sleep Hygiene refers to a range of techniques that can be used to assist in gaining better sleep without recourse to medication. NHS Choices website

On 15th August 2014 the GP sent a referral to CPE seeking advice about Adult B's ongoing management given the severity of his symptoms.

On 15th August 2014 Adult B telephoned for an ambulance because he believed SH was having a diabetic hypo. This is described in more detail in Section 2.2.5.of this Overview Report. When the paramedics arrived they spoke with SH and concluded that in fact Adult B was of greater concern.

On 16th August 2014 at 07.17 paramedics telephoned the Crisis Team and requested an urgent assessment of Adult B who they believed to be depressed and to have stopped taking his medication. They understood that he had not slept for a few days, had not been eating, had low mood, appeared paranoid and was not wanting SH to go out. SH was concerned that Adult B was more unwell and said he had been researching suicide on the internet, though Adult B denied any suicidal thoughts. It was agreed that an assessment would be conducted. During the telephone conversation the paramedic did not communicate any information associated with the safeguarding concerns about SH that were subsequently reported to West Berkshire Council.

At 10.27 SH contacted the Crisis Team to enquire when a visit would take place. The IMR records that SH was told that a time could not be specified and that the team had other people to see. The IMR indicates that SH was content with the response given.

At 11.47 a Westcall doctor telephoned Adult B in response to an earlier call to NHS 111. This related to a concern he had about rectal pain and he was advised to attend Newbury Community Hospital (NCH). Adult B's sister-in-law took him to NCH. The IMR records that Adult B attended at 12.54 and that he presented with rectal pain with bleeding and discharge, and constipation. He made no mention of mental health difficulties or family issues. An examination established that he had a physical condition related to haemorrhoids. He was prescribed suppositories.

At approximately 14.00 on 16th August 2014 the Crisis Team attended Adult B's home address to conduct an assessment which was carried out by worker W4. Adult B was seen with SH also present. Adult B reported that his mood was variable and he denied any negative, suicidal or self-harming thoughts. He said he had not taken medication for two weeks because it made him feel sick in the mornings. SH told W4 that Adult B was *"behaving like Jekyll and Hyde because when professionals visit, he makes it seem as if all is OK, but once it's just the two of them left, he becomes a very agitated different person".* SH also related that Adult B had concerns about finances and needing to move out of their flat but that these concerns were baseless.

During the assessment SH expressed concern that she sometimes felt that Adult B was going to hit her, but that he had never done so. When asked about this, in the presence of SH, Adult B denied that he would ever hit her. W4 advised SH to contact the police if she felt unsafe and also undertook to discuss the issues about medication with a colleague. The assessment concluded between 14.45 and 15.00.

At approximately 15.15 W4 called a colleague, W5 for advice and it was agreed that W4 would discuss the case further with a Westcall doctor.

A telephone conversation took place between a Westcall doctor (W11) and W4 at 18.41 on 16th August 2014. The doctor considered that short-term diazepam should be prescribed to help Adult B to manage until he could be seen by a psychiatrist on the following Monday or Tuesday. W11 advised that all other medication should be removed. The assessor undertook that the Crisis Team would arrange to collect medication from the pharmacy and deliver it to Adult B. The telephone conversation was overheard by another Crisis Team practitioner for Newbury (W6) who offered to assist by collecting and delivering the medication to Adult B. This was recorded on the BHT electronic records system, RiO: '*Plan: To arrange for W6; CRHTT to collect medication … and drop it off tonight, and at the same time remove the other medication in [Adult B's] possession as requested by the Westcall GP. H/v on Sunday on 17.8.14 to monitor mental state and assess risk*.'

SH left a voice message for the Crisis team later on 16th August 2014. The time is not recorded. In the message SH stated that she was not at home but needed to speak to W4, who had conducted the assessment earlier in the day. She left her mobile phone number and stated that the Crisis Team not call her home number as she did not want Adult B to know she had phoned them. The IMR quotes SH as saying "It's very urgent. I'm threatened. I can't go home. That's why my sister's brought me here. I need help. I really need help. The Crisis Team duty worker (W5) recalled picking up this message between 19.00 and 19.30.

It is known that SH was taken to a restaurant for meal with her sister, P that evening.

At 20.36 the Crisis Team duty worker W5 and SH spoke on the telephone. SH said she wanted to talk to W4 before he visited again as she was concerned that Adult B had not presented the full picture during the assessment visit. She stated that she was concerned about what she described as Adult B's aggressive behaviour and for her own safety and that this was a reason why she was with her sister. SH was advised that W4 would call her the following day. The IMR states that SH agreed to this.

At 20.44 W5 phoned W6 who was due to deliver medication to Adult B to advise of the conversation with SH and asked W6 to call SH back as she wanted to explain more about Adult B's symptoms. W5 told W6 that SH was not at home and had gone to stay with her sister and had agreed to be contacted the following day. W6 was at the pharmacy during the call and indicated he was under some pressure of time and his plan was see SH and assess matters when he got there.

At 20.56 W6 visited Adult B. The IMR reports that W6 found Adult B to be co-operative and he explained that SH was out with her sister. He accepted the new medication and handed over the previous medication to W6. The IMR states that W6 saw no signs of psychosis or cognitive impairment and no other causes for concern. W6 did not discuss with Adult B the concerns that SH had expressed about her safety although W6 was aware of this disclosure.

W6 agreed with Adult B that a further visit would be made the following day and for a medical review to be arranged with a psychiatrist on the Monday or Tuesday (18/19th August 2014). W6 left a phone message for W4 to confirm that medication has been delivered.

On 17th August 2014, following Adult B's arrest, a request for an Appropriate Adult to attend the police station was made by the police. An Appropriate Adult from Newbury Community Mental Health Team attended at 12.00 that day. Adult B asked for his mother to be contacted as he said he was due to look after her. The CMHT contacted West Sussex Social Services who undertook to contact Adult B's mother.

A Mental Health Act Assessment was requested by the police and was conducted at 23.40 on 17th August 2014 by an Approved Mental Health Professional (AMHP) and two doctors approved under Section 12 of the Mental Health Act in accordance with the Code of Practice.

During the assessment Adult B said that he and SH had lived beyond their means and that he had mismanaged his life, been untruthful and lived like 'Walter Mitty'. He indicated there had been tensions in his relationship with SH and that his low mood had 'rubbed off' on SH. He described how he had not heard SH return home from being out with her sister. He said he had researched suicide on the internet but that he had not had previous thoughts about harming SH. He said he did not take his prescribed medication consistently and that his problems got worse when he didn't take it. Although he used the term paranoia during the assessment, the AMHP concluded that he was referring to his feelings arising from poor choices rather than a definable symptom.

The assessment concluded that Adult B had a three to four month history of depression and anxiety arising from "an ill considered financial decision which he now regrets". This can be presumed to be the offer of money to his daughter to purchase a house with her mother (Adult B's ex-wife). The assessment found he required treatment for his depressive episode but that hospital admission was not necessary and that he had capacity to answer police questions in a formal interview with a solicitor present.

Analysis and lessons learned

The IMR highlights the differing clinical views about Adult B's presentation and diagnosis. Although Adult B had been treated for anxiety, reactive anxiety/depression and anxiety and panic the clinical advisor to BHTs IMR suggests that Adult B may have been described as having generalised anxiety. The clinical advisor points to the fact that Adult B did not meet the ICD-10[25] diagnosis having not met the six month duration criteria.

The resultant assessment at Adult B's detention in police custody determined no evidence of mental disorder as outlined in the Mental Health Act and on that basis he was found to be fit to be interviewed and that while he may have continued to require treatment for his anxiety, he did not require either compulsory detention or informal admission to a psychiatric hospital.

Adult B certainly appears to have been living with symptoms of anxiety, low mood and possibly depression. These were at a level commensurate with the treatment he received from primary care and referral to Talking Therapies albeit that there is strong evidence that Adult B was not taking prescribed medication.

The IMR also draws attention to the medication prescribed to Adult B. Again the clinical advisor to the IMR suggests that the medication prescribed by primary care was not the recommended 'first line medication for anxiety'.

Although the NDCCG IMR points to a positive experience in relation to accessing expert guidance from BHT it is not clear from the IMR what the nature of this was other than the referrals and associated contact. It is not clear that BHT were asked or offered any advice regarding medication management for Adult B.

There are conflicting accounts of SH's return home on the 16th August 2014. The IMR states that SH's sister took her home at around 23.00hrs. SH's sister disputes this assertion and has stated both to BHT and to the DHR co-chairs that she took SH back to her home and that SH then travelled home alone. BHT have

[25] The International Classification of Diseases (ICD) is the standard diagnostic tool for epidemiology, health management and clinical purposes. The 10 refers to its 10th edition, in use since 1994.

responded to this and state that this conflicts with information given by the family at interview for the IMR.

There is no evidence that the initial plan agreed in June 2014 for a full assessment by CPE and an outpatient appointment with a psychiatrist was ever followed through.

The IMR highlights the lack of weight and attention paid to the impact of Adult B's mental health and resulting behaviour on SH. There was insufficient exploration and review of this impact and only limited opportunity for SH to express her concerns and fears, notably in the telephone calls with the Crisis Team and during one limited part of the assessment visit on 16th August 2014 when she had a short time alone with W4. When these concerns were related to professionals there was a lack of further exploration and enquiry which would have assisted in forming a clearer view about her vulnerability and the potential risks to which she may have been exposed.

The record of the assessment by W4 made no reference to SH's discussion with him about her concerns and the IMR conclusion, with which the DHR panel agrees, is that this was an omission that meant the potential risks to SH, as well as her concerns about Adult B more generally were not reflected in the records. This gap in risk information was exacerbated by the fact that the details of safeguarding concerns about SH were not passed to the Crisis Team by a paramedic, who did report the concerns in question to West Berkshire Council. This meant other professionals would not have been aware of them either if accessing the record.

Assumptions were made about SH's intentions on the night of the 16th August 2014. It was wrongly assumed that SH would not return home, simply because she had described herself as feeling threatened. There was not an adequate level of enquiry as to whether SH would return home and if she did, the potential risks she might encounter given her expressions of concern and feelings of being threatened by Adult B.

There were inadequacies in the recording of interactions and interventions including that of one of the telephone calls from SH to the Crisis Team on 16th August 2014. There were wider failings in the recording of information with the Talking Therapies service and the Crisis Team. In particular these centred on a failure to record interactions in a timely way, failing to enter the time events occurred when notes were not recorded contemporaneously and not recording details of potential risk.

The BHT Safeguarding Adults policy did not adequately inform practice and the IMR finds that there was a general lack of awareness amongst practitioners of the need to give particular attention to safeguarding.

In relation to domestic abuse, it appears that this was not an issue that was well understood and that knowledge of it was not wholly embedded in practitioners' thinking in a way that would guide daily practice.

The panel has had the opportunity to listen to the recordings of the telephone call between SH and the Crisis Team during the day and later in the evening of 16th August 2014.

In the later call which took place at approximately 20.36 SH relates the fact the Adult B had called an ambulance for her but that in fact there was nothing wrong with her. She advises that Adult B was aggressive and that he could just as quickly switch back to being OK. She describes how Adult B believes they will be evicted, she confirms that they are not and talks about his concerns about money, but she states they have £X.

SH tells the Crisis Team that Adult B was not telling the whole story and that Adult B has "really lost the plot". SH asks for W4 to call her on her mobile, not at home. She also tells the Crisis Team that her sister had taken her out "because it's not safe". She also says she told W4 that she wasn't safe during his visit earlier that day. The Crisis Team asks if it SH would like W4 to make contact the following day.

At no stage in that conversation does SH indicate whether she plans to stay with her sister or whether she plans to return home.

This phone call appears to have been a key moment in the lead up to the incident. There was an opportunity to enquire in a more detailed way about the reasons why SH did not feel safe, why she felt threatened and what she considered the potential risks to be. The lack of this additional enquiry was a missed opportunity to gather more detailed information from SH that would have more accurately informed the decision about when W4 (or any other worker) might have visited Adult B.

There are acknowledged deficits in the way in which BHT responded to SH's concerns, but also in the way Adult B's case was handled, specifically in relation to recording, risk assessment and management, safeguarding practice and awareness in relation to domestic abuse.

The IMR makes seven recommendations and these are set out in Section Four.

2.2.5 South Central Ambulance Service

South Central Ambulance Service NHS Foundation Trust (SCAS) was established on the 1 July 2006 following the merger of four ambulance trusts. Its' emergency operations centres handle around 500,000 emergency and urgent calls each year. SCAS covers the counties of Berkshire, Buckinghamshire, Hampshire and Oxfordshire, an area of approximately 3,554 square miles with a population of over four million people.

The DHR panel requested an IMR from SCAS at the outset of the review. As outlined in section 1.7.1 the initial documentation received fell short of the standard expected for an IMR. Repeated requests were made for a revised IMR from SCAS. Following a series of discussions, phone calls and meetings, SCAS re-assigned the IMR to another staff member and the final version was received on 14th August 2015. This delay in receipt inevitably had an impact on the timescale for the completion of the DHR Overview Report and the recommendations made by SCAS in their IMR reflect some of the challenges experienced in getting to a final report.

SCAS contact

The SCAS IMR sets out the contact between the service and both SH & Adult B between 27th June 2010 and 17th August 2014.

On 27th June 2010 SH made an emergency call to the SCAS Emergency Operations Centre (EOC) via the 999 service. The call took place at 01.40 and SH was complaining of chest pains. An ambulance was dispatched with two crew members. On their arrival they established that the chest pains being experienced by SH were related to her asthma. She was treated at home for an asthma attack and her condition improved. The IMR notes that the ambulance crew made contact with the West call out of hours GP service, it appears, though it is not clear, so that they would co-ordinate a follow-up home visit during the daytime.

On 12th April 2011 SH contacted the SCAS EOC via the 999 service at 07.48. The call was triaged as being 'breathing difficulties'. A Rapid Response Vehicle (RRV) which is a single crewed vehicle, was dispatched. The SCAS clinician found that SH had a chest infection that was affecting her breathing and had exacerbated her asthma. Medication was administered to alleviate the symptoms SH was experiencing. There was no requirement for hospital admission and SH was advised to contact her GP if the chest infection did not resolve.

Later that day at 22.56 a further call was made to SCAS EOC via the 999 service, again SH was experiencing breathing difficulties. An RRV was dispatched and following examination, the crew member requested a double crewed ambulance to take SH to hospital. The RRV crew member had instigated treatment to alleviate SH's breathing difficulties and she was subsequently take to hospital by ambulance. The IMR notes that following the advice given by the RRV crew member who attended the call earlier that morning, SH had contacted and seen her GP who had prescribed stronger antibiotics for her chest infection.

On 24th February 2012 the SCAS EOC was contacted by a GP from the Falklands Surgery at 13.43, this was not an emergency call, but a request for SH to be transported to hospital because she was suspected to be suffering from a urinary tract infection. The transportation window was requested as being within two hours. The ambulance arrived at SH's address at 20.31 that evening, having been assigned low priority, being a non-life threatening issue and also due to numerous 999 emergencies during the day.

On 18th July 2013 at 13.01, SH contacted SCAS via the NHS 111 service. SH indicated that she had fallen, possibly fainted and had injured her wrist in the process. She was home alone and due to her disability, she could not get herself up off the floor. Initially SH refused an ambulance but the NHS 111 Call Taker connected SH to an NHS 111 Clinician. After discussion with the NHS 111 Clinician the call was passed to the 999 EOC and an ambulance was allocated, following which SH was taken to West Berkshire Community Hospital.

On 17th March 2014 the Falkland Surgery contacted the SCAS EOC at 12.22. The call was assigned as a routine event and was not appropriate for an emergency ambulance as the request was for SH to be transported to hospital to attend an Eye Casualty appointment at 15.30 that day. The GP indicated that SH needed to attend the appointment as a matter of urgency and it was agreed that SCAS would undertake the transport on this occasion. The ambulance arrived at 14.26 and SH arrived at the Eye Casualty department at 15.17.

On 18th June 2014 at 17.38 a call was received by the SCAS NHS 111 service Adult B's ex-wife. She was concerned about Adult B and said he was depressed/suicidal. The call was transferred to the 999 EOC at 17.42. Adult B's ex-wife was advised that an ambulance would be dispatched, under emergency, as and when available, within the hour and, having been allocated at 17.45 it attended at 17.56

The first attending ambulance crew that responded were due to complete their working shift at 18:00, and as such the EOC had informed them that another crew would be allocated to relieve them at the address.

This practice is undertaken where possible; to prevent ambulance crews from working more than their allocated 12 hour shift.

The ambulance crew established that Adult B had recently returned from America, cutting short his holiday with SH and other family members (who were still in the USA) as he had been informed that his mother was unwell.

The crew established that since his return from the USA Adult B had experienced difficulty sleeping. This had occurred for a number of days where Adult B had not had a full night's sleep. Due to this condition Adult B had seen:

- His own GP
- Attended the local hospital
- Been seen by the local Mental Health Team and was under the care / support of the local Crisis Team

The crew were able to establish the medications that Adult B had been prescribed by his GP and the Westcall service. They also established that Adult B's ex-wife HT had contacted the mental health Crisis Team to obtain their advice about Adult B's presentation. The SCAS IMR indicates that it was their understanding that the Crisis Team advised that HT should contact the NHS 111 Service and obtain additional advice.

As had been planned a second ambulance arrived to take over from the ambulance crew that had completed their shift. The IMR shows that the first crew arrived at 17.56, the second crew arrived at 18.16 and the first crew departed the scene at 18.27.

It was decided that the best course of action, because of Adult B's presenting mood and depressive state was that he be taken into hospital, in this instance to Basingstoke. The ambulance left Adult B's address at 18.42 and arrived at 19.05.

The IMR notes that this contact between SCAS and Adult B was the subject of a complaint by Adult B's ex-wife, HT. The complaint was made approximately two months after the incident, in the period immediately following the homicide.

As part of the review into that complaint, SCAS interviewed the four ambulance crew members involved in attending Adult B that day. The primary issue for review was the way in which the first attending ambulance crew members had interacted and communicated with Adult B during their attendance, in particular the volume of the paramedics' voice when talking to Adult B, given that some of the communication took place outside rather than inside his flat.

The IMR indicates that during the review the staff involved could not recall the specifics of the incident in detail, given the time that had elapsed between the

incident and their interviews. However, all the contents of the complaint letter were discussed. The crew member concerned was asked to undertake a self-reflection on her communication with Adult B and consider what she might have done differently and how this might alter her future interaction with patients.

The complaint investigation concluded that there was no time wasting between the two crews and although HT had indicated in her complaint that the two crews interacted and were having a laugh and exchanged words, this would be a normal interaction between two crews. HT may have thought this inappropriate, but the investigation concluded there was no malice or disrespect intended. This issue was highlighted to the ambulance crews, so that they would be more mindful of how they meet and greet each other in circumstances when patients, relatives or the public are present.

HT had also raised concerns about the clinical expertise of the ambulance crew members in relation to mental health issues. The IMR states that the complaint investigation outlined the training that SCAS staff receive in relation to mental health. SCAS has clear guidance about the actions their staff should take in relation to people with suspected mental health issues, these are set out in policy CSPP7 Care Pathway policy. SCAS staff receive initial training in mental health matters during their basic training. They do not have the same level of expertise as full time mental health professionals working in the NHS, or of Approved Mental Health Act Professionals, who conduct assessments under the Mental Health Act. In 2013/14 SCAS's mandatory update training programme included mental health, mental capacity and suicide risk.

The IMR states that the report of the complaint review was sent to Adult B's daughter, SR on 9th January 2015. It is noted that this incorrectly stated that the reflective practice exercise had been undertaken by all the SCAS staff involved in attending Adult B when it had not. The co-chair of the panel has written to SCAS asking them to address this, which they now have..

On 16th August 2014 at 07.04 the SCAS EOC received a call from Adult B via the 999 service. During the call Adult B advises the call handler that SH may be having a diabetic hypo. The panel has been able to listen to the audio recording of the call. Adult B says SH has not taken her insulin for a while and that she is "*going stir crazy*" and that she is "*very distressed*". He also refers to her as being paranoid. The call handler asks if SH has been aggressive or violent and Adult B replies that she has been "*completely off beam, yes*". The call handler asks if SH has been violent towards Adult B, he states that she has not. The call handler asks if Adult B has been unable to take SH's blood sugar level "*due to how she is acting*" and Adult B confirms this. The call handler asks Adult B if he can test SH's temperature by touching her skin to see if she is hot or cold and Adult B replies "*she thinks I am going to be violent toward her*". SH can then be heard (faintly) in

the background saying "*that's because you are*." Adult B then says, "*I am not*". The call handler does not probe this further, but asks if there is any risk to their crew and Adult B states "*there is no risk to your crew, (pauses) I don't know to be honest*". After confirming SH's name Adult B then says "*it's all fairly dysfunctional at the moment, I have to say*". The call handler then advises that "*the help has been organised for you*" and gives Adult B advice about collecting SH's medication together and "*when the crew arrive, tell them what's gone on before they go to SH, you should meet them at the door if possible*". He advises Adult B not to give SH anything to eat or drink in the meantime "*unless there is any risk to you of course*". The call handler then advises the crew will be there as soon as they can.

The call was triaged as requiring a 999 emergency response and an ambulance was allocated to the incident. At 07:06 the SCAS EOC Call Taker entered an event comment: "*Approach with caution, patient very agitated*"..

At 07:09 the SCAS EOC Call Taker entered an event comment: "*Pt agitated and very confused but not violent, wont (sic) let her husband near her as she says he will hurt her, could hear patient in background very distressed*".

This comment was in response to how Adult B was describing SH at that time. The recording of the call has been reviewed as part of the DHR. It is the view of panel that having listened carefully a number of times that this comment about the level of agitation exhibited by SH is not reflected in the tone of her voice on the recording.

At 07:11 the allocated ambulance arrived at the incident address. At 08:29 the SCAS EOC Call Taker entered an event comment: "*Also dealt with the patient's husband*".

When the ambulance crew arrived they talked to SH, there is no mention in the IMR as to whether Adult B spoke to them before they entered the flat. SH told the crew she was fine and that in fact it was Adult B she was concerned about. The crew continued to conduct an assessment of SH to ensure she was not experiencing a diabetic emergency, which after examination, they determined she was not.

The crew also examined Adult B and there were no signs that led them to believe he required hospitalisation. A Mental Capacity Assessment form was completed that established Adult B had capacity.

The crew decided that specialist input might be needed and with this in mind contacted the mental health Crisis Team. The call was recorded and has been reviewed. The SCAS crew say nothing material about any risk to SH in the call. They mention that Adult B doesn't want SH to leave the house but then go on to say that SH is "*fine*". This is despite the fact that they also faxed a submission to West Berkshire Council, outlining a number of safeguarding concerns they had about SH. As a result, their concerns about risk to SH were not fed into the Crisis Team.

The IMR states that they are unable to recall whether the concerns and allegations of emotional/financial abuse were highlighted during the call.

The crew talked to SH about her concerns about what the IMR describes as her social and living conditions and took these seriously. The IMR does not state whether Adult B was present when she had this discussion.

The crew completed a Safeguarding/Vulnerable Adult form which was faxed by them, to SCAS offices at 08.30 on 16th August 2014. The concerns the crew raised on the form were: emotional/psychological abuse, financial/material abuse, an increase in non-physical abuse, that no obvious injuries to SH were present and that in their view there was no immediate risk to SH.

There was a delay in the faxed Safeguarding form being sent on to Adult Social Care. Faxed Vulnerable Adult forms that are received over weekends and Public Holidays are collated by the safeguarding staff upon their return to work on a Monday morning (or the next working day). These are then logged and faxed off to the relevant Social Service Department for their attention. It is presumed by SCAS that these faxed forms are only accessed by Social Services staff working normal office hours.

At 10.58 on 16th August 2014 Adult B again contacted SCAS EOC via 999, he was complaining of rectal pain. The IMR states that the call was triaged and that the notes show the advice given initially was that "the individual needs to contact a primary care service within six hours". This would have involved a transfer to the relevant out of hours GP by SCAS and the out of hours GP contacting Adult B.

Adult B refused to accept this delay and the call was transfered to a Clinical Support Desk Practitioner (in this case a nurse) to re-triage and discuss with Adult B. The IMR states that the course of action noted was to contact a Primary Care Service within two hours. The call was transferred through to the West Call Out of Hours Berkshire GP service. The call was closed off by SCAS at 11:32.

The NDCCG IMR describes Adult B's later attendance at hospital, having been taken there by his sister-in-law.

On 17th August 2014 at 07.30 SCAS EOC was contacted by Thames Valley Police, who informed the call handler that they had been contacted by a male who claimed he had murdered his wife by strangulation. An ambulance was allocated and at 07.31 the attending ambulance was advised to wait at a position close to the address of SH and Adult B until the police were on scene to make access safe. At 07.42 the attending ambulance crew informed SCAS EOC that SH was "deceased, suspicious circumstances". The Duty Bronze Officer was informed at 07.44 and the Duty Silver Officer was advised at 07.45.

At 09:13 the EOC was informed by the Duty Bronze officer that all SCAS vehicles were clearing from the incident address, and were now required to meet at the SCAS Newbury Resource Centre and that the Police Criminal Investigations Department required statements from the ambulance staff that attended the incident.

Analysis and lessons learned

The contacts between SH and SCAS in 2010, 2011, 2012 and 2013 appear to be routine and do not indicate anything unusual in terms of presentation, response or outcome. There is no indication from these contacts of anything other than an individual requiring routine advice or intervention from SCAS in relation to SH's long-term conditions.

The first contact in 2014 took place in March and SCAS responded by assisting in transporting SH to hospital for an eye appointment. Again, there is nothing in this contact to indicate any other concerns.

The contact on 18th June 2014 where SCAS crews attended Adult B was instigated by his ex-wife, HT. This related to Adult B's reporting depression and suicidal thoughts, thought he later told the co-chairs were not actually present. It is not clear from the IMR what degree of assessment of Adult B's mental state was conducted, but their response in taking him to hospital indicates they were concerned about his mental health and the potential risk he may have posed to himself. Although SCAS staff are provided with training in relation to mental health, they do not possess specific expertise in the assessment of mental health problems or mental illness. The crews were aware that Adult B's ex-wife had contacted the mental health Crisis Team that day about her concerns for his mental health. It would have been reasonable for the SCAS crew(s) to have contacted the Crisis Team to establish what level of contact or input they had with Adult B and to take advice about management or potential input from them, rather than taking him to hospital in Basingstoke.

It is reasonable to conclude that their response in taking Adult B to hospital was appropriate in the absence of in depth expertise in mental health and the lack of other information. They were clearly concerned enough about his mental state to believe that he required specialist medical assessment in Accident & Emergency from a liaison psychiatrist.

The matter of the complaint from HT to SCAS has been discussed by her with the co-chairs and the outcome of the complaint has been communicated to them and to HT and her daughter. It is not the role of the DHR to comment specifically on the process or outcome of this, but to note that the review found no malicious intent in the way the SCAS crew member spoke to Adult B. Actions have been taken to address the deficits in communication highlighted in the complaint and it is for SCAS to ensure that HT and SR are assured by the outcome of the complaint review.

On 16th August 2014 SCAS responded to a call from Adult B in which he indicated SH was having a diabetic hypo. The recording of the call set out earlier in this section describes the conversation that can be heard between the call handler and Adult B. The recording of the conversation is somewhat at odds with the way in which it has been summarised in the written record. In particular, Adult B describes SH as being aggressive. He also states that SH is worried that he is going to be violent towards her. SH can be hear faintly saying "*that's because you are*". The IMR also records SH as being heard on the recording to say "*Yes he will hurt me*". In listening to the call several times, the co-chairs are unable to hear SH saying these words.

Adult B denies that he will hit SH but the call handler does not probe this any further. In the written record described in the IMR, the call handler describes SH and "*very agitated*" and "*approach with caution*". When listening to the recording SH in fact sounds very calm.

It is appreciated that the role of the call handler is a complex and demanding one, and that there are a set of specific questions they must ask, but it would have been reasonable to have expected that once the issue of potential physical violence had been raised that this might have been explored further. The focus of the concern seems to have been upon risk to Adult B rather than considering the potential risk to SH and her expressed concern, albeit in one short sentence. Equally, the call handler was of the assumption, on the basis of what he had been told, that SH was suffering from a diabetic hypo, a condition that can cause a degree of agitation or irrational behaviour.

The IMR considers whether the call handler should have contacted the police. Given that no violence had taken place and there was no explicit report of this, it would have been inappropriate to do so on the basis of information in his possession. SCAS staff are trained in risk assessment and the IMR makes clear that had there been any immediate threat of violence then they would have contacted the police.

When the SCAS crew attended they did elicit information from SH about her concerns in relation to Adult B. They did appropriately conduct an assessment of her physical health which determined she was not experiencing a diabetic hypo. The SCAS crew did respond to the information they received from SH and properly completed a Safeguarding/Vulnerable person form and faxed it at 08.30. There was a delay in the form reaching the adult social care. SCAS routinely forward these forms on weekdays, this one was faxed on a Saturday and thus was not forwarded until Monday (18th August 2014). SCAS are aware that these forms are not routinely accessed by social care staff at weekends. Despite making the submission to West Berkshire Council, no information about the safeguarding referral was passed to the mental health Crisis Team by SCAS.

The engagement or not of police in such cases should not have a bearing on how the submission of Safeguarding forms are responded to. This is a learning point for local organisations. They will need to ensure that all organisations have a clear understanding of process, expectations and working patterns in relation to receipt of Safeguarding forms, particularly during periods outside normal office hours and weekends.

The SCAS crew did contact the mental health Crisis Team and this resulted in their attendance later on 16th August 2014.

The other key learning from the IMR is that SCAS staff do not, nor might they be expected to have, detailed or specialist knowledge of mental health. However, there is a case to consider whether more training and awareness of mental health, and appropriate responses, including knowledge of local services and how to access advice would be helpful in improving responses across the service.

The delays in receiving an IMR of an appropriate standard were unfortunate. There are issues of capacity and expertise within SCAS that are being addressed and are a focus of a review of staffing within the service. This is appropriate and should ensure more timely and effective response to requests for IMRs in the future.

The IMR makes six recommendations and these are set out in Section Four.

2.2.6 Sovereign Housing Association

Sovereign Housing Association (SHA) owns and manages over 36,000 homes across the south and south west, it is one of the largest housing associations in England. SHA owned and managed the property that SH and Adult B rented. They held a joint assured non-shorthold tenancy at the address where the incident took place from 4th June 2007.

SH had been a tenant of SHA for 18 years prior to her death. She had resided in Thatcham from 1st April 1996 to 4th June 2007. She then moved to the address where the incident took place in Newbury, the tenancy agreement started on 4th June 2007.

Adult B did live with SH as her spouse at the address in Thatcham, but the SHA records do not show that date he moved into the property. The IMR does state that SH advised SHA of the change of her surname on 29th July 2003.

The IMR provides detail of a range of contacts between SH and SHA dating back to 2003. The majority of these relate to payment, or non-payment of rent and issues of repair and maintenance.

In July 2005, after a series of contacts about rent arrears and the serving of a notice of Seeking Possession, SH informs SHA that she has “confessed all to her husband” about the level of rent arrears and that he will now “sort it all out” by paying the full amount of arrears and have the monthly rent debited from his bank account. It appears from the IMR that the level of outstanding rent was significant.

In late 2005 the process of seeking a transfer from current property to a ground floor flat or bungalow begins due SH’s worsening physical health and lack of mobility. A new tenancy offer was made in May 2007 and the couple moved into the property where the incident occurred. Although the flat was within a scheme that was supported by a warden service, neither SH or Adult B made use of this service.

The remainder of contacts noted in the IMR relate to matters of repairs and maintenance.

Analysis of involvement and lessons learned

The majority of contact by SHA was with SH and recorded contact with Adult B is limited to his signature on documents, including the tenancy agreement. Contact was predominantly about rent or rent arrears and maintenance issues relating to the flat. There is no record of any concern about domestic abuse or domestic violence.

