Psychological Approaches



# SERIOUS INCIDENT INVESTIGATION REPORT

# THE CARE AND TREATMENT OF Mr Christopher Stone-Houghton

## APRIL 2025

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## CONDOLENCES

The investigation panel would like to extend their sincere condolences to the family and are immensely grateful for their participation in this investigation. We have noted and responded to their questions that fall within the scope of this report. It is our sincere wish that this report does not add to their pain and distress but assists in addressing issues and questions raised by the events surrounding the tragic deaths of Mr and Mrs Stone-Houghton.

Whilst acknowledging the formal requirement of this report, at the request of their family, Mr and Mrs Stone-Houghton are referred to throughout this report by their first names Chris and Ruth.

## INTRODUCTION

1. This report was commissioned by NHS England under their Patient Safety Incident Response Framework (PSIRF) 2022[1].

2. Psychological Approaches were commissioned by the Head of Investigations NHSE – Southeast to undertake the review.

3. The victim and perpetrator were married, so a Domestic Homicide Review (DHR) was also commissioned by the Portsmouth Community Safety Partnership (CSP). This began in December 2022. The draft report was submitted to the Home Office DHR Quality Assurance Panel in September 2024. This was made available to the panel.

4. The primary focus period for this independent investigation is from mid-June 2022 to September 2022.

5. Additional information about the services referred to in this report can be seen in **Appendix 2**.

## LIAISON WITH THE FAMILY

6. The panel and the report's commissioner from NHS England met virtually with the victim's son and the family's solicitor on the 19/6/24. The aim of the meeting was to share the draft terms of reference and to hear the family's specific concerns. A second face-to-face meeting with the son and daughter, who were accompanied by two family friends, was held on the 19/8/24. In this meeting it was agreed that members of the panel would continue to meet on an ad-hoc basis to update the family with progress.

7. During the meeting, the family requested consideration be given to some support being offered to some close friends who had been involved in the discovery of the incident. This request was passed to the Trust, and following further discussion, information has been shared with the family as to how further support may be sought.



[1] https://www.england.nhs.uk/patient-safety/patient-safety-insight/incident-response-framework/

## BACKGROUND

8. On the 14/9/22 Mr Stone-Houghton, known as Chris, was 66 years of age, is alleged to have killed his wife Ruth of 27 years in their family home, before taking his own life.

9. Chris had worked as a director in a small independent business for many years. The business was badly affected by the Covid 19 pandemic and in April 2022 the owners, in consultation with Chris, decided to close the business permanently. Chris managed this process on behalf of the owners, extending to the sale of inventory and making staff redundant, including himself and his wife, all of which, the family report he found to be very stressful.

10. Chris's family noticed the early signs of his deteriorating mental health around Christmas 2021, which manifested as increased anxiety and depression. He had no previous history of mental health problems.

11. Their concerns heightened, and the family arranged for Chris to have help from his GP and via a self-referral to a local talking therapies service called 'Talking Change'.

12. Chris's son, who spoke with his parents on most days, made the initial online referral to Talking Change on his father's behalf on the 5/5/22. However, when Chris did not subsequently respond to their follow-up email the referral was closed as per their policy.

13. Chris, accompanied by Ruth, attended Chris's GP surgery on the 12/5/22. The consultation appeared to focus on his physical health, due to his recent weight loss and led the GP to refer him for diagnostic blood tests and to request a stool specimen for microbiology. These tests did not detect any abnormality.

14. On the 26/5/22 Chris attended a second GP appointment again with Ruth during which she became distressed and gave further detail regarding her husband's mental health difficulties. As this was a different GP, he agreed to discuss the case with his colleague who they had previously met, to consider a referral to mental health services. A follow-up call was subsequently arranged for the 15/6/22 which resulted in the GP making a referral to the local Crisis Recovery & Home Treatment Team (CRHTT).

15. At 11.00am the same day, on advice from the GP, Chris continued with a pre-arranged telephone consultation with Talking Change.[2] When the call was received from the Talking Change service his son has described a

[2] This was arranged after the family raised concern about the closure of the previous referral.

difficult conversation because lots of information appeared confused. This left the son unsure that the caller was using the referral form related to his father. During the call, Chris became distressed leading to the call being terminated.

16. Later the same day, after an initial telephone triage Chris was accepted onto the caseload of the CRHTT, and a home visit was conducted at 19.00hrs.

17. Over the next few days, face-to-face assessments and a telephone consultation took place to develop a care plan. This included a face-to-face assessment by the team's psychiatrist at her clinic on the 20/6/22.

18. During the assessment with the CRHTT consultant psychiatrist, Chris reluctantly acknowledged he was experiencing anxiety and depression. The consultant was concerned that he was not disclosing the full extent of his suicidal ideation and diagnosed a severe depressive episode with psychotic symptoms. She prescribed Mirtazapine 15 mg daily (antidepressant) and diazepam (sedative) 2mg as required up to three times per day.

19. Over the following three days, the team continued to liaise with Chris and his wife, either by telephone or on one occasion face-to-face. Chris expressed ongoing concerns regarding his prescribed psychiatric medication. In response to his concerns, one of the team's doctors called to emphasise the importance of continuing to take them.

20. Between the 25/6/22 and the 29/6/22 Chris had two further visits at home from the team, during which his mental state appeared to fluctuate. He was assessed again on the 29/6/22 by the team's consultant. She considered him to be a little brighter but remaining restless and reluctant to take diazepam. He denied thoughts of suicide but did agree to an increase of the mirtazapine to 30mg daily.

21. Two more home visits took place on the 30/6/22 and the 2/7/22. During these visits, it was recorded that Chris appeared a little improved but discussed experiencing an anxiety attack. He also informed the visiting mental health professional (MHP) that he had not been taking his blood pressure (BP) medication for 10 days and that his BP was now very raised. He denied any suicidal ideation or thoughts of harming himself.

22. On the morning of the 4/7/22 the CRHTT received a call from Chris's wife to say that he had made a serious suicide attempt by cutting his wrists and neck. He had been taken to hospital by ambulance accompanied by his son.

23. Following the initial examination at the Emergency Department (ED) at Queen Alexandra Hospital, he was assessed by the ED mental health liaison team who recommended a Mental Health Act (MHA) assessment.

24. After assessment of his physical wounds by surgeons, Chris was formally assessed and detained under section 2 of the MHA on the afternoon of 5/7/22. Unfortunately, transfer to a mental health unit was not immediately possible, leading him to be admitted and held on D3 ward at Queen Alexandra Hospital. During this time, it was recommended by the mental health liaison team that he remain under constant observation by a member of staff due to continued risk of suicide/self-harm.

25. Chris was eventually transferred by secure ambulance to Hawthorn ward, an acute adult mental health ward at St James Hospital, in the early hours of 7/7/22 and nursed on level 2 (15-minute) observations.

26. Following assessment by the ward's consultant psychiatrist and multi-disciplinary team (MDT), Venlafaxine 75mg (antidepressant) was prescribed with the plan to reduce and stop the mirtazapine. The decision was also made to move him to Brooker ward, an older people's mental health ward on the 11/7/22, where he would be 'hosted'[3]. The care team from the acute admission ward would continue to provide clinical oversight.

27. The clinical records indicate that during his admission, Chris tended to isolate himself in his room. Throughout this time, the family remained in daily contact with him and, where possible, his care team. His concerns regarding his psychiatric medication persisted. It was noted on numerous occasions that he questioned or resisted taking his medication.

28. On the 19/7/22 the CRHTT manager attended an MDT discussion ('Board Discussion') on Hawthorn ward. Later the same day Chris was assessed by the consultant who knew him from the CRHTT. She considered that there had been little to no improvement in his mental state and altered his prescription, as follows: Venlafaxine (antidepressant) 225mg and Risperidone (antipsychotic) 2mg. She spoke with the family to inform them of these changes.

29. Over the following days, there was little information in the clinical records to indicate an improvement in his mental state, although his mood did appear to lift a little following periods of leave with his family.

30. On the 25/7/22 Chris was reviewed by his inpatient consultant. He considered him to appear clearer in his thinking, less muddled and he did

[3] In this context hosting means that whilst he physically resided on Brooker ward Chris's care remained the full responsibility of the Hawthorn ward team.

not seem preoccupied or paranoid and there was no thought disorder. The decision was therefore taken to rescind his section 2 and Chris became an informal (voluntary) patient. During this review Chris continued to express his view that he felt his prescribed medication was not helping but agreed to continue to take it.

31. On the 26/7/22 the inpatient consultant met with the family to explain the rationale for rescinding the section 2. Chris's son, who attended the meeting, remembered the reasons included' his father's lack of engagement with Occupational Therapy, the lack of provision of psychology as an inpatient, and the belief that he would be better in the caring and loving environment of his home. Whilst Ruth acknowledged the above, she expressed concern at Chris's ongoing concordance with medication as he had previously been resistant. Therefore, when he was to be discharged home, Ruth requested twice daily visits to support him in taking his medication.

32. Over the following few days, Chris spent short periods of time off the ward with friends and family which he seemed to enjoy.

33. On the 1/8/22 Chris was seen by the inpatient consultant who described him as: "*calm and cooperative, not restless or agitated, still flat but more engaging and spontaneous, no suicidal thoughts, accepting of medication and has noticed medication is making him feel better".* The plan was for a discharge Care Program Approach (CPA)[4] meeting the following day.

34. The discharge CPA meeting took place the following day with no one present from the CRHTT despite them being invited. The family's recollection of the meeting was that it appeared somewhat chaotic, with a late change of rooms and a number of invited attendees unable to make it. However, the discharge went ahead on the 2/8/22. The family again raised their request for support from the CRHTT with administering medication but were told that this hadn't been a problem in hospital (though in fact it had), so was unlikely to present difficulties at home.

35. Over the following six weeks, prior to the incident on the 14/9/22, the clinical record indicates Chris was visited at home by the CRHTT on approximately seven occasions, he received eleven telephone follow-ups and was discussed by his MDT on three occasions. At one of these meetings, he was seen and reviewed by the consultant within the team.

[4] The Care Programme Approach describes the approach used in mental health to assess, plan review and coordinate the range of treatment care and support needed for an individual with complex care needs. In August 2022 it was superseded by the Community Mental Health Framework.

36. Towards the end of August, the CRHTT agreed that the crisis aspect of Chris's presentation was now resolved, and he would be more appropriately looked after by the Early Intervention in Psychosis team (EIP). A referral was made but the EIP team rejected this because he was over 65.

37. Following the rejection by the EIP team, the CRHTT requested Cognitive Behavioural Therapy for Psychosis (CBTp)[5] for Chris. Following a psychological assessment this was deemed appropriate, and a referral was made.

