Independent investigation into NHS mental health care

Anne Richardson Consulting Ltd

Date: November 2025

Contents

Independent investigation into NHS mental health care

Introduction

1.1 This is the report of a Mental Health Homicide Review (MHHR) commissioned by NHS England (NHSE – East of England)[1] of mental health care provided for X who had been in contact with mental health services (the Trust). X died from a fall from a height. X's wife, Y, was subsequently found to have died due to strangulation. The Major Crime Team concluded that the deaths were due to murder and suicide.

1.2 This MHHR, focused upon the NHS, was completed in partnership with a Panel established to deliver a Domestic Homicide Review (DHR or DADR[2]). The report of the MHHR should be read alongside the report of the DHR which contains a wide range of information about X and Y, the care they received, and other services with which they were in contact.

1.3 The authors of the MHHR have tried to meet their duty to outline the evidence relating to the mental health care and support that was provided for X and identify ways in which the mental health NHS service could be improved. We have made recommendations to support others who might face similar circumstances.

1.4 Our team is aware that our report may be very difficult for members of both families to read, and our team would like to offer our condolences to all those who were affected.

2 Methodology

2.1 Our team, a senior group of independent clinical professionals[3], was appointed by the NHSE in late 2022 to lead an NHS review into the circumstances of the NHS mental health care that was provided for X. Terms of Reference (TOR) for the review and our methodology which has been integrated with that for the DHR, is provided in the main report attached (Appendix 2, page 26).

2.2 Our team initially undertook a desktop review of documentary evidence; this included electronic records of mental health care at the Trust and records about care for X and Y provided in primary care. Our team also had access to the report of a comprehensive investigation commissioned by the Trust that was completed in 2021, and evidence submitted for the DHR. Documents associated with the provision of mental health care in the Trust were reviewed, including policies relating to the provision of specialised care for adults with mental ill health, risk assessment and management, policy on provision for carers, liaison with

[1] NHS England (2015). The Serious Incident Framework: Supporting Learning to Prevent Recurrence'. https://improvement.nhs.uk/documents/920/serious-incidnt-framwrk.pdf

[2] DADR - Domestic Abuse Related Death Review.

[3] Information about the team can be found in the main report.

families, and liaison between mental and physical health services. In addition to information relating to the past, our team considered more recent and current evidence relating to the development of the service and plans for transformation of mental health care.

2.3 In addition to documentary evidence, confidential interviews were held by videoconference and in person with several members of the Trust clinical staff, including staff who had known X and Y personally to understand the details of the assessments and care provided for them. Adapted Salmon Principles were used for this non-judicial investigation meaning that all those interviewed personally were contacted in writing with information about the investigation and its Terms of Reference. All witnesses were assured that their testimony would be confidential and that no personally identifying information would be included.

2.4 Members of both families were contacted to provide information about the MHHR and the DHR, and they were invited to participate. Conversations by videoconference with a member of Y's family were undertaken in partnership with the DHR chair. However, members of X's family did not feel able to respond.

3 Background

3.1 This report contains information about X and the mental health NHS care that he was given prior to the incident. Full information about Y's circumstances and the support provided for her is available in the report of the DHR.

3.1 X was diagnosed with `depression with somatoform/psychotic symptoms in the context of a strong family history' and hypochondriacal disorder. His history included problems associated with substance misuse. X had a range of significant physical health issues and he occasionally experienced thoughts of suicide as well as intrusive thoughts. In addition to a range of treatments for his physical problems, pain and anxiety, X had been prescribed antidepressants and anti-psychotic drugs.

3.2 X was initially referred to mental health services by his GP and, after an assessment, he was given a diagnosis of depression and hypochondriacal disorder. He was treated as a an outpatient of specialised mental health services and discharged back to his GP later that year. X's GP re-referred him several times over the next few years, and he was seen on those occasions, but X's presentation remained broadly similar.

3.3 During Covid, X's GP asked the mental health team to review him. X had lost weight; he had stopped his anti-depressant and anti-psychotic medication and was re-experiencing the intrusive thoughts he had experienced formerly. The consultant re-started X's antipsychotic medication and discussed the idea with X of a referral to the local drug and alcohol recovery service; however, Covid restrictions were operating at the time and X did not want to attend.

3.4 A year later, X reported a recurrence of his intrusive thoughts; he was agitated and worried about getting Covid; he was also experiencing pain and constipation. X's GP referred him for further investigations for the latter.

3.5 X attended the Emergency Department and the following month he was taken to hospital by ambulance having had an infection and a pneumothorax. It also emerged that X had taken an overdose of his medication and steps were taken to refer X to the pain clinic.

3.6 The consultant spoke to X who reported that his mood and appetite were still poor. X disclosed that he had stopped taking his antipsychotic medication again, and the consultant reinstated this when X telephoned him. The incident occurred shortly afterwards.

4 The incident

4.1 Police informed the Trust staff that X took his own life by jumping from a height. It was subsequently established that X's wife, Y, had died from strangulation.

5 Findings

5.1 The MHHR was conducted alongside the DHR, and full information about the methods, processes and Terms of Reference may be found in the full report.

5.2 Overall, our team has no reason to believe that the referral or care arrangements made for X were inappropriate. X's GP referred him to the specialised mental health service for an assessment and treatment at the point when his symptoms worsened, and he was seen promptly. X was managed in outpatients by a consultant psychiatrist who saw him approximately monthly for advice and for management of his mental ill health in a manner which was fully consistent with guidance.

5.3 Checks of the electronic records and correspondence also suggest that the communications within the Trust and between the Trust and the primary care team were delivered efficiently and effectively. The specialised mental health and primary care services liaised effectively in relation to X's care and the records show that X could re-engage when necessary. X was discharged when he typically stopped attending outpatients, and/or when he started to feel better.

6 Conclusions and recommendations

6.1 Our team worked alongside and in partnership with the team delivering a Domestic Homicide Review. More detail about Y can be found in the DHR report. The Mental Health Homicide Review focuses upon the mental health care provided within the Trust, and is focused predominantly upon X's needs, the NHS services he received and relevant developments in the Trust since the time of the incident.

6.2 Our team would like to extend their condolences to the families involved in this tragic incident. We are aware that our investigation reports may be very difficult for members of both families to read. However, we hope that the narratives therein, and the recommendations that have been made to strengthen services, will help them to understand that steps have been taken to reduce risks not only for those who experience mental ill health, but also those who live and work with those providing care and support.