As part of the IMR process SHA have identified that their procedure relating to Anti-Social Behaviour, Domestic Abuse and Hate Behaviour had not been reviewed in June 2013 as was required and that specific training related to domestic violence training for Support Officers and Housing Plus co-ordinators had not taken place. These have been addressed by the recommendations in the SHA IMR.

2.2.7 West Berkshire Domestic Abuse Service – A2 Dominion

An IMR was requested to establish whether there had been any contact between the West Berkshire Domestic Abuse Service and SH or Adult B. The IMR states that following checks of relevant records there was no contact or involvement.

There is consequently no further analysis nor lessons to be learned.

2.3 Views of the family

In conducting this review the panel has sought the views of family members in order to inform its understanding of the incident and the events that led up to it. The Co-chairs have met with the following members of the family:

- The sisters and brother-in-law of SH
- One of the sons of SH
- The daughter of Adult B
- The ex-wife of Adult B

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

2.3.1 Summary of meeting with the sisters and brother-in-law of SH

The Co-chairs met with SH's two sisters and her brother-in-law on 1st June 2015. The purpose of the meeting was to provide them with more information about the process of the DHR and to seek their views about the events that led up to the incident. For the purposes of this report, the sisters are referred to only by their first initial.

W & P stated that Adult B had done a lot of caring for SH and they had not experienced anything in pervious years that led them to believe there were any problems in the relationship between SH and Adult B. Indeed, they related that Adult B had been a strong advocate for SH. W & P described Adult B as a proud man and that this may have contributed to him not disclosing his anxieties and concerns more fully to professionals.

P talked about the Florida holiday and said that Adult B had been anxious before going there and that he was particularly concerned about driving in the USA. Whilst there Adult B had remained anxious and then he told P that his mother was unwell and that he needed to return home immediately, this was after being there for only three or four days.

Adult B was in contact with W on his return from Florida. He complained to her of his sleeplessness and also said he had no appetite. Adult B's daughter telephoned W following the admission to Basingstoke Hospital on 18th June 2014 to advise of this incident, she told W that Adult B had been to a sleep clinic.

Adult B went to visit W again a couple of days later, he was at this point concerned about insurance cover for SH while she was still in the USA and for her journey home. W set up a Facebook account for Adult B so he could see what SH was doing on holiday and for them to keep in contact more easily.

W stated that Adult B was very focused on SH coming home and that he felt this would alleviate his concerns and anxieties. W stated that Adult B did not “seem himself at all”.

Adult B’s brother-in-law went to the airport (accompanied by Adult B) to collect SH on her return from the USA. He advised SH to tell Adult B to see his doctor. He believed from his conversations with Adult B that his doctor would not prescribe him stronger medication and believed that he was not coping well. His impression and that of W & P was that no one was doing anything to support Adult B, that he needed help but that they could not see that this was happening.

On Thursday 14th August 2014 Adult B’s brother-in-law visited him and SH at their home. During this visit Adult B talked about his belief that he may have defrauded his mother and that he had concerns about a lack of money.

On Saturday 16th August 2014 SH rang her sister W. She said that Adult B had woken her in the night and told her she ought to pack a bag because they were going to be arrested. It is presumed that this was in the context of Adult B believing he had committed a fraud. SH told her sister that the mental health Crisis Team were coming to visit and that she “wanted him (Adult B) taken away” as she could not cope or sleep. It is believed that it was in this conversation that SH told her sister that she had asked Adult B to make arrangements for her pension and disability benefits to be paid into her own bank account - rather than an account held by Adult B – so that she had enough money for essentials (cigarettes etc). SH then told her sister that Adult B had refused to do this.

SH’s sister P accompanied Adult B to see his GP that morning (16 August 2014). When P spoke to SH that day, SH said she was worried about the things that Adult B was saying about being arrested, about bailiffs coming to the flat and she had “had enough of it”. SH also told P that she was more concerned because Adult B had stood over her with a pillow.

During this conversation, P suggested that she take SH out for meal that evening. During that evening and while still at the restaurant, SH spoke with the mental health Crisis Team on the telephone. She had previously left a message with them and had asked that they call her back on her mobile and not on the home phone. W & P report that SH told the crisis team that she felt threatened and that Adult B was now keeping the curtains closed and not letting her put the lights on.

During the meal at the restaurant, P encouraged SH to stay with her but she wanted to go home. They believe that the mental health Crisis Team assumed that SH was not going to return home, an assumption they feel very strongly to have been flawed. In the meeting both sisters stated that SH had no intention of staying with either of them and was always going to return to her home address.

When SH returned home after the meal she sent a text message to P saying she was back home and that Adult B was asleep.

On Sunday 17th August 2014 W was attempting to contact SH as she had not called her that morning, as was her usual practice. On getting no answer she tried other family members. She was later contacted by one of SH's sons who informed her that SH was deceased and that Adult B had been arrested.

The two sisters shared a number of questions and concerns they had about the response of services to SH and views about Adult B:

- Both sisters believed that Adult B was "not himself". They share slightly different views about Adult B's mental health with one more convinced than the other that Adult B had mental health problems.

- The sisters believed that in the context of what was happening, Adult B was more likely to kill himself than anyone else.

- They do not believe that SH "was a battered wife" and said that "she wore the trousers".

- The sisters believe that communication with services and between services could have been better. They believe that the mental health crisis team should have seen SH and Adult B separately during the visits to their home address. They do not believe enough time was spent with Adult B and they were distrustful of the mental health crisis team. They said that no one ever asked SH how Adult B really was or how she was coping. They didn't feel that the Crisis Team were treating the situation as a crisis, for example they felt that response times to messages left by SH were unreasonably slow.

- They do not understand why the police did not alert other agencies after Adult B's presentation to Newbury Police Station.

- Both sisters were keen to have sight of the Berkshire Healthcare NHS Foundation Trust internal review report. They had been interviewed for that review and had not, at the time of meeting the co-chairs, had sight of the report. The family members in question have now seen the Trust's report and been given the opportunity to comment on it.

Both W and P were keen to praise the police and were pleased to have had the chance to input to the DHR process. W and P along with SH's mother and their advocate met with the panel on 18th December 2015. They had been sent a copy of the draft report three weeks prior to the meeting to enable them to consider it in detail. The discussion focused on the findings and recommendations of the report and the inclusion of their tributes to SH at the start of the report.

2.3.2 Summary of meetings with SH's son and daughter-in-law

One of the Co-chairs, Andy Fry and the panel co-ordinator, Susan Powell met with SW, SH's son and his wife, DW on 28th July 2015. The other co-chair was unable to attend this meeting. The meeting was also attended by their advocate from AAFDA.

A good deal of the meeting was focused on SW and DW's concerns and questions about the DHR process and their engagement with it. SW and DW expressed their frustration over not knowing what was happening in respect of the DHR process and requested information on the timeline.

SW and DW expressed their wish to have been kept more informed about the DHR and to have felt 'more in the loop'.

A discussion took place about SW and DWs view that the initial contact with the family being by letter wasn't appropriate. Susan Powell said that her learning has been that the family would be dealing with so many officers and processes requiring engagement and information at a very difficult time and that those responsible for the DHR should find an alternative way of connecting with the family. It was also discussed that the 'point of contact' for the family may not always appreciate that they had a role in communicating with other family members – this had not been made clear in original letter.

SW and DW expressed their continued disagreement over the 'independence' of the Chair and said that they had found some correspondence from the Chair of the West Berkshire Community Safety Partnership about the matter insensitive. As outlined in the introduction to this Overview Report, SW and DW became concerned about the independence of the appointed Chair following receipt of advice on the matter from their AAFDA advocate. They had previously been

notified of the appointment of the co-chair, Steve Appleton and agreed that they would meet him at a second meeting on 11th August 2015.

All agreed that the National Guidance is not clear on some aspects of the DHR process and SW and DW's advocate clarified that the Guidance is under review.

SW and DW requested a summary of the DHR process to date. A summary was generated by Susan Powell and shared with SW and DW at a subsequent meeting on 11th August 2015.

SW asked which family members would receive a copy of the report and requested that he and DW receive a copy in advance of others. Andy Fry agreed to consider this request and to respond.

The meeting then went on to discuss SW and DW's reflections on the incident and for them to provide some family history.

They described how SH had met Adult B about 22 years ago. SW was living with SH at the time and supporting her after the breakdown of her first marriage. He subsequently moved out.

SW and DW described how, prior to the incident, they had perceived Adult B as a nice, caring man who did what he could for SH. They described how Adult B handled the finances and that he provided SH with an allowance. They said that Adult B was a "powerful man" who was used to being in control and that financial control appeared to have become a feature of his relationship with SH.

They described how SH was "hurting" over Adult B's relationship with his daughter SR, SW said he saw that this had an impact on SH and her relationship with Adult B. They described that it was the family's view that Adult B did everything for his daughter, SR and that his focus was on her. They feel that he favoured her over all other family members and his daughter's children over his step-grandchildren. They also said that he provided SR with significant financial support. Adult B could treat family members differently. It was reported that through his control of finances, Adult B had a direct impact on SH's ability to 'treat' her son, daughter-in-law and their children, particularly on their birthdays.

SW and DW described how on one occasion when SH was in hospital for a chemotherapy appointment, Adult B prioritized taking his daughter out for the day rather than staying with SH. SW said he had directly questioned Adult B about his loyalty to SH over this but did not act on his concerns.

They also described how Adult B maintained regular contact with his ex-wife, HT and that she often telephoned Adult B, including during the night requesting that he visit her, which he did. They describe demands on Adult B from HT and SR.

In relation to the matter of Adult B offering financial support to SR and HT to purchase a house, they said that after Adult B had requested they hand back the money he had given them, following disclosure of the arrangement to SH, his daughter "sent a hurtful text" to SH about this. The panel is not aware of the content of this text message nor the date it was sent.

SW said that he thought Adult B was trying to do the right thing by everyone.

SW said he felt that SH did not confide her concerns to him because she wanted to avoid any confrontation. SH did not describe her concerns to SW or DW.

Other family members were in receipt of support from AAFDA and contact with SW's brothers was also discussed.

A second meeting took place on 11th August 2015. This meeting was attended by both co-chairs and Susan Powell. Their advocate was unable to attend for personal reasons but SW and DW were happy to go ahead with the meeting as planned.

The initial focus of this second meeting was to talk SW and DW through the DHR process again and to respond to their request for an update of the process so far and what would be happening next. This was provided in a written summary. Steve Appleton also took the opportunity to provide SW and DW with some information about his background, experience and his role in the DHR, not only as co-chair but as the independent author and what this involved.

There was also a discussion about the draft Overview Report. It was agreed that this would be shared with SW and DW for review and if helpful Steve Appleton agreed to meet with them to discuss the report. SW and DW were also advised that in response to their query at the previous meeting, they would receive the report at the same time as other family members, but that it would not be finalised to incorporate any comments or feedback until all those comments had been received from all parties to which it had been sent for review.

SW and DW then spent some time describing some other issues that they had recalled since the previous meeting that they wished to share.

They re-emphasised how they believed Adult B had become abusive towards SH through his control of money. He also withheld cigarettes from SH on occasions. They felt that Adult B appeared to have an obsessive element to his personality.

They described how he kept a series of box files in the flat that contained receipts, holiday information etc and that these were overly ordered. They questioned if he was perhaps too organised.

They described how when SH was going to be 60, Adult B had told her she could have a party or go on a holiday, but not both. This was another example of Adult B exerting financial control over SH and using coercion as a means of controlling her. SH asked DW if she would prepare a 'surprise' party for her. Everyone in the family but Adult B knew about this.

It remains SW and DW's view that Adult B changed at the point of taking his flexi-retirement.

They also described how SH's sister W had told them that SH had asked Adult B for her pension money and disability benefits to be paid into her account so that she had some control over her finances. This arrangement was never put in place and SH's pension and disability benefits were not paid into her own bank account.

The meeting concluded with a discussion about contacting SW's brothers and agreement about ongoing contact with Susan Powell and the co-chairs.

A further meeting took place with SW and DW and their advocate on 18th December 2015. This meeting provided an opportunity for them to review the Overview Report with the co-chairs and panel co-ordinator. They had been provided with a draft of the report three weeks prior to the meeting to enable them to consider it in detail. A productive discussion was held covering a range of issues including the conclusions and recommendations in the report, as well as clarification and amendment of some passages in the text. As a result of the meeting the report was updated to reflect their feedback.

2.3.3 Summary of meeting with Adult B's ex-wife and daughter

The co-chairs and the panel co-ordinator met with Adult B's ex-wife, HT and his daughter, SR on 2nd March 2015. The purpose of the meeting was to provide them with more information about the process of the DHR and to seek their views about the events that led up to the incident and any relevant history and background information. For the purposes of this report they are referred to only by their initials.

HT stated that she had met Adult B when she was 19 and he was 21. She said that they had had a 'turbulent' relationship and that during their marriage they had separated a couple of times. They first met in Wales, and then lived in London before moving to Abingdon in Oxfordshire. Adult B was working for Thames Water. HT said that during their marriage she had suffered with depression and

that this had been a source of tension in their relationship and that Adult B was not always particularly understanding of her illness and its impact on her. She said that her depression had caused her to become very dependent on Adult B. She reported that when they moved to Abingdon after SR was born her mental health was more stable.

HT said that Adult B "doted on SR" but that that the marriage was still not good and there were some rows. HT reported one incident of physical violence, she stated that Adult B once head-butted her during an argument. She said there were no other incidents involving violence or domestic abuse and that during most arguments Adult B would simply leave the house.

HT and Adult B eventually separated and subsequently divorced. Adult B paid maintenance for SR and had regular contact with her, seeing her once a week. HT said that after Adult B met SH he would see SR every other weekend.

HT said that SR would sometimes suggest that Adult B was behaving strangely and that she thought SH was jealous of her, given the attention that Adult B paid to her. Because of this perceived jealousy, Adult B would visit SR and HT's home.

Both HT and SR talked about the 'secret days' that Adult B would sometimes have with SR that SH did not know about. This '*arrangement*' continued for some years and only ceased in June 2014.

When SR was 16 she moved to Thatcham and HT soon followed. They both saw Adult B and HT stated that she now got on well with him and they often met. Adult B would sometimes share his concerns with her.

HT and SR were both aware of Adult B's retirement plans. They said that he had offered SR money from the lump sum he was due to receive to enable her to buy a house.

When it was clear that the money offered would probably not be enough to enable an outright purchase, they said that Adult B had suggested that HT sell her house and that she and SR buy a house together which would be big enough for SR, her husband and two young children as well as HT.

They reported that Adult B was excited about this development, but both SR and HT knew that he had not told SH about these plans. They said that Adult B was nervous about telling SH. They suggested that money was always a secret and that Adult B had 'bailed out' SR a couple of times and paid for a number of holidays.

SR said that Adult B had contacted her to let her know he was returning from Florida early – he told her he was having trouble sleeping. He told her he had planned a story with SH and had pretended that his mum was unwell.

SR said that Adult B came straight to her flat on his return from Florida and then went home to try to sleep. In the run up to SH returning Adult B was anxious about driving to the airport to collect her. He visited SR's flat when she was out and left a note saying he could not pick SH up and left a set of house and car keys. In the note he asked that SR's husband collect SH. (In fact the husband of one of SH's sisters collected her from the airport, accompanied by Adult B.)

SR contacted HT when Adult B returned from Florida as she was concerned about him. HT contacted Adult B to enquire how he was but he was resistant to offers of help and expressions of concern.

Adult B had attempted to return to work, but SR reported that he left early on his first day back at work and came to visit her. She said he seemed anxious and said he had been ruminating on things. This proved to be Adult B's last day at work.

SR said that Adult B had become more distracted and seemed more anxious, this was apparently out of character.

HT and SR were not sure of the exact date but reported that Adult B went to his GP and also to the Minor Injuries Unit locally and had got some sleeping pills. On 18th June 2014 during a visit to see Adult B, SR and HT were concerned about him. HT said that she had called the mental health crisis team but that they were not very helpful and simply suggested that they call the 111 service. They did contact the NHS 111 service, who dispatched an ambulance, in part in response to the report that Adult B had expressed thoughts of suicide.

According to SR and HT the ambulance crew told Adult B that he couldn't go to Prospect Park Hospital in Reading because he had 'not been ill for long enough'. HT made a complaint to South Central Ambulance Service (SCAS), who conducted a review into her complaint, though at interview both HT and SR said they had not seen the report. Their complaint centred on their view that his treatment by SCAS staff had "stripped him of his dignity and caused him to lose faith in system". Although speculative this may have reinforced the subsequent behavior that saw him downplay his symptoms when engaging with professionals.

As a result of the ambulance attendance Adult B was taken to Basingstoke Hospital and spent one night there. SR collected him the following morning (19th June 2014) and said she felt he seemed calmer initially but was almost immediately anxious again. He was phoning her frequently, texting her a lot and coming to her flat.

SR and HT believe that Adult B told SH about the money he had given them on the day she returned home from Florida. As a result of this, he contacted them both and said that he could now only give them half the money he had promised. SR said that when Adult B rang her about this he told her that SH was not angry with her but was not very happy with him. SR reported that both Adult B and SH visited her the following day at her flat and that they seemed OK.

SR said that in the following days Adult B became more anxious about the money and about his own finances and as a result asked her to return all the money he had given. He had also told SH about the 'secret days' and he told SR he had been arguing with SH. SR did agree to give the money back but believed that SH was driving this and making Adult B ask her for the money. SR then went on holiday on 8th August.

SR and HT were aware of Adult B's presentation at Newbury Police Station but were unclear what had triggered this. They were also aware that Adult B had disclosed some of these issues to SH's brother-in-law.

SR reports that she had told Adult B that given his anxieties and the stress being caused to them both, he needed to choose what he wanted to do, specifically, either stay with SH and not see SR any more or leave SH and be able to see SR. She said this was not intended as an ultimatum, simply a setting out of options to try and resolve matters more definitively.

SR recalls that Adult B called her during Saturday 16th August 2014 and told her he was going to see the bank. He told her that he had called his employer and told them he had committed fraud and believed they were going to take his company car back.

SR did not recall any further conversations with Adult B after that. On Sunday 17th August 2014, SR was visited by the police who advised her of SH's death and Adult B's arrest. She said this was a complete shock and that in fact she had assumed when she opened the door to the police they were going to tell her that Adult B had harmed himself. She said that all her concern and that of HT was focused on Adult B and his state of mind.

Both SR and HT were keen to praise the police and were pleased to have had the chance to input to the DHR process.

2.4 Summary of meeting with perpetrator

The co-chairs of the panel met with Adult B on 1st May 2015. The interview was conducted at HMP Bullingdon where Adult B was being detained following his conviction in February 2015 and where he had spent the previous months on remand.

The purpose of the interview was to enable Adult B to provide his own view of the events of 16th August 2014 and to provide information regarding his personal background, circumstances, relationships with his wife, ex-wife and daughter and to establish if there were any other areas of review that the panel needed to undertake in the light of the interview itself.

Adult B had previously been married to HT. They met in Wales when Adult B was working in a hotel as a chef. They married in 1978 and then moved to London where Adult B got a job with Thames Water. He worked for Thames Water and its successor agencies, the National Rivers Authority and the Environment Agency for 34 years. When Adult B and HT moved to London, HT enrolled at the University of Sussex but did not complete her course. Adult B reports that the relationship was 'up and down' and they were "good friends but a lousy couple".

When HT gave birth to their daughter, SR, the couple moved from London to Abingdon in South Oxfordshire. Adult B reported that at this time HT experienced periods of depression. He said he found this hard to live with but tried to be supportive, describing life as being 'fraught' at times. Adult B said that on reflection he felt he had not been as tolerant of HTs depression as he could have been. Adult B said that the birth of their daughter exacerbated the difficulties in his and HT's relationship. Adult B stated that he left the marital home when SR was still a baby and moved to Reading. He kept in close contact and had regular visits to see her at weekends.

Adult B said that he met SH when his daughter was about two or three years old and that they met through a lonely-hearts page. He said that their relationship had been good over the following 20 years. When they first met SH was still married but separated and that he and SH lived together for about 10 years before they got married. He said that they had a good life together and that they took regular holidays in Europe together, but that they also liked to do things separately, usually in the evening but that they "were very close". He maintained that they never had a row and that although they had their differences they always talked them through.

Adult B reported that he had remained friends with his ex-wife HT and that SH found this hard to deal with. He stated that he often talked with HT and that he "used her as a confidante" and that although SH found this hard he thought she understood it. Adult B said that he always sought to put his daughter first but that he also tried to look after the needs of SH's children even though they were older than his daughter.

He reported that there was some friction between him and SH over his relationship with his daughter, who he saw every two weeks. Adult B said that he did spoil his daughter and that he sometimes had 'secret days' when he would go to see her and take her out on trips that SH did not know about. He said that he felt guilty about this, that they only happened two or three times a year but that he didn't tell SH because he "did not want to risk a drama".

Once his daughter had left school, Adult B was working at the Environment Agency, had a good salary and had more disposable income because he was no longer paying maintenance. He and SH took three holidays a year. They began to think about Adult B's retirement options and following discussions with his employer it was agreed he would retire and draw his pension, but continue to work a reduced week. This in fact was financially advantageous to him. Adult B stated that he was looking forward to the change in working pattern and to enjoying his 'retirement time'.

As part of his retirement package Adult B was due to receive a lump sum payment. He discussed with his daughter the idea of taking some money from this pot to give to her to put towards a house for her and her partner and child. Adult B confirmed that he did not discus this idea with SH, he said he had planned to do so but it "took a while to do so". He did eventually disclose this information to SH. He did said that SH was upset that he had not confided in her about this and although she had initially agreed with the plan he had described, she changed her mind and told him to get the money back.

Adult B said that things started to deteriorate for him when he went on holiday with SH and a number of other family members, including her younger sister to Florida. He said that he had trouble sleeping, did not know why but says he was not at this point troubled by any specific concerns, although he had some anxiety about driving while in Florida, something that had not been an issue on previous trips. He said that he began to feel anxious. He agreed a story with SH that they would tell others in the party that his mother was unwell and that he needed to return to the UK. He subsequently travelled back alone but remained in contact with SH via the internet, through email and Facebook, on which his sister-in-law had created an account for him.

On his return Adult B reported that he had felt ill and went to the GP to get some sleeping pills, as his lack of sleep had become worse. He described an incident on 18th June 2014 when he had felt so concerned about his lack of sleep and general anxiety that he called an ambulance. On attending the scene, the ambulance crew determined that he required hospital attendance and he was taken to hospital in Basingstoke. Adult B had told the ambulance crew that he was thinking of harming himself, though he now reports that this was a lie and that he only said this to ensure they would take him to hospital.

Adult B says he felt embarrassed about lying to the ambulance crew, but that at the time he "felt terrible through lack of sleep" and was "anxious about SH" who was still in Florida. He now believes this was "irrational". Adult B spent one night in hospital in Basingstoke.

During the time the ambulance crew were in attendance at his home, Adult B's ex-wife and daughter were also present. Their concerns about the way in which the ambulance crew responded to Adult B are set out in the summary of their discussion with the co-chairs, and were the subject of a complaint to SCAS. Adult B said that he did not recall the ambulance crew being difficult and was not aware of the complaint.

Adult B reported that he made several visits to his GP practice between his hospitalisation and the incident. He received anti-depressant medication, beta-blockers and sleeping pills. He said that he got very scared and that nothing was helping him. He did consider talking therapies which had been offered by his GP and did get an assessment appointment. He said that he had reached the stage where he felt he could not cope any more.

Adult B said that he initially stuck to the medication regime for about four weeks.

SH returned from Florida and her brother-in-law collected her from the airport with Adult B because Adult B was anxious about driving to pick her up. Adult B described how he felt much better on SH's initial return but swiftly slipped back into feelings of anxiety. These anxious feelings centred on money. Adult B was now off work on sick leave, he did initially try to go back to work but could not concentrate and took more time off. He was in contact with his employer during this period. He described being scared about this, he felt his work life and non-work life had both gone wrong. He felt his illness might go on for a long time and this fed into his worries about money. He also described his "search for the golden pill" that would make him feel better, as an explanation for his repeated consultations with the GP practice. He described himself as "a pest to my GP" and that he tended to "put a gloss" on how he was feeling during those consultations. He also felt that his priority should be to look after his daughter, ex-wife and SH but was unsure how he could do this in his current state of health.

Adult B then described how he had thoughts that he had defrauded his mother of a significant amount of money which resulted in him presenting at Newbury Police Station.

Adult B described how he managed all the finances and that SH was “not good with money”. He paid for everything and he gave SH what he described as “play money” for her day to day expenses and housekeeping etc. He felt that SH was concerned about his worries about money.

It was during this period that Adult B spoke to his ex-wife and daughter about getting back the money he had given them to purchase a house. The purchase process was well advanced and he said that he found this scenario very stressful. He said that his ex-wife and daughter were angry with him about going back on their agreement.

Adult B described how at this stage he felt he was looking at everything “through a pane of glass” and said he had dis-associative feelings and felt he was not at all himself but could not see how he could improve how he felt.

On 16th August 2014 Adult B reported that he thought SH was experiencing a diabetic hypo and called 999. He does not recall SH saying that she was concerned that he would hurt her during the conversation with the ambulance service call handler. He said that he felt very low at this point. He denied any feelings of aggression or violence towards SH at this point and stated that he had “never laid a finger on her”. The ambulance crew did attend and interviewed SH and Adult B separately.

Adult B then talked about the contact with the Crisis Team, and that someone came to visit him and met with him and SH separately. It was planned that the worker would return with more medication for Adult B.

Later on 16th August 2014 SH went for a meal with her sister and Adult B says he stayed at home. SH called Adult B from the restaurant, he then says he took some sleeping pills and went to bed.

Adult B stated that he woke at about 01.00 hrs on 17th August 2014and he saw that SH was asleep on the sofa and that this was not normal. He says he paced around and felt hopeless about the situation, he thought about calling the Crisis Team but didn’t do so. In the morning he stated that he “felt it all had to end”, and he began researching suicide methods on the internet. He said that he felt that if SH was not there it would be easier for him to kill himself. He felt there was no-one who could help him for the length of time he needed or in a place that he needed though he could not articulate the specifics of this.

During the conversation Adult B could not recall the details of the incident itself, but did remember calling the police to tell them that he had killed SH.

At the time of interview Adult B stated that he felt that prison had now given him "everything on the inside that he needed on the outside".

2.5 Summary of meeting with Adult B's employer

The co-chairs met with representatives of Adult B's former employer, the Environment Agency (EA) on 3rd June 2015. Those present were Nick Hodgkinson who was Adult B's line manager and Ollie Parsons, the Human Resources Business Partner for Adult B's department of the EA.

The purpose of the meeting was to provide them with more information about the process of the DHR and to seek their views about the events that led up to the incident and any relevant history and background information.

Nick stated that he had been Adult B's line manager since 2009 but had worked with him for approximately 15 years, the last 10 of which had been in the same team. Adult B was based in offices in Reading, but Nick was based in Newcastle so did not have regular face-to-face contact with Adult B, this tended to be about once a month.

Adult B's job was Property and Energy Manager. He had three people in his team which was part of the Facilities Management Technical Team. The team is involved in supporting operations with a focus on energy management across the 170 EA properties in England. Adult B had over 30 years experience in the sector.

Nick reported that Adult B was a popular colleague and that he was seen by many as a 'friendly uncle" type of person who appeared quite paternal in his approach to colleagues. People would go to him with their concerns and issues and he was seen as reliable. Nick stated that there had not been any issues with Adult B's work. He was seen as a productive individual. His sickness record was good, with very few absences and there had never been any disciplinary issues. Adult B was seen as a sociable person by those who worked with him.

Adult B was approaching his 60th birthday (he was 60 in July 2014) and in May 2014 began exploring the options for flexible retirement. The EA agreed to this which meant he would work a three day week, working reduced hours and be able to take his pension.

Nick reported that Adult B had begun his flexi-retirement in May 2014and after about a month of the new working pattern, went on holiday to Florida. Adult B contacted Nick on his early return from the holiday, Nick believes this to have

been about four or five days into the annual leave period. Adult B emailed Nick to advise of his return to the UK and said that this was due to his mother being unwell.

Nick stated that the email was followed up by a phone call from Adult B (date unknown). During the conversation Adult B told Nick he was not feeling well, was not sleeping and pre-warned Nick that he might not return from annual leave.

In fact Adult B did return to work but went home early on the first day and did not return. This was the first point at which Nick recalls thinking that there was any issue. Adult B's colleagues reported that on that day he did not seem himself and thought he appeared agitated.

Adult B advised Nick that he had seen his GP and that he now had a sick note. Nick recalls that the sick leave period began on 23rd June 2014. Adult B was signed off work with anxiety/panic. The first sick note ran until 1st July 2014 and the subsequent ones were each for a month.

During his sick leave Adult B would regularly call Nick on the phone, often on a Friday morning. Nick recalls that Adult B seemed nervous at the start of the calls but then became calmer. Adult B repeatedly told Nick he did not know what was wrong with him, but that he was still not sleeping and that he felt anxious. He told Nick that he had been to see the GP trying to get sleeping pills but couldn't get them, but also said he was on anti-depressant medication.

Nick and Ollie stated that there is no formal protocol within the EA for ongoing contact during a period of sick leave, but the human resources advice is for line managers to maintain regular contact without putting pressure on an employee to return to work.

During one of their phone calls, Nick talked to Adult B about Occupational Health input, which Adult B accepted and Nick sent him details so he could arrange an appointment. This appointment took place on 3rd July 2014.

The EA has an employee assistance scheme and Adult B would have been able to access support and talking therapy input through this service more quickly than it was available to Adult B through the NHS. Counselling was offered to him but he declined it.

Nick stated that Adult B had not found the Occupational Health input, or their report, of particular help to him as he believed it was too heavily focused on his inability to return to work. Adult B said that he did not think his work was a contributing factor to his being unwell, in fact he thought it made him feel better.

He also denied that his flexi-retirement was any kind of factor in how he was feeling.

On Friday 16th August 2014 Adult B called Nick at some time between 16.00 and 17.00. Nick stated that Adult B seemed more distressed and told him that he had been wandering around Newbury during the day. Nick recalls that Adult B told him that he was calling from Newbury Police Station and he 'confessed' to Nick that he had defrauded his mother. Nick recalls attempting to reassure Adult B who said he would call his daughter.

On Monday/Tuesday 18th/19th August 2014 Nick took a call from the police to say that Adult B had been arrested but did not disclose why. Nick later took a call from one of Adult B's colleagues who advised that Adult B had been arrested following SH's death. She was aware of this because it had been reported in the local media.

Nick provided a statement to the police as part of the criminal investigation and one of Adult B's colleagues did attend the hearing in Reading.

Nick said that there were no visible signs in the run up to Adult B's absence from work that there was anything wrong, that he had any problems or issues. Nick was not aware of any signs of any change in Adult B's behavior prior to the period of sick leave.

The EA were in contact with Adult B following his conviction and his employment with them has now been formally terminated.

2.6 Independent Consultant Psychiatrist report

During the review process, the DHR panel noted that Adult B had received differing diagnoses of his mental health condition. This was also an issue that SH's son and daughter-in-law had highlighted. In order to understand better how these diagnoses had been reached and what impact if any, the differing diagnoses may have had on Adult B's treatment and care, the DHR panel asked NHS England (South) to assist in commissioning an independent report from a Consultant Psychiatrist.

The Consultant Psychiatrist, Dr. Series, of Oxford Health NHS Foundation Trust carried out this review and produced a report of his findings for the panel. The full report can be found in Appendix One.

Summary of Dr. Series report

On balance, Dr. Series considers that the diagnostic finding of the two forensic experts that Adult B had been suffering from psychotic depression at the time of the incident is more reliable than those of the CRHTT and the Mental Health Act assessors who saw him earlier. This is largely because the forensic experts had access to a very wide range of collateral information about Adult B's condition from the statements of Adult B's family and friends, and they had the benefit over the CRHTT of knowing that Adult B had committed the act which he did. They had much longer to assess Adult B, and much more information about him.