38. A CBT therapist, tasked with referring Chris for psychological therapy after his discharge, said at interview to the panel:

> *"I thought it was very unfortunate that he wasn't taken on by EIP because he ticked all the boxes. The next best thing was CBT under the community psychology team. So, I referred him to the two-hour weekly psychology meeting, to get a plan B together. The dominant narrative was that he had been uncharacteristically and severely unwell but now he is coming out of it, and he needs some help in coming to terms with what had happened to him. After the events, I felt there might have been a depressive delusional picture".*

39. Before the CRHTT knew of the tragedy, it was recorded that Chris had been accepted for CBTp, but the wait could be over a year. Family work would be offered in the interim and the support of the Nurse-led Clinic.



[5] nice.org.uk/guidance/qs80/chapter/quality-statement-2-cognitive-behavioural-therapy

## ADDRESSING THE TERMS OF REFERENCE

40. Recommendations and Opportunities for Learning are listed in the 'Summary of Findings' section.

## ToR 1 - include demographic details of CSH identifying any protected characteristics or health inequalities that may have influenced access to and delivery of appropriate healthcare.

41. Chris was a white British male. He was aged 66 at the time of the incident and had no known previous history of poor mental health.

42. He was a company director for a small business where he had worked and developed his career for approaching 50 years.

43. He lived with his second wife, Ruth of 27 years in their own house. They had 2 grown up children.

44. Together, he and Ruth also ran independently a small on-line business from their home.

45. Ruth, their children and a wider circle of close friends were involved and supportive during Chris's acute mental health crisis.

46. Chris appears to have been guarded about his mental health experiences when talking with professionals and was unable to articulate these and minimised his distress. He was also reluctant to take psychiatric medication as prescribed. A small number of clinicians that we spoke to said that these were common characteristics in the presentation of older people with mental health problems. The panel found this perception to be unhelpful in that it saw older people as a homogenous group with fixed beliefs which couldn't be changed, rather than individuals with differing needs.

47. The NHS Long Term Plan and NHS Mental Health Implementation Plan 2019/20 – 2023/24 set out that the NHS will ensure consistent access to mental health care for older adults with functional needs (i.e. depression, anxiety and severe mental illnesses). Further, that age barriers to admission should no longer exist and access to older people's mental health support will be based on needs and not age [6].

48. Despite the recommendations described in the above paragraph, Early Intervention in Psychosis (EIP) teams are designed to treat the 14 to 65 age group. They are based on the premiss that the sooner someone receives

[6] https://www.england.nhs.uk/mental-health/adults/older-people/

treatment for psychosis then the better their chances of recovery are. They are tasked primarily with reducing the time adults with psychosis wait to get appropriate treatment. Teams are expected to see referrals with 'suspected psychosis' within 14 days, provide a detailed assessment and then, if appropriate, commence treatment and EIP support*. The support that should be offered is in line with the NICE guidance for Psychosis and Schizophrenia in Adults (QS80)[7] and includes medication (antipsychotics), psychology, family work, carer's support, employment and vocational support and a comprehensive screening (and possible onward referral) for any underlying physical health issues.

49. With reference to the age criteria the panel sought the opinion of a consultant from an external EIP service. They indicated that due to the length of time an individual would be on the case load of their EIP service they would be unlikely to offer an assessment and package of care after the age of 63 years.

50. As a man in his mid 60's, Chris encountered challenges in accessing the treatment package most appropriate to his needs because his local EIP services are commissioned to provide care for patients between the ages of 14-65. This local policy corresponds with national policy which is in contrast to the recommendations in the NHS Long Term Plan and NHS Mental Health Implementation Plan 2019/20 – 2023/24 – that access to older people's mental health support will be based on needs and not age.

## ToR2 - Produce a full chronology from 6 May 2022 of contact with Mental Health, Primary Health Care, and third sector services.

A detailed Chronology of events is provided in **Appendix 1.**

## ToR 3 - Identify the key practice episodes for analysis emerging from the chronologies, identify further key lines of enquiry (if appropriate).



* https://www.england.nhs.uk/wp-content/uploads/2023/03/B1954-implementing-the-early-intervention-in-psychosis-access-and-waiting-time-standard.pdf
[7] https://www.nice.org.uk/guidance/qs80

51. The key practice episodes identified by this independent panel for further analysis under the ToR are.

    - The self-referral (supported by his son) to Talking Change in the early stages of Chris's illness
    - The initial engagement with the Crisis Team
    - The assessment by ED Mental Health Liaison following Chris's suicide attempt
    - The Mental Health Act Assessment
    - His mental health care at QAH
    - His transfer to mental health inpatient services including transportation
    - His assessment, care and treatment on Hawthorn and Brooker wards including the impact of hosting
    - Discharge back to CRHTT
    - CRHTT follow up
    - Referral to EIP and psychological therapy and family support by CRHTT.

52. These are addressed where relevant in ToR 4 - 10 of this report.

## ToR 4 – Determine if CSH's healthcare needs and risks (of suicide/ and harm to others) were fully understood and that was reflected in the most recent treatment plans.

### Risk to self

53. Chris's healthcare needs and risks were comprehensively assessed and fully understood at his first assessment by the CRHTT, despite the Solent Mental Health Risk Review dated 17/6/22 putting him at low risk of harming himself. This is because suicide risk is difficult to assess and can change very quickly. Since September 2022 clinicians have been specifically instructed not to use such risk assessment predictions[8]. Instead, the assessment should focus on the person's needs and how to support their immediate and long-term psychological and physical safety.

[8] https://www.nice.org.uk/guidance/ng225/chapter/Recommendations#risk-assessment-tools-and-scales

54. The understanding of the risk he posed to himself completely changed after his suicide attempt. The description of Chris's risk and his care needs during the Mental Health Act assessment were comprehensive.

55. As part of his admission process to Hawthorn ward at 00.34 on the 7/7/22 his risk to self was reassessed and noted to be high, which would be appropriate given the recent serious suicide attempt.

56. From the time he was 'hosted' on Brooker ward, communication between the staff on Brooker and his care team was limited. This restriction hindered a comprehensive understanding of his mental state, especially given his withdrawal from ward activities and lack of engagement with the nursing staff. The panel wondered if Chris had been at all able to form a therapeutic relationship with the staff in the face of his levels of social isolation.

57. During interviews with two registered nurses from Brooker ward, the panel asked how they would have developed a therapeutic relationship with Chris, when he frequently isolated himself in his room. They told us that staff would attempt to spend some time with patients such as this, and that if they held a 1:1 individual session this would be recorded in the clinical notes. The panel found no recorded evidence of any 1:1 session. This will have contributed to the paucity of information available to the care team for the assessment of risk and the planning of his care.

58. Despite this the Solent Mental Health Risk Review dated 2/8/22 had reverted to assessing Chris as low risk of harming himself and a low risk of harming others. Although his paranoid ideas were acknowledged, his risk to others was thought to be low due to his family support and his denial of having any thoughts about harming others.

59. However, there is an inconsistency in the Discharge Summary dated 8/8/22, which states "*Declined consent to share pt data with specified 3rd party: Wife Ruth"* while the same document contains the statement "*Nurse feedback has been very positive. Christopher has been engaging well with staff, taking his medication and there have been no risk incidents*". In the opinion of the panel, the care team should have been alert to the implications of this refusal to share information with the person who they were relying on to support his recovery in the community and monitor his adherence to his prescription.

60. Further, this description of the nurse feedback as being 'very positive' does not accord with the nurse feedback recorded in the notes which uniformly describes Chris as being withdrawn and frequently self-isolating. The panel believe that this information at discharge conveyed the impression that he was more advanced in his recovery than was the reality. Thus, it did not

reflect either his care needs, or the support needs of his family, at discharge.

61. It appears that there was no jointly agreed care plan for Chris's care in the community following his discharge to the CRHTT on 2/8/22. However, the CRHTT team undertook an assessment at a home visit on 3/8/22, where it is recorded that Chris had not been compliant with his prescribed medication. A Community Plan of Care and a Safety Plan were completed, and the views of his wife were noted. Despite this, it is recorded that he had declined to share information with his wife, but this was not commented on in the care plan. Again, this discrepancy should have been explored.

62. Chris was reviewed regularly at home visits until the in-person review with the same CRHTT consultant who had seen him before his suicide attempt and during his inpatient stay. She concluded that:

> "*His risk of self-harm and suicide are low at present, but his risk to himself were he to become unwell again, would be high*."

After this, from the 25/8/22 until the 14/9/22 (the day of the incident) contact was solely by telephone with the last contact taking place on 12/9/22. During this time, contact with the CRHTT was with health care support workers, whose notes were not always countersigned.

63. In the opinion of the panel, the historical reluctance of Chris to adhere to his prescription should have been the subject of active monitoring by the team. This should have involved both a discussion with his wife without him present and a review of his packets of medication to ascertain if the remaining tablets aligned with his prescription. The risk of non-adherence was insufficiently recognised and so was not given prominence by the team.

**Risk to others**

64. The Royal College of Psychiatrists' Good Practice Guide: Assessment and Management of Risk to Others (2016, page 8), explains the qualities of a good risk formulation:

> 'Risk formulation is based on …. risk factors and … other items of history and mental state. It should take into account that risk is dynamic and, where possible, specify factors likely to increase the risk of dangerousness or those likely to mitigate violence, as well as signs that indicate increasing risk. Risk formulation brings together an understanding of personality, history, mental state, environment, potential causes and protective factors, or changes in any of these. It should aim to answer the following questions:

- How serious is the risk?
- How immediate is the risk?
- Is the risk specific or general?
- How volatile is the risk?
- What are the signs of increasing risk?
- Which specific treatment, and which management plan, can best reduce the risk?'

65. Chris's risk to others was assessed as 'low'. The panel believe that indeed, the homicide could not have been predicted. Nothing in his history suggested that he had the capacity for violence, and he did not indicate that he had any thoughts of harming his wife.

66. However, it is the panel's view that a good risk formulation should have included, at a minimum, the impact of relapse of his illness on risk, including the likelihood of a relapse in the context of non-concordance with medication and/or further life stressors.

## ToR 5 – Determine if the design of the inpatient service, transition to (and from) community services (Including Home treatment teams) system, i.e. the management structure and governance system around the team(s) (e.g. policies, procedures, specifically case and risk management, supervision, confidentiality, and MCA), supported professionals to carry out their duties to the expected standard.

### Initial experiences with the CRHTT

67. The CRHTT do not hold 'caseloads' meaning that patients see whichever staff are free on a particular day, much like a 'taxi rank' system. When Chris was taken on by CRHTT following the initial assessment by the same nurse over three days, he struggled to establish a rapport with the multiple MHPs who subsequently visited him. The panel believe that, in conjunction with his paranoid thoughts, this is likely to have impacted negatively on his willingness to confide in them the full extent of his symptoms.

### Transfer into the Mental Health Unit

68. Following Chris's suicide attempt, he was assessed by the ED mental health liaison team. It was quickly recognised that he required assessment for admission to hospital under the Mental Health Act (MHA).

69. The process for admission to hospital under the MHA is prescribed in law. For admission under Section 2 of the Act, three professionals, an Approved Mental Health Professional (AMHP) and two doctors, one of whom should be section 12 approved[9], are required. These professionals must each make independent decisions on whether a person meets the legal criteria for admission. The criteria are:

    - The person is suffering from a mental disorder of a nature or degree which warrants their detention in hospital for assessment (or for assessment followed by treatment) for at least a limited period, **and**

    - The person ought to be so detained in the interests of their own health or safety or with a view to the protection of others.