6.3 Our team considered that X's care was of a generally good quality, and we believe that the evidence shows X's care to have been delivered in accordance with national guidance at the time. However, X presented a challenging mix of symptoms and risks which the evidence suggests might have been strengthened if they had been linked more closely together. For example, whilst X's physical problems were being investigated, his mental health was managed entirely within the framework provided by the Trust and primary care. X had been referred, but not been seen in time, for an assessment by the psychology team for pain management, and/or for any psychological consideration of his medically unexplained symptoms despite these having been present for several years. There was no integrated formulation or a joined-up plan for mental and physical aspects of his care, despite what would appear to have been causal links between them.

6.4 Our team also notes the very significant range of escalating challenges that were present at the time of the incident. Covid had been taking its toll, and it appears that those restrictions may have interacted with some system-level challenges in the Trust just at the point when X's mental health (and those of his wife) had begun to worsen. X gave his psychiatrist reassurances about the nature of his thoughts, but national guidance meant that only those patients deemed `complex' could be seen face-to-face. This meant that the opportunities to assess and respond to more subtle changes that might possibly have been evident had it been possible to see him personally were not available.

6.5 Our team makes no criticism of the psychiatrist's judgement in this regard; the notes show that X had shown himself reluctant to share information before. However, our team has noted several areas that we believe would strengthen

the service as a whole to respond more flexibly, reduce potential risks, and improve the engagement of families in the delivery of routine care. Our recommendations also include information relating to challenges that have been experienced in the levels of senior medical staffing.

6.6 Our team notes that the Trust has already taken a range of steps to reduce risk, improve care, and strengthen learning to support families and the main report describes these in more detail. We hope that the following recommendations will be helpful in strengthening the mental health care in what is already a strong and well-respected team at the Trust.

6.7 **Recommendation 1** The Trust should continue to develop and reinforce links between mental and physical care not only in relation to care provision, but also communications within the primary, mental health and acute hospital sectors. The aim is to train staff, raise awareness, and improve the quality of early assessments and treatments to reduce gaps that can exist in NHS primary, secondary and tertiary care between physical and mental health problems. The aim is to reduce delays to effective assessment, joined-up formulations, and reduce `diagnostic overshadowing[4].'

6.8 **Recommendation 2** The Trust has taken a range of significant steps to improve the way that training about risk is undertaken (including risk of suicide in association with physical problems such as chronic pain or physical disability). However, the Trust should now ensure that the delivery of, and effectiveness of, risk simulation training is audited to assess and monitor its effectiveness.

6.9 **Recommendation 3** The Trust should review and increase awareness amongst staff of the need for holistic assessments of service users; this means ensuring that the Trust strengthens and maintains DIALOG, the new care planning framework to ensure that assessments, including assessments for carers, are considered within the context of their wider family relationships and their social networks (ref. `Think Family' policy).

6.10 **Recommendation 4**. We recommend that `The `Community Transformation' model should be evaluated to ensure that it is possible to refer patients on, obtain a specialised opinion, and take a more team-based focus. The aim is to ensure that service users can be assessed as outpatients, where appropriate, in partnership with primary care, be given brief psychological interventions, receive medication, be referred on and/or be monitored. In this way, key performance indicators of service-user satisfaction and access to specialised advice should be developed to assess and respond to this change.

[4] This is a term that is used when medical risks such as chest pain or other signs of ill health are missed or misattributed because the patient's primary diagnosis overshadows all else.

7 Introduction

7.1 This is the report of a Mental Health Homicide Review (MHHR) commissioned by NHS England (NHSE) East region, of mental health care provided for X, who had been in contact with mental health services. X died in 2021 from a fall from a height. X's wife, Y, was subsequently found to have died due to strangulation. The Major Crime Team concluded that their deaths were due to murder and suicide.

7.2 The MHHR, focused upon the NHS, was completed in partnership with a Panel established to deliver a Domestic Homicide Review (DHR[5]) under the auspices of the Community Safety Partnership (CSP). The report of the MHHR should be read alongside the report of the DHR which contains a wide range of information about X and Y, the care they received, and other services with which they were in contact.

7.3 The authors of the MHHR have tried to meet their duty to outline the evidence relating to the mental health care and support that was provided for X and make recommendations that reduce risks for others. We have also described some of the ways that the service has changed since the time of the incident. Our team is aware that our report may be very difficult for members of the families involved, and our team would like to offer our condolences to them.

8 Methodology

8.1 Our team, a senior group of independent clinical professionals, was appointed by NHSE to lead an NHS review into the circumstances of the NHS mental health care that was provided for X (see Appendix 1 for more information about the team). Agreement was reached that the MHHR would be completed alongside and in partnership with a Domestic Homicide Review (DHR) Panel under the auspices of the CSP. Our team is aware that members of the families may not be familiar with the structure and process of DHRs and MHHRs, so we have provided some brief information below.

8.2 Objectives for DHR and NHSE reviews overlap; for example, they are independent of the NHS services provided for X and Y; they focus on learning for services and information for families, and they are designed to reduce risks for families and the public. However, DHRs have statutory authority; reports are prepared for the Home Office and have a broader range of coverage. DHRs

[5] DHRs have more recently been renamed DADRs: Domestic Abuse Related Death Reviews

focus mainly upon the victim and any risks associated with domestic violence. They have a broad remit, and they consider the wider family picture, particularly the family of the victim; they gather information from police, social services, education, primary NHS care, specialised NHS care, ambulance services and relevant other non-statutory services. NHS investigations by contrast, are predominantly focused upon the specialised mental health NHS services that were provided for the perpetrator and the services and processes (such as risk assessments, care planning, treatment, etc) that may be required to improve care. Authority for DHRs is described in law[6]. Authority for NHS investigations is set out in NHS guidance by and is available on the NHSE/I website[7].

8.3 The arrangements for DHRs and MHHRs, particularly when they are managed together, make it possible for those involved in their delivery to take a wide perspective of the support provide for perpetrators and victims' families and develop their conclusions together. In this case, our team had information about X and Y from primary care, social care services, NHS staff from specialised mental health services and others. We also had the benefit of conclusions drawn in an internally commissioned review of care provided in the Trust; Individual Management Reviews (IMRs) commissioned by the DHR Chair, and the coroner's report.