On balance, Dr. Series thinks that the initial diagnosis of anxiety rather than depression led to a delay in prescribing appropriate antidepressant and antipsychotic treatment for Adult B. Several factors contributed to the delay, including Adult B's recorded tendency to underreport his symptoms to professionals, and what appears to have been a failure by professionals to interview family and/or friends carefully and take their views into account.

Dr Series states that it may be that a delay in seeing a doctor rather than other health professionals contributed to the misdiagnosis. He does not suggest that non-doctors are unable to make diagnoses, but that medical psychiatric training encourages a more analytical approach to diagnoses which might have been helpful in this case.

Notwithstanding the above, Dr. Series states that homicide is an extremely rare event, even in those with psychotic depression, and that he has not seen anything which suggests to him that this event should or could have been predicted or avoided. More appropriate treatment given earlier and more consistently might have reduced the risk of homicide, but it may well not have prevented it.

2.7 Independent Psychiatric Nurse report

As part of the review the DHR panel wished to gain an independent view of some of the nursing practice described in the IMR provided by BHT. Through NHS England, the panel commissioned Cathe Gaskell, an independent expert in nursing and mental health to review the aforementioned practice. The full version of the report can be found at Appendix Two. A summary of Ms. Gaskell's conclusions is set out below.

The report identifies and highlights a number of areas where practice was not in line with BHT's operating procedures and policies and some staff's clinical practices fell below an acceptable standard.

Some staff made clinical judgments in both services that Ms. Gaskell differentiates as weak rather than poor judgments, and there were areas where a lack of competency was demonstrated by staff in relation to their skills in the recognition of risk and suicidal ideation, knowledge of safeguarding and domestic abuse awareness and practices.

The practices of the mental health team staff should be set in the wider context of two services that where, at the time, swamped with very high activity levels and with increased expectations by the creation of an open inclusive or self referral crisis phone service, accessible across all of Berkshire.

Staff were functioning within services where there were not clearly defined roles or filters to access, so staff were treating a wide range of acuity, with presentations ranging from mild symptoms, to relapsing patients, to severe and enduring mental illness. Adult B appeared to get lost in this system. This was further contributed to by the volume of contacts impacting on both staff judgment and communication amongst the teams.

There was a blurring of roles and responsibilities between CPE and CHRTT and there was a sense of the team perception being that they were "*under siege*" from the unrelenting requests for their services and this resulted in staff signposting patients when they did not have the time to safely maintain or work with all clients requesting their services.

A range of permanent, locum and agency staff worked, some without adequate training, without at times access to supervision. Attempting to deliver a diluted service to reduce the backlog of referrals. This may have influenced the fact that SH's needs were also lost within the volume of information received by the CHRTT service.

Ms. Gaskell's overall independent opinion is that staff were working within a highly pressured, highly stressful environment with multiple contributory factors affecting their performance and judgments which then impacted on the efficacy and quality of the service offered by BHT at the time preceding the incident. In overall terms, the significant issues identified were systemic in nature. There were, however, also clear examples of poor professional practice by individuals within the Trust.

Ms. Gaskell's report makes a number of recommendations which BHT have accepted and are developing responses to at the time of writing. It is anticipated that these will be incorporated into their action plan in response to the DHR.

Section Three

Key findings

3.1 Key findings

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

- As a woman with a physical disability, SH was at potentially greater risk of domestic abuse and in particular of coercion and control.

- SH was at times concerned about the level of attention paid by Adult B to his daughter and there was some tension between them about this. It is known that this was also a source of some concern from other members of SH's family.

- Adult B had experienced a two and a half month period where his mental health had deteriorated. He was living with the symptoms of anxiety and depression. It is not clear what caused the onset of these symptoms, but it is clear that they were persistent and caused him distress.

- Adult B had recently taken flexi-retirement from his job with the Environment Agency, where he had worked (including in its predecessor organisations) for 30 years. Although it was planned that he would continue to work three days a week, this was still a significant life change for him.

- Adult B's employer was supportive and responded appropriately to his period of sick leave. Occupational Health input was offered as was counselling/talking therapy but Adult B did not take this up. From our conversations with his employer we are aware that had he taken up that offer he could have accessed those counselling and talking therapy services almost immediately and would therefore not have had to wait for input from NHS services in Berkshire.

- Adult B had maintained a friendly relationship with his former wife and was in contact with her. It is not known whether SH was fully aware of the extent of that contact. His ex-wife was concerned about Adult B's health in June 2014 and was instrumental in accessing health care services for him via SCAS, which resulted in his assessment at Basingstoke Hospital.

- Adult B maintained a close relationship with his daughter. In our interviews it was clear that she was a central focus in his life. His contact with her was regular but not all of it was known to SH.

- There was a degree of secrecy in relation to Adult B and his contact with his daughter. In particular this manifested itself in his initial non-disclosure

of a proposed financial arrangement to support his daughter and ex-wife in buying a house using some of his retirement pension lump sum. He only disclosed this to SH in the month before the incident and her reaction was perhaps unsurprisingly negative.

- The proposed house purchase fell through because Adult B requested the money back. At the same time Adult B was continuing to have concerns about finances and believed that he would be short of money following his flexi-retirement and that he and SH might be evicted. In fact, despite the flexi-retirement, Adult B would have been financially better off, with the combined pension and salary, then he was when in full time employment.

- Adult B had frequent contact with his GP surgery in the period leading up to the incident. He sought both face-to-face consultations and telephone advice. He was also used the out of hours GP service, Westcall and accessed NHS 111. He was clearly able to make contact with primary care professionals and was not inhibited in doing so.

- When presenting to healthcare professionals, both GPs as well as mental health professionals, the information provided to us suggests that Adult B was not always open and honest about how he felt and the effect of his symptoms on his thinking and behaviour.

- The frequency of presentation to the GP surgery and the frequent changes in the prescribed medication are a key feature of the period leading up to the incident. The information provided suggests that the symptoms that Adult B was presenting were proving difficult to address and that the GP's sought to identify the most efficacious pharmacological intervention. Adult B not complying with the recommended medication regime perhaps impeded this to some extent.

- The NICE guidance is clear about the most appropriate first line treatment and it certainly appears that despite the assertion in the NDCCG IMR, this guidance was not adhered to. However this must be tempered by the differing views offered about the actual diagnosis and there is a divergence of view between the GP and the clinical advisor retained by BHT.

- The initial diagnosis of anxiety rather than depression led to a delay in prescribing appropriate antidepressant and antipsychotic treatment for Adult B. Several factors contributed to the delay, including Adult B's recorded tendency to underreport his symptoms to professionals, and what appears to have been a failure by professionals to interview family and/or friends carefully and take their views into account.

- The GP's did appropriately refer Adult B for talking therapy services and liaised with the CPE, making a referral and following it up.

- The Crisis Team was functioning beyond its capacity, that is to say that levels of demand for the service were high. Staff were functioning within a set of services that lacked clearly defined roles or filters to access. This resulted in staff treating a wide range of acuity, with presentations ranging from mild symptoms, to relapsing patients to severe and enduring mental illness. Adult B appeared to get lost in this system.

- A range of permanent, locum and agency staff worked in the mental health services, some without adequate training, and at times without access to supervision.

- BHT staff were working within a highly pressured, highly stressful environment within which a number of contributory factors affected their performance and judgments.

Section Four

Conclusions

4.1 Conclusions

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

- Been conducted according to National Guidance and best practice, with effective analysis and conclusions of the information related to the case.
- Established what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and support vulnerable people and victims of domestic violence.
- Identified clearly what those lessons are, both within and between agencies, how and within what timescales they will be acted on and what is expected to change as a result.
- Reached conclusions that will inform recommendations that will enable the application of these lessons to service responses including changes to policies and procedures as appropriate; and
- Will assist in preventing domestic violence homicide and improve service responses for all vulnerable people and domestic violence victims through improved intra and inter-agency working.

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

4.1.1 Conclusions of the DHR panel

Predictability and preventability

The review has not found any evidence to indicate that physical violence had ever been a major factor in SH and Adult B's relationship. There is one incident, outside the timeframe of the DHR where Adult B is alleged to have 'head-butted' his ex-wife HT during an argument a number of years previously but this could not be substantiated. No further evidence that he ever physically harmed SH prior to the incident could be identified.

There is one reference to an occasion when SH awoke to find Adult B standing over her with a pillow, but again the detail of this is not clear and cannot be substantiated.

Adult B's anxiety had been increasing to the point where his behaviour had become more unpredictable. SH made it clear in her telephone conversation with the Crisis Team on the evening of 16th August 2014 that she felt threatened and that she did not feel safe but this was not followed up. Her concerns had been expressed in the call to SCAS on 16th August 2014 and again to the Crisis Team worker, W4 during the assessment visit.

Adult B's previous behaviour could be described as controlling at times and as such it constituted domestic abuse. For example, he managed the finances of the household, but in the period leading up to the incident this took a more controlling form. Adult B withheld money from SH, is believed to have prevented her from leaving the flat in the week(s) preceding the incident and is thought to have withheld food and cigarettes from her. The withholding of food could have been particularly injurious given SH's diabetes. In fact, the controlling behaviour led to SCAS formally reporting safeguarding concerns for SH to West Berkshire Council although these concerns were not shared with the Crisis Team.

In reviewing the IMRs and supporting information, as well as the two independent Nurse and Psychiatrist reports, the panel have concluded that there were missed opportunities to identify and clarify the risk presented to SH. There was evidence of increasing risk towards SH from Adult B.

When weighing the information presented, the panel has come to the conclusion that despite the changing risk, in the context of Adult B's worsening anxiety and depression, the *potential* for physical harm towards SH could have been predicted and steps taken to reduce it. However, there was nothing in Adult B's presentation or behaviour in the period leading up to SH's death that indicated that Adult B was

likely to kill her. On that basis, the panel concludes that her death was neither accurately predictable nor preventable.[26]

The evidence presented to the review

This review has been characterised by the strong consistency of evidence and information presented to it by the various agencies who had contact with SH and Adult B. The facts of the case are not in dispute by any organisation.

Understanding of SH's needs and the risks to her

SH's needs were lost within the volume of information received by the CHRTT service and as a result were not afforded enough significance or priority in the CHRRT's thinking or responses.

Assumption combined with a lack of professional curiosity resulted in a paucity of actual knowledge about risk factors towards SH from Adult B. In addition, flawed assumptions about SH's intentions regarding where SH would spend the night following her visit to a restaurant with her sister on the evening of 16th August 2014 influenced the decision making about the degree of priority applied to her concerns by the CRHTT.

Adult B's presentation to healthcare professionals

When presenting to healthcare professionals, Adult B did not always disclose his circumstances to them and attempted to *"'hold it together'* by providing a more positive version than was actually the case. This lack of disclosure resulted in healthcare professionals not always being in possession of the full facts relating to his mental and physical health. This in turn had the potential to influence their responses to him.

There probably was a misdiagnosis of Adult B, and in the view of the independent psychiatrist, depressive disorder should have been identified earlier than it was. The independent psychiatrist considers that the diagnostic finding of the two forensic experts that Adult B had been suffering from psychotic depression at the time of the incident is more reliable than those of the CRHTT and the Mental Health Act assessors who saw him earlier.

Decision making by mental health professionals and their knowledge of domestic abuse

Some BHT staff made weak clinical judgments in relation to Adult B and there were areas where a lack of competency was demonstrated by staff in relation to

[26] The family agree with the Home Office letter, dated the 25the January 2018. The family firmly disagrees with the conclusion that the homicide was neither accurately predictable nor preventable.

their skills in the recognition of risk and suicidal ideation, knowledge of safeguarding and domestic abuse awareness and practices. The decision taken by W4 on the 16th August 2014 to discuss whether Adult B might physically harm SH in a conversation with both adults present was a serious error of judgement.

Furthermore, the knowledge of domestic abuse and domestic violence amongst healthcare professionals within primary and secondary care was variable in its depth and application. This highlights the gaps that exist in the embedding of knowledge, awareness and how to respond in relation to domestic abuse across the sector that must be addressed following this incident.

Organisational capacity within the mental health crisis team

The CHRTT was functioning beyond its capacity, that is to say that levels of demand for the service were high. Staff were functioning within a set of services that lacked clearly defined roles or filters to access. This resulted in staff treating a wide range of acuity, with presentations ranging from mild symptoms, relapsing patients and those with severe and enduring mental illness. Adult B appeared to get lost in this system.

Information sharing

There were deficits in the flow of risk information between SCAS and the Crisis Team. In particular SCAS did not communicate their safeguarding concerns or the submission of the safeguarding form to West Berkshire Council. Had they done so the intervention of the CRHTT worker might have been different.

Section Five

Recommendations

5.1 Recommendations

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

5.1.1 DHR Overview Report Recommendations

Many of the issues raised in the IMRs that have been analysed and commented upon in the Overview Report are subject to recommendations within those IMRs. The DHR panel therefore offer the following overarching recommendations for local action:

1. We recommend that local mental health crisis services be strengthened, not only in terms of capacity to ensure swift response, but that they maintain evidence based methods for interview, assessment and response to mental health crisis. The matter of investment in these services will rest with local commissioners, but it is clear that these services must be responsive.

2. We recommend that updated information and advice be provided to GPs in the recognition and treatment of mental health needs. Furthermore we recommend that BHT put in place processes for regular updating of GPs about how and in what circumstances to refer to their services.[27]

3. We recommend that the requirement to conduct Carers Assessments be re-emphasised in both health and social care and that the outcomes of such assessments be appropriately shared between professionals and agencies.

4. We recommend that protocols for sharing risk/safeguarding information between SCAS and social services be reviewed and strengthened in light of the deficits highlighted in the DHR.

5. We recommend that GPs be advised to give consideration to services available through occupational health and employee assistance schemes provided by employers. This action would be assisted by the compilation of a list of employers in the county who provide occupational health and occupational health psychology services.

[27] The DHR panel is aware that this programme of training for GPs has been implemented

6. We recommend that health and social care professionals must wherever possible seek the views of an appropriate individual, for example spouse, carer, other relative and that this principle should be incorporated into health and social care professionals ongoing training and development.

7. We recommend that NHS England and the Home Office undertake work to examine the impact of the conflicting requirements of confidentiality and the Duty of Candour in the context of the conducting of Domestic Homicide Reviews and Mental Health Homicide Reviews. This case has demonstrated how these duties conflict and this places particular distress on families. The co-chairs will write to NHS England and the Home Office about this separately.

8. We recommend that the Home Office revise the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews, to make clear the criteria that need to be met for a DHR Panel Chair to be considered fully independent.

5.1.2 Recommendations made in the individual IMRs

NDCCG recommendations

1. It is recommended that in view of this tragic event, the profile and awareness of domestic abuse should be raised in general practices in Newbury & District CCG area, with training and linking in to the Safer Communities Partnership at West Berkshire Council.

   Specific proposal: to deliver GP Support Referral Service (previously known as IRIS) training package to all 11 practices in the CCG, and to strengthen the link between the Domestic Abuse Reduction Co-ordinator and the practices.

   Measure of success: that all 11 practices complete GP Support Referral Service training package before the 31st March 2016, delivered by the Co-ordinator to develop professional relationships with practices. An audit of GP practices will be undertaken to demonstrate that the GP Support Referral Service training has been implemented and that refresher training is undertaken annually.

2. It is recommended that across the CCG GP Practices to hold clinical meetings to share patients with vulnerabilities (defined as patients in whom symptoms are not resolving despite usual treatment) amongst colleagues so that any GP who might consult this group of patients is fully briefed (in addition to the detailed information in the electronic record.) This could take the form of Clinical Case Review discussions in house and during regular mental health meetings conducted with the local consultant psychiatrist and/or a local community psychiatric nurse, in order to tap into their expertise and clinical advice.

   Specific Proposal: To promote secondary care mental health consultant visits to practices (already underway) and to include the remit to discuss difficult clinical cases during those meetings

   Measure of Success: GPs report clinical learning on mental health cases in those meetings, using them for appraisals and continuing professional development recorded learning, as identified by self-reporting. Minutes of these meetings should be recorded and audited annually as part of overall Safeguarding procedures overseen by the named professional for Safeguarding in the CCG.

3. It is recommended that through this enhanced interface between clinicians in primary and secondary care, closer working on more challenging cases can take place both for the direct benefit in that case, and for wider learning.

   Specific proposal: promote the usage of email and telephone discussion between primary care & secondary care mental health consultants, underpinned by the improved professional relationships created in recommendation two.

   Measure of Success: clinicians report better interface and communication with secondary care, and vice versa as identified in the annual Berkshire Healthcare Foundation Trust commissioned survey of GPs regarding their service provision

BHT recommendations

1. It is recommended that comments about practice identified in the IMR should be considered by the relevant managers with a view to providing feedback to the staff concerned.

   Measure of success: All staff will be aware of the IMR, its findings and recommendations. Evidence that the report findings have been shared with staff.

   Accountable individual: CPE – Urgent Care manager CRHTT - Head of Crisis Resolution & Home Treatment Service

2. It is recommended that consideration be given to promoting awareness generally amongst practitioners, of the need to give particular attention to the identification of potential safeguarding issues where there is a combination of: (a) severity of symptoms which are persistent and not improving; (b) family members expressing distress as a result; (c) where disability may be a factor which adds to vulnerability.

   Measure of success: Training will have been provided to mental health staff about involving families and carers in drawing conclusions about a patient's mental health particularly where they are indicating a different view to that of the patient. Safeguarding training will also be provided to staff regarding all risk factors including disability. Training records will show compliance with training requirements. A quarterly documentation audit will demonstrate that families and carers have been involved in care planning.

   Accountable individual: Head of Clinical Training

3. It is recommended that policy and practice within CPE is reviewed in relation to ensuring that GPs' specific requests for a psychiatrist's opinion are routinely referred to a CPE psychiatrist for consideration, particularly where there is evidence of failure to respond to treatment.

   Measure of success: An audit will show that GP requests for a psychiatrist opinion are followed or the reason why this has not happened clearly documented in the patient records. A baseline measure will be taken in January and quarterly audit of 50 records will be completed to monitor compliance.

   Accountable individual: CPE – Urgent Care manager

4. It is suggested that processes in IAPT might be reviewed in order to ensure that any post-referral information recorded on RiO is evaluated and appropriately communicated to allocated practitioners.

   Measure of success: All patients upon entry to the service, including self-referrals, are now checked to see if they have a Rio history. If they do have a Rio history a summary is transferred to IAPTus - all IAPT team leads and supervisors now have access to read only Rio. A monthly random audit of cases will demonstrate this is now a robust service process –success will be measured that all RiO history has been checked where the patient is known to services in 100% of cases.

   Accountable individual: Clinical Director for IAPT

5. It is recommended that policy and practice be reviewed in all teams with a view to ensuring that times of contacts are routinely entered on RiO progress notes.

   Measure of success: A quarterly audit will show that times of contact with patient are clearly documented in the patient records.

   Accountable individual: Head of Crisis Resolution & Home Treatment Services

6. It is recommended that staff be reminded of the need to complete the RiO Risk Assessment tool as soon as possible after an assessment and before the end of a shift.

   Measure of success: Staff will be aware of the need to complete the RiO Risk Assessment as soon as possible after an assessment. A quarterly audit will demonstrate compliance with this standard.

   Accountable individual: Head of Crisis Resolution & Home Treatment Services

7. The family members of Adult B and SH who provided information and comments for the investigation, asked to receive a copy of the investigation report. It is suggested that consideration is given to this request and to an appropriate level of feedback.

   Measure of success: Family members of SH and Adult B will have received a copy of the report.

   Accountable individual: Director of Nursing and Governance

Sovereign Housing Association recommendations:

1. Operating procedures are up to date and reflect good practice

   i. By March 2015 undertake a review of SHA's anti-Social Behavior, Domestic Abuse and Hate Behaviour Procedure and publish a revised/updated procedure.

      Measure of success: An appropriately approved, reviewed and updated Sovereign Anti-Social Behaviour, Domestic Abuse and Hate Behaviour Procedure in place by March 2015 and a documented publication date to all relevant Sovereign staff, also by March 2015. Thereafter, bi-annual documented reviews and publications of the procedure.

2. Front line housing/support staff are trained in domestic violence so they can recognise the signs and know how to respond

   i. By 31 March 2015 review training records for all front line housing/support staff to confirm domestic violence training has been completed in the last two years

   ii. From March 2015 all new SHA front line staff to complete an e-learning package 'Understanding Domestic Abuse" within their six month probation period.

   iii. By June 2014 all staff delivering SHA's new older person's service from April 2015 to be trained on understanding domestic abuse.

Measures of success:

All current housing / supported housing staff trained in domestic violence and individuals training records reflect this training has taken place within the last 2 years by 31 March 2015.

On-line e-learning domestic violence module completed in induction periods for all new housing staff from March 2015 and Sovereign's Safeguarding Steering Group audits confirm this.

The accountable individual within Sovereign for implementation is the Housing Services Director.

SCAS recommendations

1. The current "Action Plan" template utilised in the Serious Incident Requiring Investigation (SIRI or SIs) forms part of all investigation packs within SCAS.

2. A review of the number of staff employed within the Safeguarding department to establish if there are sufficient numbers to effectively manage current work-load from across the SCAS region.

3. To look at the feasibility of having Vulnerable Adult / Children Safeguarding forms that SCAS staff have faxed into Safeguarding, forwarding these onto the respective Social Services agencies within the required 48 hour time frame.

4. Staff employed within the Safeguarding Department who undertake investigations, attend an IMR Investigations and writer's course.

5. As a Quality Assurance process, all IMRs be reviewed by the SIRI Review Group or a specifically named sub group of the SIRI Review Group Panel, to ensure that investigations provided by any SCAS member of staff, meet the required standards as set out in the Home Office Multi-Agency Statutory Guidance for the review of Domestic Homicides.

6. The Emergency Services Manager will discuss the complaint incident HT submitted with the Paramedic, with a view to obtaining a personal reflection on her personality and how that may impact upon patients.

In order to take forward the recommendations, SCAS will issue a Clinical Memorandum. A Clinical Memorandum requires SCAS staff to adhere to specific requirements / actions / practise or guidelines as would be explained in the memorandum itself.

The Clinical Memorandum is sent to each SCAS employee's email address, and is placed onto the SCAS intranet to allow access to the document there as well.

SCAS staff have an obligation to ensure that they are up to date with any Clinical or Operational Memorandums / Directives. These are also displayed on station Notice Boards to ensure maximum expose and compliance.

The failure to comply with a Clinical Memorandum can result in the professional registration of that person (if s/he is a Paramedic), being placed at risk (Paramedic are registered with the Health Care Professions Council and follow a Code of Conduct). If required disciplinary action will be taken should a full internal investigation deem those actions necessary.

Measures of success:

The number of flagged incidents to SCAS by the Mental Health Crisis Teams / Safeguarding bodies will provide one measure of success, dependent upon the number reported to SCAS.

SCAS raise between 60 and 110 safeguarding referrals a day and to so physically filtering them is not an option at this time. SCAS will of course monitor where it can and this includes external monitoring from the likes the CQC and the 36 safeguarding boards SCAS as an organisation attends.

The more likely route that a breech will be identified is through the SCAS DATIX system reporting system / a complaint or concern reported by our own staff, other Health Care Professionals or the public (Patient Experience Team) with reference to Safeguarding issues, which will then be investigated accordingly.

There will be an expectation that SCAS staff have/ will have read the Clinical Memorandum. It would have been sent to their work email address, which they can access at work and at home. The staff have an obligation to ensure that they update themselves and are expected to check notice boards for any new notices, memorandums and directives upon return from any length of time off / sickness etc.

The memorandums, directives etc. are also retained on the SCAS intranet which even if they had deleted (by mistake) their emails, the original is always available in the respective folders.

SCAS has developed an audit tool with local authority colleagues to audit safeguarding referrals. This has been adapted to undertake single agency audits so SCAS can now internally audit our referrals. This will cover specific elements of the actions/ recommendations from the DHR.

With respect to other actions/ recommendation of a corporate nature SCAS expect these will take longer to address and as they complete these they will update and share the action plan.

Accountable individuals: The Executive Director with responsibility for safeguarding, the Head of Safeguarding and the Assistant Director for Patient Safety and Quality.

Recommendations from Independent Review of Nursing Practice – Berkshire Healthcare NHS Foundation Trust (see Appendix Two)

1. The senior management team must clarify and differentiate the purpose of the CHRTT and CPE service models and ensure both services are reviewed and remodelled, to match capability with meeting capacity.

2. Another level of triage should be considered to ensure that not all calls are processed and passed through to CHRTT; some should be diverted to either social care or non-health services.

3. Activity levels for both of the services should be set in line with capacity, and a staff skill mix set that is appropriate against the acuity and activity presented.

4. Staff to be supported to develop skills in effectively responding to and managing users of the crisis service presenting with personality disorders. Working with senior staff to develop effective responses that work towards reducing high levels of phone contact.

5. Permanent staff should be recruited and supported to manage caseloads based upon evidence-based guidelines and ensuring patient safety at all times.

6. Staff welfare should receive a greater priority from senior management and a renewed focus on staff retention and health should be increased in areas with repeated high turnover with risks of staff burnout.

7. The admission system should more fully support allocating of contacts to a team or group of individuals, versus contact with a new staff member for each service contact, to promote consistency in the response and to ensure that a trusting relationship may be developed.

8. Bespoke advanced mental health telephone counselling skills must be provided for all staff and refreshed biannually. Staff should not work in these services without undertaking a competency-based training.

9. Staff should receive training in identifying suicidal ideation that is based on an evidence-based model and includes covert signs and managing ambivalence within telephone contact.

10. Staff should receive and be able to access consistent and high quality clinical group and 1-1 supervision.

11. Staff should have access to motivational interviewing skills to better improve their telephone relationships with those in crisis or hard to engage clients.

12. An escalation criterion tool should be implemented, which helps staff consistently identify current and past risk behaviours and triangulate them with other information such as concerns expressed by other professionals. This tool should be regularly audited.

13. Risk assessments should include gathering a holistic patient history based on past mental health history, family and employment factors as well as the presenting symptoms.

14. A greater recognition should be given to family involvement in developing treatment plans especially when the service focus is inpatient avoidance, families views and history must be included in planning effective community based care.

BHT action plan in response to Independent Review of Nursing Practice

Recommendation	Accountable Individual	Measure of Success
The senior management team must clarify and differentiate the purpose of the CHRTT and CPE service models and ensure both services are reviewed and remodelled, to match capability with meeting capacity	Chief Operating Officer	Both services will have clearly defined service models with capacity levels defined. Specifications will be available and capacity will be tracked All referrals are triaged by Common Point of Entry and the monitoring of referral data against capacity will be the measure of success.
Another level of triage should be considered to ensure that not all calls are processed and passed through to CHRTT; some should be diverted to either social care or non-health services.	Chief Operating Officer	Evidence will be provided that another level of triage has been considered. There are commissioning implications associated with this recommendation however the Trust acknowledges that having another provider able to manage social crisis calls would be beneficial to patients.
Activity levels for both of the services should be set in line with capacity, and a staff skill mix set that is appropriate against the acuity and activity presented.	Chief Operating Officer	Activity levels will be set in line with capacity. Staff skill mix will be defined using Department of Health policy guidance for crisis response and home treatment teams.

Recommendation	Accountable Individual	Measure of Success
		All referrals are triaged by Common Point of Entry and the monitoring of referral data against capacity will be the measure of success. Staffing levels will be provided as a measure of success
Staff to be supported to develop skills in effectively responding to and managing users of the crisis service presenting with personality disorders. Working with senior staff to develop effective responses that work towards reducing high levels of phone contact.	Head of Clinical Training	Identified senior staff and managers will be supported to attend specific training for staff via the Thames Valley Initiative The Knowledge and Understanding Framework Awareness level training for personality disorder. The percentage of senior staff and managers who have attended this training or equivalent training. Consistent regular staff supervision within the CRHTT service (every 4- 6 weeks). This will demonstrate that staff are receiving support to manage challenging patients.
Permanent staff should be recruited and supported to manage caseloads based upon evidence-based guidelines and ensuring patient safety at all times.	Head of Crisis Resolution & Home Treatment Services	The service will demonstrate an improvement in recruitment and turnover figures from 2014 baseline The service will seek to achieve Home Treatment Team Royal College of Psychiatry accreditation scheme as a measure of success (HTAS Scheme).
Staff welfare should receive a greater priority from senior management and a renewed focus on staff retention and health should be increased in areas with repeated high turnover with risks of staff burnout.	Head of Crisis Resolution & Home Treatment Services	A staff SPACE group will be established and attendance monitored against staffing levels. Measures of success: Consistent regular staff supervision within the CRHTT service (every 4- 6 weeks) – this will demonstrate that staff are receiving support to manage patients.

Recommendation	Accountable Individual	Measure of Success
		Percentage of staff who have accessed stress management and resilience training The service will demonstrate an improvement in recruitment and turnover figures from 2014 baseline
The admission system should more fully support allocating of contacts to a team or group of individuals, versus contact with a new staff member for each service contact, to promote consistency in the response and to ensure that a trusting relationship may be developed.	Head of Crisis Resolution & Home Treatment Services	This recommendation is difficult to implement because a crisis team and home treatment team work shifts that cover 24 hours a day 7 days a week. Therefore the ability to see the same person is not always possible; however during the day this will be achieved 70% of the time. The service will seek to demonstrate that each locality team provides care to the patients' resident in their area. A baseline audit will be conducted in January 2016 and then quarterly to demonstrate that patients have seen consistent staff during the day whilst on the caseload of the crisis and home treatment team.
Bespoke advanced mental health telephone counselling skills must be provided for all staff and refreshed biannually. Staff should not work in these services without undertaking a competency-based training.	Head of Clinical Training	A new suicide risk training will be launched in Spring 2016 which will include in-depth bespoke training on advanced mental health telephone counselling skills. The percentage of staff trained in telephone counselling skills will be monitored on a quarterly basis
Staff should receive training in identifying suicidal ideation that is based on an evidence-based model and includes covert signs and managing ambivalence within telephone contact.	Head of Clinical Training	A new suicide risk training will be launched in Spring 2016 which will include in-depth bespoke training on advanced mental health telephone counselling skills. The percentage of staff trained in telephone counselling skills will be monitored on a quarterly basis

Recommendation	Accountable Individual	Measure of Success
		Consistent regular staff supervision within the CRHTT service (every 4- 6 weeks) – this will demonstrate that staff are receiving support to manage patients.
Staff should receive and be able to access consistent and high quality clinical group and 1:1 supervision	Head of Crisis Resolution & Home Treatment Services	Consistent regular staff supervision within the CRHTT service (every 4- 6 weeks) – this will demonstrate that staff are receiving support to manage patients.
Staff should have access to motivational interviewing skills to better improve their telephone relationships with those in crisis or hard to engage clients.	Head of Clinical Training	The bespoke training on advanced mental health telephone counselling skills will include motivational interviewing skills. The percentage of staff trained in telephone counselling skills will be monitored on a quarterly basis
A criterion tool should be implemented, which helps staff consistently identify current and past risk behaviours and triangulate them with other information such as concerns expressed by other professionals. This tool should be regularly audited.	Head of Crisis Resolution & Home Treatment Services	A tool will be implemented and staff compliance will be shown through audits of the service risk assessment tool to demonstrate identification of current and past risk behaviours including triangulation of concerns expressed by other professionals.
Risk assessments should include gathering a holistic patient history based on past mental health history, family and employment factors as well as the presenting symptoms.	Head of Crisis Resolution & Home Treatment Services	An audit of risk assessment will demonstrate the gathering of a holistic patient history based on past mental health history, family and employment factors as well as the presenting symptoms.