    The professionals are also required to explore less restrictive alternatives to detention under the act such as treatment in the community or in hospital informally with the patient's consent[10].

70. Ensuring an admission to hospital using the mechanisms provided in the MHA requires organisations to work together to anticipate demand and meet need. The relevant professionals need to be available to make the assessments, a bed needs to be offered, and, in Chris's case, he needed to be physically well enough to engage in the process following the injuries sustained by his suicide attempt.

71. The organisation and management of the MHA assessment, including communication between mental health and physical health services and the provision of an AMHP by the local authority, was effective. Chris was formally detained under section 2 MHA on the afternoon of 5/5/22 shortly after he had been deemed physically well enough to be assessed.

72. At that time, according to the clinical records, the plan was to admit to Brooker ward, an older people's mental health ward. However, transfer was not immediately possible. It has been difficult to determine precisely the cause of the delay in admission. Shortly after 17:30hrs on 5/7/22 a junior doctor sent a 'transfer summary' which had been requested by Brooker ward and just before 18.00hrs an email from Brooker ward was sent requesting for the transfer to be delayed until the following day as:

[9] Section 12-approved doctor A licenced doctor who has been recognised under section 12(2) of the UK's Mental Health Act 1983 (amended in 1995, 2007), who has specific expertise in mental disorders and has received training in application of the Act.

[10] Mental Health Act 1983 (publishing.service.gov.uk)

*"… it is late in the day our doctors have gone home now and we are awaiting a discharge tomorrow… Then we can accommodate this request in normal daytime hours, which is more appropriate for the patient also*".

73. Chris was not transferred to Brooker ward the following day but to Hawthorn ward, an adult acute mental health ward, in the early hours of the morning of 7/7/22. It appears that the proposed destination ward was changed after a Lead Nurse in older people's services reviewed the case in discussion with a speciality doctor and without meeting Chris and decided that (contrary to the opinion of those who had assessed him for MHA detention) he was not suitable for an older people's ward and so new arrangements were made to transfer to Hawthorn ward.

74. Delays in transfer to mental health units are a common experience in mental health services and often, as with this case, people must wait in the physical health hospital until a mental health bed becomes available.

75. In such circumstances the MHA detention applies to the physical health hospital until the transfer to a mental health unit can be facilitated. This can lead to a complex position where the patient is physically located in a service which is not designed to meet their primary mental health needs. Services therefore need to work together to ensure the individual's needs are adequately met whilst they await transfer.

76. In Chris's case this working together resulted in two strands of input into his care, provided by two separate organisations, whilst he remained on ward D3. Firstly, his direct care was the responsibility of D3 ward (Portsmouth Hospital University NHS Trust) which led on the planning and implementation of his care plan and were legally responsible for his detention in hospital. Then, oversight of his mental health care was provided by the ED mental health liaison team (Southern Health NHS Foundation Trust). His constant observation and supervision were ultimately the responsibility of D3 ward though this was provided by a combination of mental health nurses from the ED liaison team or from an agency who were not a substantive part of the D3 team.

77. The panel were concerned that the need to explore his actions and his risks with him in the immediate period after his suicide attempt would be unlikely to have been met in such an environment with a staff member allocated temporarily, shift by shift, in a busy ward.

78. This complicated arrangement also potentially contributed to the family's poor experience of this period of care. This included: difficulties in understanding whether Chris was receiving his prescribed medication, gaps and inconsistencies with the constant observation, and a lack of information

about when he was to be transferred. The family indicated that they raised these concerns at the time, but did not receive answers.

79. From the interviews with staff, the panel understand that the psychiatric liaison team suggest or prescribe medication, but it is administered by the D3 ward staff. We know that Chris had ongoing concerns about taking his prescribed medication. The impression, that the daily management of a psychiatric patient in crisis is undertaken by non-psychiatrically trained staff in a busy acute ward, is of concern.

80. When it eventually happened, the transfer to the psychiatric ward took place using a secure ambulance/ transfer with Chris being accompanied by four strangers. This caused distress to his family, as they were told they could not be present to support the transfer. This experience would have been difficult for someone in the grip of depression and paranoia who had only three days earlier made a serious attempt on his life.

81. The panel find that this transfer process was subject to an unnecessary delay, was unsympathetic to Chris's needs and unhelpful in promoting the family's engagement with his care.

**Design of inpatient services**

82. As a man in his mid 60's, with a first onset of acute mental illness Chris's health needs did not neatly fit with either the older people's or acute adult inpatient wards. The need to monitor his blood pressure, (particularly in view of the potential side effects of his prescribed medication) could be better met by the older people's service and those who met him felt that he would be better suited to their quieter and more settled environment. Despite these considerations, he was not frail and the assessment and treatment of his first onset, acute mental illness would have been better suited to the acute adult mental health ward.

83. As already outlined, the NHS Long Term Plan and NHS Mental Health Implementation Plan 2019/20 – 2023/24 sets out that access to older people's mental health support will be based on needs and not age.

84. To best meet Chris's needs a compromise was reached that he would be 'hosted' on Brooker ward but would remain under the care of the Hawthorn ward team. In essence this meant that the planning and reviewing of the care plan was done by the Hawthorn team but the day-to-day delivery of that care and monitoring of his mental health was undertaken by the Brooker team. To facilitate the necessary flow of information between the two wards it was intended that there would be daily handovers between the

two nursing teams and that staff from Brooker ward would report into and attend the Hawthorn weekly ward round.

85. The investigating team learnt that Brooker ward is subdivided into two areas: eight beds for those with a functional mental illness (such as that being experienced by Chris) and 14 beds for organic mental illness (dementia). Nurses can cover either area and whilst a 'named nurse' system is used, their role seems to focus more on ensuring set processes are completed, than establishing a therapeutic alliance and seeking a deeper understanding of the individual patient using their professional skills.

86. From the time of Chris's 'hosting' on Brooker ward, the information sharing between the two teams appears to have been limited. This reduced the opportunities for a full understanding of his mental state, particularly in view of his levels of withdrawal from ward activities and his lack of engagement with the nursing staff. As noted above, the panel doubted if Chris had been at all able to form a therapeutic relationship with the staff in the face of his levels of social isolation. The lack of this contributed to a paucity of information being available to the Hawthorn care team for the assessment of risk and the planning of his care.

87. Everyone we spoke to told us that 'hosting' was a regular occurrence in 2022 but that it was fraught with difficulty, and we were pleased to hear that the practice is no longer commonly used.

**Discharge back to CRHTT**

88. During the annual leave of the in-patient consultant, Chris was reviewed by the CRHTT consultant (who had assessed him in the community) on 19/7/22. She concluded that there had been little to no improvement in his mental state and increased his antidepressant.

89. He was seen by his in-patient consultant on his return from leave on the 25/7/22, who started making plans for his discharge in two days' time. He was eventually discharged on 2/8/22, despite the nursing notes consistently describing him as being withdrawn and unforthcoming.

90. The 'hosting' arrangement had resulted in his care team having limited knowledge and understanding of his social withdrawal and lack of engagement. Importantly, neither the nurses on the older adults' ward, nor his care team, had insight into his inner world, despite his history of a recent serious suicide attempt. After the initial MHA assessment, there is minimal evidence of attempts by anyone in the MDT to understand why he tried to take his life.

91. The panel conclude that the information-gathering about Chris's level of recovery was flawed. The care team did not liaise sufficiently with the old age colleagues who were providing his daily care. His enduring anxiety about taking medications was not highlighted as a risk and so was not communicated to the CRHTT who were taking over his care. In fact, the referral from the ward team to the CRHTT, dated 2/8/22, described him as engaging "*fully*" in his treatment programme, "*including medication and psychological input from OTs."*

92. We were advised that part of the process for determining if discharge was appropriate was how periods of home leave went. They appeared to go well however, Chris was opposed to taking his prescribed medication and when he was granted 6 hours leave to 'test' how he was, this did not include medication administration, so it could not 'test' how he would take his medications at home. An **opportunity for learning** is identified that where leave is used to test out readiness for discharge, teams should ensure it incorporates likely challenges faced in delivery of the community care plan.

93. The CRHTT did not attend the CPA, so there was no recorded agreement about what the care plan should include in the community. The panel explored this with the inpatient consultant and heard that in his experience the relationship with CRHTT was not as seamless as it should be and there was often a lack of ongoing dialogue, an issue that he had raised with his managers. We also recognise that the discharge planning meeting was arranged at short notice.

94. On return to the care of the CRHTT, Chris was not assigned a care coordinator upon discharge, as we would expect for CPA patients. And again, his discharge to CRHTT meant he did not have an allocated worker. Instead, several staff members were involved in his care. Consequently, the family had yet to have a single point of contact with whom they could establish rapport, express their concerns, and/or identify their needs.

95. Guidance from NHS England within the NHS Long Term Plan published 2019[11], on transition away from the Care Programme Approach towards the Community Mental health Framework for Adults and Older People states, amongst its five broad principles, the provision of:

> "*A named key worker for all service users with a clearer multidisciplinary team (MDT) approach to both assess and meet the needs of service users, to reduce the reliance on care co-ordinators and to increase resilience in systems of care, allowing all staff to make the best use of*

[11] https://www.mentalhealthlaw.co.uk/media/2022-03-01_NHS_England_CPA_position_statement.pdf

*their skills and qualifications, and drawing on new roles including lived experience roles*".

96. It further states, with regard to the needs of carers:

"*Better support for and involvement of carers as a means to provide safer and more effective care. This includes improved communication, services proactively seeking carers' and family members' contributions to care and support planning, and organisational and system commitments to supporting carers in line with national best practice*".

## ToR 6 – Confirm that Solent NHS Trusts Domestic Abuse policy and procedures are compliant with the Hampshire Safeguarding Adults Multiagency Partnership's policy and procedures.

97. The Solent Safeguarding Children, 'Young People and Adults at Risk Policy' (May 2022) and 'Domestic Abuse policy (Nov 2021) are both compliant with Hampshire Safeguarding Adults Multiagency Partnership's policy and procedures. Staff receive appropriate training, and we were pleased to hear that staff are offered specific supervision in relation to safeguarding adults practice.

98. Family and friends have very clearly expressed that prior to this tragedy Chris and Ruth were in a committed and loving relationship. There was never any history of violence by Chris and there was never any indication that Ruth was vulnerable or at risk from him.

99. It is however agreed by all that Mrs Stone Houghton's death most likely occurred as a direct consequence of a catastrophically violent act by her husband in the context of his psychotic illness.

100. We discuss in further detail in ToR 7 where there were gaps and deficiencies in contact with the family, in particular in relation to: assessing Ruth's needs as a carer, offering her opportunities to give feedback on her husband's condition privately, without him present, responding to the family's concerns about their ability to care for Chris at home, and in assisting the family's understanding of psychotic illness. In fact, the panel have been told by the family that Ruth sought help for herself because of the stress of supporting her husband. Ruth's level of distress does not appear to have been recognised by the CRHTT and there is no mention of it in their records.