8.4 An initial meeting with the DHR chair, a member of our team, and the Head of Investigations East of England Region took place to discuss the scope and limitations of the MHHR. Agreement was reached to establish formal Terms of Reference (TOR) which were then agreed with members of the families for X and Y (Appendix 2).

8.5 Our team initially undertook a desktop review of documentary evidence (Appendix 3); this included electronic records of mental health care at the Trust and records about care for X and Y provided in primary care. Documents associated with the provision of mental health care in the Trust were reviewed, including policies relating to the provision of specialised care for adults with mental ill health care, policies on risk assessment and management, policy on provision for carers; information about the way that the Trust liaises with families, and information about the way that mental and physical health services operate. In addition, our team considered more recent evidence about some of the ways that the service has been developed and strengthened since the time of the incident.

8.6 Confidential interviews were held (some in person and some held by videoconference – see Appendix 4) with several members of the Trust clinical

[6] Domestic Homicide Reviews are commissioned according to statutory guidance under Section 9(3) of the Domestic Violence, Crime and Victims Act (2004). https://www.gov.uk/government/publications/revised-statutory-guidance-for-the-conduct-of-domestic-homicide-reviews

[7] NHS England and NHS Improvement (2015). The Serious Incident Framework: Supporting Learning to Prevent Recurrence'. https://improvement.nhs.uk/documents/920/serious-incidnt-framwrk.pdf

staff, including staff who had known X and Y personally, to understand the details of the assessments and care provided for them. We held face-to-face meetings and several video conferences with representatives from the part of the service where X and Y were in receipt of care (Community Psychiatric Nurses, a Nursing Assistant and Occupational Therapist); the Consultant Psychiatrist leading the team delivering care for Y linked with the Clozapine clinic; the Associate Specialist with responsibility for care provided for X in outpatients; the Mental Health Liaison Team Service Manager; the Deputy Director of Nursing responsible for physical/mental health policy; the Deputy Medical Director; the Managing Director for West Strategic Business Unit; the Medical Lead for Safeguarding (an acute general medical Consultant), and the Professional Lead for Adult Social Work and Social Care whose role concerns support for carers.

8.7 Adapted Salmon Principles were used for this non-judicial investigation meaning that all those interviewed personally were contacted in writing with information about the investigation and its Terms of Reference. All witnesses were assured that their testimony would be confidential and that no personally identifying information would be included. A representative from our team liaised with the DHR chair in relation to communications with members of Y's family, but X's family did not feel able to respond to our invitation.

9 Background

9.1 What follows is a brief narrative summary of the electronic record. Information from the clinical records kept when X was initially referred for treatment for his mental health problems indicates that X had reported school to have been relatively uneventful. However, X truanted as a teenager, and he left without any qualifications. After school, X started an apprenticeship, and he stayed for 4 years, but then he went into business with his brothers. Latterly, X stopped working because his symptoms of anxiety, physical problems, and depression.

9.2 X and Y were together for almost thirty years. Y had a diagnosis of paranoid schizophrenia and a longstanding history of contact with services, but her mental health, according to her relative to whom our team spoke, had been largely stable, despite a range of symptoms which she managed herself in combination with drug treatment and support from the clinical team[8].

9.3 Y enjoyed spending time with her family; she liked cooking; was an active person, including work in cafes, in a call centre and in volunteer roles. Y's

[8] The service provides community mental health treatment for adults with mental health problems, including those in crisis. The service uses a recovery-based approach for those age 18-65 including Personality Disorder and Neuro-Developmental disorders and those with a psychotic or mood disorder. The teams are multidisciplinary teams consisting of doctors, community nurses, psychologists, occupational therapists, social workers, vocational and employment advisors, specialist personality disorder workers, workers supporting carers, drama and art therapists.

relative said that the couple were broadly happy, although there were the usual irritations and periodic squabbles or bickering. Both X and Y were moderately heavy drinkers. However, neither Y's relative nor members of NHS (primary or specialised) teams had reason to think that domestic violence featured in their lives. Y's relative was also clear that X had not acted as his wife's carer; rather, the couple were equally supportive of one another.

9.4 Over the period of his contact with mental health services, X was diagnosed with `depression with somatoform/psychotic symptoms in the context of a strong family history' and hypochondriacal disorder. In addition, he had a range of significant physical ailments; these included: rosacea for which antibiotics were sometimes needed, reflux, Barretts Oesophagitis, gout, hiatus hernia, symptoms associated with significant weight issues and, latterly, unexplained abdominal and facial pain. X believed he had undiagnosed gastrointestinal cancer. In addition to a range of treatments for his digestive problems, pain and anxiety, X had been prescribed antidepressants and anti-psychotic drugs.

9.5 X was initially referred to mental health services due to anxiety and concerns about his physical health. He was assessed by the Crisis, Assessment and Treatment Team (CATT) now known as the Crisis Resolution and Home Treatment Team and he was given a diagnosis of depression and hypochondriacal disorder. He was treated as an outpatient with Venlafaxine 150mg daily (an antidepressant) and Olanzapine 15mg (an anti-psychotic) and he was discharged back to his GP when his mental health improved.

9.6 A year later, X called the CATT team again and the community mental health team (CMHT) now known at the Adult Community Mental Health Services (ACMHS). It had been necessary for X to cease taking Olanzapine due to his increased weight and raised cholesterol. X's depression was still present, and he acknowledged that, from time to time, he had suicidal thoughts. However, X's risk assessments and his verbal reports confirmed that he apparently had no intention to act on them.

9.7 A two-year gap of time elapsed without X needing support from mental health services but X's mood deteriorated once again, and his physical symptoms then became more evident. The consultant noted that X's mental health problems were mainly focused on his depression, including intrusive depressive somatoform/psychotic thoughts. Such thoughts are not uncommon amongst those with a diagnosis of depression, typically causing significant emotional distress (anxiety, panic, and poor sleep). Such thoughts challenge GPs and specialised mental health staff alike because they are difficult to treat. However, they seldom translate into action or behaviour. It is therefore important to note, given the case notes report that X reported thoughts on several occasions that he might kill his mother, his sister or the dog, that the psychiatrist's questions

concerning the likelihood that X might act appear to have been considered appropriately and his risk of harm was thought to be low.