Recommendation	Accountable Individual	Measure of Success
A greater recognition should be given to family involvement in developing treatment plans especially when the service focus is inpatient avoidance, families views and history must be included in planning effective community based care.	Head of Clinical Training	A new suicide risk training will be launched in Spring 2016 which will include the need to involvement family and carers in the development of care plans. A quarterly documentation audit will demonstrate that families and carers have been involved in care planning.

Appendix One

PSYCHIATRIC REPORT ON DIAGNOSIS

Introduction

1. This report is prepared by Dr Hugh Series, consultant old age psychiatrist, to assist the DHR panel investigating the homicide of NT's wife.
2. I have seen the following records:
3. the Berkshire Healthcare FT SIR,
4. the RiO progress notes and a number of associated documents
5. the record of emergency assessment by Bracknell Forest Council Emergency Duty Service
6. psychiatric expert reports prepared by Dr Reid (defence) and Prof Fazel (prosecution)

Chronology

7. The following chronology is not comprehensive, but quotes passages which I regard as significant to the question of diagnosis and treatment.
8. Direct quotations are placed in single quotation marks.

Date	Item	Source
16/06/14	'Adult B saw his GP, reporting anxiety. He was prescribed amitriptyline, up to 30mg [low dose]'	Berkshire Healthcare NHS FT SIR
18/06/14	Saw GP, prescribed lorazepam, 1mg x 7. Seen in A&E, not referred to secondary MH services	Berkshire Healthcare NHS FT SIR
18/06/14	Telephone call received from Adult B - expressed to feeling anxious, stressed and not slept for several days. Started to feel anxious and stressed last week whilst on holiday to Florida, was not able to sleep - began to get very anxious and came back home at the week-end leaving his wife and family in Florida. Denies any current stressors that would impact on his mental health.	Rio progress notes
22/06/14	Wife reports Adult B stressed with panic attacks and unable to sleep	Berkshire Healthcare NHS FT SIR

Date	Item	Source
27/06/14	GP prescribes mirtazapine	Berkshire Healthcare NHS FT SIR
29/06/14	T/C - from Adult B. Quite distressed and panic about lots of worries and this seem to stem from his financial decision issues. He described his case as complex to go through. He told me that he took an early retirement and now feels he made a big mistake. He described a lot depressive symptoms, particular poor sleep, lack of energy, lack motivation, no appetite, lost interests, irritable and agitated. He reported that, he was started on Mirtazapine 15mg and this was started on Friday by his GP. He reports that prior to the Mirtazapine he was only sleeping at least 3 hours every night despite that he was started on Zopiclone 7.5mg. He also told me that, he was prescribed Lorazepam 1g within 24 hours to contain his anxiety.	Rio progress notes
07/07/14	'severe and worsening anxiety, panic attacks, depression, and lack of sleep for the past three weeks...might be experiencing excessive anxieties in the context of his psychosocial issues.'	Berkshire Healthcare NHS FT SIR
07/07/14	t/c with Adult B who spoke of having "panic attacks" currently rating them as 8-9/10. He reports having thoughts of "not wanting to be here" which he attributes now to the increased fequentcy of the anxiety. He has no plans to end his life.	RiO progress notes
07/07/14	WORKING DIAGNOSIS: Anxiety MSE(Mental State Examination): Speech: no pressure, no flight of ideas, speech was coherent and relevant Mood: He reported feeling awful, really bad, shaking from inside. Sleeping to sleep, he rated mood at 1 out 10 and anxieties at 1 out 10 on a sliding scale. He also reported that he has not yet noticed any change in his mood since medications were started. Nil evident of risks to self or others.. Sleep: said its awful, average sleep is 2 hours Appetite: force self to eat. Motivation: no Energy: no Concentration: poor Insight: he appeared to have limited insight into his mental health stressors.	RiO core assessment

Date	Item	Source
	Thought/ perception: no formal thought disorder noted or reported. Impression: He expression signs and symptoms which suggest that he might be experiencing excessive anxieties in the context of his psychosocial issues and in my view he would benefit from support with Talking therapies in developing anxiety management strategies. To refer to Talking therapies for CBT for Anxiety management. He was advice to see his GP for regular review of medications effects and side effects. For him to utilise Crisis number whenever in distress.	
07/07/14	(This is given in the RiO progress notes, which is in other respects almost identical to the RiO Core Assessment, completed by the same nurse) INITIAL FORMULATION: He is a 60 years old male who reported to have experience a sudden onset of anxieties about three weeks ago. He has been struggling to cope and she sleep pattern has been poor, mood has been low and has been having panic attack. He reported that he was started on medications mirtazapine about has not yet been therapeutic. He reported to been excessively worried about his family, finances and work. He has worries about his 94 year old mother who is unwell as he is the only child he feels it his responsibility to support her. He also reported that her wife is unwell and has family worries too. He is also worried that he might not be able to go back to work Impression: He expression signs and symptoms which suggest that he might be experiencing excessive anxieties in the context of his psychosocial issues and in my view he would benefit from support with Talking therapies in developing anxiety management strategies.	Rio progress note
07/07/14	MSE(Mental State Examination): Speech: no pressure, no flight of ideas, speech was coherent and relevant Mood: He reported feeling awful, really bad, shaking from inside. Sleeping to sleep, he rated mood at 1 out 10 and anxieties at 1 out 10 on a sliding scale. He also reported that he has not yet noticed any change in his mood since medications were started. Nil evident of risks to self or others.. Sleep: said its awful, average sleep is 2 hours Appetite: force self to eat. Motivation: no	CPE assessment

Date	Item	Source
	Energy: no Concentration: poor Insight: he appeared to have limited insight into his mental health stressors. Thought/ perception: no formal thought disorder noted or reported. Impression: He expression signs and symptoms which suggest that he might be experiencing excessive anxieties in the context of his psychosocial issues and in my view he would benefit from support with Talking therapies in developing anxiety management strategies. To refer to Talking therapies for CBT for Anxiety management. He was advice to see his GP for regular review of medications effects and side effects. For him to utilise Crisis number whenever in distress.	
08/07/14	'pacing around the house punching pillows'.	Berkshire Healthcare NHS FT SIR and Rio progress note
10/07/14	He did contact the Crisis Team on 08.07.14. He was in an agitated/anxious state, however after some time he did calm down. He was able to say that he had taken one Lorazepam earlier on and it had had no effect. He also said that his anxiety was worse at night and he was not sleeping, the Mirtazapine was not helping him. He reported that he would not be prescribed any more Lorazepam and told he could not take any Zopiclone with the Mirtazapine. Distraction techniques were discussed, but Adult B felt this was not helpful for him. It was explained to him that the nature of anxiety would make him catastrophize. He accepted this and agreed that he could sometimes rationalise things. He has been in contact with Talking Therapies and is awaiting assessment, Adult Bstated that he is willing to wait for Talking Therapies.	CPE ltr to GP
04/08/14	Adult B identified his main difficulties as anxiety and worry.	Berkshire Healthcare NHS FT SIR
15/08/14	The GP stated that Adult B had been suffering from severe anxiety for the past 10 weeks. GP had increased dose of mirtazapine to 45mg, as well as zolpidem 10mg	Berkshire Healthcare NHS FT SIR

Date	Item	Source
	[sleeping pill] and propranolol 40mg up to three time daily [beta blocker used to help shaking and palpitations due to anxiety]	
16/08/14	SH phoned ambulance, 'Pt disclosed that husband wont; allow food to be brought, money is limited to pt £150 month but daughter gets £300 per month of food in house. Pt [illegible - appeared scared?] of husband's increase in non physical abuse. Pt also disclosed being unable to leave house regularly of own accord. Concerns Emotional Abuse due to husband's mental state.'	South Central Ambulance Trust record
16/08/14	Seen at Newbury Community Hospital. The problem he presented was rectal pain with bleeding and discharge, and constipation. He made no mention of mental health difficulties or family issues. An examination established that he had a physical condition related to haemorrhoids. He was prescribed suppositories.	Berkshire Healthcare NHS FT SIR
16/08/14	Home visit by crisis team practitioner Good eye contact, and reported that his mood was variable. Stated that he is worried about his finances as well as moving house, as he feels that they will not be able to pay their bills at the rate at which their finances are dwindling. Wife however stated that was not likely to happen soon as they had £94 000.00 in savings. Adult B reported that he has not been taking his medication for the last two weeks Received T/c from Dr Latif (Westcall OOH GP) who agreed to prescribe Diazepam 10mg for Adult B for two nights, and she sent the prescription to Boots,. Plan was for CRHTT to collect the medication for Adult B as he advised that he is not driving at the moment and would not be able to collect the meds. Dr Latif also advised that CRHTT remove the other medication which Adult B had in his possession which he was not taking, i.e., the Mirtazapine and the Zolpidem.	
16/08/14	He reported that his mood was variable and denied any negative, suicidal or self-harming thoughts. He said he had not taken medication for two weeks because it made him feel sick in the mornings. He 'reported that he would be safe tonight and agreed to take his prescribed medication'. SH told the assessor that her husband was 'behaving like Jekyll and Hyde because when professionals visit, he makes it seem as if all is	Berkshire Healthcare NHS FT SIR

Date	Item	Source
	OK, but once it's just the two of them left, he becomes a very agitated different person.' She told him that Adult B's concerns about finances and needing to move house were not well founded as they had substantial savings (redacted information).	
16/08/14	There were no obvious sign of psychosis or cognitive impairment or other cause for concern from the interaction.	Berkshire Healthcare NHS FT SIR
17/08/14	Greeted by Adult B at door [not met before so not familiar] and he was pleasant and cooperative, calm and no obvious sign of distress or concern. Explained prescription and asked if I could have his "old tablets " and he was happy to give me a plastic bag and give them to me, I explained that he had tablets for 2 days and we would arrange MR asap. I also asked if his wife was about and he advised me in a casual normal manner that she had gone out with her sister. I did not pass any further comment so as to avoid causing alarm. There was no obvious sign of psychosis or cognitive impairment or cause for concern in our brief interaction and I was happy to leave.	Rio progress notes
17/08/14	**Alleged offence**	
18/08/14	Assessed in police custody for detention under Mental Health Act by Dr Ibe, Dr Barrow and John Miller (AMHP). 'Adult B said he killed his wife, he called police to tell them. He has "a selective memory" because his mind is muddled, "my mental health is based on deceit & lies ... most of my life I've lived in a Walter Mitty way, my finances. I know I killed my wife, I've sloped downwards since May." He remembers crisis team (CRHTT) visiting at about 9pm last night with medication ... says he started tablets to help him sleep, he wanted a magic pill. Not slept since May-June without tablets. Before then he slept 10 hrs a night and felt well. He described his home life as "chaotic, not traditional." He said there had been many changed in his life, he has mismanaged his life, he took partial retirement at 60, took his pension and continues working 2 days p'week. Says he lives for the day, no planning for the future. Later in interview Adult B said he gave ex wife, daughter and her husband £90,000 to help them but a house. SH "took it bad".	Bracknell Forest Council Emergency Duty Service report

Date	Item	Source
	Adult B dates his mental health problems from his gift to family from his pension, "that took away a comfortable old age ... I still had a job and pension and intended to retire at 65." He continued "my lack of planning, ill-discipline ... I panicked", but he had £40,000 returned by ex wife, and expects the remaining £50,000. Adult B and wife didn't share a bedroom, she usually slept in bedroom on the bed, he slept on settee in another room - a long term arrangement. Married to SH for 11 years. Said the flat was disorganised, he hoards pictures & memorabilia. "There was a sea change in April to May, then I went steeply down hill and lost reason, culminating in today." Adult B clarified this was because he gave his pension away to ex wife and daughter. "I wasn't truthful to them, I was descending into a sort of paranoia." Adult B "we live in an inward facing courtyard, I kept the windows closed to reduce the noise and not annoy neighbours. I've been on sick leave from June because of not sleeping. We had day trips, I did shopping, in past week my wife used her buggy to shop at Tesco. I couldn't work out what shopping we needed" - referring to his muddled thinking. "I've not eaten or drank for past 6 days, I'm constipated." "I spent the last week unaware of what I have been doing." I remember walking into Newbury police station last Wednesday? and asked to be arrested for fraudulently taking my mother's burial money". Said he has stolen about £30,000 from mother, her insurance, mother (aged 94) thought he was saving her excess money for her. Adds he spent mother's money on many holidays for him & SH, he didn't tell SH where holiday money had come from , she thought it was from his savings. "It culminated last night (Saturday), I was feeling enormous pressure in my head, I turned the lights off and closed windows ... We couldn't discuss anything .... the flat has become a prison .... coming out in the police car (after arrest this morning) was a release." "My wife has also been depressed since June, she made excuses for me ... I shut the windows for my own privacy." "On Saturday morning I was pacing around the flat, I checked SH wasn't snoring a lot, I discussed taking pills with SH. She said I can be better by relaxing & taking medication. Things reached a crescendo, got to a stage I thought she was having a	

Date	Item	Source
	hypo', and called ambulance. On Saturday there was angry words between us but not shouting ... " Medication? Adult B "none other than Mirtazepine & Diazepam. Crisis team delivered Diazepam and removed Mirtazepine, at about 9pm, my wife was out with her sister at restaurant. I felt unnaturally hot. I didn't hear her come in. I was in bed, she fell asleep on settee, she sleeps better than me. I got up & paced the flat all night until it got light. I just lost everything. I did what I did in the early hours, day light came up. I cannot see any reason why I did it other than paranoia. The way my brain is operating is how it is all I have told you." He continued "I cannot remember what I was thinking. I had a flash to die, I think I acted on that. I believe that SH wasn't aware of the truth and she was not acknowledging it. I will pose questions & she will pose strange answers, like we will move a room. She would say the Council will find me a house." How long have you had thoughts of harming SH? Adult B - "that was first time. Police can find a lot if they search my Google. I've Googled loads about suicide on medication, but I've not investigated about harming Afult A. Just random searching, I've no plans to kill my wife or anyone". "Nil alcohol, nil illicit I street drugs." He denies hearing 'voices', he heard neighbours real voices this morning. Denies interference with his thoughts, no thought control or insertion. 1. Adult B gave a reasonably clear and coherent account, although he did not recall events chronologically he back-tracked to speak of connected events or thoughts, and he reflected that he made a bad financial decision with his pension. 2. We did not elicit any signs or symptoms of psychosis. Adult B's use of "paranoia" was questioned and he denied any thoughts of being followed, being in danger, of a conspiracy against him, he denied delusional thoughts. I suggest he may be using this word to describe feelings of having made poor financial decisions and life choices narrowing ahead of him as he ages, due to insufficient capital to fund his (or their joint) retirement. 3. Adult B has a 3-4 month history of depression and anxiety arising from an ill-considered financial decision which he now regrets. He did not take medication consistently, therefore his depression wasn't treated as effectively as it might have been had his mood and	

Date	Item	Source
	compliance been closely monitored. 5. He has no thoughts of harming himself. 6. He expressed feelings of high and increasing anxiety, now relieved by being in police custody. 7. Drs Ibe and Barrow advise that Adult B needs proper treatment of this depressive episode.' 8. We agree Adult B has capacity to answer police questions in formal interview, with a solicitor present. However he needs time and a patient approach to give his best account.	
18/08/14	'A Mental Health Act assessment was requested by police and undertaken at 23.40 by an AMHP and two Section 12 approved doctors. (redacted information). He said he and his wife had lived beyond their means. He said he had mismanaged his life and been untruthful and described himself as living like 'Walter Mitty'. He referred to tensions in the relationship with his wife and said he had slept on the settee for years. He said his own low mood had rubbed off on his wife and they had not gone out much. He described the flat as like a prison and he felt a sense of release when he was taken away by police. He described how on the morning of 16 August 2014 he was 'pacing around the flat … Things reached a crescendo, got to a stage where I thought [SH] was having a hypo and I called the ambulance.' He described how later on his wife had gone out with her sister and he did not hear her come in. He said he had 'a fleeting thought to die in the early hours, I think I acted on that.' He said he had investigated suicide on the internet but had no previous thoughts of harming his wife. He said he did not take his prescribed medication consistently and that his problems were exacerbated when he stopped taking medication. He used the term 'paranoia' about his mental state but denied delusional thoughts, thoughts of being followed or in danger or subject to any conspiracy. The AMHP concluded that by 'paranoia' he was referring to his feelings arising from poor decisions and the narrowing of his life choices and having insufficient funds for his retirement. The assessment team concluded that: • There was a 3 to 4 month history of depression and anxiety arising from 'an ill-considered financial decision which he now regrets'. • He needed treatment of his depressive episode for which hospital admission was not indicated.	Berkshire Healthcare NHS FT SIR

Date	Item	Source
	• He had capacity to answer police questions in formal interview with a solicitor present.'	
18/08/14	FORMULATION: 1. Adult B gave a reasonably clear and coherent account, although he did not recall events chronologically he back-tracked to speak of connected events or thoughts, and he reflected that he made a bad financial decision with his pension. 2. We did not elicit any signs or symptoms of psychosis. Adult B's use of "paranoia" was questioned and he denied any thoughts of being followed, being in danger, of a conspiracy against him, he denied delusional thoughts. I suggest he may be using this word to describe feelings of having made poor financial decisions and life choices narrowing ahead of him as he ages, due to insufficient capital to fund his (or their joint) retirement. 3. Adult B has a 3-4 month history of depression and anxiety arising from an ill-considered financial decision which he now regrets. 4. He did not take medication consistently, therefore his depression wasn't treated as effectively as it might have been had his mood and compliance been closely monitored. 5. He has no thoughts of harming himself. 6. He expressed feelings of high and increasing anxiety. He also described feeling "numb" whilst in police custody; we agree that he is probably feeling emotionally detached from the reality of events, which is understandable. 7. Drs Ibe and Barrow advise that Adult B needs proper treatment of this depressive episode. Had we assessed him at home (ie without his arrest for a serious offence), we would not be arranging a hospital admission.	EDS contact report in custody
11/12/14	Interviewed on 11th and 15th December by Defence expert psychiatrist, Dr Reid, who diagnosed 'severe depressive episode with psychotic symptoms ICD-10 F 32.3	Defence psychiatric report
14/01/15	Interviewed on 14th and 15th Jan by Prosecution expert psychiatrist, Prof Fazel, who diagnosed 'severe depressive episode with psychotic symptoms ICD-10 F 32.3.	Prosecution psychiatric report

Date	Item	Source
	2.5.3 The investigator sought an opinion from a clinical adviser (consultant psychiatrist) on the diagnosis and medical treatment of Adult B as evident in the BHFT records. Regarding diagnosis, the adviser commented 'I note that thought was given to diagnosis and treatment by a number of professions and these were noted as 'anxiety', 'reactive anxiety/depression', and 'anxiety and panic'. Adult B's difficulties appear to be within the realm of generalised anxiety, but he did not meet criteria for ICD10 diagnosis, generalised anxiety disorder as he fell short of the required six months duration. This may suggest the diagnosis was one of adjustment disorder with a predominantly anxious manifestation. At this point the distinction between diagnoses may not have drastically affected Adult B's proposed treatment.'	Berkshire Healthcare NHS FT SIR
	[Items in italics are marked in red in the report, and are presumably comments added to the SIR report later] 'Pg3 para1.1.1 – [Adult B] was assessed whilst in custody on his immediate arrest (17/08/15) and again by an AMHP and 2 doctors the next day (18/8/14). *This is covered later in the report.* All 4 professionals determined Adult B to be in a fit state and not showing signs of psychosis. How can this assessment be accurate at this time? *That was the clinical judgment at the time - NB the particular remit of assessors undertaking a MH Act assessment.* Also considering all the professionals whom assessed Adult B in the weeks leading up to the incident and no professional diagnosed psychosis or extreme mental health conditions. How can all the professionals misdiagnose Adult B's mental state in the weeks leading up to and at time of the incident but weeks after the incident forensic psychologists assess N as psychotic? *NB para 1.2.3 – it was difficult to make an accurate assessment in view of the way Adult B presented.* There has been a major misdiagnosis of Adult B's mental state by professionals in their assessments either before or after the incident. *The issue is whether a different diagnosis should have been made on the information / presentation at the time. This is a matter of clinical judgment - see the opinion of the clinical advisor.*	Berkshire Healthcare NHS FT SIR p.29

Psychiatric diagnosis

How diagnoses are made in psychiatry

9. Making a diagnosis in psychiatry relies very heavily on the account given by the patient of his own symptoms, and the patient's previous history of mental disorder. Under usual circumstances, the information from the patient is augmented by collateral information from an informant such as family or friend, and previous medical records or a referral letter. This is not always possible, for example, if nobody who knows the patient is available, or if the patient refuses permission to speak to anyone else. At the time of the MHA assessment in custody, it is possible that no one who knew the patient was available.

10. In order to try to make the process of diagnosis as objective and reliable as possible, much research has been directed at producing standardised or operationalised definitions of psychiatric disorders. The two most widely used systems are the American Diagnostic and Statistical Manual 5th edition (DSM-5) and the World Health Organisation International Classification of Diseases 10th edition (ICD-10). The DSM-5 criteria are given below for major depressive disorder, anxious distress (a qualifier of major depression in DSM-5), generalized anxiety disorder and adjustment disorder. These are the disorders which are most relevant to the present case.

DSM-V criteria for major depressive disorder (American Psychiatric Association 2013)

Three domains A–C must be covered before a diagnosis of major depression can be made.
A. Five or more of the core symptoms present during the same 2-week period, with a change from previous functioning; at least one of the symptoms must be either (1) depressed mood or (2) loss of interest or pleasure. The core symptoms are:
Depressed mood most of the day, nearly every day, as indicated by either subjective report or noted by others (for example, tearfulness).
Markedly diminished interest or pleasure involving all, or almost all, activities most of the time.
Significant weight loss when not dieting or weight gain (a benchmark of more than 5% of body weight in a month is suggested); or decrease or increase in appetite nearly every day.
Insomnia or excessive sleep nearly every day.
Psychomotor agitation or retardation nearly every day—as observed by others, not merely subjective.
Fatigue or loss of energy nearly every day.
Feelings of worthlessness, or excessive or inappropriate guilt (which may be delusional) nearly every day.
Reduced ability to think or concentrate or indecisiveness nearly every day.
Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

B. The symptoms lead to significant distress or impairment (e.g. social, occupational).
C. The symptoms are not attributable to the direct effects of a substance (e.g. a drug of abuse, a medication) or a general medical condition.
D. The syndrome is not secondary to a psychotic disorder.[28]
E. There is no history of mania or hypomania unless induced by substances or a medical condition.
Specifiers can be coded for severity (mild, moderate, or severe), psychosis, and remission (partial or full). Non-coded specifiers include: anxious distress (see text); whether psychotic symptoms are mood-congruent or mood-incongruent; melancholia (complete anhedonia accompanied by diurnal variation in mood, early morning wakening, total despondency, and psychomotor change); and atypicality (often involving a more reactive mood, hypersomnia, increased appetite, and 'leaden' feelings in the arms or legs).

Anxious distress[29]
Anxious distress is defined as the presence of at least two of the following symptoms during the majority of days of a major depressive episode or persistent depressive disorder (dysthymia):
1. Feeling keyed up or tense.
2. Feeling unusually restless.
3. Difficulty concentrating because of worry.
4. Fear that something awful may happen.
5. Feeling that the individual might lose control of himself or herself.
Specify current severity:
Mild: Two symptoms.
Moderate: Three symptoms.
Moderate-severe: Four or five symptoms.
Severe: Four or five symptoms and with motor agitation.
Note: Anxious distress has been noted as a prominent feature of both bipolar and major depressive disorder in both primary care and specialty mental health settings. High levels of anxiety have been associated with higher suicide risk, longer duration of illness, and greater likelihood of treatment nonresponse. As a result, it is clinically useful to specify accurately the presence and severity levels of anxious distress for treatment planning and monitoring of response to treatment.

Generalized Anxiety Disorder 300.02
A. Excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least 6 months, about a number of events or activities (such as work or school performance).
B. The individual finds it difficult to control the worry.
C. The anxiety and worry are associated with three (or more) of the following six symptoms (with at least some symptoms having been present for more days than not for the past 6 months);
Note: Only one item is required in children.
1. Restlessness or feeling keyed up or on edge.
2. Being easily fatigued.

[28] From the context, it is clear that this is not intended to refer to psychotic depression, but to other psychotic disorders such as schizophrenia.
[29] This corresponds approximately to what is sometimes known as 'agitated depression'.

3. Difficulty concentrating or mind going blank.
4. Irritability.
5. Muscle tension.
6. Sleep disturbance (difficulty falling or staying asleep, or restless, unsatisfying sleep).
D. The anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
E. The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g., hyperthyroidism).
F. The disturbance is not better explained by another mental disorder

Adjustment Disorders
A. The development of emotional or behavioral symptoms in response to an identifiable stressor(s) occurring within 3 months of the onset of the stressor(s).
B. These symptoms or behaviors are clinically significant, as evidenced by one or both of the following:
1. Marked distress that is out of proportion to the severity or intensity of the stressor, taking into account the external context and the cultural factors that might influence symptom severity and presentation.
2. Significant impairment in social, occupational, or other important areas of functioning.
C. The stress-related disturbance does not meet the criteria for another mental disorder and is not merely an exacerbation of a preexisting mental disorder.
D. The symptoms do not represent normal bereavement.
E. Once the stressor or its consequences have terminated, the symptoms do not persist for more than an additional 6 months.

Psychosis and paranoia

11. ‘Psychosis’ is a rather ill-defined term whose central meaning is the loss of contact of the patient with reality. This is most commonly seen as hallucinations (false sensory experiences, usually seeing or hearing things which are not really there) or delusions (false beliefs which are out of keeping with the person’s social and cultural background, but which are held in the face of reasoned argument). Psychosis can be a feature of depression, in the form of hallucinations and/or delusions. Hallucinations in depression might occur as hearing voices which are very negative or critical in nature, sometimes commanding the person to harm themselves or others. Depressive delusions are typically negative beliefs such as that the sufferer has done something bad, is impoverished, has harmed others, is wanted by the police, deserves to die, or is seriously physically ill, for example with cancer. In an extreme case, the person might even believe that he is already dead. Psychosis can also be seen in an abnormal pattern of reasoning, where the person comes to a conclusion which a normally healthy person would not consider followed from the initial presumptions. Sometimes thinking becomes so disrupted that normal patterns of reasoning are lost and it is difficult to follow the reasoning at all.

12. ‘Paranoia’ is the belief that you are being pursued or interfered with by others in order to harm you. It can occur in depression, but it is not the only form of false belief that can occur in depression. As suggested in the EDS custody report, when NT used the word he may have been referring to his beliefs about his financial situation. At the MHA assessment NT said, ‘I cannot see any reason why I did it other than paranoia.’

13. Psychotic ideas that you have done something bad can leave to paranoid delusions because you may believe that as a result of the bad act, police or others are pursuing you and will punish you for what you have done.

Adult B’s diagnosis

14. A variety of opinions on diagnosis have been given:

    i. The initial assessment made by the Berkshire CRHTT following telephone consultations with community nurses on 18/06/14 and 29/06/14 identified both anxiety and depressive symptoms.

    ii. The diagnosis made by a community nurse on 07/07/14 was anxiety. This was qualified as: ‘He expression [sic] signs and symptoms which suggest that he might be experiencing excessive anxieties in the context of his psychosocial issues and in my view he would benefit from support with Talking therapies in developing anxiety management strategies.’ The entry refers to low mood, panic attacks and excessive worries, but does not give a diagnosis of depression.

    iii. A home visit by an occupational therapist on 16/08 refers to Adult B’s feeling low in mood and being ‘very depressed’. Adult B said he had not been taking medication for 2 weeks. Thulile (it is not further identified who this was) advised the OT to call the Westcall doctor to prescribe diazepam. This doctor prescribed diazepam (anti-anxiety medication) for 2 nights and advised CRHTT to remove the other medication, including the mirtazapine. I consider that depression should still have been considered, and attention should have been given to the need for an alternative antidepressant to mirtazapine. It may be that the working diagnosis of anxiety distracted the team from the need to treat depressive symptoms.

    iv. At a home visit by a community nurse on 17/08 Adult B appeared ‘pleasant and cooperative, calm and no obvious sign of distress or concern’ and ‘There was no obvious sign of psychosis or cognitive impairment or cause for concern in our brief interaction and I was happy to leave.’

    v. The EDS assessment on 18/08/14 by the AMHP is quoted in the table above and notes a 3-4 month history of anxiety and depression and refers to a depressive episode. The note says, ‘We did not elicit any signs or symptoms of psychosis. Adult B's use of "paranoia" was questioned and he denied any thoughts of being followed, being in danger, of a conspiracy against him, he denied delusional thoughts. I suggest he may be using this word to describe feelings of having made poor financial decisions and life choices narrowing ahead of

him as he ages, due to insufficient capital to fund his (or their joint) retirement.'

vi. The clinical adviser (consultant psychiatrist) gave an opinion based on the BHFT records (2.5.3-2.5.5 of the BHFT SIR report), commenting that 'Adult B's difficulties appear to be within the realm of generalised anxiety, but he did not meet criteria for ICD10 diagnosis, generalised anxiety disorder as he fell short of the required six months duration. This may suggest the diagnosis was one of adjustment disorder with a predominantly anxious manifestation. At this point the distinction between diagnoses may not have drastically affected Adult B's proposed treatment.'

vii. At the time of their assessments in Dec 2014-Jan 2015 both the defence psychiatric expert and the prosecution psychiatric expert diagnosed Adult B as suffering from severe depressive disorder with psychotic features at the time of the offence.

15. Adult B presented to his GP on 16/06/14 and then to psychiatric services (by phone initially on 18/06/14 but not face to face until 07/07/14) with a mixture of symptoms: feelings of anxiety and stress (though he denied current stressors on 18/06/14), panic attacks, poor sleep, feeling awful, low in mood, poor appetite, poor motivation, poor energy, poor concentration, poor insight into his difficulties, agitation (pacing and punching pillows). He said it had been a big mistake to take early retirement (29/06/14). He identified his main difficulties as anxiety and worry. His wife reported that he had unfounded concerns about finances and needing to move house. Important negative findings were that Adult B's speech was normal in rate and flow, there was nothing to suggest psychosis (but see below), no thoughts of suicide or self-harm, no cognitive impairment.

16. The two most likely diagnoses on these symptoms were depressive disorder (depression) and anxiety. There is considerable overlap between the symptoms of depression and anxiety, and they can occur together, though in standard classifications (DSM-5 and ICD-10), they are seen as distinct conditions. DSM-5 allows a diagnosis of 'depressive disorder with anxious distress', which includes some symptoms of anxiety. DSM-5 requires that symptoms be present for at least six months to make a diagnosis of generalized anxiety, but in UK clinical practice, it is common to consider this diagnosis before six months of symptoms have elapsed.

17. Both anxiety and depression can produce physical symptoms of anxiety such as racing heart, clammy skin, feeling light headed, feeling faint, panic attacks, worrying thoughts, poor sleep, poor concentration, poor appetite, fatigue, and irritability. However, the two core symptoms of depression, at least one of which must be present for a diagnosis, are low mood and loss of enjoyment, and the core symptom of anxiety is excessive worry.

18. Adult B therefore presented with a mixture of symptoms which could have been related to either of these diagnoses. With hindsight, one could argue that the initial assessment did not pay enough attention to the symptoms of depression, and was overly influenced by the symptoms of worry and anxiety (this may well have been the impression given by Adult B, because the nature

of worry is that worrying thoughts dominate one's thinking). A working diagnosis of anxiety was made, when, with the benefit of hindsight and information from later interactions, depression might have been the more accurate diagnosis.

19. At the MHA assessment on the day of the homicide Adult B said that he had mismanaged his life, lived beyond his means, and been untruthful.