101. The family have indicated that, they believe if asked at the time, Ruth would have said that she did not feel at risk from her husband. However, the panel is of the view that thoughtful exploration of her needs as a carer would have given the best opportunity to facilitate the disclosure of any concerns she may or may not have held.

## ToR 7 – Comment on the support that was offered to CSH's family between 4 July and the 15 September 2022.

102. Following his serious suicide attempt on the 4/7/22, Chris was taken by Ambulance to Queen Alexandra's Hospital ED. This was a traumatic experience for both him and his son who accompanied him as he remained

highly distressed and was trying get out of the moving ambulance. He arrived in the ED around 9.00am.

103. Their experience on arrival was supportive. They were met with compassion by a nurse and prompt liaison with members of the mental health liaison team. During the next 10 hours, he was seen by two doctors, including the CRHTT consultant who already knew Chris and his family. In liaison with the family, agreement was reached to admit him to St James Hospital under Section 2 MHA, which they found reassuring, following assessment and treatment for the physical injuries he had sustained to his wrists and neck.

104. The family's recollection of events was that, by 18.00hrs, it was agreed that he was fit for discharge from Queen Alexandra's (QA) and could be transferred to a psychiatric bed in St James Hospital. However, the family were informed that whilst a bed was free, there was no transport available to move him. This led to his admission to a medical ward at QA.

105. Over the next 48 hours, despite the assistance of the mental health liaison team, the family's experience at QA was poor. This was exacerbated by ineffective communication, mixed messages and a breakdown of trust and confidence, all whilst witnessing Chris's distress in an environment ill-suited to his clinical needs.

106. Chris was eventually transferred to St James Hospital in secure transport, with four male escorts. He arrived at 00.40 on the 7/7/22. Due to the lateness of the hour, the family were not able to support him on his arrival at the psychiatric hospital, as they had wished to. He was admitted to an acute adult admission ward and not an older adults' ward as the family had expected.

107. On the 11/7/22 discussion took place to facilitate a transfer to the older adults' ward but to remain under the care of the psychiatrist responsible for the acute admission ward.

108. The family maintained daily contact with Chris and the care team throughout his admission. Although Ruth was recognised to be the main carer, there is no record of an individual interview with her to ascertain her thoughts about her husband's care plan. The family were clearly anxious about discharge and indicated a wish to attend the CPA; it seems from the notes that it is only the diligence of Ruth which ensured their attendance as the time was changed more than once and she was not updated.

109. There was a concerning disparity between the family's request for support and what was provided. On 26/7/22, in an email Ruth, as his main carer, requested two visits per day following discharge to help to support his

adherence with his medication. However, what was ultimately delivered quickly became a reliance on telephone appointments instead.

110. At discharge, Ruth assumed the role of the primary carer and encouraged her husband to take his medication. But in an email dated 5/8/22 by an administrator within Solent NHS Trust, Chris withdrew consent to share information with his wife. The actual date which he withdrew his consent is unclear. The panel found no evidence that this important change in the relationship was discussed with either party. Furthermore, a significant result was that the family did not receive a copy of the discharge/CPA documentation.

111. Ruth was her husband's primary carer, and her efforts to obtain assistance for him were evident from her engagement with services. However, the Hawthorn team did not sufficiently recognise the demands this role placed on her. She was not given the opportunity to discuss the support she could receive for her carer's role upon discharge. No-one explored with her whether she was making a recovery from the trauma of finding her husband after his suicide attempt. The worry that he would attempt to take his life again unless she ensured that he took the medication would have felt very onerous.

112. After discharge the family felt that Ruth could no longer express her concerns as staff from the CRHTT quite soon only spoke with Chris on the telephone.

113. In addition, she did not want her husband to feel as if she was taking control of his treatment, so she only communicated with the service when he was present and at his request. The service should have offered her a Carer's Assessment, as she was the primary carer.

## ToR 8 – Having assessed the above, comment on relevant issues that may warrant further investigation.

114. We address here some of the additional concerns raised by the family about their experience of care.

115. With regard to Chris's withdrawal of his consent to share information about his care with Ruth, the panel conclude that an opportunity was missed to explore this further. This might have yielded more understanding of his internal world. There was no assessment of his mental capacity to make this decision. He was going home to live with his wife. What information might she need to have? Was he withdrawing consent in relation to all information? Or only a part? The draft DHR says *"Chris had revoked*

*consent to share information with his wife; the mental health service did not explore this, and the family were unaware of this change. The risk assessment shared with the Chair did not document the change in consent, and there was no indication that this had been discussed in the MDT or with Chris or that his family would be notified of the change."*

116. With regard to the decision to rescind the section 2, it is documented that Chris was agreeing to take his medication and to remain as an inpatient voluntarily, so the decision to rescind his liability to be detained under Section 2 MHA was appropriate and complied with the requirement to use the least restrictive practice.

117. The family have reported that they were discouraged from finding a CBT therapist in the independent sector to offer CBT for psychosis to Chris after his discharge, and they wonder why this was. The panel believe that Chris's recovery from his suicide attempt was still in its early stages. He required the framework of community mental health services, in case further urgent interventions or medication changes were needed. There would have been a risk of confusion about clinical responsibility if he was receiving CBT for psychosis in the independent sector. Further, a psychological therapist working alone would have been concerned about the risk of suicide in someone with a psychotic depression and a suicide attempt only two months previously.

118. The plan for him to be offered family work for psychosis was evidence-based and appropriate. However, although he would have been supported by a lead professional in the Nurse-led Clinic, the wait for CBT for psychosis was unacceptably long.

119. The Trust has implemented strategies to reduce this. Specifically, Assistant Clinical Psychologists have been introduced to do the screening and initial assessment and provide briefer lower-level targeted interventions. This has helped to reduce the wait time. Now, Chris would be offered a 'Foundation Stage' of about six sessions to formulate his case and decide the best pathway. In a case such as his, psychotic symptoms would be identified which would direct his care.

120. Chris had a CT scan, but the results were not provided until after his death. While the CT scan was a necessary investigation, it was not an urgent one. Nonetheless, the panel agree with the family that an opportunity to discuss his illness with him and explore his thoughts about its causation was missed.

121. The family reported considerable difficulty in obtaining all the clinical records from the Trust following their request. For example, the emails were not

provided until they were specifically requested. This is a **learning opportunity** for the Trust – that, where an appropriate request is made for clinical records, the clinical information outside the medical records should be included, for example, emails, correspondence and uploaded documents.

122. The use of the HONOS tool has no clinical relevance. It is a population measure and has not been designed to measure clinical need or outcomes.

123. The family have asked about Ruth's contact with Talking Change. The focus of this enquiry was the care of her husband. The panel have not seen any records relating to Ruth and thus are unable to comment.

## ToR 9 – Make recommendations for improvement for the Provider(s), ICB, and/or NHS England as appropriate.

Recommendations and opportunities for learning are listed in the 'Summary of Findings' section on the next page.

## ToR 10 – Review the Provider's application of the Duty of Candour to the families involved.

124. Guidance from the CQC to providers in relation to the application of a Duty of Candour states:

> *"Registered persons must act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity. And act as soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred."*

125. In discussion with Solent NHS Trust the formal responsibility for responding to Duty of Candour lies at a Divisional Level. The panel understand this would therefore have been the responsibility of the Head of Quality and Professions. Unfortunately, despite internal efforts, no 'Duty of Candour" letter has been identified, nor is there any evidence of discussions as to who may be best placed to meet with the family following the homicide.

126. The CRHTT consultant met with the family accompanied by the manager of the CRHTT on the 22/9/22, eight days after the event. This was an exploratory meeting to respond to the initial concerns which were being raised and to offer support.

127. The CRHTT consultant continued to share information in response to questions raised by the family. This included her report for the Coroner in October 2022.

128. The family were also linked with the Family Liaison Manager (FLM) who introduced herself and formally offered her support and condolences via an email on the 30/9/22. Following the introduction, the FLM maintained regular contact over the following months. As appropriate, she introduced other individuals on behalf of the Trust providing explanations to their roles.

129. The first contact with the family by a senior manager within the organisation was in February 2023, to arrange a meeting which took place on the 2/3/23. The meeting explored the processes that the Trust were putting in place to carry out an internal serious incident review and to identify further information and correspondence which the son was seeking for his own review and understanding.

130. The individual who the Trust had commissioned to carry out their serious untoward incident review was also introduced and contacted the son to share the Trust's commissioning brief.

131. At the request of the family, pathways to access support for some other close friends who had been directly affected by the tragedy were identified and information shared.

132. The panel determined that there is evidence demonstrating the Trust's communication with the family. This included face-to-face interactions with the consultant from the CRHTT and the team's manager, who also shared information and contact details for the Trust's Family Liaison Manager. However, senior officers from the Trust failed to fulfil their formal responsibilities under the Duty of Candour in a timely manner as would have been expected.

## SUMMARY OF FINDINGS

133. Chris's illness was difficult to assess. Whilst it was clearly depressive in nature on a background of loss, his vulnerability to psychotic symptoms did not immediately declare itself as his illness was evolving. It started with anxiety and depression (commonly seen together) and over several weeks paranoid beliefs developed and became prominent.

134. We concluded that Talking Change had dealt with the referral within their protocols. They are a primary care/self-referral service, commissioned to work with clients who have anxiety and depression for which CBT is appropriate. Because they are easy to access, they have high drop-out

rates and so do not follow up those who don't engage. They do not routinely liaise with mental health services as they are entirely separate.

135. In the early stages of Chris's illness, Talking Change seemed to be a reasonable treatment option, but as his illness evolved, he was referred to mental health services by his GP which was entirely appropriate.

136. His psychotic symptoms were characterised by paranoid ideas. It is likely that his difficulty in trusting made him less likely to share his mental experiences.

137. Initial engagement with the CRHTT was good. Chris was assessed promptly and in a thoughtful way which gained the confidence of both him and his family. This was an example of good practice. However, the lack of an allocated worker or caseload system meant that over time Chris saw a variety of different workers. This hindered the development of a therapeutic alliance between him and the staff.

138. Chris was seen by the consultant without delay and started on a low dose of medication which took into account both the fact that he had not had psychiatric medication before and his pre-existing high blood pressure. His reluctance to take medication was noted and was discussed with the consultant at that first assessment. During this phase of his treatment, it was appropriate to monitor the effect of his antidepressant medication.

139. Chris's reluctance to take his medication was a worrying feature of his illness from the first prescription. It elevated his risk. The panel **find** that this should have been more robustly managed by the CRHTT with monitoring of his adherence by a worker with the requisite training and experience. This an additional basis for **Recommendation 1,** that the CRHTT match patients' needs with staff with the appropriate skills.

140. The panel concluded that Chris's suicide attempt on the 4/7/22 could not have been predicted given his mental health history and the information that was shared with the mental health professionals. Given its seriousness, the detention under Section 2 MHA was appropriate.