9.8 The notes also show that X and his wife had always enjoyed a drink and occasionally over-used alcohol; the notes also show that X formerly used to use cocaine and cannabis. This is relevant to the extent that, in addition to its association with depression, substance misuse can be a trigger for risks to safeguarding. For example, the notes show that Y had presented to the emergency department with an injury to her forehead, apparently due to a fall when she was intoxicated. However, and although a referral for safeguarding was made, Y denied any domestic violence.

9.9 The consultant prescribed Amisulpride (a different antipsychotic) for X, Amitriptyline (a different antidepressant than formerly) and Diazepam (a tranquiliser). As previously in his history of contact with mental health services, X was a relatively intermittent attender once his symptoms eased, and he was usually discharged from the mental health services back to his GP.

9.10 The GP then asked the mental health team to review X's medication; he had lost three stone in weight; stopped his Amisulpride some 6 months earlier; he had also started to re-experience the intrusive thoughts he experienced formerly. The consultant noted that X was concerned about his health, and he mentioned that his own father (diagnosed with bipolar disorder) had died at around this age. The consultant re-started X's antipsychotic and discussed the idea with X of a referral to the local drug and alcohol recovery service. However, this period was characterised by development in restrictions for Covid and it is possible that X was unwilling or disinclined to attend, and he did not respond to the invitation.

9.11 X continued to attend his outpatient appointments over the telephone when circumstances required this. However, owing to the nature of the care being provided for Y's mental ill health and her need for regular injections, members of the clinical service did visit her at home. The Trust team members did not come across X at those times, and the notes show that X was often reported to be in bed.

9.12 The consultant noted that whilst X's antipsychotic drugs were controlling his paranoid thoughts effectively, but X then reported to his consultant that he was experiencing a recurrence of his intrusive thoughts; he was agitated and worried about getting Covid. Although X's symptoms had worsened, he denied any thoughts or intentions to harm Y or his mother, but he did report that his sleep was poor, he'd lost weight, and was finding it difficult to concentrate. The GP signed him off for three weeks and increased X's antidepressant medication. X then also began to complain of abdominal pain and throughout May, he

continued to report that his sleep was poor. X said that he wanted to stop his medication as it might be causing his abdominal pain and constipation. X's GP referred him for further investigations. At the same time, according to the electronic notes, it appears that Y was also becoming less well – she was becoming more paranoid, and she thought people were spying on her.

9.13 X attended the Lister Hospital with these symptoms and then, he was taken to the emergency department by ambulance having had a pneumothorax. X remained four days in intensive care. It also emerged that X had taken an overdose of his medication which he said was accidental. However, he was not prepared to see the Psychiatric Liaison Team who were consulted. X reassured them that he would speak to his own consultant when he was discharged, and steps were taken to refer him to the pain clinic. X subsequently spoke with his consultant psychiatrist, a meeting which took place over the telephone (other appointments having been missed by X) because he was still attending appointments and still experiencing pain.

9.14 X reported that his mood and appetite were still poor. X shared more information about his overdose which he said had been triggered by pain. He also admitted that he had stopped taking his Quetiapine (antipsychotic) because of his admission, and this had made him feel worse. The consultant reinstated X's antipsychotic (Quetiapine) and his antidepressant (Mirtazapine). After this, X telephoned the consultant who replied via a voicemail asking X to call him, but the incident occurred the following day.

10 **The incident**

10.1 Police Liaison informed the Trust staff that X had apparently taken his own life when he jumped at midday from the car park. X did not have anything with him except a photograph of woman who was later identified to be his wife, Y. Initially, Y was suspected of having taken an overdose (a note was found), but it was subsequently established that Y had died from strangulation and that the suicide note which had been found had, in fact, been written by X.

11 **Findings**

11.1 This section of the MHHR report concerns the findings and opinions of the MHHR team. Readers are encouraged to view both documents to obtain a full picture. Whilst work for the MHHR was conducted alongside that for the DHR, our team has limited its focus in what follows to the NHS TOR items listed below.

Examine the referral arrangements, communication and discharge procedures of the different parts of the NHS that had contact with the service user.

Review and assess compliance with local policies, national guidance and relevant statutory obligations.

11.2 X's mental health problems were complicated: he was diagnosed with Major Depression Disorder (MDD) together with anxiety and, as outlined above, he experienced intrusive unacceptable thoughts [9] which were labelled somatoform/psychotic. These took the form of occasional thoughts of harm to others, and a belief about undiagnosed gastrointestinal cancer (X was also diagnosed with hypochondriacal disorder). X's symptoms were not judged to reach the threshold for psychosis, but he was nonetheless prescribed anti-psychotic medication which eased his symptoms. He also had a range of health problems (a weight problem, poor sleep, Barrett's Oesophagitis, reflux, rosacea, a hiatus hernia, liver changes, a high cholesterol, and latterly, abdominal and facial pain. However, X's needs were not regarded as `complex' enough to need care under the Care Programme Approach (CPA)[10], the approach taken to plan and manage care which was extant at the time. Our team did not find the decision to have been inappropriate or incorrect at the time, although X's problems were complicated, and the system of care has since been changed and strengthened (see later sections below).

11.3 Our team reviewed relevant Trust policies and statutory obligations in the context of national guidance (see Appendix 3). Our team did not identify any significant omissions or errors in the way that the Trust delivered care. Several policy changes at a national level were made in the NHS[11] around the time of the incident, including guidance on care planning and risk management (see para. 11.8 et seq below) and the development of integrated community teams for people with severe mental illness. However, from 2020 onwards the significant national policy focus was upon Covid, management of risk to staff and patients, and the vaccination programme, requirements which overtook many aspects of routine NHS care.

[9] An intrusive thought is an unwelcome, involuntary, unpleasant, thought or image associated with depression and/or anxiety. Although such thoughts may also occur in someone with a psychosis, they are seldom acted upon.