20. It may well be that Adult B's belief that he had brought his family into financial difficulty because of his own poor decision to retire early and give money to his first wife and daughter should have been identified as a delusion. I consider that this was not clear-cut, at least in the early part of his illness. Firstly, it was not until later that it became clear that what he had said about his finances may not have been true, and secondly, it would have been reasonable to see this as an anxious worry rather than a delusion. People with anxiety commonly worry about money and health. The point at which this becomes a delusion is not well-defined. However, if it had been seen as a delusion arising from his depression, then it might have affected the treatment, since greater efforts might have been made to keep Adult B on an antidepressant, and the team might also have considered adding an antipsychotic drug to help with both anxiety and delusions.

21. An example of psychotic reasoning is given in the prosecution expert's psychiatric report at paragraph 4.5 where he says of Adult B:

> He also recalls thinking about what would happen to [SH] if he died, and that he should kill her first before dying from suicide. He acknowledges now that this was not rational as she had a supportive family and three adult sons. He then says that he strangled SH, and recalls being aware at the time that it was "legally wrong in my mind" but it was the "only way forward in my head."'

22. At paragraph 4.8 of his report the prosecution expert cites further examples of psychotic thinking:

> A number of Witness Statements are consistent with Adult B description of a deterioration in his mental state from June 2014 onwards. His ex-wife stated that he was in a 'terrible state,' 'very odd', with thoughts of overdose on his return from the US (page 4/7), and that this worsened over the next few weeks and he sent her 'bizarre texts' including about having 'nowhere to live' (5/7). She stated that on 13th August 2014, he told her that he had defrauded people, and was worried that she and he daughter would 'get into trouble' (5/7). One of Adult B's brother in law (SS) reported that Adult B was having 'panic attacks', was 'scared', 'a shell of who he used to be', and concerned about 'being watched by neighbours' (3/6). On 10th August 2014, Adult B told SS that he could not pay the bills (3/6). On 14th August, he was concerned that he would be arrested as would his mother (4/6). PM, SH's sister, stated in her Witness Statement dated 18/8/14 that Adult B thought 'people were coming to get him', that 'he would not answer phones' due to paranoia, and that SH told her on 16th August 2014 that Adult B believed that they

could not afford to eat or keep the lights on (3/6), that the bailiffs would evict them (3/6), and that he had looked at suicide websites (4/6) and shaken her shoulders in an aggressive manner (4/6). SR, Adult B's daughter, in her Witness Statement dated 19/8/14, said that after a discussion about SH finding out about the lump sum gift to her, she had given an ultimatum to her father on 15th August 2014 that he should divorce SH or break off all contact with her (10/11).

23. The prosecution expert's view was that at the time of the offence, Adult B suffered from psychotic depression:

> Furthermore, Adult B had psychotic symptoms, the most apparent of which were delusions of poverty. A number of Witness Statements and telephone calls from SH point to his fixed belief that he was going to be evicted, that 'bailiffs' were coming, and that he was unable to afford food and paying his bills.' The defence expert considered that Adult B's 'depression appeared to have been in remission when I interviewed him. This is consistent with his treatment at a therapeutic dose of an antidepressant in combination with an antipsychotic, and developing some therapeutic rapport with healthcare staff at HMP Bullingdon.

24. The defence expert's report is also very detailed and considers a wide range of information including witness statements by Adult B's family, work colleagues, and friends, as well as two interviews with Adult B on 11 and 15 December 2014. On page 13-14 of the defence expert's report, he notes:

> He [Adult B] reports that during early July he started to become very anxious about money and started to fear that he had made a terrible mistake with regards to giving the lump pension sum to his daughter, as he thought that he and his wife would not have enough money to live on. He told me that he knows now that this was complete nonsense, as even if he had quit work, with some mild adjustments to their lifestyle they would be fine, but at the time he was convinced that because he was not getting any better, he would not be able to go back to work and they would become penniless and would be thrown out onto the street. He stated that he started to write numerous lists of their expenditure and income, repeatedly going over this and coming to the conclusion that they could not survive. He began to worry about every small bit of expenditure and started to get obsessed with turning off all the lights, not running the tap, anything that might save them some money. He stated that this really was very out of character for him as usually it would never even cross his mind to save money in this way as he had always had enough money.
>
> He also began to worry that he thought he had committed some sort of fraud. For many years he reports that his mother used to give him money from her savings as if she did not, then have savings go over a certain level that would have adversely affect the benefits she received. He became convinced in his mind that this was some sort

> of crime and that he would have to pay all her housing benefit back and this further compounded his worries about becoming destitute… He told me that he started to explain to SH his concerns regarding money and that they would not have enough to live on and at around this time he told SH that he had given SR the lump pension sum although initially he told her he had given £40,000 instead of £90,000. He stated "she was incredibly cross that I had done this but came round to accept it. However it was still playing on my mind". He described how he began to write lists and lists of their budget repeatedly in order to try and reassure himself but this only serves to make his anxiety worse and he reports that it became a total obsession. By this point he reports that he still had no appetite at all and believes that he had perhaps lost a couple of stone in weight (he can't be sure exactly as his bathroom scales were not accurate) and he noticed that his trousers were loose around the waist. In around mid-July he reports that he began to have recurring thoughts about committing suicide. He began to think that this was the only way he could solve the situation. He described to me how he began to look up on Google websites about how he could kill himself. He stated that he did this on his iPhone secretly so as not to alert SH but eventually confessed to her what he had been looking at. He stated that things did not improve during the remainder of July, it began to get harder and harder and have conversations with people and the time seems just passed "in a haze of bad"…
> Adult B gave me the following account of the last week before the alleged offence, which I have recorded verbatim. "On the Wednesday before the offence on Sunday I was almost screaming. I had to get this money thing sorted with my mother. I went to Newbury police station. I said that I defrauded West Sussex county council. They took me to the back room and I told the whole story to a policeman. I recognise now that this is madness it just wasn't a sensible thing to do, I mean if I really had committed fraud why would I go and tell them I was doing this. I remember I phoned my boss and daughter from the police station. I felt that I was trying to make a clean breast of things. I was convinced the police would come and arrest me. I had warned SH that she would be arrested too as an accomplice. It's complete pie in the sky. The policeman said, "We'll check it out". I'm not sure if he took me particularly seriously and think he might have thought that I had been drinking, such was the state I was in."

25. The defence expert noted at page 22-23 of his report:

> In my opinion, I am very clear that in June 2014 [Adult B] experienced the sudden onset of a depressive episode, that over the course of three months worsened in severity, such that, in the weeks prior to and at the time of the alleged offence, he was very unwell and suffering from a severe depressive episode with psychotic symptoms (F32.3) as defined in the ICD10 classification of Mental and Behavioural Disorders.

In my opinion it is clear that he began to develop bleak and pessimistic views about the future. Initially these were just a preoccupation and rumination about bad things that could happen (such as worrying that his wife might have ill health whilst in America). However, as his depression worsened, it is my opinion that his worries changed to concerns about not having enough money to live on. These worries were at first overvalued and eventually in my opinion of delusional intensity (a delusion is a fixed false belief that is held with complete conviction, despite all evidence to the contrary). He became absolutely convinced that he and his wife did not have enough money to live on and that they were going to be made homeless. It is apparent from the review of his finances carried out by forensic accountants, that this was not the case, and he now too recognises that his beliefs at that time were wrong, but at the time he was absolutely convinced he was correct. These beliefs began to cause very irrational behaviour, such as refusing to put on electric lights as he did not believe he had the money to pay the bills and not running the taps. These behaviours were he reports completely out of character. Such were the strength of his delusional beliefs that in the days prior to the alleged offence, his wife reported that he was not even allowing her to spend money on food, so convinced was he that they would be destitute and were going to be evicted.

26. Both experts were of the view that at the time of the offence Adult B had been suffering from severe psychotic depression, but that he had improved considerably by the time of their interviews some months later.

How can all these different diagnoses have come about?

Psychosis

27. While both defence and prosecution forensic experts found that Adult B had been suffering from a psychotic depression at the time of the offence, the two psychiatrists and AMHP who examined him in custody found that he was suffering from depression but was not psychotic. The forensic experts, however, had the benefit of much more time to consider Adult B's condition (they each conducted two interviews with him on different days), and, critically, they had access to witness statements, custody records, and other information from a wide range of people who knew Adult B and who could give detailed information about how his condition had developed since June 2014, and how he spoke and acted when with them as opposed to how he presented to professionals.

28. Adult B's wife made the point that he 'was behaving like "Jekyll and Hyde" because when professionals visit, he makes it seem as if all is ok, but once it's just the two of them left, he becomes a very agitated different person' (RiO entry 16/08/14). In other words, Adult B may have understated his symptoms to professionals, leading some of them to underestimate the severity and nature of his condition. Without the collateral information from friends, family

and colleagues, professionals may have missed important aspects of his mental state.

29. Even though SH had communicated important information about Adult B's mental state and behaviour to South Central Ambulance staff on 16/08/14, I do not know if this information was passed on to the mental health CRHTT involved with his care.

30. Identifying the presence of psychosis depends on identifying an abnormal belief and then making a judgement about whether that belief is both false and sufficiently firmly held to count as a delusion. On the face of it, the belief that Adult B expressed to professionals that he did not have enough money because of his own previous poor decision-making could have been true. The clinical team may have thought that there was no psychosis because they could not identify any paranoid beliefs and Adult B appeared to be reasonably calm at assessment. With hindsight this would seem to have been an inadequate assessment because, having concluded that Adult B was not paranoid, they did not recognize his beliefs about poverty and failure as psychotic ideas coming from his depression. Paranoid ideas are not the only kind of psychotic ideas. It is not clear from the record how carefully the clinical team sought the views of Adult B's wife. It appears that she felt that he was more severely ill than they had understood. For example, on 16/08/14 a RiO entry reads 'T/C from SH, Adult B's wife. She wanted to speak to Joseph. She reported that she has left her family home as she is unable to cope with Adult B's paranoia.' This was just a few hours before the community nurse recorded, 'There was no obvious sign of psychosis or cognitive impairment or cause for concern in our brief interaction and I was happy to leave.' Psychosis is usually associated with more severe degrees of depression, and the perception that Adult B's symptoms were mild may have contributed to the clinical team's failure to identify Adult B's ideas about his poor decisions and lack of money as psychotic.

31. When psychosis occurs in depression, the degree of depression is usually severe. Adult B's depressive symptoms, as he described them to professionals (though not as they appeared to some others), did not appear to be particularly severe, and this may be one reason why the clinical team failed to identify psychosis.

Anxiety vs depression

32. It appears that Adult B did not see a psychiatrist until the MHA assessment which took place in custody after the incident. This seems to be the first point at which the diagnosis is referred to as a depressive episode, although depressive symptoms had been identified earlier. In general, nurses and OTs may receive less training in making diagnoses than psychiatrists, who are medically qualified.

33. As explained above, anxiety and depression overlap in the symptoms that they produce. The distinction is based on an evaluation of which symptoms are most obvious, and the presence of ‘core symptoms’ which in the case of depression are low mood or loss of enjoyment, and in the case of anxiety is excessive anxiety. It is important that the person making the diagnosis carefully considers the balance and pattern of development of the whole set of symptoms, not just the most obvious ones.

Fitness to be interviewed

34. Those who assessed Adult B in custody found him fit to be interviewed. This is only indirectly connected with the question of whether or not he was psychotic. Being fit to be interviewed refers to Adult B’s ability to understand questions put to him and to give meaningful answers. A person can be psychotic and so disordered in his thinking that he cannot be interviewed, but it is also possible that he has psychotic ideas such as delusions and hallucinations, but is still capable of thinking clearly enough to be interviewed.

35. I note the comment by the MHA assessors after the incident had happened that, ‘Had we assessed him at home (ie without his arrest for a serious offence), we would not be arranging a hospital admission.’ This suggests to me that outwardly Adult B’s symptoms appeared to be relatively mild, and, except for the occurrence of the incident, little had been discovered at interview to indicate how ill he was.

36. With hindsight, it may well have helped to have made an accurate diagnosis if Adult B’s wife had been interviewed separately (she may have been, but I have not seen a record to indicate that she was).

Treatment

37. It would be appropriate to prescribe an antidepressant for either anxiety or depression (Adult B was initially prescribed amitriptyline at low dose by his GP, later changed to mirtazapine, both of which are antidepressants, although the dose of amitriptyline was below that usually considered as effective in depression). If the patient were very agitated with poor sleep (as it seems that Adult B was) it would be appropriate to add an anxiolytic drug to help with anxiety and sleep (Adult B was initially prescribed lorazepam to help with anxiety and sleep, and zopiclone was added later to promote sleep more effectively).

38. In the CPE (Common Point of Entry in the BHFT system) letter to the GP dated 10/07/14 the GP was told that Adult B had said he would not be prescribed any more lorazepam and had been told that he could not take zopiclone with mirtazapine (both medications promote sleep, and so in theory it is right to exercise caution with the combination in case the combined effect on sleep were too strong). This left Adult B with very poor sleep, but without anything other than mirtazapine (which he said was not working) to help with sleep.

39. On 16/08/14, Dr L advised the CRHTT (Crisis Resolution and Home Treatment Team) to remove the mirtazapine as he had not been taking it. However, if a diagnosis of depression had been clearly made, then it is likely that the clinical team might have considered either encouraging Adult B to persevere with mirtazapine (as antidepressants often take 4-6 weeks to have an effect), or to switch to a different antidepressant, rather than just stop taking one altogether. It may be that these possibilities were discussed, and that Adult B was reluctant to try another antidepressant, but if this was discussed, I have not seen a record of the discussion in the notes which I have been sent.

Did early misdiagnosis affect outcome?

40. I consider that, on balance, there probably was a misdiagnosis, and that depressive disorder should have been identified earlier than it was.

41. If it is the case that the clinical team failed to identify Adult B as having a severe depressive episode with psychosis, how far might this have affected what happened?

42. First, there might have been a more concerted attempt to maintain Adult B on antidepressant medication, and less attention given to anti-anxiety medication. When it became apparent that Adult B had not been taking mirtazapine, rather than taking the medication away, there might have been an exploration of why he had not wanted to take it, and an attempt made to persuade him to try an alternative antidepressant.

43. Second, the standard treatment for psychotic depression is to consider combining an antidepressant with an antipsychotic drug such as risperidone or olanzapine. I have seen no record that an antipsychotic drug was prescribed before the incident.

44. Third, if depression had been identified earlier, there might have been an attempt to offer psychological treatment such as cognitive behaviour therapy. This is not certain, as psychological treatments are often delayed until after medication has had time to take effect, and not all people with depression are considered suitable for or want psychological interventions.

45. I do not suggest that I think that the incident would not have happened if Adult B had received more appropriate medication. Homicide is an extremely rare event, even in people with psychotic depression, and there is very little in the history as set out in the RiO notes to indicate that this was at all likely.

Summary

46. On balance, I consider that the diagnostic finding of the two forensic experts that Adult B had been suffering from psychotic depression at the time of the incident is more reliable than those of the CRHTT and the MHA assessors who saw him earlier. This is largely because the forensic experts had access to a very wide range of collateral information about NT's condition from the statements of Adult B's family and friends, and they had the benefit over the CRHTT of knowing that Adult B had committed the act which he did. They had much longer to assess Adult B, and much more information about him.

47. On balance, I think that the initial diagnosis of anxiety rather than depression led to a delay in prescribing appropriate antidepressant and antipsychotic treatment for Adult B. Several factors contributed to the delay, including Adult B's recorded tendency to underreport his symptoms to professionals, and what appears to have been a failure by professionals to interview family and/or friends carefully and take their views into account. The panel may wish to consider making a recommendation that mental health assessors must wherever possible interview an appropriate informant, and that this principle should be incorporated into training.

48. It may be that a delay in seeing a doctor rather than other health professionals contributed to the misdiagnosis. I do not suggest that non-doctors are unable to make diagnoses, but that medical psychiatric training encourages a more analytic approach to diagnosis which might have been helpful in this case. It is difficult to formulate this as a recommendation because of the very flexible way in which different professions work in a multi-disciplinary team.

49. Notwithstanding the above, homicide is an extremely rare event, even in those with psychotic depression, and I have not seen anything which suggests to me that this event should or could have been predicted or avoided. More appropriate treatment given earlier and more consistently might have reduced the risk of homicide, but it may well not have prevented it.

Dr. Hugh Series DM, FRCPsych, LLM, MA, MB, BS
Consultant old age psychiatrist
Member, Law Faculty, University of Oxford
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Reponse to Dr. Series' report from the Medical Director of Berkshire Healthcare NHS Foundation Trust

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4th December 2015

Response to NT Report on Diagnosis by Dr Hugh Series

Dr Series presents a thorough review of the issues with regard to the diagnosis and treatment of NT and the analysis and findings are broadly accepted by the Trust.

With respect to the inconsistency of diagnosis, it should be noted that symptoms may change over time and life events can impact on the mental state and development of mental illness. It is not unreasonable to consider that involvement in an alleged homicide, the death of one's spouse, subsequent imprisonment, police interviews and legal proceedings may have a marked impact on the progression of mental illness.

Dr Series' revised report seems to indicate, however, that when seen by prosecution and defence experts there was little evidence of depression with psychotic symptoms on mental state examination. In paragraph 20 he states: 'Both experts were of the view that at the time of the offence Adult B had been suffering from severe psychotic depression, but that he had improved considerably by the time of their interviews some months later'.

These diagnoses seem to have been made, particularly in the case of the defence expert, predominantly on the basis of a retrospective account by the defendant and with the benefit of hindsight. It does not appear that a mental health professional at any stage, before or after the alleged offence, carried out a mental state examination which clearly elicited severe depressive and psychotic symptoms.

Taking into account this and the weight put on views made in hindsight, paragraph 40 probably over states the case that 'depressive disorder should have been identified earlier than it was'.

Dr Series highlights the fact that homicide is a very rare event. This is particularly so in a case where there has been no previous evidence of aggressive, antisocial or threatening behaviour. The outcome in this case was extremely difficult to predict and, therefore, to prevent.

Justin Wilson MBBS MRCPsych
Former Medical Director
Berkshire Healthcare NHS Foundation Trust

Appendix Two

Independent Review of Nursing Practice -Berkshire Healthcare NHS Foundation Trust

Commissioned by the DHR panel

Nursing Advisor

Catherine Gaskell

Contents

Introduction

A Domestic Homicide Review has been commissioned by the West Berkshire Safer Communities Partnership in response to the death of SH on the 17th August 2014, in accordance with the requirements of Section nine of the Domestic Violence, Crime and Victims Act (2004).

An external nursing expert was requested and commissioned in August 2015 by NHSE to support the panel in providing and opinion on the nursing practices applied within the wider Independent review by staff working for Berkshire Healthcare NHS Foundation Trust.

Terms of Reference

The brief for the expert nurse will be to look at the clinical practices applied and to provide the DHR Panel with an independent nursing opinion concerning Berkshire Healthcare NHS Foundation Trust's involvement in this incident.

Background and Context - Brief description of the incident.

On the 17th August 2014, Adult B, a 60-year-old man of white, British background living in Newbury, contacted police to report that he had killed his wife. Police attended the family home and found SH to be dead.

Adult B was arrested on suspicion of murder. An assessment of Adult B under the Mental Health Act was subsequently arranged, which concluded that there was no evidence of psychosis and no grounds for detention in hospital.

Adult B was found guilty of manslaughter and sentenced to be incarcerated for up to six years.

Full details of the circumstances of SH's death are not yet known, beyond what Adult B disclosed during the post-incident Mental Health Act assessment. It is reported that Adult B strangled his wife in the early hours of the morning of 17th August 2014.

Nurse Advisors' Background

Cathe Gaskell is a registered mental health nurse and possesses a BSc In Professional Issues in Healthcare. Cathe has participated in and led a number of Independent (94/27) and Comprehensive Serious Incident investigation reviews in both the NHS and Independent Sectors, working as an independent advisor on nursing practices.

Methodology used.

This review into practice was undertaken using a range of evidence provided by both NHS England and the Trust in an attempt to triangulate the findings identified within the Individual Management Review (IMR) staff interviews and Trust documentation relating to clinical practices.

This review of nursing practice is therefore not a "stand alone" report but developed to inform the Domestic Homicide Review panel about the nursing practices, processes and procedures, found within two services at the time this incident. The focus of the review is on two services the Common Point of Entry team and the Crisis and Home Treatment teams.

This review of nursing practice was undertaken based applying some of the principles of a *comprehensive investigation* in that it used root cause analysis principles to look beyond the individuals concerned and seek to understand the underlying causes and environmental context in which the incident happened.

Documentation reviewed as part of information gathering:

1. Terms of reference for the Domestic Homicide Inquiry jointly chaired by Steve Appleton and Andy Fry
2. The Individual Management Review – completed by Investigator Tony Drew
3. Local Guidelines for listening to patients, relatives and confidentiality of information
4. Crisis RHTT East Assessment Documentation
5. Common Point Entry Organogram
6. Risk Assessment management in MH and LD policy and procedure
7. Safeguarding Vulnerable Adults
8. Clinical Supervision Policy
9. Domestic Abuse Policy
10. List of Training undertaken by APT and BHFT staff.
11. Risk Summary documentation.
12. Frant Training model
13. Trust Clinical Risk Training slides
14. Trust Clinical Risk Induction slides
15. Trust Clinical Risk – Suicide slides
16. Aide memoire document (undated and unsigned) for use in identifying risk.
17. Risk workshop timetable.
18. Overview of activity in CRHTT 2014 – 2015
19. Staff Turnover for CHRTT Jan – Dec 2014
20. Complaints and Compliments for Jan – Dec 2014
21. Operating Manual of CHRTT
22. Operating Manual of CPE
23. Transcripts of Tony Drew's staff interviews (not verbatim)

Opinions were sought from:

Helen Mackenzie – Director of Nursing

Isaac Esheyigba – Hub Manager

Rajay Herkanaidu – Clinical lead for the CRHTT service.

Sue McLaughlin – Nurse Consultant.

Seb Byrne – CPE Service manager

Tony Drew – Independent Investigator – TD was invited to have a conversation about the IMR, as part of background gathering for this investigation. TD had produced his findings within the investigation report very soon after the incident occurred therefore it was relevant to ask for comment on the working practices and his sense of the culture within the services he observed at the time, to be triangulated with staff feedback and evidence of clinical activity being gathered. TD declined to answer on this point and stated he had completed 30 investigation reports since this time and could not be expected to comment on or recall the culture within this team.

TD did not interview Rajay Herkanaidu – Clinical Lead for the service within his investigation.

Introduction to the Trust.

From the Trust website – September 2015

"Berkshire Healthcare NHS Foundation Trust provides specialist mental health and community health services to a population of around 900,000 people within the Berkshire. It operates from more than 100 sites across the county including our community hospitals, Prospect Park Hospital, clinics and GP Practices. It provides health care and therapy to people in their own homes.

The vast majority of the people cared for are supported in their own homes. We have 171 mental health inpatient beds and almost 200 community hospital beds in five locations and we employ more than 4,000 staff. Working in partnership with patients and their families is really important to us as this helps us to provide the best care in the right place. We support people with long-term health problems to manage their own lives as much as we can, so they can stay at home and do not need to be in hospital.

Services are organized around the six areas of Berkshire, to match the local authority boundaries. We call these Localities. Each Locality Director works together with a Clinical Director to make sure that our service management is informed by clinical knowledge and expertise. Working closely with commissioners to develop services that meet the needs of our diverse population – aiming to help people remain independent at home as far as possible. We provide many of our services in partnership with Local Authorities and also work closely with GPs, voluntary sector organizations and others.

Background and Philosophy of services.

Berkshire Healthcare NHS Foundation Trust (BHFT) services considered within the IMR investigation:

- The Common Point of Entry Team
- The Crisis and Home Treatment Team
- The Talking Therapies Team/ Improving access to psychological therapies.
- The Westcall Out of Hours GP service.

The focus of this review is on the Common Point of Entry Team and Crisis Home Treatment Teams work due to the nursing component in both teams and the focus on reviewing nursing and clinical practices within this context.

Operating Policy.

Crisis and Home Treatment Team (CHRTT)

This service has been in its current structure for three years, from November 2012, when a decision was taken to restructure the emergency and out of hours services and have a common point of entry service for accepting and directing on all mental health enquiries, crisis cases, out of hours and weekend coverage across the Trust's regions.

The central premise of the CHRTT service was that they were there to provide support to those in crisis, to decrease hospital admissions, and provide brief therapeutic interventions, and redirection back to more appropriate services. Using both phone counselling and face-to-face work within a team based approach to anyone contacting them in a crisis

The common point of entry service (CPE) is not 24/7 service however so the CHRTT takes on this role out of hours.

In 2012 community mental health teams reduced the out of hours coverage and some of this responsibility for contact with high risk clients was also given to the CHRTT service.

Definition of a crisis (as described in the CHRTT operating manual)

“A crisis is defined as the breakdown of an individual’s usual coping mechanisms. A mental health crisis occurs when a person experiences a sudden significant deterioration in their mental state, regardless of their previous mental health.

The team’s work revolves around the individual patient’s needs, placing these needs **in** centre stage, rather than the system of care. The objective of the Team CHRTT is to offer a choice of treatments to those people with acute mental health needs who would prefer to be treated in the security and familiarity of their own environment and local community. Services are also provided after admission to hospital, to restore relationships and contact with the patient’s community, and help the patient reduce the stigma attached to psychiatric hospitalisation by minimizing the need for admissions to hospital.

The key features of the service are that it is mobile, responsive and acts as a *gatekeeper* to psychiatric hospital beds for those people in the acute phase of mental health illness. It also provides a service to facilitate timely discharges from hospitals back into the community, and support in patients home once discharged from an inpatient setting.

The service comprises an integrated, multidisciplinary community based Mental Health Team whose aim is to provide an intensive, safe and effective home based assessment and treatment service for adults 24 hours, 7 days a week as an alternative to inpatient care during times of mental health crisis. “

Objectives of the CRHTT

For those people who become very ill and enter into a mental health crisis that would otherwise require the level of support and care only available in a hospital, the CRHTT service will provide to patients living in Berkshire:

1. A service to acutely unwell people living in their own homes, that is available 24 hours a day 365 days a year.
2. Skilled treatment and support to allow people to recover at home; treating people in the least restrictive environment and with the minimum of disruption to their lives.
3. Assistance to people where appropriate to avoid admission to hospital.
4. Support to people to facilitate admission and timely discharge to/from inpatient facilities.

5. Mental Health Liaison services into the Accident and Emergency Services.

These services will be available for patients to access through their Care Coordinators and for new patients through a referral into Common Point of Entry (CPE). The team also provides rapid assessment and treatment to those acutely unwell people previously known to services. It is also the entry route for referrals outside of CPE operating hours (0800hrs – 2000hrs).

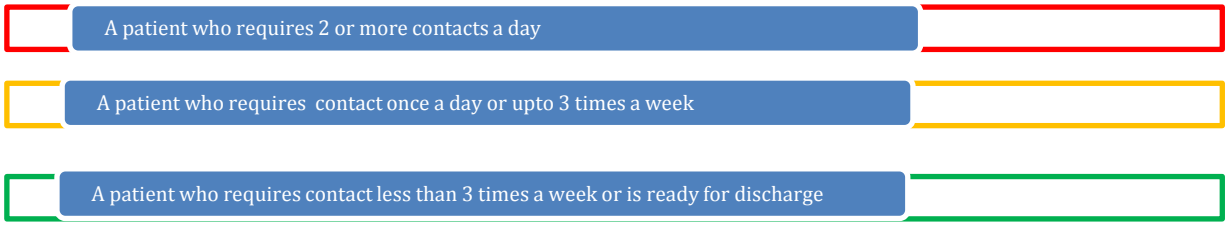
Both hubs will comprise a staff mix of qualified and unqualified mental health practitioners, providing the capability and agility within the service to respond to peaks and troughs in service demand. Staff will be rostered by the Hub Manager, working flexibly across the following shift patterns:

- Early Shift: 07:30hrs – 15:30hrs
- Late Shift: 13:30hrs – 21:00hrs
- Night Shift: 21:00hrs – 07:30hrs

The operating manual specifies that no individual in the team hold a case- load but there is a patient categorization caseload tool, which is to help plan prioritization of patient needs for the team responsible for the client.

There are specific tools within the operating manual to help staff make decisions about prioritizing resources for clients and identifying risks posed and therefore levels of contact.

For example a patient-zoning grid is in place, to assist in categorising the risk rating presented by patients and help with assigning capacity to each case:



There is also a guide to help staff collate at each handover a record of the contact and priority given to clients who had been assessed on a shift-by- shift basis. This is a colour-coded grid, which enables staff to consistently rate the urgency of service provision designated for each contact.

This should occur after each contact made with services.

PURPLE: Patient admitted
RED: Patient to be seen in 4 hours
AMBER: Patient to be seen same day/contacted by service
GREEN: Patient does not require same day service.

Comment.

Both the managers of CHRTT and CPE recognized that these tools are not always utilized due to the capacity restraints and the volume of work in 2014.

Staff were likely to prioritise clients with severe and enduring mental illness firstly, and that according to CHRTT a lot of time was taken up with managing clients with personality disorders, who may ring repeatedly and threaten self-harm if they did not gain an immediate response and time from staff.

There is not currently an established service for personality disorder patients in the Trust and reportedly community mental health teams passed these patients over to CRHTT for contact and on going low level management particularly out of hours and over weekends.

In Adult B's case he was not appointed a care coordinator during his interface with services because the risk levels he presented with, were not deemed high enough to identify one.

Service Activity levels.

This model illustrates the demand on CHRTT services for the past three years.

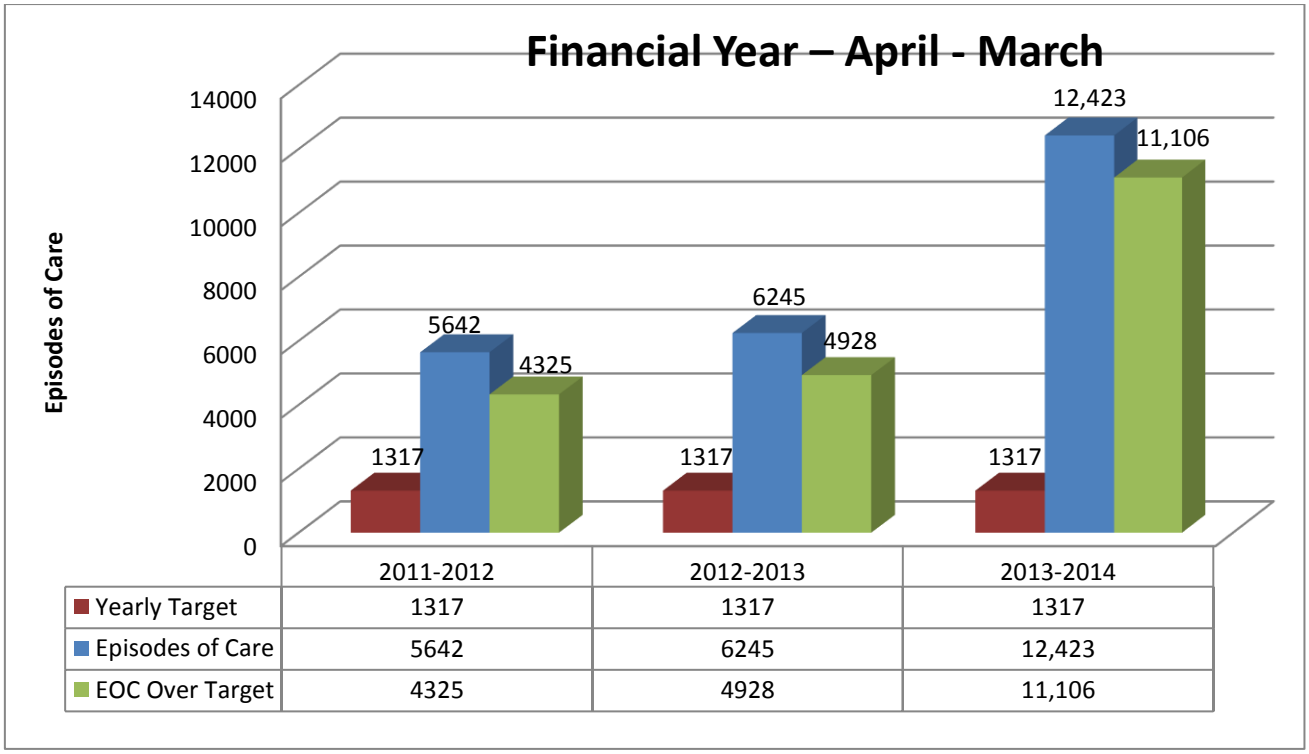
The annual target for activity was over extended from 2012 and this has continued to increase in 2013-2014, where there was a demand for an additional 11,000 episodes of contact to be provided.