141. His stay on an acute medical ward, albeit with a staff member allocated to monitor him, must have been an isolating experience. The panel were concerned that the need to explore his actions and his risks with him would be unlikely to have been met in such an environment with a staff member allocated temporarily, shift by shift.

142. Following interviews, the panel understood that the psychiatric liaison team suggest or prescribe medication, but it is administered by the ward staff. The impression that the daily management of a psychiatric patient in crisis

is undertaken by non-psychiatrically trained staff on a busy medical ward, is of concern and any delays in finding a psychiatric bed should be kept to an absolute minimum. It was therefore worrying to note that his transfer was delayed by over 24 hours.

143. After Chris's serious suicide attempt and the initial assessment period, his experience at QA Hospital was poor, further adding to his distress in an environment ill-suited to his clinical needs.

144. The transfer to the psychiatric ward took place using a secure vehicle with Chris being accompanied by four strangers at around midnight of the following day. The panel **find** that this transfer process was subject to delay, was unsympathetic to Chris's needs and unhelpful in promoting the family's engagement with his care. This finding is the basis of **Recommendation 2,** that the Mental Health Trust identify a named person to monitor the care and progress of patients in the general hospital awaiting a psychiatric bed. They should meet with the patient, liaise with carers and minimise both the delay in transfer and the potential for disorientation and disempowerment of the patient and their family.

145. The panel heard that Chris's move to an older adults' ward was arranged so that he could be in a quieter environment, where his physical health could be more intensively monitored. However, this reduced the opportunities for his care team to build their knowledge of him and replicated his previous outpatient experience.

146. His inpatient admission was characterised by his self-isolation, low mood and risk of self-neglect. Despite this, it was difficult to ascertain when health care professionals sought to explore his inner world to understand what may have contributed to his suicide attempt on the 4/7/22 and thus mitigate future risks.

147. Whilst Brooker ward was likely to be less noisy and unsettled than Hawthorn, its staff appear more attuned to dealing with frail and infirm patients than with individuals such as Chris. So, whilst acknowledging that the transfer had the support of the family, both the focus of the ward team and the resources available, i.e. one registered nurse and two support workers during the day (on the eight-bedded functional side) were less suited to his clinical needs.

148. The panel **find**, based on the clinical notes and the interviews, that the liaison between Chris's clinical team and the hosting ward was limited, with few opportunities for the transfer of information. In the view of the panel, the practice of 'hosting' a patient on a different ward from that of their care team can lead to fragmentation of care. The panel understood that this has

largely – but not totally – ceased by the Trust. Cessation of this practice is appropriate, and so the panel make **Recommendation 3,** that any continuing 'hosting' is subject to audit and management oversight, including the implementation of a protocol to ensure appropriate additional support is provided.

149. The decision to rescind the Section 2 was appropriate because at assessment on the 25/7/22 Chris was found to have capacity about the decision to take his prescribed medication. This decision complied with the requirement of the mental health act to use the least restrictive practice.

150. The decision to discharge Chris from hospital did not appear to take into account the full range of important clinical information. The inpatient consultant relied on his reviews of the patient, and these were not supported by a flow of accurate information.

151. The panel conclude that the information-gathering about Chris's level of recovery was flawed. The care team did not liaise sufficiently with the old age colleagues who were providing his daily care. His repeated anxiety about taking medications was not highlighted as a risk and so was not communicated to the CRHTT who were taking over his care. The decision to discharge was not necessarily wrong, but the lack of both supporting information and the necessary liaison with community services made it unsafe.

152. The CRHTT did not attend the CPA, so there was no recorded agreement about what the care plan should include in the community. The panel **found** that systems were not in place to support more effective decision making about his discharge and therefore make **Recommendation 4,** that a care plan must be jointly agreed between the discharging team and the team taking over care in the community.

153. The support given to Chris's family did not always meet their individual needs as carers who were integral to the effective delivery of the community care plan. There is no record of an interview with Ruth on an individual basis and there was a disparity between the family's request for support and what was provided to assist Chris in adhering to his prescribed medication. This left them feeling isolated while carrying responsibility for the administration of his pills. The panel believe that there should have been individual contact with Ruth to ascertain her hopes, fears and expectations. This is highlighted by the panel as a **Learning Opportunity.**

154. During interviews, the panel identified longstanding challenges within the CRHTT that had been communicated to senior managers at the Trust. The team did not demonstrate a culture of reflection, and communications

among team members was perceived as sometimes lacking respect. These issues merit further exploration by the Trust and the panel emphasize this as a **Learning Opportunity.**

155. The consultant from the CRHTT who assessed Chris on 24/8/22, concluded that he was: *"In recovery from severe depressive episode with psychotic symptoms. His risk of self-harm and suicide are low at present, but his risk to himself were he to become unwell again, would be high."* He agreed to a referral the Early Intervention in Psychosis (EIP) team.

156. The referral made to the Early Intervention in Psychosis (EIP) team was rejected on the grounds of age. Whilst this is national policy for the commissioning of EIP services, it is contrary to NHSE & NICE guidelines and is the basis for the **Recommendation** for Hampshire & Isle of Wight Healthcare NHS Foundation Trust (HIOWH) to review the local criteria in view of relevant NHSE and NICE guidance.

## Best Practice

157. The initial engagement with the CRHTT was good. Chris was assessed promptly and in a thoughtful way which gained the confidence of both him and his family. This was an example of good practice.

158. In a further example of exemplary practice, the CRHTT consultant sought a second opinion on her initial management of Chris from a colleague who worked with older adults, because he was older than her usual patient group in the CRHTT service. Her colleague replied positively and cited the good practice that psychology services were available to the CRHTT.

159. The mental health liaison team's care of Chris in the ED was compassionate, prompt and effective.

## Feedback from the Trust, following review of report for accuracy. Request to note:

160. The senior staffing in the **CRHTT has been strengthened**. In 2022, the Crisis Team had 0.5 whole time equivalent service manager, this has since been increased to 1.0 whole time equivalent. A full-time Trainee Advanced Clinical Practitioner has been implemented, who will remain with the team on successful completion of their portfolio. The leadership team has strengthened their governance arrangements, introducing a monthly governance meeting and improved audit schedules. The staffing establishment has been reviewed and increased, and the team has held team building days, they have introduced treatment pathways, implemented

a protected carer's link role 1-day per week, and had training in Comprehend, Cope, Connect (CCC). In addition, the team is recruiting an in-reach worker, to work with the inpatient team, to assist with robust discharge planning.

161. In 2023, the Trust reviewed the **application of Duty of Candour**. This led to improved governance for incidents that may meet the criteria for Duty of Candour. This was achieved by providing bespoke training to teams, a rewrite of the Being Open and Duty of Candour policy and implementing an enhanced monitoring process.

## Opportunities for Learning for the NHS Trust

**Learning Opportunity 1**

162. Where leave is used to test out readiness for discharge, teams should ensure it incorporates likely challenges faced in delivering the community care plan, for example, the administration of medicine.

**Learning Opportunity 2**

163. Where an appropriate request is made for clinical records, the clinical information outside the medical records should be included, for example, emails, correspondence and uploaded documents.

**Learning Opportunity 3**

164. Through training, supervision and policy guidance, the Trust should encourage clinicians to always ask those in a close caring relationship with a patient, directly and in confidence, as to whether they feel at risk in the context of their caring role, irrespective of any history or indication of previous risk.

**Learning Opportunity 4**

165. During the investigation, the panel observed instances of delivery of care that occurred in relative isolation (see paragraphs 57 through to 60). This resulted in inadequate information sharing and poorly informed care plans. Exploring the practice of 1:1 sessions, the structures of communication and the clinical supervision of team members would help to reduce such instances.

**Learning Opportunity 5**

166. Difficulties within the CRHTT warrant further exploration by the Trust to support staff working reflectively in a supportive environment

**Learning Opportunity 6**

167. The Trust should review their investigation process and staff support. No member of staff that we interviewed had been formally interviewed by the Trust during its internal investigation. Most of the staff who were interviewed and knew about the tragic outcome of this case, had found out, it seems, by chance.

**The expectation of the panel is that the above learning points will be addressed by the trust via the existing quality governance structures.**

## Recommendations for Hampshire & Isle of Wight NHS Trust (HIOWH)

### Recommendation 1 - (Lead organisation - Legacy Solent NHS Trust – (HIOWH NHS Foundation Trust)

168. The CRHTT should review their system of patient allocation to ensure that patients are supported to develop a therapeutic alliance with allocated staff, and that patient's needs are matched with staff with the appropriate skills.

### Recommendation 2 - (Lead organisation - Legacy Solent NHS Trust – (HIOWH NHS Foundation Trust)

169. The Mental Health Trust should establish systems both for minimising the delay in transfer to psychiatric beds and ensuring that such transfers minimise the potential for disorientation and disempowerment of the patient and their family. The panel recommend that this would be best achieved by allocating a named person to such patients to make sure that during their time in the general hospital, their psychiatric needs are met, there is liaison with carers and their need for a bed is prioritised.

### Recommendation 3 - (Lead organisation - Legacy Solent NHS Trust – (HIOWH NHS Foundation Trust)

170. Any continuing 'hosting' is subject to audit and management oversight, including the implementation of a protocol to ensure additional and appropriate support is provided.

### Recommendation 4 - (Lead organisation - Legacy Solent NHS Trust – (HIOWH NHS Foundation Trust)

171. A care plan must be jointly agreed between the discharging team and the team taking over care in the community.

### Recommendation 5 - (Lead organisation - Legacy Solent NHS Trust – (HIOWH NHS Foundation Trust)

172. The Trust should ensure that carers are always offered an assessment of their caring needs which enables them to give feedback privately and facilitates thoughtful exploration of how they can be best supported in their role.

**Recommendation 6 – (Lead organisation - Legacy Solent NHS Trust – (Hampshire & Isle of Wight Healthcare NHS Foundation Trust)**

173. Access to Early Intervention in Psychosis services are reviewed in line with relevant NHSE and NICE guidance. Clinical protocols should be developed to facilitate access to services for individuals approaching 65 based on need rather than age.