[10] CPA is a process to support assessment, planning, review and coordination of treatment, care and support for people with complex needs in contact with specialised mental health services. Typically, only people with schizophrenia or other psychotic and/or very complex diagnoses would be included. The basis for providing care has been changed significantly since the time of the incident. In 2021 the CPA changed. More information can be found at https://www.england.nhs.uk/publication/care-programme-approach-position-statement/

[11] https://www.england.nhs.uk/publication/2021-22-priorities-and-operational-planning-guidance

11.4 Patients were first admitted with Covid during 2020 and partial lockdowns were implemented in July followed by the `rule of six' in September. A second lockdown was established in November 2020. The Trust issued a letter to all patients explaining that all non-essential care would be provided over the telephone. This meant that care for X (but not Y who, with schizophrenia and a recorded level of personal risk needed to have her regular Clozapine injections provided) was provided over the telephone. The notes show that X was worried about Y getting Covid at this time; worried about Y's mental health which was (possibly relatedly) getting worse; his weight had gone down, and his reported levels of pain were increasing. The electronic records show that X became increasingly worried about Covid and that he was worried about Y whose mental ill health had also deteriorated.

11.5 X's consultant spoke with him over the phone and X reported that his medication was helping him and although he reported occasional intrusive thoughts of harming people, the consultant judged these not to reach the threshold for psychosis. In the opinion of the consultant, X's thoughts and mood were good, and his insight was described as fair. However, X did say that he was drinking up to a bottle of wine a day at weekends (albeit not in the week). However, X declined to attend the local drug and alcohol recovery service and although the notes are silent on this matter, it is possible that Covid restrictions made him reluctant to go.

11.6 Checks of the electronic records and correspondence suggest that the communications within the Trust and between the Trust and the primary care team were delivered efficiently and effectively. The specialised mental health and primary care services liaised effectively in relation to X's care and the records show that X, who generally ceased to keep appointments when he improved, could re-engage when his circumstances changed or if he needed a review of his medication. X was discharged when he typically stopped attending outpatients, and/or when he started to feel better.

11.7 Overall, our team has no reason to suppose that the referral or care arrangements made for X were inappropriate. X's GP referred him to the specialised mental health service for an assessment and treatment whenever his symptoms worsened, and he was seen promptly. X was managed in outpatients by a consultant psychiatrist who saw him approximately monthly for advice and for management of his drug regime. X's risks (of self-harm or harm to others) were judged to be low. Although our team believes that X's care was managed effectively in relation to the evidence and in the context of national guidance, we also consider that there are ways in which the service might be strengthened to reduce future risks. It is important to note the difficulties that the Trust has experienced in recruiting senior medical staff and managing mental health outpatients.

Examine the effectiveness of the service user's care plan and risk assessment, including the involvement of the service user and their family.

11.8 Care planning is the process of delivering treatment and care. Care planning and risk assessment are both informed by formal assessments of mental illness (diagnosis) and a formulation (influenced by social, environmental and other factors). As described above, X was not judged to have had a complex or severe mental ill health problem. He was therefore not on CPA (see footnote 10) and his care coordination was managed only by his consultant in the outpatients' department.

11.9 The Trust team in conversation with our team were clear that X would not have been listed under the CPA, and our team agrees that, technically, X's level of complexity would not normally have attracted this level of mental health care. However, it is arguable that X's problems might have triggered a more effective partnership between mental health and acute general medical services. It is also possible that other interventions might have been made earlier to address the complex mix of physical, psychological, and mental health symptoms (Medically Unexplained Symptoms or MUS) that X presented. For example, the notes show that although X had been referred after his spell in hospital to the pain clinic (to psychology services) but the incident occurred before he could be seen. It is possible that an earlier referral would have been helpful, and our team has therefore included a recommendation below.

11.10 Trust policies and practice around risk assessment at the time (and currently) follow national NHS guidance and guidance published by the Royal College of Psychiatrists. Risk assessments typically covered information about `static' factors (historical evidence relating to, for example, harms or child abuse) as well as `dynamic' factors which can change over time, such as alcohol, mental state, attitudes, or social factors. Like the risk assessments which normally form part of a plan for care (whether on CPA or not), risk assessments in the Trust would be developed when an individual's formulation and/or diagnosis is put together with factors such as a patient's personality, his or her age, gender, personal history, social, cultural and family context.

11.11 The Trust uses different electronic forms for the various specialties (such as adult mental health (AMH), child services (CAMHS), learning disabilities, forensic, and perinatal care), and these are kept on the electronic record called `Paris'. Paris now permits an `alert' to be recorded at the front of the electronic case record so that evidence relating to a particular risk (such as suicidal intent, or evidence of harm to others) can be seen more easily and shared within the team.

11.12 The Trust provides training for all staff in different ways, depending on their qualifications and role. All staff receive risk training at least each year and this is audited. Bespoke training in clinical risk assessment for Band 5 staff and higher is delivered annually through the Trust e-learning system.

11.13 At the time of the incident, the Trust assessed, recorded and managed risk for each individual at several points: when an initial referral was made; when significant change in mental state occurred, and/or when/if care was reviewed or ended. At the very minimum, risk was assessed annually. Risk was and is also now managed at the level of the clinical team to permit sharing of information about patients, particularly those identified as having a severe mental health problem such as Y. Risk formulation meetings (which include a focus on safeguarding) take place in every community team, and compliance with the requirement to record risk assessments for every individual is audited at least annually. This process is overseen by the Trust Safety Committee and the Quality and Risk Management Committee.

11.14 As regards the quality of the risk assessments made for X, although the notes show a thorough account of his formal, medical (psychiatric) symptoms, there is relatively little information about X's social circumstances, the nature of his relationship with his close relative or Y, and relatively little mention of the social, economic, and other psychological factors that might have exacerbated or mitigated his symptoms. This means that whilst X's general psychiatric assessment was of a good quality (his diagnosis, cognitions, and symptomatology were recorded) the bigger picture was less well elaborated. This is relevant since X had several known risk factors (such as chronic pain, depression, a history of self-harm) which may have been exacerbated in the context of changes in the familial, economic, and relationship circumstances that had formerly served as mitigations[12].

11.15 Our team therefore also agrees with the conclusion of the authors of the initial internal investigation completed by the trust which said: `Sharing information about X's overdose should have been carefully considered in terms of the impact it may have had on his ability to provide care for Y. Although it is not possible to say whether or not it would have been appropriate to share information with Y's care team, this should have been actively considered and addressed directly with X, to find workable solutions to maintain safety'. Our team has therefore reiterated this recommendation below which we hope will help to strengthen the connections provided for and about families who are engaged in the provision of mental health services.