This affected service provision in the following ways:

1. Staff skills became diluted with the call volume being too high to undertake more than short-term contact and supportive signposting.

2. Staff turnover increased with the work pressures again related to call volumes.

3. The CPE service manager described the use of both NHS professional staff and agency staff increased to cover vacancies, which reduced the skill mix within the service, as not all staff had been trained in telephone counselling at the time of the incident.

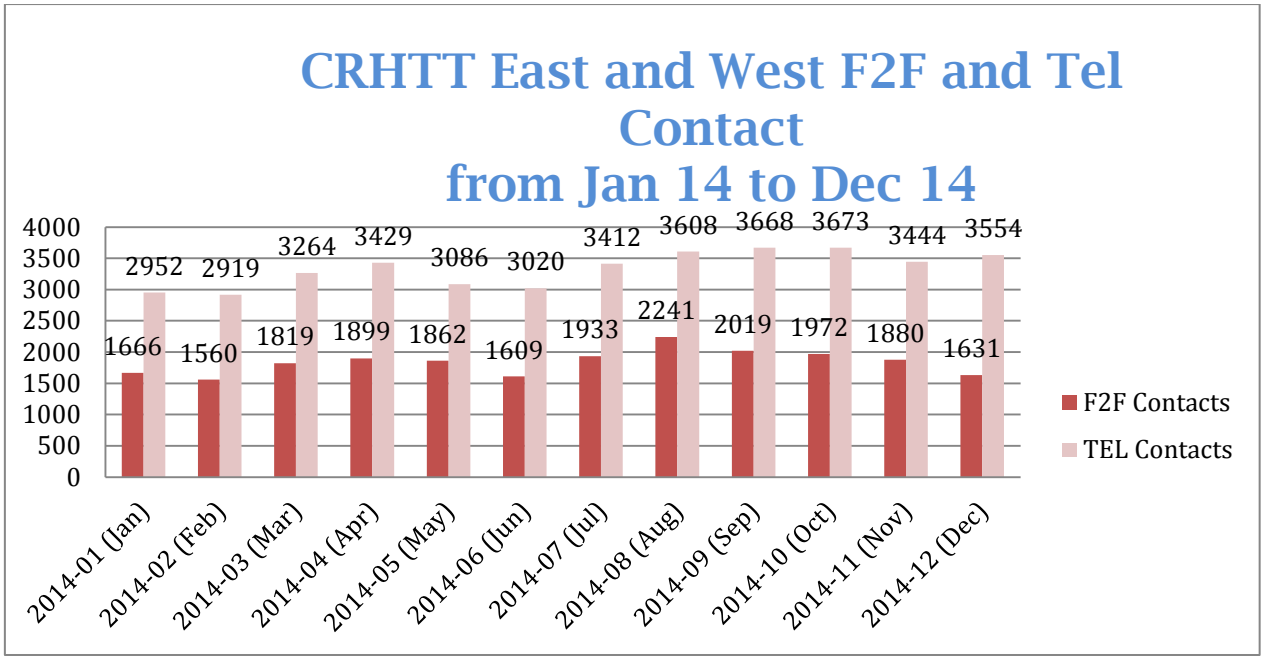


Contacts

This consequently demonstrates the high levels of activity, particularly relating to telephone contacts for the service.

According to the clinical lead, the pressure of telephone contacts reduced staff's ability to undertake face to face assessments, it was felt that some staff then felt reluctant to undertake face to face work due to the pressures it created for the remainder of the team back at base combined with the heavy work load they were already under.

In August with a total of 3668 calls received, this works out at a potential 118 calls received every day, that month.



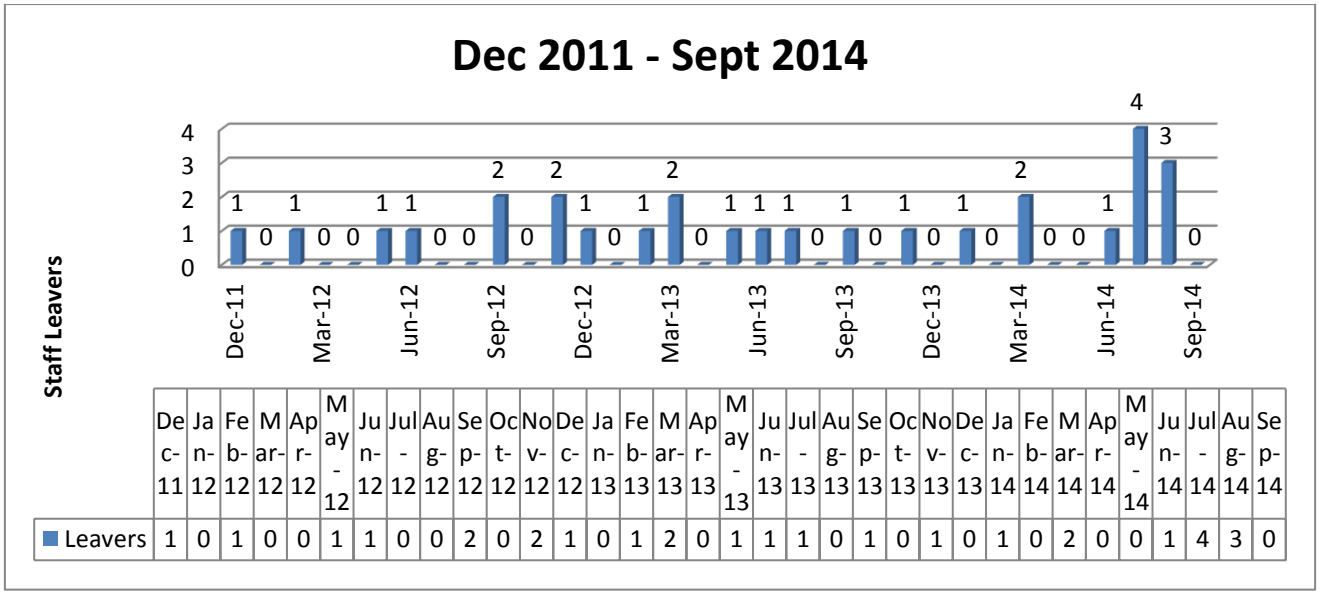
Information about staff leavers

This graph demonstrates that the services were particularly stretched in June/July/August 2014 with 8 staff members leaving during this period.

This was higher than at any other time recorded between December 2011 and September 2014.

This correlates with staff interviews conducted by Tony Drew, where staff reported a backlog of referrals and not much time to reflect on decisions, at the time of the incident occurring.

This undoubtedly impacted on the quality of service, clients received as agency and NHS professional's were employed to fill staff post's whilst recruitment took place and staff skills and expertise varied within the teams.



Patient Experience feedback.

Complaints received about the CHRTT during 2014 were small in numbers, when balanced against the high number of contacts and activity. However we do not know what the complaints themes were or if they were repeat issues.

- 17 complaints were recorded in total for the year
- 20 compliments were recorded in the same time frames

Compliments were higher than the complaints numbers received which is a positive achievement for the service.

Operating Model – Common Point of Entry (CPE team)

The Common Point of Entry team has recorded a 30% increase above agreed activity resulting in 800 calls a month with, until recently, no additional resources to meet this volume of contacts.

This service has recorded high turnover of staff due to burnout and staff are anecdotally recorded as leaving at the rate of 1-2 per month. This trend continued in 2015.

Currently, the service is running on the use of a high number of locums whilst recruitment is taking place, for some additional Band 7 nursing posts, to manage the acuity of calls and up-skill other team members.

The service manager felt the difficulty of running a service largely with locums, is that investment in training and skills are lost when they invariably leave.

CPE Service Objectives (as listed in the Operating Policy)

1. All urgent care referrals that are telephoned to CPE will triage within 24 hours and referred onto CRHTT determined by clinical presentation.
2. All adult referrals will be screened on receipt of referral and RAG rated based upon level of risk.
3. Face to face local assessment at a place and time convenient to the patient will be offered
4. The Common Point of Entry assessment team will undertake an assessment that includes for all patients:
    - A clinical diagnosis and clinical formulation of the presenting problem
    - An assessment of insight and motivation to access treatment.
    - A mental health cluster assessment based on HONOS PBR
    - A detailed standardized risk assessment.
5. Seamless transfer onwards to the relevant service with clear details to explain next step.
6. The Referrer and GP (if different) and patient will be notified of the results of the assessment treatment choice within 10 working days
7. All referrals to CAMHs will be registered and transferred on the same day to CAMHS CPE for triage
8. All referrals to IAPT will be registered and transferred onto IAPT and to the onward relevant East & West Talking Therapies Service on the same day.
9. All referrals will be registered and transferred immediately to OPMHS and LD services
10. GP Liaison will enable same day access to a Consultant Psychiatrist & pharmacy link
11. Enquirers will be directed to the most appropriate support/voluntary/Local Authority/community service at the time of enquiry.

Client Groups

1. All New referrals for Adult Secondary Care mental health services
2. All existing patients who have a priority pass to re-enter services
3. Urgent referrals to all services
4. All primary care self referrals and relevant referrals to IAPT
5. All referrals to CAMHS
6. All referrals to OPMHS
7. All referrals to LD services

8. All referrals to Specialist Services that can be accessed with no requirement for care co-ordination
9. All enquirers, callers and carers
10. Liaison Service for GP's, LA's, Police, other professionals

Service Level Agreement

1. Crisis referrals – can only be made by a GP and require a response within 4 hours.
2. Urgent Referrals – initial contact within 24 hours
3. Amber Referrals – initial contact to be attempted within 72 hours
4. Routine Referrals – Initial assessment completed within 28 days
5. Crisis referrals must be clinician to clinician discussion
6. GP written to on discharge or exit from CPE with details of actions taken.
7. All patients seen for a face-to-face assessment will be asked to complete a CPE service satisfaction rating.

Timeline

Chronology / Incident Description.

Adult B was in touch with mental health services from 15.6.14 until the serious incident on the 17.08.15.

This was reported as his first episode of contacting mental health services, as he had no known history of previous mental health or forensic behaviours recorded. There was also no history of domestic abuse recorded.

There is a detailed chronology held within the IMR, which has been summarised to list contacts in the 64 days Adult B presented to services before the incident occurred on the 17.08.14.

Summary of contacts:

Contacts with GP: 10 contacts

Contacts with Westcall Doctors: 3 contacts

Contact with CHRTT: 3 phone contacts and 2 face-to-face assessments on the 16th.

Contact with Common Point of Entry Team: 3 phone contacts

Contacts with Paramedics or 111 services: 4 contacts.

Contacts with Talking Therapies: 1 face-to-face meeting.

SH made 4 phone contacts with the CHRTT and was met by an assessor on the 16th August.

This illustrates the number of services involved with Adult B during this time frame, although it is not clear any of them took ownership of his case.

Why did this happen ?

Adult B was a new contact with no known history of mental health concerns, or help seeking behaviours, when he contacted the Common Point of Entry team in June 2014.

Adult B had contacted emergency services after returning from a holiday in America, when he experienced severe levels of anxiety, which may have stemmed from a combination of psychosocial factors. He was not open about personal issues and it was reportedly important for Adult B to appear normal to the outside world.

Known stressors included:

- Relationship problems with his wife, conflicts between his first wife and family and current wife.
- Perceived financial worries after taking partial retirement and a belief he had lived beyond his means.

During this period, Adult B sought help for his anxiety in a number of ways including calling emergency services where a Westcall doctor initially called him back. He then saw his GP and through contacts with Common Point of Entry team (CPE) was directed to the Crisis and Home Treatment Team (CHRTT) Adult B was then referred to The Talking therapies team (IAPT) and he was also prescribed medication by his GP. Adult B felt the medication and contact with CPE and CHRTT did not resolve his symptoms and he stopped taking medication two weeks before the incident.

Adult B expressed that his symptoms were increasing and he displayed “care seeking” behaviours by clusters of contacts with health care teams in an increasingly agitated state. An example of a cluster of contacts is described below:

- 15.6.14: Adult B phoned 111 – was called back by a Westcall doctor, complaining of not sleeping for 3 nights, seen and diagnosed with insomnia. Prescribed Zoplicone 7.5.mg.

- 16.6.14: Adult B saw GP reporting anxiety. Prescribed Amitriptyline up to 30 mg.

- 16.6.14: First contact with Common Point of Entry (CPE) team and given contact numbers and advice and suggested a physical health check to rule out underlying problems.

- 16.6.14: Adult B telephoned 111, Paramedics attended and he was taken to Accident and Emergency services at Basingstoke Hospital where he remained overnight. He was assessed by a mental health liaison nurse who concluded there was no indication of any need to refer to secondary services.

Adult B made contact with at least four separate health professionals and services within a 24-hour period, which was out of character for him, as he did not have a prior history of presenting in this way.

This could be interpreted as an example of the conflicted or ambivalent behaviours Adult B presented throughout the following few weeks, where he sought help from multiple sources when feeling very anxious but when in contact with health care staff he then minimised his symptoms and denied harm to self or others.

Adult B agreed when staff redirected him to other services and he withdrew from contact until he experienced or could not tolerate the next episode of anxiety.

This pattern of contacting multiple sources continued throughout June and July, with Adult B denying when asked, any intentions for serious risk to himself or others.

29.6.14: Adult B contacted the Crisis and Home Treatment Team, he spoke to a nurse and was described as being quite distressed, describing poor sleep and appetite, lack of energy and motivation, irritability and agitation. Distraction techniques were suggested but he said he had tried these and it had not helped.

There did not appear to be a system in place to identify and respond to escalating distress expressed by client who did not have a previous mental health history and was unknown to services. Adult B's presentation amongst the volume of contacts at this time did not hit what the services identify as a "crisis point" and therefore did not trigger an urgent face-to-face referral.

7.7.14: Adult B contacted the Crisis Team a week later and he reported thoughts of "not wanting to be here" which a staff member attributed to the increased frequency of his anxiety. It is documented that Adult B had no plans to end his life, however Adult B had given staff a message that his risk of self-harm may be increasing with the ambivalent statement of " not wanting to be here."

It is not uncommon for clients to make covert statements about ending their life and then withdrawing them when confronted with a direct question about risk. This occurs for a number of reasons including client ambivalence, but the withdrawal of a covert intention to self-harm should not be assumed by staff as the client *then* not remaining at risk.

At this point, it would have been reasonable to have facilitated a face-to-face assessment or referred Adult B to a senior member of the team, for wider team opinion. Adult B had contacted the crisis team twice in 24 hours and he was still an unknown patient.

A face-to-face assessment may have allowed for a relationship to have been established with one member of staff who could attempt to build rapport with Adult B. A wider assessment including family views could have been undertaken with to build a coherent picture of Adult B's crisis.

On the same day as contacting CHRTT, Adult B then instituted a telephone assessment with the CPE team and reported severe and worsening anxiety, panic attacks, depression and lack of sleep for 3 weeks. He referred to triggers, he referred to changes of work patterns, again Adult B denied suicidal ideation but he stated he felt "awful, really bad, shaking from the inside and wanting this all to end. "

This assessment resulted in a referral to The Talking therapies team / Improving access to psychological therapies team (IAPT) for cognitive behavioural therapy for anxiety management. The assessor reported that risk to self or others was nil evident.

At this point Adult B is utilising the pattern of expressing anxiety and to some extent his agitation, but is not admitting outright his plans (if he has any) to assessors, which may be linked to being paranoid as his wife later claimed, or Adult B not having access to consistent contact with any member of the two teams so not having established a relationship he is willing to begin to confide in.

A member of the CPE advised Adult B to see his GP for a review of medication. He was given the CHRTT number to contact if he became distressed.

At this time the RIO records should have indicated Adult B had been in contact with the CHRTT team previously, as he sometimes called both teams on the same day.

At this point Adult B appears to be being passed between services (CRHTT and CPE) services without a consistent person overseeing his care, apart

from his GP. He is now directed to a third service (IAPT) and told he will be assessed at a later date by them.

Applying the CHRTT patient zoning model, Adult B's continued contacts with the teams would rate him between a yellow and red rating and should have indicated to the shift leader that his anxieties were increasing and a more detailed assessment was needed.

One day after this contact on the 8.7.14 SH contacted the CHRTT and reports she is tearful and at the end of her tether, Adult B is described as" pacing around the house, punching pillows" SH expresses she is in a lot of pain and cannot take anymore. SH is advised by CHRTT, that Adult B is awaiting an IAPT assessment; this is agreed as a preferred option, and for Adult B to contact CHRTT for further support.

This was another missed opportunity to commence a face-to-face assessment. Consideration could have been given to undertaking a carer's assessment of Adult B to help clarify what was his ability in his role in caring for his wife and was he able to undertake the role at this time.

On the 10.7.14 two days later the GP sent a referral marked urgent by fax to the CPE team and reporting Adult B was "very frightened by the way he was feeling" and could he be seen in clinic.

That same day CPE contacted IAPT and the GP and stated Adult B had responded positively to an IAPT opt in invitation. CPE advised that Adult B was willing to wait for IAPT and could be redirected back to CHRTT again if needed.

Again this redirection may not have been perceived as helpful by Adult B, he has been in contact with both the CHRTT team and CPE team, and had been assessed and redirected back on a number of occasions and escalation to a Psychiatrist had not taken place despite his GP's faxed request.

Adult B continued to care seek via contacting his GP and he was seen by IAPT on 4.8.15 at which point NT confirmed he had a reluctance to contact the CRHTT or CPE Teams again "*as he was not helped by ringing these numbers*." Adult B was sent Cognitive Behavioural Therapy information by post after this initial assessment and given a further appointment on the 18.8.14.

Adult B reported needing to care for his wife, due to her having a physical disability. This was an opportunity to recommend a carer's assessment.

It was not clear that CPE and CHRTT collaborated in managing Adult B's care or contacts or if they recognized the client was seeking advice from both services

and what this might indicate in terms of Adult B's escalating distress and increasing crisis.

Adult B stopped contacting the CHRTT and CPE services after the 4.8.14, until the 15.8.14 when Paramedics became involved.

15.8.14: The GP sent a further referral to CPE asking for support and advice with Adult B's on going management due to the severity of his symptoms.
The GP noted that Adult B had been suffering from severe anxiety for the past 10 weeks, was constantly struggling to leave his house as a result.

" He had been in contact with the crisis team during this time, but that they had offered no long term follow up… he had had contact with IAPT but he did not have the level of concentration or is unable to engage in activities to try and help with recovery "

16.8.14: Paramedics contacted the CHRTT requesting an urgent assessment of Adult B who they described as "…depressed, he had stopped meds, he had not eaten or slept for a few days and his wife had reported he was deteriorating and had been researching suicide on the internet…"

16.8.14: SH contacted CHRTT asking when Adult B would be assessed.
She was told a time could not be given as the team also had others to see.

This could be seen as a blunt response provided to a relative who was reporting a crisis situation to professionals. A more sensitive response to SH could have been expected as staff had already been alerted to the deterioration of Adult B's health by paramedics earlier in the shift and the increasing severity of his symptoms.

Adult B attended hospital for rectal bleeding in the early afternoon.

At 14.00 hours on the 16.8.14, Adult B was assessed face to face by a crisis team practioner for approximately 45 – 60 minutes.

The actions of this team member fell below expected practice in several areas:

Adult B's version of events which described him to be calm, did not correspond with the urgency of behaviours reported previously by Paramedics or his GP and this was confirmed by his wife, therefore the differing presentation Adult B demonstrated, did not appear in documentation to be sufficiently probed by the staff member.

SH's concerns about the possibility she may be hit, which should have been identified as domestic abuse, was not reported as a safeguarding alert. This was particularly concerning as SH was deemed a vulnerable person, due to the nature of her physical disability resulting in her using a wheelchair.

SH's concerns about domestic abuse were discussed with her husband present, which could have increased her risk of abuse and is contradicted in the Trust policy guidelines. The Trust policy on "Safeguarding Vulnerable Adults from Abuse" (local policy) advises the following:

- Any member of staff (including non-qualified, agency and volunteers) who becomes aware of a safeguarding concern should ensure that emergency assistance for the client, if required, is obtained without delay. Staff should listen carefully and sympathetically to what the adult tells them but avoid asking detailed or probing questions that might affect the investigation or future therapeutic input.
- Do: Stay calm and listen; Take what you are being told seriously; offer support to help them stop the abuse happening; Be aware that medical or other evidence might be needed;
- Do not: Press the person for more details; Assume that someone else will take action; Contact the alleged abuser; Promise to keep it a secret; Be afraid to contact Social Care or the Police.

There was limited recognition of SH as being able to play a part in her husband's care and treatment and also as a more accurate historian of his behaviours and risks.

A more holistic assessment may have recognised Adult B as a carer for his wife and referred him for a carer's assessment.

It was a reasonable expectation that the assessor contacted the safeguarding team and took advice over the allegation made by SH that she felt Adult B may hit her. This information may have been relevant when another member of the team took a phone call from SH later that evening.

However the documentation of this visit was noted within the IMR, to have been poorly recorded and with a lack of safeguarding knowledge and reporting evident from the staff member.

After this assessment, advice from a Westcall Doctor about taken about the case and short-term Diazepam was prescribed

20.36: A call from SH was received by Duty staff at CHRTT, also raised a number of concerns regarding practice during the call.

In the phone transcript the CHRTT assessor appeared to be placing the responsibility on SH, for not confronting her husband's less than frank account with staff during the face-to-face assessment, without considering the risks this may increase for SH.

The CHRTT assessor may not have known that SH was in a wheelchair but she advised the assessor, during the conversation, that she was disabled.

SH also makes an important admission that she told the earlier assessor that she was not safe, this is not pursued with immediacy but the response is that the assessor could make contact probably the following day.

SH also implied that she thought that the assessor was returning but he did not, he just phoned back.

Later on during the evening of the 16.8.15 the CHRTT duty worker explored with another team member, who was attending the home of Adult B later on with new medication, the possibility of him calling SH back, the team member was reluctant to do so at this time, as he was dropping off medication and did not know much about the case.

There appears to be a break down in communication between the duty workers ability to articulate intuitive concerns, to the attending member of staff.

It was noted that post incident a non urgent safeguarding alert had been made concerning SH, but not shared with CHRTT, and could this have influenced practice?

Depending on the time of the referral, it should have increased the timeliness of Adult B being seen, and during a face to face assessment been recognized as a trigger, when SH divulged her concerns for her physical safety on the 16.8.14.

If reported to the safeguarding lead that an expressed risk of physical violence alongside the known psychological abuse alert had been made, it may have sped up the safeguarding teams involvement, but it may not have ultimately altered the course of events.

If the point of the second home visit was as a follow up visit regarding Adult B's mental state by dropping off medication, then good practice would have

been to consult with his wife firstly, as Adult B had a history of presenting differently to professionals than to his wife and GP.

During this assessment Adult B was assessed as not presenting any overt risks and an assumption was made that SH was not returning to the house that night. The pressures of work, again, limited the time spent on this assessment as the CHRTT staff member reportedly was going to undertake another assessment afterwards.

The number of staff involved in the phone contacts and two different staff undertaking face to face assessments contributed to a fragmented picture of Adult B's presentation and behaviours.

It was decided by the individuals involved in assessing Adult B during this period that he did not present overt risks within the phone calls or IAPT session therefore he was not escalated to a psychiatric assessment nor was a face to face assessment offered by the CPE and CHRTT services until the 15.8.14

The zoning tool in place at the time would indicate Adult B was deteriorating by the number of contacts he was making to services and coupled with two requests by his GP for him to be seen.

According to the staff interviews (conducted by Tony Drew) it was accepted practice that a telephone assessment is based upon individual clinical judgments and staff are encouraged to use the MDT if they are not sure.

With the reported backlog of calls and short staffing in this time frame, staff may not have felt able to seek clinical advice if there was a pressure to respond to the next call. The CPE service manager reported supervision had been sporadic when the service was so busy.

The criterion indicating need for a Common Point of Entry psychiatric assessment were:

- Diagnostic clarity when a CPE/ Triage /face-to-face assessment is unclear. A full documented assessment will be expected and a diagnosis is needed to decide on a treatment pathway.

- Diagnostic clarity for a GP e.g. bipolar disorder suspected and whether to prescribe antidepressants or mood stabilizing medication. This may be helpful in a one off assessment.

- Request for assessment and advice on medication when the presentation is complex or failing to respond, or past history of severe mental illness. It is

not appropriate when the case is straightforward and a simple increase of an antidepressant is indicated this can be negotiated with the GP from the hub.

- In a situation where a patient with an established diagnosis e.g. major mental illness has relapse and there is a need to assess before re-starting or changing existing medication.

- New possible causes of psychosis.

NT's behaviours met two of the following criterion:

- Diagnostic clarity for a GP as the GP asked for an assessment in clinic on two occasions.

- Diagnostic clarity when the triage assessments were not resolving Adult B's anxieties and care seeking behaviours.

There was lack of clarity over the role of the CPE team – which signposted back to CHRTT and eventually IAPT, but did not respond to the GP requests for assessment.

The role of CHRTT, which undertook an assessment and holding role without offering treatment, had an overlap with the role of CPE for Adult B. This lack of clarity meant that Adult bounced between a number of services without ownership by one team or one individual.

IAPT did not assess his crisis to be of an urgent nature and after an initial assessment sent NT information in the post with some other alternative support mechanisms and a follow up appointment.

An MDT review may have identified a more urgent care package was required, and a carers' assessment could have been activated with support given to the GP in managing the contacts and physical discomfort experienced by Adult B.

The wider MDT may have considered the needs of SH who was contacting the service asking for help for her husband and this could have involved her in the treatment plan and elicited a more accurate picture of Adult B's presentation and severity of symptoms.

Adult B was assessed by a number of staff with different experience and skills, some were very experienced in nursing and assessments, and he did not present in a way, or spoke in a way, that made them concerned for his immediate safety or the safety of his wife.

Potentially significant issues.

Adult B had no previous history of mental health concerns, this was a rapid onset of distressing symptoms indicating a depressive episode which Adult B was having difficulty clearly expressing his needs.

1. Adult B presented with clusters of contacting health professionals and a range of services (111, ambulance / Westcall doctors) within short time frames, expressing his anxiety and concerns and distressing physical symptoms. He made statements indicating elevated risk but when questioned directly he denied self-harming or harm to others behaviours.

2. Adult B spoke to multiple individual practitioners when he called the CHRTT and CPE teams, which could have impacted on his ability to build a trusting or consistent relationship with any member of staff over the phone.

3. Adult B's expressed anxiety and references in conversation such as he "wanted all this to end" but these comments did not register with staff as significant or implying elevated risk.

4. Adult B was not offered treatment by the CHRTT team, which could have consisted of brief therapy sessions, but he was spoken to and re assessed.

5. Some of the staff interactions recorded did not appear to be skilled interventions, whilst recognising the staff team were working to a high workload but there was minimal recognition of non-explicit references within the conversational content and little evidence of probing of Adult B's ambivalence when asked directly about his intent.

6. SH's views were not included in planning care and treatment for her husband and potentially important information about his change in behaviours were not recorded, especially in the light of her disability and therefore vulnerability.

7. The risks Adult B posed presented by SH were missed on several occasions in terms of staff raising a safeguarding alert in response to her concerns about Adult B's deterioration and her expressed feelings of being threatened.

8. The skills staff require to deliver phone counselling and conduct phone assessments may have been underestimated by the Trust

Contributory factors.

Patient Factors

Adult B was not known to mental health services. He did not have a documented history of mental health concerns.

Adult B was not always explicit in what help he required. He expressed anxiety and agitation in phone calls but also denied risks to himself or others when directly questioned.

Adult B was the main carer for his wife, who was disabled and in a wheelchair.

Adult B was described as "becoming paranoid" by his wife to paramedics.

Adult B had stopped taking medication prescribed by his GP.

Adult B had not been sleeping and had a poor appetite and had reportedly been researching suicide methods on the Internet.

Adult B had no previous history of violence or aggression known by health professionals.

Adult saw a doctor on the morning of the incident for his physical health needs concerning haemorrhoids/ rectal bleeding and constipation. The Dr treating Adult B, noted his anxiety but believed it was due to pain and discomfort experienced due to his physical health needs.

Staff factors

There was a backlog of referrals at the time of this incident and this may have increased pressure on team members to make decisions speedily.

Multiple staff had contacts with Adult B over a 2-month period this led to different members of the team holding different knowledge sets about him.

Adult B did not have an identified care coordinator amongst the staff team as to the volume and acuity of work presenting to CHRTT meant he did not meet a crisis point.

Adult B had not been seen or assessed by a psychiatrist from either the CPE or CHRTT teams at the time of this incident.

Staff did not recognize safeguarding issues when they arose concerning SH, and therefore policy around safeguarding practice was not followed.

Staff did not recognize that Adult B's patterns of increased phone calls and GP contacts, as indicating increasing risk and distress.

Staff did not appear to recognize the escalating anxiety expressed by Adult B nor identify non-explicit references to suicide in his phone calls.

Task factors

Some team members preferred phone contact than face-to-face contact with patients.

The escalation process to prompt a face to face meeting may have been set too high and did not include triggers such as frequent calling of services and relatives contacting services.

Staff in both CPE and CHRTT may have identified the IAPT colleagues picked up *working* with clients and perceived they were in a gatekeeping role, mainly to prevent hospital admissions.

Tools that helped screen and identify prioritizing clients based on risk and deteriorating coping skills were not consistently applied due to the volume of calls.

Staff were expected to cover the CPE role out of hours and therefore signposting versus treatment, may have become the norm.

Communication Factors.

Staff in CPE and CHRTT were not sharing information between them about clients who were contacting both services and there was a lack of ownership of Adult B's care and management.

Links with safeguarding teams were not made concerning SH despite staff having knowledge of her expressed concerns about her husband's behaviours.

Interpretation of Adult B's phone conversations and intent may not have been correct and potentially overly optimistic. Adult B stated, "…He wanted it to end…" this was interpreted on a phone assessment as Adult B wanting the anxiety to come to an end.

Phone assessments may not always give a complete picture of a clients presentation and meaning behind words, as facial gestures, posture, body position, clothing, are not able to be observed.

Phone assessments may not always be the clients preferred choice of communication (either SH's or Adult B's.)

Staff in the team had different skills, experience and expertise in conducting phone assessments.

Time pressures placed on staff reduced the amount of communication between team members such as sharing clinical information about clients.

Time pressures due to short staffing, reduced the ability to complete comprehensive face to face reviews.

Equipment

The inoperability of laptops, in Newbury is an issue for both communication and staff safety as they reportedly frequently lost contact.

Work environment

CPE reported the work environment to be cramped and noisy and not user friendly for call handling.

CPE team reports a workspace shared by many other staff and with a shared break out space, which does not promote staff being able to take a break in a private setting.

Organizational

The activity levels were higher than expected in both CPE and CHRTT teams, and services had not always been staffed to meet capacity, hence staff had difficulty meeting service expectations with the staff numbers in post.

24-hour service cover by a psychiatrist was not provided to escalate concerns or seek advice from on complex cases out of hours.

There was a backlog of referrals at the time of this incident and this put pressure on team members to complete contacts in as short a time as possible and respond to the most urgent calls.

The staff skills required for these roles were more advanced than what was set in the service specification and some staff did not have the advanced skills and expertise to manage both the volume and acuity of the calls.

It was not considered unusual for GP's to seek to escalate cases to secondary care while awaiting Talking Therapies and this may have contributed to the GP's requests being overlooked.