## APPENDIX 1

## Chronology

**All entries taken from the Trust clinical record, unless otherwise specified.**

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| **29 January 2020** | The first two cases of Corona virus are confirmed in the UK |
| **30 January 2020** | The World Health Organisation (WHO) declares a global health emergency |
| **20 March 2020** | The UK government orders all pubs, restaurants, bars and other social venues across the country to close |
| **20 March 2020** | The chancellor announces the government will pay 80% of wages for workers at risk of being laid off, known as the "furlough scheme" it required businesses to apply and administer the scheme |
| **23 March 2020** | The prime minster in a televised address announces the first national "lockdown" and says Britons should only go outside to buy food and exercise once a day, or to go to work if absolutely necessary |
| **10 May 2020** | The prime minster announces a conditional lifting of "lockdown" and says that people who cannot work from home should avoid public transport. |
| **29 June 2020** | The health secretary announces the first regional "lockdown" which is applied in Leicestershire |
| **22 September 2020** | The prime minster announces new restrictions in England, including a return to working from home. |
| **31 October** | A second national "lockdown", is announced which last for 5 weeks before changing to a three-tier system |
| **6 January 2021** | The prime minster announces a third national "lockdown" |
| **End of 2021** | CSH in conjunction with the other Directors make the decision to run down and close the four jewellery shops which had been operating as a family-owned business for over 100 years. The business was |

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| | solely dependent on its high street operation, with no online presence. CSH's family recognised the stress that this put on him as he had worked in the business his entire working life. |
| **19 March 2022** | The business is closed. |
| **13 April 2022** | CSH transferred money from his account to his son to keep it safe. His wife later states that he is becoming "paranoid about money safety" |
| **5 May 2022** | The family become increasingly concerned at CSH's mental health. Following some research, his son makes a referral to Talking Change. He understands that they should contact CSH directly, within 5 days and confirms this with his father. |
| **12 May 2022** | Due to the increasing concerns of the family, CSH's wife arranges an urgent *in person* appointment at their GP practice. The focus appears to be more on his physical health and weight loss, as outcome is to order blood tests and a request for a stool sample. |
| **25 May 2022** | CSH's son contacts Talking Change to follow up the referral made on the 5 May. He is told that an appointment was emailed to his father but as they had not had a response, their policy was to close the referral.<br>A new referral was made by the son. |
| **26 May 2022** | CSH attends a second *in person* appointment at their GP practice with his wife. They see another GP who agrees to discuss the case with the GP who met them on the 12 May and then refer to mental health services. |
| **6 June 2022** | CSH and his wife join friends on a week holiday which is difficult and not enjoyable due to CSH's deteriorating mental health |
| **14 June 2022** | Following CSH's wife discovering a questionnaire from Talking Change which had been emailed to CSH's laptop, his son joins his father to complete the form. The son said it was very difficult and his father was very reluctant for it to be submitted. He was tearful and frightened and talked of wanting to end his life. |
| **15 June 2022** | Referral to CRHT by GP. T/C to family by a nurse from the team, in which she arranged a home visit that same night. Accepted onto HTT caseload. |
| **16 June** | Second home visit by Nikita Neal. She recorded a deteriorating mental state with paranoid ideation. |

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| **17 June** | T/C to HTT from Mrs SH. She thinks CSH is getting worse. At a subsequent call, she said the situation had settled. CSH declined offer of a medical review that afternoon. |
| **20 June** | Assessed in person by CRHTT consultant. CSH endorsed depression and anxiety and expressed his reluctance to take medication. Diagnosis of severe depressive episode with psychotic symptoms. CRHTT consultant concerned that he was not disclosing the full extent of his suicidal ideation. Prescribed Mirtazapine 15 mg at night and diazepam 2mg as required up to three times per day. |
| **21 June** | T/C to home by nurse to arrange in-person visit the following day. Mrs SH asked if it could be with Nikita, but she was off duty. |
| **22 June** | Team staff member visited at home. Mrs SH said that CSH seemed less able to comprehend things since he saw the consultant. CSH said he was taking his medication and endorsed occasional thoughts of harming himself. Family given phone numbers to call in the event of a crisis. |
| **23 June, 09.49** | Mrs SH called the CRHTT because of concerns about CSH's blood pressure – whether the medications will affect it. This has caused CSH to decline the medication prescribed. She also said that he had appeared very paranoid the previous day, with friends. |
| **23 June, 16.05** | Doctor called to discuss concerns about blood pressure but no reply. Family subsequently called and spoke to a senior support worker. Their questions about blood pressure were discussed. CSH said he had missed his psychiatric medication and the importance of this was emphasized. |
| **25 June** | Seen at home. CSH seemed suspicious at first and appeared depressed. Had taken last dose of mirtazapine that morning instead of the previous night. Was given information about the need for consistency of medication. |
| **27 June** | Home visit. CSH reported that his mood seems to have improved over the last couple of days. |
| **28 June** | T/C to family to arrange telephone review with consultant for the following day. |
| **29 June** | Consultant phoned CSH. He seemed a little brighter. Has often been restless but had not wanted to take diazepam. Denied thoughts of life not being worth living. Agreed to increase mirtazapine to 30mg at night. |
| **30 June** | HV. CSH appeared somewhat improved and less suspicious. He reported no current thoughts of self-harm or suicide. |

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| **2 July** | HV. CSH reported having a panic attack two days previously. He said his mood was settled and his anxiety was 5/10 (where 10 is a panic attack). He was taking his medication and denied suicidal ideation. They discussed anxiety management techniques. |
| **Monday 4 July** | T/C to team base from Mrs SH who reported that CSH had cut his wrists and neck. This was a surprise to the family. He has been conveyed to the general hospital.<br>Mental health liaison team doctor at the general hospital completed the first recommendation for admission under section 2 MHA. It was uncertain whether the severity of his injuries would necessitate surgery. |
| **5 July, 12.25** | Seen in the general hospital ward by the psychologist. Surgery not necessary. She reported that CSH lacked insight and was hesitant about taking medication and accepting treatment. |
| **5 July, 17.42** | CSH was assessed for admission under section 2 MHA by the CRHTT consultant and the AMHP. He had delusions (false beliefs) of persecution and excessive guilt. It was concluded that he lacked capacity to decide on his treatment so he should be admitted under section 2 MHA. He said he was 'hesitant and nervous' about taking an antipsychotic. He had not taken the prescribed diazepam, despite considerable encouragement. |
| **5 July, 17.57 emails in solicitor's bundle p 909** | email to the doctor in the acute hospital from a staff nurse "I have received the transfer summary…as it is late in the day, could you please hold on transferring this gentleman until tomorrow…" |
| **7 July, 00.30** | Admitted to ward in local psychiatric hospital after midnight.<br>He was assessed as being at high risk to himself, and low risk to others. When assessed by the on-call doctor, he said that someone had hacked his phone and computer to persecute him, that he regretted his self-harm and said he needed help. |
| **7 July** | Board review with inpatient consultant. Physical health tests agreed to check for a cause for CSH's mental disorder.<br>CSH appeared anxious. He told the nurse that he was scared of being in hospital. The wounds on his wrists were cleaned and re-dressed. His antidepressant was changed to venlafaxine 75mg with the plan |

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| | to reduce and stop mirtazapine. Nursing reports show that he stayed in his bedspace with minimal interaction with others. Nursed on Level 2 (15 minute) observations. |
| **8 July clinical notes and email** | Inpatient consultant board review and then reviewed in-person by the ward doctor. CSH was told that he has leave with friends and family. Mirtazapine reduced to 15mg at night, and risperidone was started in a dose of 1mg twice daily. Diazepam 2.5mg three times daily also added.<br>Pharmacy requested that baseline antipsychotic monitoring be completed for risperidone.<br>The ward doctor confirmed in an email dated 8 July that a full set of baseline blood tests had been taken, and a referral had been sent for a CT head scan.<br>Nursing notes show that CSH had been calm, appearing polite and timid and with a low mood.<br>Blood tests reported as no further action required.<br>It was noted that CSH had an appointment at the general hospital to remove his stitches on 11 July. |
| **Weekend 9 & 10 July** | Nursing notes report that CSH spent time in his bedspace.<br>Saw family.<br>CSH's mood remained low. He took his medication after being prompted. |
| **11 July** | Ward round with inpatient consultant. Described as 'low in mood, confused at times, speaking to family, isolative in bedroom'.<br>CSH appeared perplexed and withdrawn.<br>For removal of stitches today. Mrs SH requested to speak to the inpatient consultant and was given the number.<br>Level 2 observations. Periods of escorted leave extended to four hours. The family requested transfer to an elderly care ward, saying that CSH was finding the ward too noisy. |
| **11 July, 18.34** | Transferred to elderly care ward. It was noted that CSH can sometimes be reluctant to take medication. Appeared settled with minimal engagement. Nursed on L2/15-minute observations.<br>(No record in clinical notes of meeting between Mrs SH and inpatient consultant, but Mrs SH refers to a meeting in her email of 17 July.) |
| **12 July** | Missed morning medications due to being asleep. Appeared very low and declined food and fluids during the morning. |

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| | Mrs SH called to arrange a visit. CSH declined, and she arranged to visit the following day.<br>CSH spent the day on his bed, saying little. Staff encouraged him to eat and drink. |
| **13 July** | Inpatient consultant board review – venlafaxine XL increased to 150mg daily. CSH's food and fluid intake increased, he looked more relaxed, and he spent time off the ward with his wife. She reminded the ward staff that his stitches should be removed. |
| **14 July** | Food and fluid intake maintained and although he spent his time in his room, he chatted to staff when they entered.<br>Spent time off the ward with his wife. |
| **15 July clinical notes and email** | Mood appeared low in the morning, and he responded with one-word answers. He accepted his medication but declined breakfast. He had lunch and spent time in the grounds with his wife.<br><br>email from Mrs SH to a locum consultant in old age psychiatry in error (had been given the wrong email address for CSH's consultant), asking for information about CSH's level of activity and his opportunities to talk to psychology. She was given the email address of the inpatient consultant. |
| **Weekend 16 & 17 July** | Mood seems unchanged. Spent time in the grounds with his wife each afternoon.<br>email from Mrs SH to inpatient consultant sent 17 July, further to their meeting on 11 July, expressing her concerns that he was withdrawn and unengaged and asking if psychotherapy or CBT would be available, and how he could be best helped. |
| **18 July clinical notes and emails**<br><br>**example of good practice** | CSH is described as "Low in mood, unwilling to attend to ADLs [Activities of Daily Living] despite motivation from staff. Somewhat paranoid and anxious about taking medication, took lots of convincing and reassurance but did eventually take."<br>CSH requested to see a doctor and this request, plus a request to review his medication, was emailed to the inpatient consultant's team. CSH declined to join Occupational Therapy (OT) ward group and went out to the grounds with his wife.<br><br>emails initiated by CRHTT consultant asking for a colleague in old age psychiatry to review her management of CSH, as his age was outside her usual working age adult caseload. |