[12] https://www.mentalhealth.org.uk/explore-mental-health/a-z-topics/suicidal-thoughts

11.16 As regards concerns relating to safeguarding (part of the assessment of risk) the notes show that neither X nor Y had ever raised any concerns, but our team considers that it would always be appropriate to seek a good level of broad information about the social and familial context within which mental health occurs (the policy called: `Think Family[13]). Such information is very important in relation to risk management and crisis planning – the triggers that are commonly apparent when someone relapses. More information about the importance of family engagement can also be found in the report of the DHR.

11.17 The internal investigation report made a recommendation in relation to the way that risk is managed; it says: `The Clinical Risk Assessment and Management for individual Service Users policy should be updated with the wording amended from "…physical, social and psychological factors may be considered …" to "…physical, social and psychological factors must be considered …". Our team agrees with this recommendation, which we understand has now been implemented. However, we also note that the Trust has taken action to strengthen partnerships and connections between care systems for people in contact with mental and physical health care systems and further information about this is also elaborated below.

Review the appropriateness of the treatment of the service user in the light of any identified health needs/treatment pathway.

11.18 Our team considers that X's treatment was appropriate and that his treatment pathway was followed in accordance with both national and local guidelines. However, X's mental health care and the assessment and care of his physical health did not seem to be as well connected as would have been ideal. There were three possible reasons for this.

11.19 Firstly, it is clear that Covid restrictions limited access to mental health assessment and care to some degree. Although the tragic deaths of X and Y were wholly unexpected and our team believes that no blame should be ascribed to the consultant who took responsibility for X's care coordination when telephone conversations were the only option, there is no doubt that Covid prompted an increase in X's anxiety. Together with a recorded deterioration in Y's mental health around the same time, it is likely that Covid contributed to a deterioration in X's mental state, and this restricted the service's capability to assess him other than by telephone.

[13] `Think Family' is an initiative that was introduced by the Department for Children, Schools and Families (DCSF) in 2008 following the Cabinet Office 'Families at Risk' Review. Since then, the approach has been expanded and developed, particularly in mental health services nationally. `The Triangle of Care, Carers Included: A Guide to Best Practice in Mental Health Care in England' (2013) the Carers Trust.

11.20 Secondly, there is a context within which the organisation of Trust services provided were challenged in several ways over and above Covid. Staff shortages (particularly shortages of senior medical staff) were challenging with each consultant managing two to three hundred patients each.

11.21 Thirdly, X's physical health seems to have been deteriorating. We cannot know the details, or whether X's anxiety lay at the root of his fears given his long history; he had certainly had a great many investigations which had come to nothing. X had been diagnosed with hypochondriacal disorder, and he was a worrier. However, X's weight had gone down significantly, and he collapsed with a pneumothorax (a collapsed lung) and admitted that he had also taken an overdose which the notes suggest was triggered in part due the pain he had been reporting.

11.22 In the following paragraphs, we have highlighted developments since the time of the incident which look likely to lead, at least in part, to improvement in the way that care is provided in the Trust.

Community Transformation

11.23 In combination with a rise in new referrals post-Covid, long waiting times, and a fairly high rate of non-attendance for outpatients' appointments, the Trust has reviewed the way that community care is being delivered. Internal stakeholder focus groups were held for doctors and the wider clinical teams to explore access, new ways of working, and care pathways.

11.24 The community transformation programme is intended to be built around a specialist mental health team and a new system of care coordination (DIALOG – see below) to link with Adult Community Mental Health Service (ACMHS), the Flexible Assertive Community Treatment Team (FACT), Improving Access to Psychological Therapies (IAPT), the team leading Brief Interventions, the Primary Care Liaison team, the Crisis Resolution and Home Treatment Team, the Early Intervention in Psychosis Service, Inpatient Services, and a telephone advice system. The plan is for stakeholders, including those based in primary care, to `consult to' rather than `refer to' secondary mental health services to strengthen engagement with service users and families, and evaluate.

11.25 Community transformation should provide an appropriate setting for newly referred patients to be assessed, be given brief psychological interventions, receive medication, be referred on and/or monitored if they do not meet criteria for care coordination by the community mental health teams and/or are not in crisis. The system is being piloted (including X's GP team) working with several surgeries including families who are participating in the plan.

Care Planning

11.26 The Trust has been moving towards a new system of care planning and risk assessment called DIALOG+. This is an evidence-based user-led process designed to record patient-reported experience measures (PREMS) and patient-reported outcome measures (PROMS) which directly assess the lived experience of service users. The aim is to capture perspectives on a person's health status and essential subjective constructs such as health, quality of life, goals, and social inclusion.

11.27 The DIALOG+ process leads to an individual Recovery plan which is more focused on looking at the positive rather than the negative aspects of care. However, physical, social and psychological aspects of individual experience must be included, and formal risk assessment and crisis planning is included alongside a safety plan. The system identifies clearly the social and familial or organisational factors which have a bearing on a service user's personal and clinical circumstances. The focus is solution-focused and based on strengths as well as needs.

11.28 Whilst DIALOG+ is based on service users' views, the system also includes items which are reported by staff and it records any discrepancies about, for example, judgements on risk to self and/or others. Our team believes that the system will improve the extent to which service users and their wider families are engaged in their care. Plans are in place to audit the new system and record the impact.

Risk assessment

11.29 The Trust has amended the way that the electronic record presents information about risk, including in response to the investigation that was commissioned after the deaths of X and Y. In addition to strengthening information provided about physical health needs, the changes mean that risk is being embedded into case notes so that it is not physically possible to open a Case Note without checking the risk assessment first. In addition, the forms have been re-designed with a view to identifying a much closer partnership between the patient and the member of staff.

11.30 A new Enhanced Risk Assessment (ERA) Team has been established within the Trust with oversight by the Executive Director of Quality and Medical Leadership and the lead for adult mental health and forensic psychology. This new team consists of three facilitators (Assistant Psychologists), input to the Community Forensic team and the Low Secure Unit to improve links between general and forensic services via training, provision of resources,

communications (signposting, liaison with MAPPA[14]). The ERA Team offers support on assessment, case management, and treatment. The resources include written information for staff (a `Grab Pack') in the relevant section of the Trust intranet. The aimed-for outcomes include risk reduction, improved formulation, strengthened communications and stronger management plans.