Education and Training

Expert In-house training in phone counselling was not in place at the time of this incident.

Staff in the CHRTT did not receive motivational questioning skills training, so some of the questions in the recorded phone calls did not appear facilitative or supportive.

Domestic Abuse awareness was not available as a training workshop in the Trust at this time.

Suicide Prevention was not taught within the clinical risk workshops and induction. Suicide Awareness and prevention appears to have been conflated with risk recognition rather than being taught as a specialist area.

Training delivery within the Trust did not have identified learning outcomes or competency assessments within the sessions.

Team factors

Due to the high numbers of contacts staff in CHRTT preferred phone contacts as they were reportedly faster.

Staff shortages increased the workload and impacted on the time available to respond to and think about exploring emerging issues, when a high caseload was also present.

Staff worked with locums, and agency staff so communication was not always established between the differing members.

Some team demonstrated some symptoms of burnout and avoided face to face work and counselling sessions therefore they may not have used these skills effectively to work with clients, which had become diluted due to the volumes of workload.

The Trust recognized the service failings that arose between the three services below and have noted their concerns in their published Quality Accounts 2013/2014.

Excerpts from the Quality Accounts 2013/2014

Common Point of Entry, Crisis Resolution Home Treatment Team (CRHTT) and Community Mental Health (CMHT). The interface between these three teams has been of some concern. It is important that it is clear which team is taking ownership of vulnerable and at risk patients at any time and that there is effective communication between services and with referrers, partners, patients and families at all stages of the care pathway. Patients often present with complex problems, which could fall between agencies and services so excellent collaboration is required. One common example would be the combination of mental health, substance misuse and social problems. CRHTT caseloads are often much higher than the service was originally designed to cover.

A review of CPE has been commissioned and a business case for additional investment into CRHTT has been presented to commissioners under mental health 'parity of esteem' proposals because their caseloads continue to be over and above the level originally commissioned.

Notable Practices

- The CHRTT recognizes the shortfall in skills and training within the Trust and has purchased specialist external training for CHRTT staff.

- Supervision is mandatory and provided for all staff in CHRTT and is monitored.

- The CPE service manager employs locum staff with Accident and Emergency Liaison experience, who have enhanced skills in triage.

- Both service leads in the CPE and CHRTT services recognize the quality issues caused by higher activity levels than they were budgeted for and have escalated these concerns to senior management.

- Both service leads in the CPE and CHRTT expressed concerns for staff welfare and the high levels of turnover in their teams and demonstrated empathy for staff trying to manage the acuity of need.

- CHRTT has a low number of complaints for its services in 2014 and this was exceeded by compliments received.

Conclusion and Lessons learned :

Feedback reported from CHRTT service lead on changes made to his team post the homicide:

- All staff are now aware of the importance of inputting the date and time of visit as well as the name and role of professional visiting the client.
- Staff must to carry out assessment face to face rather than over the phone. Staff are also aware of the need to explore and follow up concerns face to face rather than over the telephone
- In areas where there is poor Vodafone network such a Newbury, Staff write their report on a word document and copy and paste onto RIO rather than trying to input directly as this could lead to loss of information
- Training that has taken place in addition to domestic abuse include, telephone crisis counselling; management of sociality; risk assessment and management
- Service Improvement plan in progress for CRHTT including governance, staff support and lesson learnt from serious incidents are all features on the plan
- There is now more robust records audit being carried out in the service. Issues raised by the audit are directly raised with staff to improve practice
- A psychiatrist is now available for staff at weekends to discuss to discuss complex cases
- CPE and CRHTT have a closer working relationship + Monthly Interface meeting in place
- Progress note template has been changed, embedded and audited monthly
- Staff involved have reflected on their practice by producing reflective practice logs and sharing these in supervision.
- £1.2m has been invested across Berkshire into the CRHTT service in recognition of a service under resourced.

Summary

In advising of responding to the terms of reference:

The brief for this Expert Nurse will be to look at the clinical practices applied and to provide the DHR Panel with an independent nursing view of Berkshire Healthcare NHS Foundation Trust's involvement.

This report has highlighted a number of areas where practice was not in line with the Trust's operating procedures and policies and some staff's clinical practices fell below an acceptable standard.

Some staff made clinical judgments in both services that I would differentiate as weak judgments, rather than poor judgments, and there were areas where a lack of competency was demonstrated by staff in regard to their skills in recognition of risk and suicidal ideation, knowledge of safeguarding and domestic abuse awareness and practices.

My reasoning for describing the clinical skills used in assessments as weak specifically in relating to actions taken the 16.08.14, were due to staff attempting to clarify and discuss to a limited extent the information they had about Adult B and SH, and this demonstrates a degree of reflection.

The first assessor contacted the Westcall Dr and discussed his assessment of Adult B, and new medication was prescribed for Adult B that evening based on this information.

The duty worker at CHRTT, who spoke to SH, did pass on this information to the second assessor before attending the family house again, she advised him to contact SH. However he chose not too.

The second assessor did appreciate that Adult B's case was of concern, after overhearing a conversation in the office and he volunteered to provide the new medication before assessing another patient.

Neither assessor identified signs that Adult B was in significant distress at the times he was seen by them. Adult B did not disclose any intention of his actions within the coming 12 hours. Adult B also was seen by other health professionals on the 16.8.14 and they also did not document significant distress.

The practices of the mental health team staff however, should be set in the wider context of two services that were at this time, swamped with very high activity levels and with increased expectations by the creation of an open inclusive of self referral crisis phone service, accessible across all of Berkshire.

Staff were functioning within services where there were not clearly defined roles or filters to access, so staff were treating a wide range of acuity, with presentations ranging from mild symptoms, to relapsing patients to severe and enduring mental illness. Adult B appeared to get lost in this system. This was further contributed to by the volume of contacts impacting on both staff judgment and communication amongst the teams.

There was a blurring of roles and responsibilities between CPE and CHRTT and there was a sense of the team perception being that they were “under siege” from the unrelenting requests for their services and this resulted in staff signposting patients when they did not have the time to safely maintain or work with all clients requesting their services.

A range of permanent, locum and agency staff worked, some without adequate training, without at times access to supervision. Attempting to deliver a diluted service to reduce the backlog of referrals. This may have influenced the fact that SH’s needs were also lost within the volume of information received by the CHRTT service.

However a low number of complaints about the services could be interpreted as the majority of clients using the services found no cause to complain and 20 compliments were given in the same time frames.

My clinical opinion is, staff were working within a highly pressured, highly stressful environment with multiple contributory factors affecting their performance and judgments which then impacted on the efficacy and quality of the service offered by this Trust at this time.

Recommendations

1. The senior management team must clarify and differentiate the purpose of the CHRTT and CPE service models and ensure both services are reviewed and remodelled, to match capability with meeting capacity.

2. Another level of triage should be considered to ensure that not all calls are processed and passed through to CHRTT; some should be diverted to either social care or non-health services.

3. Activity levels for both of the services should be set in line with capacity, and a staff skill mix set that is appropriate against the acuity and activity presented.

4. Staff to be supported to develop skills in effectively responding to and managing users of the crisis service presenting with personality disorders. Working with senior staff to develop effective responses that work towards reducing high levels of phone contact.

5. Permanent staff should be recruited and supported to manage caseloads based upon evidence-based guidelines and ensuring patient safety at all times.

6. Staff welfare should receive a greater priority from senior management and a renewed focus on staff retention and health should be increased in areas with repeated high turnover with risks of staff burnout.

7. The admission system should more fully support allocating of contacts to a team or group of individuals, versus contact with a new staff member for each service contact, to promote consistency in the response and to ensure that a trusting relationship may be developed.

8. Bespoke advanced mental health telephone counselling skills must be provided for all staff and refreshed biannually. Staff should not work in these services without undertaking a competency-based training.

9. Staff should receive training in identifying suicidal ideation that is based on an evidence-based model and includes covert signs and managing ambivalence within telephone contact.

10. Staff should receive and be able to access consistent and high quality clinical group and 1-1 supervision.

11. Staff should have access to motivational interviewing skills to better improve their telephone relationships with those in crisis or hard to engage clients.

12. An escalation criterion tool should be implemented, which helps staff consistently identify current and past risk behaviours and triangulate them with other information such as concerns expressed by other professionals. This tool should be regularly audited.

13. Risk assessments should include gathering a holistic patient history based on past mental health history, family and employment factors as well as the presenting symptoms.

14. A greater recognition should be given to family involvement in developing treatment plans especially when the service focus is inpatient avoidance, families views and history must be included in planning effective community based care.

Chronology

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

Samaritans does not have a chronology
Victim Support does not have a chronology
EDT have no chronology as they had no involvement
Citizens Advice Bureau have no chronology as they had no involvement
A2Dominion has no chronology.

Date	Event	Outcome	Source
June 2003	Request for help with turning on taps	Closed 16 June 03 with 'No further action'.	WBC IMR Chronology
29/07/2003	General Contact	Note made on Capita stating "SW has requested a change of surname to SH, Copy of marriage certificate sent"	Sovereign IMR Chronology
19/02/2004	Rent	Note on Capita stating "message left on 2004 ansaphone for SH to ring me as no payments coming on to the account"	Sovereign IMR Chronology
01/03/2004	Rent	Rent arrears letter sent by SHA	Sovereign IMR Chronology
09/03/2004	Rent	Rent arrears letter sent by SHA	Sovereign IMR Chronology
16/03/2004	Rent	Rent arrears letter sent by SHA	Sovereign IMR Chronology
31/03/2004	Rent - Pre Notice visit made by SHA	No reply, card and account balance posted through letterbox	Sovereign IMR Chronology
13/04/2004	Notice of Seeking Possession served on ST by SHA through letterbox because of rent arrears		Sovereign IMR Chronology
15/04/2004	Note on Capita stating "tenant paying £400 today"		Sovereign IMR Chronology
16/04/2004	Standing Order mandate received from ST for monthly payments of £290 commencing 18 May		Sovereign IMR Chronology
May 2004	Request for OT assessment	Closed 4 Jan 2005 "All Services Provided".	WBC IMR Chronology

25/05/2004	Rent arrears letter sent by SHA		Sovereign IMR Chronology
04/06/2004	Visit to SH made by SHA Officer.	Note of visit “SH has been declared disabled from May 2004. She will receive a disabled car and be exempt from medical fees. This will mean she will have more available income, She will increase standing order to £300 per month and investigate why no payment for May”	Sovereign IMR Chronology
08/06/2004	T/C regarding rent	Note on Capita “rang and left message for tenant to call urgently re standing order as unable to claim May payment	Sovereign IMR Chronology
15/06/2004	Letter received from SH advising error with standing order down to her bank and has arranged for standing order for £320 to start 18 June 2004		Sovereign IMR Chronology
14/09/2004	Criminal Damage to Dwellings - This incident relates to SH having her kitchen window damaged by what she believed to have been a pellet from an air gun which had shattered the glass.	There were no witnesses to this offence and the CEDAR record was filed due to lack of evidence.	Thames Valley Police DHR Chronology. Criminal Damage to Dwellings - CEDAR report FA9174111/04
	Repair number 423594 raised — glazing window		Sovereign IMR Chronology
22/09/2004	Repair number 424981 raised — board and secure window		Sovereign IMR Chronology

11/10/2004	Letter received from SH regarding outstanding rent and advising she had had car trouble and had to pay £850 to repair. Offer made of £400 on 17 October 2004 then £400 following month		Sovereign IMR Chronology
22/10/2004	Letter received from SH with cheque for £400 and advising has applied for loan which should be granted in 7-10 days. Wage slip copy enclosed		Sovereign IMR Chronology
02/11/2004	Repair number 431548 raised — repair leak		Sovereign IMR Chronology
03/11/2004	Rent statement sent from Sovereign to SH confirming balance due		Sovereign IMR Chronology
15/11/2004	Repair number 433875 raised — hall smoke alarm — repair		Sovereign IMR Chronology
25/11/2004	Letter received from SH advising loan was delayed as forms lost and now completed again. Bank confirmed have forms and payment should be made next well.	Rent statement sent by Sovereign confirming balance owing	Sovereign IMR Chronology
30/11/2004	Repair number 436145 raised —fit hand rail and grab rail		Sovereign IMR Chronology
06/12/2004	Visit made by Sovereign.	Man in property advised SH in hospital and will let her know of visit	Sovereign IMR Chronology
14/01/2005	Rent. Telephone call received from SH advising will make payment this week and again in 2 weeks		Sovereign IMR Chronology

15/01/2005	Transfer application form competed and signed by SH	Application requests a 2 bedroom property as her sister comes and stays with her when her husband is away on business. Reason for requesting a transfer cited as “I am disabled and problems getting up and down stairs to get in doors”	Sovereign IMR Chronology
18/02/2005	Letter sent from SHA acknowledging receipt of transfer application and advising been placed in Category F.	Letter also refers that a Housing Officer will contact her within one month to discuss requirements in more detail	Sovereign IMR Chronology
20/05/2005	Notice of Seeking Possession served on SH by SHA due to non-payment of rent. Notice posted through letterbox		Sovereign IMR Chronology
07/06/2005	Letter sent from SHA arranging home pre-court visit on 17 June 2005		Sovereign IMR Chronology
17/06/2005	Visit made by SHA.	No reply, card and statement posted through letterbox	Sovereign IMR Chronology
21/07/2005	Letter dated 14 July received from SH apologising for being behind with her rent and advising she has confessed all to her husband who will sort it out by paying the full total of arrears and have the monthly rent paid from his rent account Request made for total amount to pay and a new direct debit form		Sovereign IMR Chronology
08/08/2005	Robbery of Personal Property . SH reported this offence which was a robbery to another person.	Robbery of Personal Property	Thames Valley Police DHR Chronology. CEDAR report FA1999100/05

Undated (but reference made in the correspondence to it being 8 August 2005)	Handwritten and undated note from SH advising cash paid over the counter this morning — 8 August 2005. Note also advising she has come clean about the rent problem to her husband who is signing a loan agreement at the back on Friday Reference made to SHA receiving a cheque for £9,000 and the rest can be deduced from his account at £50 per month Note also says husband is taking over paying the rent from his account every month Question asked that if all the above is done before the Court will this be enough to not evict		Sovereign IMR Chronology
22/09/2005	Repair number 522629 raised — smoke detector faulty		Sovereign IMR Chronology
02/11/2005	Letter received from SH dated 29 October advising situation has changed and will keep changing as has to use her wheelchair more and more and living in an upstairs apartment is getting more difficult. Stating when first applied wanted a bungalow or ground floor flat but in discussions with		Sovereign IMR Chronology

	husband and doctor feel a 2 bedroom house would be belier as husband says if they went for a larger house he will pay for a stair lift for her. Needs 2 bedrooms as husband is away on business she needs someone to stay with her Can't write as hands paralysed hence typed letter		
10/11/2005	Letter received from SH requesting be considered for house and bungalow	Letter sent from SHA acknowledging letter dated 29 October and enclosing 2 medical forms for completion and return Letter of support from doctor also requested which should be sent direct to SHA	Sovereign IMR Chronology
08/12/2005	Letter received from Thatcham Medical Practice advising of SH's medical condition and mobility problems		Sovereign IMR Chronology
19/12/2005	Transfer visit carried out by SHA at ST's home	Evidence of applicants' financial resources completed and signed by both SHnd Adult B	Sovereign IMR Chronology
10/01/2006	Medical assessment form completed for transfer		Sovereign IMR Chronology
12/01/2006	Letter sent from SHA confirming medical priority given to transfer application		Sovereign IMR Chronology
02/06/2006	Letter received from SH requesting contact when a suitable property becomes available		Sovereign IMR Chronology
07/06/2006	Letter sent from SHA confirming Category A		Sovereign IMR

	status on transfer list		Chronology
15/09/2006	Criminal Damage to vehicles - This was a report of a criminal damage to a car whilst in a car park.	SH was originally named as a witness but after further enquiries it was found that she had not witnessed the actual damage. The CEDAR record was filed due to lack of evidence.	Thames Valley Police DHR Chronology CEDAR report - FA9543543/06
29/01/2007	Repair number 648556 raised — remove trees		Sovereign IMR Chronology
25/02/2007	Disabled adaptation. Letter received from SH requesting bath is replaced with a shower		Sovereign IMR Chronology
06/03/2007	Letter sent from SHA referring to letter dated 25 February about request to have bath removed and replaced with a shower	Letter advises a referral to the Occupational Therapist at West Berkshire Council will need to be made and they will visit Disabled adaptations leaflet enclosed with better giving telephone number to contact	Sovereign IMR Chronology
	Letter sent from SHA to Occupational Therapist, Social Services regarding SH's request to remove the bath and replace with a shower. Letter confirms SH is disabled and uses a wheelchair and that in SH's letter she describes her need for the adaptation as great	Request made for OT to contact SH	Sovereign IMR Chronology
07/03/2007	Letter sent from SHA confirming place on transfer list and supporting letters passed		Sovereign IMR Chronology

	to appropriate manager		
23/03/2007	SH made contact to discuss option of Level Access Shower (LAS).	Not taken forward as SH was on list for re-housing and would therefore not be eligible.	WBC IMR Chronology Physical Disabilities Team
14/05/2007	Visit made to SH by SHA relating to transfer request.	Note of visit states “situation becoming increasingly urgent. Specialists letter requested	Sovereign IMR Chronology
21/05/2007	Tenancy audit visit carried out and audit form completed and signed by Housing Officer	Not signed by SH	Sovereign IMR Chronology
24/05/2007	Repair number 707916 raised — lightswitch repair Repair number 707918 raised — plaster . repair		Sovereign IMR Chronology
30/05/2007	Internal SHA e-mail advising pre-void inspection carried out on 30 May and tenant has requested to keep tenancy of 24 Hartmead until 24 June and pay rent on both 9 Carnarvon and 24 Hartman Reference to a recharge for £40 to be applied to the property for an internal kitchen door that the tenant no longer has.		Sovereign IMR Chronology
	New tenancy offer	Letter sent from SHA offering a tenancy of 9 Carnarvon Place from Monday 4 June 2007 Offer letter advises an appointment to sign the tenancy will be made in due course and: • Weekly rent is £151.27 • Rent is calculated on basis of 4 rent-free weeks	Sovereign IMR Chronology

		• Letter requests SH and Adult B read the tenancy agreement carefully, drawing attention to clauses relating to pets and changes in occupants	
	New tenancy offer	New tenancy sign up and checklist completed and signed by SH Details confirm: • Property address • Details of all people who will live there • Received keys • Confirmation wish to accept offer of tenancy	Sovereign IMR Chronology
04/06/2007	Rent payment card ordered		Sovereign IMR Chronology
26/06/2007	Emergency contact keyholder details recorded as PAC 207		Sovereign IMR Chronology
02/07/2007	Repair number 713422 raised — gas leak		Sovereign IMR Chronology
	Repair number 713428 raised — gas leak		Sovereign IMR Chronology
03/07/2007	Letter sent from HA advising of balance of £517.99 owing on rent account Direct debit mandate enclosed	Request made to pay outstanding amount either in cheque or by DD	Sovereign IMR Chronology
04/07/2007	Note made on Capita stating “credit balance from Harimead Road to be transferred over Balance to date is £517.99.”	Letter sent with DID mandate enclosed	Sovereign IMR Chronology
10/07/2007	Note made on Capita stating “new DD to		Sovereign IMR

	commence 1 August 2007. First payment increased by £892.00”		Chronology
01/10/2007	Settling in visit	Note on Capita stating “settled in well”	Sovereign IMR Chronology
04/08/2008	Repair number 829058 raised — toilet — blocked		Sovereign IMR Chronology
04/12/2008	Repair number 854020 raised — shower head blocked		Sovereign IMR Chronology
20/01/2009	Repair number 863063 raised — leak — repair — water pressure — repair		Sovereign IMR Chronology
23/02/2009	Repair number 870190 raised —leak— under — basin		Sovereign IMR Chronology
19/05/2009	Letter sent from SHA to SH referring to a meeting held that afternoon with her about entrance gates, fire doors and anti-social behaviour		Sovereign IMR Chronology
22/07/2009	Repair number 921024 raised — extractor fan — repair		Sovereign IMR Chronology
	Repair number 921025 raised — front door repair (door not fitting correctly banging when communal door closes)		Sovereign IMR Chronology
19/02/2010	Repair number 967456 raised — front door lock (unable to lock)		Sovereign IMR Chronology
07/04/2010	Handwritten note made in scheme diary stating “9) Away 2 weeks’		Sovereign IMR Chronology
05/05/2010	Improvement works - Handwritten note made in scheme diary stating “9) Patio — Sarah Towey”		Sovereign IMR Chronology
06/05/2010	Letter from SHA referring to a letter works	Permission not given as gardens	Sovereign IMR

	requesting permission to extend the patio area to the flat.	are communal and patios part of communal gardens. Also an issue with gas supplies running close to the area	Chronology
31/05/2010	Repair number 1012987 raised— wardrobe door repair (replace door closure)		Sovereign IMR Chronology
	Repair number 1015988 raised — lounge ceiling repair		Sovereign IMR Chronology
27/06/2010	Telephone and Patient Contact. 999 - Chest Pain – SH.	Acute Asthma Attack - Pt was treated at home and did not require hospital Admission.	South Central Ambulance Service NHS Foundation Trust Serious Case Review Chronology. Call Log/Patient Clinical Record/Continuation Form.
28/07/2010	Contact following total knee replacement – requesting grab rails		WBC IMR Chronology Physical Disabilities Team
19/08/2010	Repair number 1030366 raised — shower repair		Sovereign IMR Chronology
27/08/2010	Self-assessment completed	Placed on OT waiting list	WBC IMR Chronology Physical Disabilities Team
16/09/2010	Repair number 1036543 raised — go today — attend to airing cupboard door		Sovereign IMR Chronology
	Repair number 1036546 raised — lounge ceiling repair		Sovereign IMR Chronology
12/04/2011	Telephone and Patient Contact. 999 -	Breathing Difficulties - Due to	South Central

	Breathing Difficulties – SH	Chest Infection. Patient transported to Royal Berkshire Hospital for assessment.	Ambulance Service NHS Foundation Trust Serious Case Review Chronology. Call Log/Patient Clinical Record/Continuation Form.
	Telephone and Patient Contact. 999 - Breathing Difficulties – SH	Breathing Difficulties - Due to Chest Infection. Patient transported to Royal Berkshire Hospital for assessment. Second visit to this patient today	South Central Ambulance Service NHS Foundation Trust Serious Case Review Chronology. Call Log/Patient Clinical Record/Continuation Form.
16/05/2011	SH seen at West Berks Community Hospital ref asthma (deteriorating mobility noted)		WBC IMR Chronology
15/06/2011	Repair number 1116791 raised — fit plate heat exchanger		Sovereign IMR Chronology
18/07/2011	ASB/nuisance.	Handwritten note made in scheme diary stating “9) c/c noise from visitor in flat 34”	Sovereign IMR Chronology
29/07/2011	Assessment visit		WBC IMR Chronology Maximising Independence Team
04/08/2011	‘Short review’ completed.		WBC IMR Chronology Maximising Independence Team
17/08/ 2011	Handwritten note made in scheme diary stating “9) Mislaid keys”		Sovereign IMR Chronology
18/08/2011	Equipment provided – shower chair, Rutland		WBC IMR Chronology

	trolley, grab rails, etc		Maximising Independence Team
22/09/ 2011	Repair number 1139437 raised — switch: GT — sparks from light switch		Sovereign IMR Chronology
03/11/2011	Telephone and Patient Contact. 999 - Chest Pain – SH	Chest Pain - 2 day hx of chest pain. Patient transported to Royal Berkshire Hospital for assessment	South Central Ambulance Service NHS Foundation Trust Serious Case Review Chronology. Patient Clinical Record
06/12/2011	OT assessment		WBC IMR Chronology Maximising Independence Team
09/12/2011	Equipment delivered (Mangar Sit u Up). Left Carers Assessment to complete.	The follow-up Care Plan noted that: “Carers Assessment given to client for Adult B to complete. He has done this and sent it back to the Market Street offices however it cannot be found. Discussed the situation with SH, she reported that at the moment they are coping however if anything changes they will contact us again. Agreed for case to be closed.”	WBC IMR Chronology Maximising Independence Team
12/12/2011	Confirmed new equipment was helping.		WBC IMR Chronology Maximising Independence Team
19/01/2012	Handwritten note made in scheme diary stating “9) DN” Note: (DN is an abbreviation used to		Sovereign IMR Chronology

	denote District Nurse)		
25/01/ 2012	Care Plan completed	. Includes following comment: "Risk of carer stress – Adult B has completed a carers assessment and sent this back to the Market Street offices however this cannot currently be found. Adult B and SH report that at the moment they are managing however if things change they will contact WBC for a reassessment."	WBC IMR Chronology Maximising Independence Team
31/01/2012	Letter advising no further services.		WBC IMR Chronology Maximising Independence Team
24/02/2012	Telephone and Patient Contact. H.C.P Admission – SH	Urine Retention - for last 24 hours. Transported to Royal Berkshire Hospital for assessment.	South Central Ambulance Service NHS Foundation Trust Serious Case Review Chronology. Call Log/Patient Clinical Record/Continuation Form.
17/04/2012	Repair number 1203796 raised — tap — overhaul any type of tap		Sovereign IMR Chronology
	Repair number 103798 raised — lock — overhaul any lock complete		Sovereign IMR Chronology
31/05/2012	Repair number 1215768 raised — go today — light — repair		Sovereign IMR Chronology
27/06/2012	Repair number 1222265 raised — OOH — cistern not flushing		Sovereign IMR Chronology
28/06/2012	Repair number 1222294 raised — cistern —		Sovereign IMR

	overhaul any cistern — go today		Chronology
	Repair number 1222420 raised — cistern — overhaul any cistern — go today		Sovereign IMR Chronology
24/07/2012	E-mail received from SH requesting a home visit and advising of the following issues: • cars parking over the curb so she can't get around on her mobility scooter • bedroom is adjacent to a fire door which most visitors use • trying to sleep when visitors are chatting, banging outside her bedroom and keeping their lights on which comes straight though her curtains, playing music, on hands free mobile on full blast • resident lives close to her and asked her to be quiet as they park right outside her bedroom window shouting and banging car doors • all visitors and carers park outside her bedroom window • many times she can't park outside her own home and end up parking in the visitors car park to have to carry her shopping all the way to the fiat, this causes great pain		Sovereign IMR Chronology
02/082012	ASB/nuisance	Note on Capita stating "SH finds it very noisy being near the parking	Sovereign IMR Chronology

		area. Support officer will discuss with care agencies. Advised about moving”	
07/08/2012	Note on Capita stating “DD amended as rent charges for cleaning changed. Letter sent”		Sovereign IMR Chronology
07/11/2012	Repair number 1256608 raised — shower — repair		Sovereign IMR Chronology
22/01/2013	Email received from SH advising been unable to report faulty shower as telephone number calling constantly engaged		Sovereign IMR Chronology
	Repair number 1277103 raised — attend to unblock drains in wet room shower		Sovereign IMR Chronology
31/01/2013	Repair number 1280167 raised —bathroom light — repair		Sovereign IMR Chronology
13/02/2013	Repair number 1283886 raised — possible leak		Sovereign IMR Chronology
10/04/2013	Case notes record: “Spoke to SH about a Carers Assessment for her husband as it is time for a review. She says they are managing fine at the moment and they didn’t need the carers assessment at this stage. If circumstances change she would let us know”.		WBC IMR Chronology Physical Disabilities Team
19/04/2013	Handwritten note made in scheme diary stating “9) Crutches given from store”		Sovereign IMR Chronology
12/07/2013	Call from SH chasing repair and advising unable to get through on telephone		Sovereign IMR Chronology
	Repair number 13027648 raised—no hot water		Sovereign IMR Chronology

18/07/2013	Telephone and Patient Contact. 111 - Wrist Injury – SH	? Wrist - Transported to West Berkshire Community Hospital for assessment.	South Central Ambulance Service NHS Foundation Trust Serious Case Review Chronology. Call Log/Patient Clinical Record/Continuation Form.
15/11/2013	Repair number 13065335 raised — no hot water		Sovereign IMR Chronology
25/11/2013	Repair number 13068526 raised — fit plate heat exchanger		Sovereign IMR Chronology
23/12/2013	Repair number 13078368 raised — light — renew lamp holder or flex or rose		Sovereign IMR Chronology
09/01/2014	Section 2 (hospital discharge) attached to Raise		WBC IMR Chronology Maximising Independence Team
03/02/2014	Repair number 13093663 raised — GT water is leaking onto lights and smoke alarm		Sovereign IMR Chronology
	Repair number 13093666 raised — ceiling repair after leak		Sovereign IMR Chronology
20/02/2014	Note on Capita stating SH had called in “to request for someone to go out and clean her cupboards and cooker as spray paint went all over her cupboards and cooker following ceiling repair. Unable to clean off herself as elderly and disabled”		Sovereign IMR Chronology
	Note on Capita stating SH “called back to say that the clean up was not satisfactory - spoke		Sovereign IMR Chronology

	to xxx who attended and he will return"		
12/03/2014	Routine Diabetes review for SH with Practice Nurse Falkland Surgery	Note made of pain due to ongoing back problem (for which Adult was also seeing specialist orthopaedics). Holistic assessment of acitivity, including a depression screen, without significant problems identified	Falkland Surgery IMR SH Chronology - GP records
17/03/2014	Unrelated physical problem- soreness and redness of eye. SH met with Locum GP Consultation Falkland Surgery	Reviewed by Eye Specialists same day to rule out diabetes related eye problem. Blepharitis diagnosed (eyelid inflammation), no other significant problem identified	Falkland Surgery IMR SH Chronology - GP records
	Patient Contact. Dr Surgery - Booked Transport for SH	Eye complaint - Hospital Appointment - Transported to Royal Berkshire.	South Central Ambulance Service NHS Foundation Trust Serious Case Review Chronology. Call Log/Patient Clinical Record/Continuation Form.
19/03/2014	Higher blood sugar readings, discussion between Diabetes practice nurse and Diabetes practice lead GP to alter medication. SH met with Practice Nurse Falkland Surgery	Change of diabetes medication to an injectable diabetes treatment	Falkland Surgery IMR SH Chronology - GP records
14/04/2014	Contact to follow on from data-cleaning activity. SH requested a bathing assessment to see if she is eligible for a walk-in bath.		WBC IMR Chronology Access For All Team
06/06/2014	Medication review prior to holiday in USA. Discussed medication increase because some ongoing high blood sugars. GP telephone consultation Falkland Surgery with	Increase in dose of injectable diabetes treatment agreed with GP, up to standard dose of this medication	Falkland Surgery IMR SH Chronology - GP records

	SH		
07/06/2014	Handwritten note made in scheme diary stating “9) Away — 3 wks”		Sovereign IMR Chronology
	Adult B and his wife went on holiday to Florida in a group of 12 family members.		Berkshire Healthcare NHS Foundation Trust IMR Chronology
12/06/2014	Adult B returned home early to the UK by himself.		Berkshire Healthcare NHS Foundation Trust IMR Chronology
15/06/2014	Adult B phoned 111 and was called back by a Westcall doctor. He said he had returned home early from holiday because of an emergency relating to his mother, and had not slept for three nights.	He was advised to attend Newbury Community Hospital (NCH) where he was seen and diagnosed with insomnia. He was prescribed zopiclone 7.5mg.	Berkshire Healthcare NHS Foundation Trust IMR Chronology
	Telephone. 111 - Sleeping Problems – Adult B	Just back from Florida and has been unable to sleep for last three days. Disposition of Call was for individual to contact GP Practice or Local Service within 24 hours.	South Central Ambulance Service NHS Foundation Trust Serious Case Review Chronology. Call Log
	Consultation about Insomnia. Westcall GP telephone consultation with Adult B	Zopiclone sleeping tablet prescribed as a short term treatment	Falkland Surgery IMR Adult B Chronology - GP records
16/06/2014	Adult B saw his GP, reporting anxiety.	He was prescribed amitriptyline, up to 30mg.	Berkshire Healthcare NHS Foundation Trust IMR Chronology
	Consultation about anxiety symptoms, reported to have started 1 week previously. Concern expressed about wife staying behind in USA and her ill health. Also concerned	Amitriptyline 10mg anti anxiety medication started short term	Falkland Surgery IMR Adult B Chronology - GP records

	about some financial issues and his unwell elderly mother. GP3 Face to Face Consultation GP Falkland with Adult B		
17/06/2014	Worsening anxiety symptoms. GP4 Telephone Consultation GP Falkland with NT	Amitriptyline increased to 30mg	Falkland Surgery IMR Adult B Chronology - GP records
18/06/2014	Worsening Anxiety symptoms. GP1 Face to Face Consultation GP Falkland with Adult B	Additional prescription for lorazepam 1mg for extra relaxant effect as a short term medication. Referred to Talking Therapies service	Falkland Surgery IMR Adult B Chronology - GP records Berkshire Healthcare NHS Foundation Trust IMR Chronology
	Call to 111 because of Suicidal symptoms. NT spoke with NHS 111 and Basingstoke Hospital Emergency Department	Emergency ambulance despatched and Adult B taken to Basingstoke A&E Department. Assessed by A&E Doctor and assessed as low risk suicide but referred to Liaison Mental Health team the next day	Falkland Surgery IMR Adult B Chronology - GP records
	Telephone. 111 - Feeling Suicidal – Adult B	Disposition of Call - 999 - Ambulance dispatched to address.	South Central Ambulance Service NHS Foundation Trust Serious Case Review Chronology. Call Log
	Telephone and Patient Contact. 999 - Suicidal Thoughts – Adult B	Having thoughts of Suicide, generally very low mood. Family members report patient behaviour has been out of character for him. - Transported to North Hants Hospital for assessment.	South Central Ambulance Service NHS Foundation Trust Serious Case Review Chronology. Call Log/Patient Clinical Record/Continuation Form.