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| **19 July** | Board review attended by CRHTT manager. CSH was subsequently reviewed in person by the CRHTT consultant, who concluded that there had been little to no improvement in his mental state.<br>CSH said he felt faint in the mornings. He was very low in mood and flat in affect with little to no eye contact.<br>Plan: Daily sitting and standing blood pressures<br>Increase Venlafaxine to 225mg in the mornings<br>Increase Risperidone to 2mg and change to be administered in the evening. CRHTT consultant to call CSH's family to inform them.<br>Pharmacist requested repeat blood test for potassium level.<br>Occupational therapist discussed activities with CSH. He spent time off the ward with his family. |
| **20 July** | Declined to join OT ward group. Spent time with Mrs SH.<br>Later, he declined his night medications and asked to see the doctor the following day. With encouragement, he did accept the tablets.<br><br>email from Mrs SH to the clinical secretary. She understands that the CRHTT consultant had reviewed CSH, and she wonders if that is because the inpatient consultant is away. She requests a family meeting to discuss the care plan and the CRHTT consultant's feedback on her meeting with CSH.<br>The CRHTT consultant replied that she was covering the inpatient consultant's absence; she had asked a colleague to seek the family's feedback on CSH's progress; she did not think that he had made any progress, and she had increased his antidepressant and antipsychotic. |
| **21 July** | Board review – plan to review medication.<br>CSH had breakfast and lunch in the dining room (instead of staying in his room) but declined to join the OT group. He spent time off the ward with his wife. His friend brought a Tablet in so that CSH could watch his son's graduation. |
| **22 July** | Had discussion with OT about the activities available – CSH seemed more interactive with the OT and told her about himself. The plan remained to review his medication. Seen by social worker and presented as anxious and withdrawn. He declined to go to the dining room for his meals and was interacting only if approached. Mrs SH arranged to visit on the following two days (Saturday and Sunday). |

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| **Weekend 23 & 24 July** | Spent the mornings in his room; on the Sunday, he had the curtains closed and the lights switched off. He expressed concern that his medications were not working; he wanted to see the doctor to ask if he could be discharged. He went out with his family in the afternoons, after which his mood appeared to lift. He accepted his medications. |
| **25 July** | Seen by the inpatient consultant, who recorded the following findings and actions: "Initially stated he did not think he needed medication as he felt clearer and less muddled. I suggested this may be due to medication and he agreed. He then understood that some progress had taken place but this slow and he was educated about medication and the length of time taken to respond. He was clearer in his conversation. He did not seem pre-occupied or paranoid. There was no thought disorder. His responses were little more spontaneous.<br>Plan: discuss with family<br>rescind section 2 - as agreeable with treatment plan and demonstrated capacity<br>discharge cpa for Wednesday morning -if discussion with family does not suggest any further role for inpatient care<br>Ot to attempt to engage and translate any care plans to HTT for support on discharge<br>psychology support following response to antidepressant medication"<br>The nursing notes for that morning describe that CSH "spent most of the morning in his room with the curtains shut, he did spend a short time in the garden and sat in the corridor but declined to come out for meals or to sit on ward areas." That afternoon he had a visit from his wife and subsequently remained in his bedspace, appearing low in mood and declining to come out into the ward area.<br><br>email from Mrs SH sent 25 July to the inpatient consultant referencing her email of 17 July and again requesting a meeting to discuss the assessment and treatment plan for her husband.<br>He replied, explaining that he had been on leave for the previous 10 days, but would be available to meet the following afternoon.<br>email from the inpatient consultant to Lead Nurse attaching the discharge paper from section 2 MHA for CSH. |

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| **26 July clinical notes and email** | Board review with inpatient consultant. Status summarized as: “Independent with personal care, most of time in his room, short time in garden, declined to come out for meals, good diet, no suicidal ideations expressed, reported feeling okay but low in mood, slept well.”<br>Later, he met with OT for information about men’s shed and interactions. She suggested that her colleague could continue working with him when he returns home.<br>Later, CSH was seen with his wife and son by the inpatient consultant. CSH was taken off section 2 as he had demonstrated capacity to consent to his medication. Plan - CSH can continue his rehabilitation at home with the support of community services as the ward environment has not been conducive to increasing his activity levels. CSH should remain on his medication for at least six months. The family expressed concerns about suicidality, and they were told that the risks had reduced, that there had been no risk behaviours on the ward, and that this could be tested at home. A plan was made for up to six hours of home leave on Thursday and discharge on Friday 29 July.<br>email from Mrs SH dated 26 July: “…We can see that the longer he stays on the ward not engaging his recovery will be slower. Our concerns do remain about him continuing to take the medication once home, as although he has assured us, he will, we have been down this road before which was very difficult for us trying to make sure he was taking it, and then discovering he wasn't. Therefore, we are very keen on the twice daily visits to begin with to ensure he continues to take his medication…” |
| **27 July** | Board review with inpatient consultant: “Independent with personal care, good diet intake, making eye contact, spending time in bedspace with curtains shut, declining to spend time on ward areas, visited by family, home visit planned for Thursday, poor sleep overnight… Family concerned about potential discharge. CSH is not engaging with inpatient services. To be encouraged to engage with OT today.”<br>CSH’s family visited in the afternoon.<br>Nursing notes describe that CSH’s presentation on the ward was: “in his bedspace throughout the shift, he been same presentation, remains in his room, had meals in his room minimal engagement, He remains on L2/15 minutes observation, no new risk identified, remains low in mood.” |
| **28 July clinical notes and email** | Board review with inpatient consultant. The clinical update was: “Low in mood, isolative, did not engage with family during visit, poor food and fluid intake, sitting in the dark over-night, self-caring, reasonable sleep.” |

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| | CSH went on home leave during the day and returned as planned. No issues were reported by himself or Mrs SH.<br><br>email from Mrs SH to inpatient consultant, asking about the transport arrangements for the CT head scan on 1 August, and requesting a meeting for the following day to discuss the plan for CSH's discharge. |
| **29 July** | CSH was seen by the OT to discuss his planned activities and the OT support available for him after his discharge.<br>Discharge CPA as arranged for Tuesday 2 August.<br>CSH declined to attend a ward OT group and remained sitting in his chair. Later, he spent time off the ward with his wife. |
| **Weekend 30 & 31 July** | CSH had breakfast and his morning medications. He complained of constipation which responded to a senna tablet. On the Saturday, he declined lunch, saying his appetite was poor. He was described as low in mood, staying in his room with minimal engagement.<br>In the afternoons, he spent time off the ward with friends and family. |
| **1 August** | CSH was described as quiet, accepting medication but with poor engagement with staff and spending most of his time on the ward in his room: "shutting the world out and himself (closed curtains, keeping in the dark)".<br>Mrs SH took him for a scan.<br>Seen by inpatient consultant, described as: "calm and cooperative.<br>not restless or agitated, still flat but more engaging and spontaneous, no suicidal thoughts, accepting of medication -notices medication is making him feel better". Plan:<br>"Discharge cpa tomorrow<br>htt to monitor in the community<br>ot to look at behavioural reactivation next week." |
| **2 August** | Board review with inpatient consultant.<br>Plan: "Arrange discharge CPA 02/08 (today) and plan discharge for same day. CRHT 48 hour follow up, will likely need period of home treatment." Referral made to CRHT. This described him as engaging "fully" in his treatment programme, "including medication and psychological input from OTs." |

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| | CSH reported difficulty in emptying his bowels. Staff encouraged him to be more active on the ward. CSH started to walk around the ward.<br>The family were given confusing messages about the time of the discharge CPA meeting and only attended at the right time because of Mrs SH's checking.<br>The meeting was attended by the inpatient consultant, ward staff, CSH and his wife and son. CSH said he was feeling much better, and that he was taking his medication. The nurse said that CSH was engaging well with ward staff. Mrs SH said that she was worried about his psychotic illness. The inpatient consultant said that the depression had been the trigger for this, and the depression was now being treated. The Risk Review described him as being at low risk to himself and low risk to others. |
| **3 August** | HV by CHRTT.<br>In this documentation, under 'Historical Overview', it is recorded that CSH was not compliant with his prescribed medication. A Safety Plan was completed, and the views of Mrs SH were noted<br>Under 'Consent to Share', it is solely recorded 'declined to share pt data with wife'.<br>The documentation records details of CSH's illness and describes his current mental state as "flat in mood and affect…not currently recognizing the degree of psychotic symptoms associated with his decline." No current thoughts of suicide were elicited. CSH was content with his medication regime. |
| **4 August** | HV by CRHTT. Seen with wife, who described her support for him to establish a routine. He had been able to do some jobs and paperwork. |
| **5 August clinical notes and email** | HV by CRHTT – seemed settled. No visit tomorrow as it was a family celebration.<br><br>email exchange between secretaries about providing a copy of the CPA document to Mrs SH – one secretary replied in an email dated 5 August: "I had a query surrounding sending this letter as the patient's consents were changed on Wednesday [3 August] to not share with his wife. This was done by the Crisis Team…spoke to them and agreed the letter to be sent to Crisis nurse and they will discuss with Mr. A." |
| **Sunday 7 August** | T/C from Mrs SH – family member has visited so please postpone the planned visit until the following day. |

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| **8 August** | HV by CRHTT. CSH needed reassurance from his wife but became more comfortable as the visit progressed. He seemed not to accept that he was making progress, although he had undertaken some tasks that morning. Remained happy with his medication but was finding that the home visits were an interruption to his day. Was scheduled for a session with psychology the following day so the next CRHTT visit would be in two days' time. |
| **9 August** | CBT therapist recorded that CSH attended the first of the two on-line group sessions on 'Emotional First Aid'. The therapist wrote: "He sounded reasonably well-engaged and agreed to attend session 2…" CRHTT MDT. |
| **10 August** | HV by CRHTT. Seen with Mrs SH. There was a full discussion and mental state examination all of which suggested that CSH was making progress with his recovery. The risk of harming himself was assessed as low to moderate while CSH remained supervised by others and the risk to others was assessed as low. |
| **11 August** | CSH attended the second of two on-line group sessions on Emotional First Aid: "Unfortunately some technical issues meant that he was unable to unmute and make verbal comments, but he sent text messages indicating he was following the session. I emailed relevant handouts from both sessions to [him] after the group." |
| **12 August** | HV by senior health care support worker. CSH presented as calm throughout, but he appeared anxious "with his leg continually shaking". CSH expressed uncertainty about attending a party over the weekend, because he feels anxious in large groups with people he doesn't know. The family had requested no home visits over the weekend due to family commitments. |
| **15 August** | HV from CRHTT. Seen with wife. Had obtained medication for constipation from his GP. CSH reported no change in mood, but his wife reported that she sees much improvement. CSH and Mrs SH both happy for him not to be seen every day, and there was "some discussion around discharge planning". There were no reported thoughts of harming himself. |
| **16 August** | T/C from senior health care support worker to hand over information from CRHTT consultant about the need to notify DVLA when he is planning to start driving. There was a discussion about the need to start |

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| | medication for constipation, and a sense of frustration that this problem had not been managed by the ward, as it started while he was an in-patient.<br>CRHTT MDT. |
| **17 August** | T/C to CSH, who appeared bright and said his constipation was resolving. He denied any concerns or worries, and did say that he thought he was improving. Agreed for the next appointment to be at CSH's home in two days' time.<br>Email sent by staff to CRHTT consultant, asking when next medical review was planned, as Mrs SH would like her son to be present and he was scheduled to be unavailable at the end of the month. Following the MDT discussion, the medical review was scheduled for 24 August. |
| **18 August** | CRHTT MDT: "Flat affect still and not feeling self-improvement, but wife reports good progress. Anxious in social circumstances".<br>In-patient ward recorded: "Telephone call to Radiology, QAH to chase results of CT head. This has not yet been reported on." |
| **Friday 19 August** | HV by CRHTT: "bright in mood and engaging throughout<br>Described much improved mental health and reduction in suspicion around technology…no concerns re mood, appetite improved and sleeping well. currently self-reports no suicidal ideation and has engaged well with the team." |
| **22 August**<br><br>**email from OA consultant @ p 981 in solicitor's bundle** | HV by CRHTT, wife present. Improvement maintained. The risk appeared low and CSH is described as engaging with the team and compliant with medication.<br><br>email from Old Age colleague giving opinion on CRHTT consultant's initial management of CSH - broadly, CSH's management had been appropriate, and he would not have been thought to need OA services because he had no evidence of frailty. The prompt provision of psychological intervention within the CRHTT was cited as an example of good practice. This was not available in the older peoples' mental health services. In this respect, CSH had been better served by being within working age adult services. |