11.31 A Zero Suicide framework[15] has been implemented to strengthen leadership, training, improvements in risk, engagement with service users, and treatment. The approach is multi-factorial and is designed to reduce risk at all points across the spectrum including screening, individual assessment, treatment, and follow up, including at the level of the organisation or culture within which care is provided, as well as at the clinical level.

11.32 The Trust has also invested in a Simulation Suite to support delivery of training for staff. The aim is to train all staff involved in mental health crisis care. The approach uses experiential learning using role play and by simulating conversations between clinician, service user and family, to rehearse and problem-solve in relation to risk, self-harm, harm to others, confidentiality, and other areas. `Experts by Experience' are involved in the development of case-based scenarios and the delivery. So far, feedback from staff appears to have been very positive and our team was impressed with these developments. However, we also believe that it will be challenging to ensure that sufficient staff can be trained to scale using the very sophisticated Simulation Suite. Our team would therefore encourage the Trust to audit the simulation training effectively.

Physical health care

11.33 Physical health care pathways are currently being developed designed to improve connections for care in physical and mental health services. This is needed because evidence suggests that people with mental health problems, learning disabilities or older people and conditions such as sepsis may too easily be missed because clinicians focus mainly on the mental health symptoms, or misattribute symptoms which are actually signs of illness. Called `diagnostic overshadowing', the phenomenon has been well elaborated in services for people with learning disabilities where medical risks (chest pain or other symptoms of potential signs of ill health) are missed because they are misattributed.

[14] MAPPA refers to the Multi-Agency Public Protection Arrangements which exist across health and social care systems to reduce risks posed by offenders.

[15] Stapelberg, N., Sveticic, J., Hughes, I., Almeida-Crasto, A., Gaee-Atefi, T., Gill, N., Turner, K. (2021). Efficacy of the Zero Suicide framework in reducing recurrent suicide attempts: Cross-sectional and time-to-recurrent-event analyses. *The British Journal of Psychiatry,219*(2), 427-436. doi:10.1192/bjp.2020.190

11.34 Led by the Trust's Deputy Director of Nursing & Partnerships the new initiative is designed to upskill staff, improve communications and liaison across the acute and mental health services; improve transitions from mental to physical care services and reduce risks. The work is also intended to address the challenges presented in acute settings of violence and aggression, eating disorders, care of catheters, delirium, ligatures, overdose, and/or suicide prevention.

11.35 A mental health `Task and Finish' group has been working to create collaborative pathways and education initiatives with the mental health trust. The aim is to agree terminology, agree shared practice, reduce stigma associated with mental health, co-produce and improve care for patients with mental ill health who come into acute settings. In particular, the ambition is to improve levels of knowledge and support staff who experience violence and aggression. A suite of training resources is being developed and the mental health and acute hospitals plan to agree on the use of risk assessment tools, recommend supportive interventions and support staff. Our team commends the Trust for developing these proposals and we have therefore included a recommendation to support their development, which we hope will have an impact for those patients, like X, whose needs crossed several traditional care system boundaries.

12 **Conclusions and recommendations**

12.1 Our team has focused upon the mental health care provided within the Trust, and is focused predominantly upon X's needs, the services he received and relevant developments in the Trust since the time of the incident. Our team worked alongside and in partnership with the team delivering a Domestic Homicide Review report which is available. More detail about Y can be found therein.

12.2 Our team would like to extend their condolences to the families involved in this tragic incident. We are aware that our investigation reports may be very difficult for members of both families to read. However, we hope that the narratives therein, and the recommendations that have been made to strengthen services, will help them to understand that steps have been taken to reduce risks not only for those who experience mental ill health, but also those who live and work with those providing care and support.

12.3 Our team considered that X's care was of a generally good quality, and X's care was delivered in accordance with national guidance at the time. However, X presented a challenging mix of symptoms and risks which the evidence suggests might have been strengthened if they had been linked more closely together. For example, whilst X's physical problems were being investigated,

his mental health was managed almost entirely within the framework provided by the Trust and primary care. X had been referred, but not been seen in time, for an assessment by the psychology team for pain management, and/or for any psychological consideration of his medically unexplained symptoms despite these having been present for several years. There was no integrated formulation or a joined-up plan for mental and physical aspects of his care, despite what would appear to have been causal links between them.

12.4 Our team also notes the very significant range of escalating challenges that were present at the time of the incident. Covid had been taking its toll, and it appears that those restrictions may have interacted with some system-level challenges in the Trust just at the point when X's mental health (and that of his wife) had begun to worsen. X gave his psychiatrist reassurances about the nature of his thoughts, but national guidance meant that only those patients deemed `complex' could be seen face-to-face. This meant that the opportunities to assess and respond to more subtle changes that might possibly have been evident had it been possible to see him personally were not available.

12.5 Our team makes no criticism of the psychiatrist's judgement in this regard; the notes show that X had shown himself reluctant to share information before. However, our team has noted several areas that we believe would strengthen the service to respond more flexibly, reduce potential risks, and improve the engagement of families in the delivery of routine care. Our recommendations also include information relating to challenges that have been experienced in the levels of senior medical staffing. We hope that the following recommendations will be helpful in strengthening the mental health care in what is already a strong and well-respected team at the Trust.

12.6 **Recommendation 1** The Trust should continue to develop and reinforce links between mental and physical care not only in relation to care provision, but also communications within the primary, mental health and acute hospital sectors. The aim is to train staff, raise awareness, and improve the quality of early assessments and treatments to reduce gaps that can exist in NHS primary, secondary and tertiary care between physical and mental health problems. The aim is to reduce delays to effective assessment, joined-up formulations, and reduce `diagnostic overshadowing[16].'

12.7 **Recommendation 2** The Trust has taken a range of significant steps to improve the way that training about risk is undertaken (including risk of suicide in association with physical problems such as chronic pain or physical disability).

[16] This is a term that is used when medical risks such as chest pain or other signs of ill health are missed or misattributed because the patient's primary diagnosis overshadows all else.

However, the Trust should now ensure that the delivery of, and effectiveness of, risk simulation training is audited to assess and monitor its effectiveness.

12.8 **Recommendation 3** The Trust should review and increase awareness amongst staff of the need for holistic assessments of service users; this means ensuring that the Trust strengthens and maintains DIALOG, the new care planning framework to ensure that assessments, including assessments for carers, are considered within the context of their wider family relationships and their social networks (ref. `Think Family' policy).