	Adult B telephoned CPE regarding stress, anxiety and lack of sleep. He denied any psychosocial stressors.	He was given contact numbers and advice about managing anxiety and advised to take his medication. As this was his first episode, suggested that he has a complete physical health check completed by his G.P. to rule out underlying problems.'	Berkshire Healthcare NHS Foundation Trust IMR Chronology
	Adult B later telephoned 111 while with his ex-wife.	Paramedics attended and he was taken to A&E at Basingstoke Hospital where he remained overnight. He was assessed by a mental health liaison nurse who concluded that there was no indication for any referral to secondary services. He was referred back to his GP on 19/6/1 4. [This episode was not reported to BHFT]	Berkshire Healthcare NHS Foundation Trust IMR Chronology
19/06/2014	Assessed by Mental Health Practitioner in response to A&E referral the night before. Similar triggers discussed in this assessment as in the original consultation 16/6, including his wife's ill health Mental Health Team (referred by Basingstoke ED)	Full Mental Health Assessment completed. Medication was planned to continue as already prescribed. GP follow up recommended if not improving	Falkland Surgery IMR Adult B Chronology - GP records
20/06/2014	Consultation because of continuing anxiety symptoms. Refers to ml. GP1 Face to Face Consultation GP Falkland with Adult B	Further medication issued with the plan to continue as already prescribed	Falkland Surgery IMR Adult B Chronology - GP records

	Adult B saw his GP.	He is reported as saying that he was hoping to feel better after his wife's return from holiday.	Berkshire Healthcare NHS Foundation Trust IMR Chronology
22/06/2014	Consultation because of continuing anxiety symptoms. Westcall GP telephone consultation with Adult B	Advice to contact Falkland Surgery GP for continuity of plan	Falkland Surgery IMR Adult B Chronology - GP records
	Telephone. 111 - feeling Stressed Out – Adult B	Feeling Suicidal - Assessment at Hospital one week before. Disposition of call - To speak to GP Practice within one hour. If practice not open within this period they need to speak to the out of hours service (Westcall, Thatcham, Newbury)	South Central Ambulance Service NHS Foundation Trust Serious Case Review Chronology. Call Log
	SH returned from holiday. In response to a call to 111, a Westcall doctor telephoned	SH who explained that Adult B had become very stressed with panic attacks and unable to sleep. The doctor spoke to Adult B at length who said he was feeling awful and suffering from sleep deprivation and just needed something to help him sleep. He denied any psychosocial stressors or any previous mental health issues. He said medication had so far not helped. The doctor offered to see him at NCH but advised that he was already prescribed medication 'at the top end'. It was left that Adult B would	Berkshire Healthcare NHS Foundation Trust IMR Chronology

		see his GP in the morning for blood tests and could call back in the meantime if needed.	
23/06/2014	Consultation because of continuing anxiety symptoms. GP2 Face to Face Consultation GP Falkland with Adult B	Initiation of physical tests to rule out physical cause for symptoms. Additional prescription for propranolol anti anxiety medication	Falkland Surgery IMR Adult B Chronology - GP records
	Adult B saw his GP.	Blood tests were ordered. It is reported that these were unremarkable.	Berkshire Healthcare NHS Foundation Trust IMR Chronology
27/06/2014	Consultation because of continuing anxiety symptoms. GP2 Face to Face Consultation GP Falkland with Adult B	Change of prescription from amitriptyline to Mirtazapine, another anti anxiety medication	Falkland Surgery IMR Adult B Chronology - GP records
	Adult B saw his GP.	He was started on mirtazapine	Berkshire Healthcare NHS Foundation Trust IMR Chronology
29/06/2014	Handwritten note made in scheme diary stating “9) Back from Florida’		Sovereign IMR Chronology
	Adult B telephoned the Crisis Team and spoke to a nurse (W7).	He was said to be quite distressed which seemed to stem from financial decisions he had made. He referred to early retirement as ‘a big mistake’. He described poor sleep and appetite, lack of energy and motivation, irritability and agitation. Distraction techniques were suggested but he said he had tried this and it had not helped. He was given advice about medication. ‘Currently he has no suicidal thoughts and intent or thoughts to harm others. Plan:	Berkshire Healthcare NHS Foundation Trust IMR Chronology

		offer support when rings; referral to CPE for full assessment and OPA with a psychiatrist.'	
01/07/2014	Consultation to discuss results of physical tests. GP1 Face to Face Consultation GP Falkland with Adult B	Results discussed as normal so far, further tests awaited	Falkland Surgery IMR Adult B Chronology - GP records
	Adult B contacted his GP about constipation.		Berkshire Healthcare NHS Foundation Trust IMR Chronology
03/07/2014	Consultation because of continuing anxiety symptoms. GP2 Face to Face Consultation GP Falkland with Adult B	Review of condition, and maintenance of current medication regime	Falkland Surgery IMR Adult B Chronology - GP records
04/07/2014	Consultation because of continuing anxiety symptoms. GP1 Telephone consultation GP Falkland with Adult B	Maintenance of current medication regime	Falkland Surgery IMR Adult B Chronology - GP records
06/07/2014	Adult B telephoned the Crisis Team about continuing difficulties sleeping despite medication.	He was given advice which he indicated was 'good'. An agreed plan was recorded for him to contact IAPT on Monday, and to contact the Crisis Team again if needed	Berkshire Healthcare NHS Foundation Trust IMR Chronology
07/07/2014	Adult B phoned the Common Point of Entry to Mental Health Services because of continuing anxiety symptoms. Similar triggers discussed in this assessment as in the original consultation 16/6, including his wife's ill health 09/07. Self Referral Assessed by Berkshire Healthcare Mental Health Team	Full mental health assessment carried out by Mental Health Practitioner from Common Point of Entry Mental Health team. No changes in medication. Agreed with GP referral to Talking Therapies service. Offered use of Crisis Team contact details if in need	Falkland Surgery IMR Adult B Chronology - GP records

	Adult B telephoned the Crisis Team and reported panic attacks which he rated as 8-9/10. He reported thoughts of 'not wanting to be here which he attributes now to the increased frequency of his anxiety.	He has no plans to end his life. CPE have been informed and will follow up with an assessment as he has no history of mental illness.'	Berkshire Healthcare NHS Foundation Trust IMR Chronology
	Telephone assessment by CPE assessor (WI).	Adult B reported severe and worsening anxiety, panic attacks, depression and lack of sleep for the past three weeks. He said he felt terrible and that it had hit him like a bullet'. He denied any previous mental health issues. He referred to potential triggers of a change of work pattern and financial worries after he had helped his daughter with her mortgage — he said he had not initially told his wife of this but when she had been told of it she was upset but had accepted it. He referred to other worries - his mother's health, his wife's health and her family worries, and that he might not be able to go back to work. He also reported suffering from constipation which he attributed to his mental state. He denied any suicidal ideation or plans but said he felt 'awful, really bad, shaking from inside' and wanted 'all this to end'. There was said to be no evidence of thought	Berkshire Healthcare NHS Foundation Trust IMR Chronology

		or perception disorder. Risk to self or others was said to be 'nil evident'. The assessor concluded that Adult B 'might be experiencing excessive anxieties in the context of his psychosocial issues.' The recorded plan was to refer him to IAPT for CBT for anxiety management. He was advised to see his GP for regular review of medication. He was given the Crisis Team number to contact if he became distressed.	
	IAPT logged a referral.	Patient alerts indicated Severe PHQ-9 and Severe GAD-7 scores.	Berkshire Healthcare NHS Foundation Trust IMR Chronology
	SH telephoned the Crisis Team (WO).	She was said to be very tearful and 'at the end of her tether. She said she was in a lot of pain and cannot take any more.' Adult B was 'pacing around the house punching pillows'. The Crisis Team practitioner spoke to Adult B who was agitated and anxious but calmed down. He had been in contact with IAPT and was awaiting assessment. 'We discussed CRHTT input but [Adult B] felt he might be better waiting for Talking Therapies.' iPlan: [Adult B] to contact GP tomorrow to discuss medication options and	Berkshire Healthcare NHS Foundation Trust IMR Chronology

		CRHTT input ... will use crisis number if he needs further support. 'W8 did not perceive a high level of risk in the situation.	
09/07/2014	Adult Bsaw his GP.		Berkshire Healthcare NHS Foundation Trust IMR Chronology
	Consultation because of continuing anxiety symptoms and marked physical manifestation of this (shaking, short of breath, sweating.) Attends with wife present at Adult B's request. GP1 Face to Face Consultation GP Falkland with Adult B.	Further mental health assessment by GP. Referral to Common Point of Entry mental health secondary care service	Falkland Surgery IMR Adult B Chronology - GP records
10/07/2014	The GP sent a referral marked 'urgent' by fax to CPE.	The GP reported that medication was not helping and Adult B said he was 'very frightened by the way he's feeling' and was telephoning the surgery daily. The GP commented that the surgery was unable to suggest anything other than IAPT who could not see him yet. The GP asked if Adult B could be seen 'in clinic'.	Berkshire Healthcare NHS Foundation Trust IMR Chronology
		CPF Team Leader (W9) decision making. W9 contacted IAPT and confirmed that Adult B had responded positively to an 'opt-in' invitation and was awaiting an assessment. CPE wrote to the GP	Berkshire Healthcare NHS Foundation Trust IMR Chronology

		to advise that Adult B had been assessed on 7/7/14 and referred to IAPT. CPE advised that Adult B was willing to wait for IAPT and could be encouraged to contact the Crisis Team again if needed.	
10/07/2014	Letter from Common Point Entry to discuss Adult B case and to inform GP of full assessment taken place via self referral on 07/07. Response from Common Point of Entry	No further change in plan or input taken	Falkland Surgery IMR Adult B Chronology - GP records
11/07/2014	Consultation because of continuing anxiety symptoms. Wife present at Adult B's request. GP2 Face to Face Consultation GP Falkland with NT	No further change in medication. Maintenance of the plan and awaiting Talking Therapies intervention	Falkland Surgery IMR Adult B Chronology - GP records
	Adult B saw his GP.	He was advised that he could increase his medication.	Berkshire Healthcare NHS Foundation Trust IMR Chronology
16/07/2014	Telephone triage by the IAPT daily supervisor (W2).	The assessor concluded that a Step 2 CBT service was appropriate including work on panic and sleep hygiene.	Berkshire Healthcare NHS Foundation Trust IMR Chronology
24/07/2014	Adult B saw his GP.		Berkshire Healthcare NHS Foundation Trust IMR Chronology
25/07/2014	Adult B saw his GP.		Berkshire Healthcare NHS Foundation Trust IMR Chronology
	Consultation because of continuing anxiety	Maintenance of the current plan,	Falkland Surgery IMR

	symptoms. Also reported a throat problem. GP5 Face to Face Consultation GP Falkland with Adult B	awaiting Talking Therapies intervention. Referred for investigation of the throat problem	Adult B Chronology - GP records
04/08/2014	Face to face assessment at IAPT (W3).	Adult B identified his main difficulties as anxiety and worry. He expressed worries about not having enough money for retirement, losing his job, not being well enough to return to work, feeling he cannot go out. 'I can't cope while I'm out there. I want to stay in my sheher/prison[house? A Risk assessment was recorded in the IAPTUS notes. Regarding self-harm and suicide, Adult B denied any plans, intentions, preparations, history, or escalating factors. He reported thoughts such as 'I want this to stop'. He identified his wife and daughter as protective factors. He denied any risk to others. He denied risk of exploitation. Regarding risk of neglect, he reported 'finding it more difficult currently, for example bathing and cooking due to reduced energy, supported by wife.' Regarding neglect of others, he reported 'needing to care for his wife at times due to her having a physical disability.., denied any concerns	Berkshire Healthcare NHS Foundation Trust IMR Chronology

		currently about neglect.' He expressed reluctance to contact the Crisis Team and CPE as he was not helped by ringing these numbers previously. He said he would 'speak to his wife in the first instance and would consider ringing if necessary' He denied any domestic abuse, past or current. His goals were to get back to work, to reduce anxiety and worry, to increase enjoyment of activities. 'Treatment plan: Signposting around finances and carer support, also telephone GSH [Guided Self Helpi for worry' CBT materials were sent to Adult B by post and a follow up telephone appointment made for 18 August 2014. He was sent contact details for the Citizens Advice Bureau and a leaflet on support for carers.	
05/08/2014	Consultation because of a separate unrelated physical problem. GP6 Face to Face Consultation GP Falkland with Adult B	Examined and treated with non medication methods	Falkland Surgery IMR Adult B Chronology - GP records
07/08/2014	Case transferred to Physical Disabilities Team to process above.		WBC IMR Chronology Access For All Team
08/08/2014	Consultation to investigate a new throat problem. ENT Surgeon Royal Berkshire	Investigations done at the clinic normal. A trial of a medication for	Falkland Surgery IMR Adult B Chronology -

	Hospital	acid reflux was started and a further investigation was ordered	GP records
11/08/2014	SH placed onto OT Waiting List (Priority 4)		WBC IMR Chronology Physical Disabilities Team And LTC
14/08/2014	Consultation because of continuing anxiety symptoms despite over a month on the current medication regime. GP2 GP Falkland Telephone consultation with Adult B	Increase in mirtazapine anti anxiety medication agreed, and a referral back to the Common Point of Entry mental health service was initiated	Falkland Surgery IMR Adult B Chronology - GP records
15/08/2014	The GP sent a further referral to CPE, asking for advice and support with Adult B's ongoing management in view of the severity of his symptoms.	The GP stated that Adult B had been suffering from severe anxiety for the past 10 weeks, was constantly anxious and struggling to leave the house as a result. He was said to be under financial pressure and 'pressures within the relationship.' His sleep was said to be extremely poor. 'He has had contact with the crisis team during this time but they have offered no long-term follow up for him.' He told the GP that he had a first meeting with IAPT but 'finds he does not have the level of concentration or is unable to engage in his activities to try and help with his recovery.' The GP had increased mirtazapine to 45mg in in addition to zolpidem 10mg and propanolol 40mg up to 3X	Berkshire Healthcare NHS Foundation Trust IMR Chronology

		daily.	
	It is reported that Adult B went to the police station to disclose that he had been dishonestly taking his mother's money over a period, and defrauding the local authority responsible for her care. There is no confirmation that an offence was committed		Berkshire Healthcare NHS Foundation Trust IMR Chronology
	It is reported that Adult B called an ambulance for his wife because he felt she needed medical attention for diabetes. When paramedics arrived they spoke to SH and concluded that Adult B was of more concern.		Berkshire Healthcare NHS Foundation Trust IMR Chronology
	Adult Protection - Adult B attended Newbury SDO to report his alleged fraud of his mother of approximately £30,000 over a period of 20 years. He was currently suffering from depression and believed that he had done this. He had collected cheques from his mother at her home address which she believed were going into a savings account which he believed he had spent. This alleged offence is a West Sussex job as his mother lives there.	There were only two days between this report and the murder. 15/08/14 was a Friday and the report was made in the evening. By the time the murder happened, it appears that little had been done to further this report. This seems acceptable given the nature of the report and the fact that there were no obvious indicators of threats of violence to himself or anyone else.	Thames Valley Police DHR Chronology – Niche report - 43140156449
16/08/2014	Consultation because of continuing anxiety symptoms. Westcall GP	Diazepam relaxant medication prescribed for short term use in addition to other regular medication	Falkland Surgery IMR Adult B Chronology - GP records
	Consultation because of separate unrelated physical problem. Westcall GP Telephone	Topical (non medication) treatments prescribed to help this	Falkland Surgery IMR Adult B Chronology - GP records

	Consultation.		
	Patient Contact. 999 - Query Hypoglycaemia - ST	Husband called 999, stating his wife was having a "hypo". On crew arrival patient was well and not displaying any symptoms of this or anything else. SH expressed her concerns regarding her husband's detiorating mental health. She was not transported to hospital as there was no medical need.	South Central Ambulance Service NHS Foundation Trust Serious Case Review Chronology. Call Log/Patient Clinical Record
		Call Log indicates Husband to be agitated and confused but not violent. SH was heard in the background to say "Wont let her husband near her as she says he will hurt her" *(Not exact words heard on recording).* Pt in background very distressed.	South Central Ambulance Service NHS Foundation Trust Serious Case Review Chronology. Call Log/Patient Clinical Record
		Crew submitted a Vulnerable Adult Referral for SH, citing Emotional/Physical Abuse and Financial/Material Abuse.	South Central Ambulance Service NHS Foundation Trust Serious Case Review Chronology. Vulnerable Adult Form
	999 - Initial Call was for Audlt A, once on scene Adult B was also a patient	Mental Health Concerns. Wife reported deterioration with mental health, he is very anxious and paranoid. Also states he has not taken his medication for a week. Pt	South Central Ambulance Service NHS Foundation Trust Serious Case Review Chronology. Call

		was not Transported to Hospital.	Log/Patient Clinical Record
		Due to symptoms a Mental Health Capacity Assessment Form was submitted by the Attending crew. Adult B was not transported to hospital.	South Central Ambulance Service NHS Foundation Trust Serious Case Review Chronology. Mental Capacity Form.
	Paramedics telephoned the Crisis Team	Requesting urgent assessment of Adult B who was said to be depressed, to have stopped taking medication, not to have eaten or slept for a few days, with low mood, worried, appearing paranoid, not wanting his wife to go out, speaking in hushed tones worried about neighbours hearing. SH was said to be worried that he was deteriorating and had been researching suicide on the internet. Adult B denied suicidal thoughts. It was agreed that an assessment would be carried out.	Berkshire Healthcare NHS Foundation Trust IMR Chronology
	SH telephoned the Crisis Team,	Referring to the earlier call from paramedics. She queried when a visit would take place. She said the situation's getting worse. He needs to be seen quite soon She was told a time could not be given and that	Berkshire Healthcare NHS Foundation Trust IMR Chronology

		the team also had others to see. SH said 'OK, that's fine, thank you'.	
	A Westcall doctor telephoned Adult B	In response to an earlier 111 call. Adult B expressed concern about rectal pain. He was advised to come in to Newbury Community Hospital.	Berkshire Healthcare NHS Foundation Trust IMR Chronology
07.04am	South Central Ambulance Service (SCAS) were called out to SH and Adult B's address. A referral was made (dated 08.30 16 Aug 14) which noted concerns ref 'non-physical abuse', e.g. restricting SH's movement and access to finances; stated: "Concerns-emotional abuse due to husband's mental state". The report gave the view that the adult was not at immediate risk. It is not yet clear who the referral was sent to, but we do know the Berkshire Healthcare Foundation Trust's Crisis Home Treatment Team visited later on the same day.		WBC IMR Chronology
10.58am	Telephone Contact. 999 - Rectal Pain - Adult B	Clinical Support Desk dealt with this call. Dispostition of call was To contact a Primary Care Service within two hours.	South Central Ambulance Service NHS Foundation Trust Serious Case Review Chronology. Call log
	Adult B attended Newbury Community Hospital taken by his sister-in-law.	He was examined by a Westcall doctor (W1O). The problem he	Berkshire Healthcare NHS Foundation Trust

		presented was rectal pain with bleeding and discharge, and constipation. He made no mention of mental health difficulties or family issues. An examination established that he had a physical condition related to haemorrhoids. He was prescribed suppositories.	IMR Chronology
Pm	At some point during the afternoon the Crisis Home Treatment team (out of hours mental health assessment team) visited and decided no further action was needed.		WBC IMR Chronology
	Assessment visit by Crisis Team practitioner (W4).	Adult B was seen in the presence of his wife. Adult B presented as pleasant with good eye contact. He reported that his mood was variable and denied any negative, suicidal or self-harming thoughts. He said he had not taken medication for two weeks because it made him feel sick in the mornings. He 'reported that he would be safe tonight and agreed to take his prescribed medication'. SH told the assessor that her husband was 'behaving like Jekyll and Hyde because when professionals visit, he makes it seem as if all is OK, but once it's just the two of them left, he becomes a very agitated different person.' She told him that Adult B's	Berkshire Healthcare NHS Foundation Trust IMR Chronology

		concerns about finances and needing to move house were not well founded as they had £94k in savings. SH expressed concern that she sometimes felt he was going to hit her but that he had never done so. Adult B, when asked, said he would not do so. The assessor advised SH to call the police ii she felt unsafe. The assessor undertook to discuss medication with a colleague. The assessor then left at approximately 2.45 or 3pm.	
	Crisis Team assessor (W4) telephoned a colleague at the Hub (W5) for advice.	The outcome was that the assessor undertook to discuss further with a Westcall doctor.	Berkshire Healthcare NHS Foundation Trust IMR Chronology
	Telephone consultation between the assessor (W4) and Westcall doctor (WIl).	The doctor considered that short-term diazepam should be prescribed to help Adult B to manage until he could be seen by a psychiatrist on the following Monday or Tuesday. She advised that all other medication should be removed. The assessor undertook that the Crisis Team would arrange to collect medication from the pharmacy and deliver it to Adult B. The telephone conversation was overheard by another Crisis Team practitioner for Newbury (W6) who offered to assist by collecting and	Berkshire Healthcare NHS Foundation Trust IMR Chronology

		delivering the medication to Adult B.	
	Rio entry by assessor (W4) of his plan	Plan: To arrange for MR; CRHIT to collect medication ... and drop it off tonight, and at the same time remove the other medication in his possession as requested by the Westcall GP. H/v on Sunday on 17.8.14 to monitor mental state and assess risk.' The assessor telephoned Adult B to inform him of this plan.	Berkshire Healthcare NHS Foundation Trust IMR Chronology
	Time not known — Voice message from SH to the Crisis Team	'I really need to speak to [the Crisis Team assessor]. I'm not at home at the moment. I'll give you my mobile number which is [....] Please do not let [Adult B] know I've phoned you. Do not ring the home number at the moment. It's very urgent. I'm threatened. I can't go home. That's why my sister's brought me here. I need help. I really need help.' The Crisis Team Duty worker recalls picking up this message at around 19.00 to 19.30.	Berkshire Healthcare NHS Foundation Trust IMR Chronology
	Telephone call - Crisis Team Duty worker (W5) and SH.	SH explained that she wanted to speak to the assessor before he visited again because her husband had put on a calm and reasonable	Berkshire Healthcare NHS Foundation Trust IMR Chronology

		front and had not presented the full picture. She was concerned about his aggressive behaviour and her own safety and for that reason she was not at home and was with her sister. SH was advised that the assessor would be able to call her the next day. SH agreed to this and thanked the staff member.	
	The Hub Crisis Team Duty worker (W5) telephoned W6 (who was due to deliver medication to Adult B) to tell him of SH's call and asked him to call Adult B back as she wanted to explain more about Adult B's symptoms.	W5 indicated that SH was not at home and had gone to stay with her sister, and that SH had agreed to being contacted the next day. W6 (who was outside the pharmacy in Newbury about to collect Adult B'smedication) indicated that he was under time pressure and his plan was to see Adult B and assess the situation when he got there.	Berkshire Healthcare NHS Foundation Trust IMR Chronology
	Home visit by Crisis Team practitioner (W6) to Adult B.	Adult B showed W6 into the lounge. Adult B was pleasant and co-operative and explained that his wife was out with her sister. He accepted the new medication and handed over his old medication to W6. There were no obvious sign of psychosis or cognitive impairment or other cause for concern from the interaction. It was left that the Crisis Team would make contact in the morning to arrange another	Berkshire Healthcare NHS Foundation Trust IMR Chronology

		visit on Sunday, and for a medical review to be arranged with a psychiatrist on the Monday or Tuesday. W6 left a telephone message for W4 confirming that the medication had been delivered.	
17/08/2014 07.28am	Murder - Adult B called Thames Valley Police on a 999 call to report that he had murdered his wife by strangling her. He also said that he had been on pills for depression.	Police and ambulance attended and confirmed that SH had died. Adult B was arrested and has been charged with her murder. This was a fast and appropriate response to this report, ensuring that the welfare of the persons involved was the priority followed by securing evidence necessary for a thorough investigation.	Thames Valley Police DHR Chronology - 43140157661
07.30am	Telephone and Patient Contact. 999 - Call from TVP - Husband Strangled Wife	Initial call came from the Police. Adult B stated to the Police that he had strangled his wife. Ambulance called. On arrival the crew confirmed Recognition of Life Extinct.	South Central Ambulance Service NHS Foundation Trust Serious Case Review Chronology. Call Log/Patient Clinical Record/Continuation Form.
09.46hrs	Emergency Duty Service received contact from Thames Valley Police “wanting to know whether Adult B is known to Social Care as he had phoned place (sic – police?) at 7.30 this morning to tell them he had murdered his wife”.		WBC IMR Chronology
	Note on Capita stating “COPY OF CI 2014		Sovereign IMR

	EMAIL SENT @ 10.38 PC Waifs called through from gate asking for warden due to an incident this morning, xxx advised no warden was on site OOH. xxx called through to 101 and asked PC Waifs to call us if they needed assistance as we have an on call who could attend if required, we believe possibly flat 9 as paramedics arrived this morning (not called by us) - awaiting call from PC Watts. Inspector Chrissie Ellison badge 5751 called to advise no warden required at this time and was unable to advise us of the incident at the moment. I received a call @ 09.55 from James Woodcock (813) Reading CID asking for CCTV footage from the last 26hrs which I advised I am unable to assist with today, James is happy to wait until tomorrow for this when the main office is open & the manager is on site. He was also looking for any medical information we hold on the residents & what kind of complex Carnarvon Place is, I am quite limited as to what medical information I can pass over as we do not have anything listed on Capita except from when the resident called through to raise repairs & advised they were disabled in a wheelchair. Resident is listed on our Saturn system but as they were not supported they had no alarm & no updates were sent through since they moved into the property in 2007. I have spoken to xxx who advised it was OK to email		Chronology

	James this information. URN 362/17082014”		
10.50hrs	Abbie Murr, Head of Service, EDS, phoned the following but was unable to reach: Rachael Wardell Alison Love Patrick Leavey Stephen Stace Linda Watsham (Messages left where possible)		WBC IMR Chronology
11.15hrs	Return phone call from Alison Love		WBC IMR Chronology
17.40hrs	Referral closed to EDS (but see below)		WBC IMR Chronology
2100hrs	EDS contacted Alison Love to say that police had been in contact again and were asking for a MHA assessment for Adult B.		WBC IMR Chronology
	Police informed the Crisis Team of the incident; a Datix Report was entered.	It is reported that at approximately 7.30am Adult B telephoned police to say that he had strangled his wife. Police attended and found SH deceased. Adult B was taken to Newbury Police Station and was arrested on suspicion of murder. It is reported that an initial post mortem indicated that SH died around at 06.00.	Berkshire Healthcare NHS Foundation Trust IMR Chronology
18/08/2014	Note on Capita stating “Incident on 2014 17/08/2014. SH has died. Police are investigating”		Sovereign IMR Chronology
Mid morning	Phone call from John Muller EDS AMHP to Alison Love. He reported that MHA assessment had concluded that Adult B was capacitated and		WBC IMR Chronology

	would therefore be interviewed by the police today.		
11.27am	SCAS alert received by WBC's Safeguarding Team.		WBC IMR Chronology Safeguarding Team
	AFA received EDT report re death in suspicious circumstances.	Report forwarded to LTC PD team.	WBC IMR Chronology Access For All Team
	A request was received from Police for an Appropriate Adult to attend the police station while Adult B was interviewed.	An Appropriate Adult from Newbury CMHT attended at 12.00 hours. The Appropriate Adult's report indicates that Adult B 'admitted strangling his wife while she was asleep on the settee.' Bail was refused. Adult B asked for his 94 year old mother to be contacted as he was due to look after her. Newbury CMHT contacted West Sussex Social Services who undertook to contact Adult B's mother A Mental Health Act assessment was requested by police and undertaken at 23.40 by an AMHP and two Section 12 approved doctors. When interviewed Adult B said that he had fraudulently taken £30,000 from his mother and thought the local authority might be intending to prosecute him over this. He said he had gone to the Police Station [on 15 August 2014] and asked to be arrested. He said	Berkshire Healthcare NHS Foundation Trust IMR Chronology

		he and his wife had lived beyond their means and had gone on holidays funded by his mother's money. He said he had mismanaged his life and been untruthful and described himself as living like 'Walter Mitty'. He referred to tensions in the relationship with his wife and said he had slept on the settee for years. He said his own low mood had rubbed off on his wife and they had not gone out much. He described the flat as like a prison and he felt a sense of release when he was taken away by police. He described how on the morning of 16 August 2014 he was 'pacing around the flat ... Things reached a crescendo, got to a stage where I thought [SH] was having a hypo and I called the ambulance.' He described how later on his wife had gone out with her sister and he did not hear her come in. He said he had 'a fleeting thought to die in the early hours, I think I acted on that.' He said he had investigated suicide on the internet but had no previous thoughts of harming his wife. He said he did not take his prescribed	

		medication consistently and that his problems were exacerbated when he stopped taking medication. He used the term 'paranoia' about his mental state but denied delusional thoughts, thoughts of being followed or in danger or subject to any conspiracy. The AMHP concluded that by 'paranoia' he was referring to his feelings arising from poor decisions and the narrowing of his life choices and having insufficient funds for his retirement. The assessment team concluded that: • There was a 3 to 4 month history of depression and anxiety arising from 'an ill-considered financial decision which he now regrets'. • He needed treatment of his depressive episode for which hospital admission was not indicated. • He had capacity to answer police questions in formal interview with a solicitor present.	
	72 hour initial findings report completed. Immediate actions included: debriefing and support for staff; consideration of family support in conjunction with police family liaison; statements from key staff; full		Berkshire Healthcare NHS Foundation Trust IMR Chronology

	caseload review of all red rated' cases.		
19/08/2014	Adult B appeared before reading Magistrates and was remanded in custody to HMP Bullingdon.	He was interviewed by a RCMHS mental health practitioner. He denied any suicidal ideation. He signed an Agreement to share information' confirming his agreement to BHFT sharing information with his solicitor and with HMP Bullingdon Mental Health Team.	Berkshire Healthcare NHS Foundation Trust IMR Chronology