12.9 **Recommendation 4.** We recommend that `The `Community Transformation' model should be evaluated to ensure that it is possible to refer patients on, obtain a specialised opinion, and take a more team-based focus. The aim is to ensure that service users can be assessed as outpatients, where appropriate, in partnership with primary care, be given brief psychological interventions, receive medication, be referred on and/or be monitored. In this way, key performance indicators of service-user satisfaction and access to specialised advice should be developed to assess and respond to this change.

Appendix 1

The Investigation Team

Anne Richardson, Director of ARC, is a clinical psychologist by training who specialised in work with adults with severe mental ill health and long-term needs. She is an experienced teacher/trainer and communicator, having worked as joint Course Director of the D Clin Psy at UCL. As head of mental health policy at the Department of Health, she was instrumental in the development of the National Service Framework for Mental Health and, with Sir Jonathan Michael, for the development and delivery of the national learning disabilities inquiry `Healthcare for All' (2008). Anne chaired the Expert Reference Group (2016/17) for an investigation into deaths in Southern Health and has worked since 2010 as one of NHS England's providers of independent investigations.

Dr Hugh Griffiths is a former consultant psychiatrist in the North-East of England where he carried responsibility for inpatient and community psychiatry for adults, recovery and rehabilitation for people with severe and long-term mental disorders, as well as liaison services in general hospitals. As Medical Director of the Northern Centre for Mental Health he was responsible for the development of guidance on changing roles for consultants, support for medical managers, and clinical leadership of the Mental Health Collaborative. Latterly, as Deputy and then as National Clinical Director for Mental Health (England) at the Department of Health, he led the development of the Government's Mental Health Strategy "No Health Without Mental Health" (2011) and was instrumental in its subsequent Implementation Framework. He worked until recently as a non-Exec in the north of England.

Adrian Childs started his career in Surrey in the mid-1980s, training as both a general and mental health nurse. He has been a director of nursing at Newcastle, Northumberland and North Tyneside Mental Health Trust and his last post was as Director of Nursing at Leicestershire Partnership Trust. Adrian earned a distinction in his MSc at the University of East London in the mid-1990s; he also holds a diploma in leadership, mentoring and executive coaching. Adrian has contributed to several national working parties including the development and appointment of Consultant Nurses and development packages for nurses working with severe personality disorders. His previous experience includes serving as deputy chief executive and director of nursing at Devon Partnership NHS Trust and Newcastle, Northumberland and North Tyneside Mental Health Trust. In 2014 he was made Honorary Professor for the Faculty of Health and Life Sciences at De Montfort University, Leicester.

Appendix 2

1. Terms of Reference for the Review

This Domestic Homicide Review (DHR) is commissioned in response to Y's death.

The review will focus on events and intelligence from partner agencies to understand how/if X's use of substances changed, which the Panel felt may have had an impact on behaviours within the relationship. It is noted that prior to this timeframe, should there be any other relevant information that would contribute to the Domestic Homicide Review providing insight into the relationship this would also be shared with the Review Panel.

The review is commissioned in accordance with Section 9, of The Domestic Violence, Crime and Victims Act 2004.

The Domestic Abuse Partnership Board appointed an Independent Chair for this review and write the Overview Report. The chair was not employed by, nor otherwise directly associated with, any of the statutory or voluntary agencies involved in the review.

The Domestic Homicide Review contains the full terms of reference.

HEALTH RELATED TERMS OF REFERENCE FOR THE MENTAL HEALTH HOMICIDE REVIEW (MHHR)

The investigation is to be conducted in partnership with the Domestic Homicide Review into the death of Y.

The investigation will examine the NHS contribution into the care and treatment of X from his first contact with specialist mental health services up until the date of the incident.

Critically examine and quality assure the NHS contributions to the Domestic Homicide Review.

Examine the referral arrangements, communication and discharge procedures of the different parts of the NHS that had contact with the service user.

Review and assess compliance with local policies, national guidance and relevant statutory obligations.

Examine the effectiveness of the service user's care plan and risk assessment, including the involvement of the service user and their family.

Review the appropriateness of the treatment of the service user in the light of any identified health needs/treatment pathway.

To work alongside the Domestic Homicide Review panel and Chair to complete the review and liaise with affected families.

To provide a written report to NHS England that includes measurable and sustainable recommendations to be published either with the multi-agency review or standalone.

To develop a Learning Document for wider circulation.

Appendix 3

Documentary evidence

1. The Trust's electronic records (for X and Y).
2. GP Partnership chronology for primary care contacts.
3. Primary care chronology of contacts and care.
4. Internal Review of Care and Treatment for X and Y provided by the Trust.
5. The National Serious Incident Framework March 2015 3-day initial review ('72-hour review')
6. Adult Community Mental Health Services Operational Policy for Adult Community Mental Health Services.
7. The Trust Policy and Operational arrangements for `Clinical Risk Assessment and Management' (2020).
8. Enhanced Risk Assessment (ERA) – implementation of proposals to improve the assessment and management of risk posed to others by some service users.
9. Coroner's Report.
10. Domestic Homicide Review (DHR) into the death of Y- Individual Management Review (IMR) [date redacted].
11. Physical health of people with mental health and/or learning disability – draft policy, Power Point presentation and consultation documents.
12. The Trust Mental Health Task and Finish Group TOR to create a collaborative approach between mental and general hospitals in the locality.
13. The Trust policy on the Transfer process from mental to general hospital care.
14. Transforming Outpatient Care – document outlining plans and early implementation of system change.
15. Adult Community Transformation Programme: Carer's Project - Deep Dive.

Appendix 4

Consultees

Y's close relative and family supporter

Head of Safer Care and Standards

Consultant Psychiatrist & Deputy Medical Director.

Deputy Director of Nursing and Partnerships.

Safeguarding Lead Nurse, Senior Service Line Lead, Adult Community Services and Corporate Safeguarding Team.

Head of Social Work & Safeguarding/AMH.

Professional Lead for Adult Social Work & Social Care.

Consultant Anaesthetist, Watford General Hospital.

Consultant Psychiatrist for Y

Consultant Psychiatrist for X

Managing Director for West Herts SBU

Mental Health Liaison Team Service Manager

Head of Adult Services

Community Psychiatric Nurse

Nursing Assistant

Psychiatric Nurse.