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| **23 August** | Manager of Early Intervention in Psychosis team e-mailed re possible referral to their service re follow up, however as advised they only work with persons up to the age of 65 and so [CSH] is not eligible for this team.<br>CRHTT MDT: “Needs planning / decision re follow up. Ready for discharge. Mental State: Much improved. Substantiated by wife also.” |
| **24 August** | CSH seen by CRHTT consultant: “He presented as objectively much better than when I have seen him previously in the acute phase of his illness. He still had a flattened and restricted affect. There were no physical manifestations of anxiety, and he rated his mood as 8/10 with 10 being the best and said that he was "nearly" back to his normal self…He denies any psychotic phenomena, including the persecutory delusions and delusions of guilt he had before. He is now able to use phones and computers normally. He denies any thoughts of self-harm or suicide and finds it hard to believe that he acted so out of character when he was unwell.<br>We talked about the possibility of increasing one of his antidepressants, but [CSH] remains reluctant to change medication…[he] agrees to the referral to EIP, and he and his family recognise that he does not require CRHT support anymore.<br>Medication<br>Venlafaxine M/R 225mg mane<br>Mirtazapine 15mg nocte<br>Risperidone 2mg nocte<br>Impression<br>In recovery from severe depressive episode with psychotic symptoms. His risk of self-harm and suicide are low at present, but his risk to himself were he to become unwell again, would be high.” |
| **25 August** | T/C from CRHTT to arrange next contact: “Explained…we will keep up with contact till we know the outcome of the EIP referral. He said he won’t need contact over the weekend because he is busy, but he will call on Monday sometime when best suits him as he isn't sure when he will be free.” |
| **29 August** | T/C from CSH – reports having a good weekend and is seeing friends. Denied any suicidal thoughts. He had been declined by the EIP team due to being one year over their age threshold. His care would be discussed the following day, and he would be updated by phone call the day after. |

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| **31 August** | T/C from CSH, asking if he would be referred to the EIP service. He was told that he was one year above the threshold, but he will be referred to other groups. CSH reported that he had been shopping, and that he felt relaxed and calm. He did not have any issues with his medication or with side effects. He denied suicidal ideation. The next T/C was arranged for two days' time.<br>Email to psychology, asking if CSH can be offered CBT for psychosis (CBTp). Plan: Once outcome of psychology is known, referral form to be completed for recovery team. |
| **2 September** | CRHTT MDT which concluded: "A noted improvement in his mental state. Ready for discharge however just waiting for psychology. No reported suicidal ideations, no thoughts to harm others or self. Engaging with the recommended plan, going out with no concerns."<br>T/C to CSH from CRHTT: "answered the phone call, appeared flat in tone of voice, his wife was also with [him].<br>-He reports his medication is working well for himself-things are more positive with his recovery.<br>-He reports no thoughts of wanting to self-harm or any plans to end his life.<br>-He has lots planned this weekend but didn't elaborate in conversation around these plans, he is aware that we are now starting to reduce daily contact down with the view of looking to 2 x weekly<br>as discussed with Clinical Manager CRHTT<br>-CSH agreed to have a TC to assess mood and mental state – 5th September 2022.<br>-He is happy and aware around the plan of looking at Psychology referral, which was discussed previously with him, he is also aware that we are still awaiting more details on this.<br>Risk: -No suicidal thoughts or plans." |
| **Monday 5 September** | T/C to CSH from CRHTT: "… sounded bright in mood. Tone and volume in voice normal. Not distressed. Stated he had no concerns/side effects of medication.<br>Reported to of had a good weekend with friends -went for a meal. Didn't feel the need to discuss anything with myself. Only to mention that his wife was a "bit worried" about the next plan…-he wondered what team he will be under. I reported that we are still waiting to hear.<br>Is happy for our next contact to be on Friday.<br>HV @ 14_14:30 HOURS on Friday. Assess mood and risks." |

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| **6 September** | T/C from CBT therapist to discuss onward care. Booked for assessment and review by phone on Friday 9 September. |
| **7 September** | CRHTT MDT: “Remaining on caseload until [CBT therapist] has reviewed. Two visits per week (1 to be face to face). |
| **9 September** | T/C to CSH by the CBT therapist to review wishes/needs re potential psychology input. Mrs SH joined for the latter part.<br>They briefly reviewed CSH’s illness and recovery: “He feels largely recovered, saying his mind is much more peaceful now, but would still like to see himself getting back to more normal routines – work… trips out. Mrs SH also perceived that he seems to have less enjoyment of things…<br>Spoke about how therapies can be helpful in making sense of what has led to these kinds of episodes potentially, also keep tabs on recovery and generate helpful ideas for the future. [CSH] expressed that he wishes to explore this kind of work… agreed that I would make a referral for CBTp within the community psychology team.”<br><br>The scheduled home visit did not occur because CSH had spoken to the CBT therapist on the phone that day. CSH did not express concern about this and agreed for his next HV to be on Monday 12 September. |
| **12 September** | Short T/C from CSH to CRHTT office at 15.00hrs, asking when his HV would take place. He was informed that it was scheduled for two days’ time. It is recorded that ‘he was fine’ with this. |
| **14 September** | The day of the homicide and suicide.<br>CSH left a suicide note, he was sorry and indicating that he may have killed his wife because he thought she had been drugging him as long ago as last year.<br><br>Before the CRHTT knew of this tragedy, it was recorded that CSH had been accepted for CBTp, but the wait could be over a year. Family work could be offered in the interim. Both him and his wife had wanted this. Potentially to be referred to the nurse-led clinic to offer support, as well. |

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| | Their bodies were discovered by CHS's ex-wife who had remained a close family friend and held a spare key to the house. She had been called by the couple's son when Mrs SH failed to respond to calls from another friend whom she had planned to meet that morning. |
| **22 September** | CRHTT consultant and the CRHTT manager met with CSH's son, his girlfriend and his Godfather. It was disclosed that the nature of CSH's psychosis had changed and more latterly, he had thought people were following him. CSH had been out walking when he became concerned that helicopters were following him. CRHTT consultant had not been made aware of these symptoms. |
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## APPENDIX 2

## Services Involved

This table provides a key to the health services (as they were provided at the time of the incident) referred to in this report.

| Organisation | Team | Service Provided |
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| **Portsmouth University Hospitals NHS Trust** | D3 ward Queen Alexandra Hospital. | Provides medical care for people who are physically unwell. |
| **Southern Health NHS Foundation Trust** | ED Mental Health Liaison Queen Alexandra Hospital | Provide mental health assessment if needed to those attending ED |
| **Craneswater Group GP Practice** | | NHS GP practice that Mr Stone-Haughton was registered with. |
| **On the 1/10/24 -**<br><br>**Solent NHS Trust along with Southern Health NHS Foundation Trust became Hampshire & Isle of Wight Healthcare NHS Foundation Trust (HIOWH)** | Brooker Ward, Limes Unit, St James Hospital | Older people's mental health inpatient ward |
| | Hawthorn ward, Orchards Unit, St James Hospital | Acute adult mental health inpatient ward |
| | Crisis Resolution Home Treatment Team | The CRHT service aims to support adults 18+ who are experiencing a significant and severe mental health crisis in order to initiate the first steps to recovery across Portsmouth City. |
| | Early Intervention in Psychosis Team | Assess, treat and support people (between the ages of 14-65 years old) who may be experiencing their first episode of psychosis. We do this in the community – either in or near your home. |
| | Talking Change | Initially developed in 2008 as an NHS Talking Therapies Service (formerly known as IAPT), it was developed to improved delivery of, and access to, therapy services for anxiety and depression. It was recommended in NICE guidance as an evidenced-base psychological therapy |

## APPENDIX 3

## Terms of Reference

**Terms of Reference for Independent Review**
**NHS England, Hampshire and Isle of Wight ICB and Solent NHS Trust**
**STEIS: 2022/21101**

**Purpose of the Review**

By applying an appropriate model of system-based learning this review will identify opportunities for system and service development and make recommendations to support improvements in patient safety within the provider and ICB.

**The review will:**

- Build on the internal review completed by Solent NHS FT and the Domestic Homicide Review commissioned by Portsmouth Safer Community Partnership
- Independently assess the quality of the care and treatment provided to CSH against best practice, national guidance, and Trust Policy/protocols.
- Identify further opportunities for service improvement that may be applicable on a local, regional, or national basis.

The outcome of this review will be managed through corporate governance structures in NHS England and Hampshire and Isle of Wight ICB formal Board sub-committees.

This review is anchored in the principles of openness, fair accountability, learning and continuous improvement and it is expected that affected family members and staff are fully informed of the review, the review process and understand how they can contribute to the process.

**1.Terms of Reference**

1.1 Include demographic details of CSH identifying any protected characteristics or health inequalities that may have influenced access to and delivery of appropriate healthcare.

1.2 Produce a full chronology from 6 May 2022 contact with Mental Health, Primary Health Care, and third sector services.

1.3 Identify the key practice episodes for analysis emerging from the chronologies, identify further key lines of enquiry (if appropriate).

1.4 Determine if CSH's healthcare needs and risks (of suicide/ and harm to others) were fully understood and that was reflected in the most recent treatment plans.

1.5 Determine if the design of the inpatient service, transition to (and from) community services (Including Home treatment teams) system, i.e. the management structure and governance system around the team(s) (e.g. policies, procedures, specifically case and risk management, supervision, confidentiality, and MCA), supported professionals to carry out their duties to the expected standard.

1.6 Confirm that Solent NHS Trust 's Domestic Abuse policy and procedures are compliant with the Hampshire Safeguarding Adults Multiagency Partnership's policy and procedures.

1.7 Comment on the support that was offered to CSH's family between 4 July and the 15 September 2022.

1.8 Having assessed the above, comment on relevant issues that may warrant further investigation.

1.9 Make recommendations for improvement for the Provider(s), ICB, and/or NHS England as appropriate.

1.10 Review the Provider's application of the Duty of Candour to the families involved.

## 2. Timescale

2.1 The review process starts when the investigator receives the Provider documents, and the review should be completed within 6 months thereafter.

## 3. Initial steps and stages

NHS England will:

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

3.2 Arrange an initiation meeting between the Provider, commissioners, investigator, and other agencies willing to participate in this review.

## 4. Outputs

4.1 We will require monthly updates and where required, these to be shared with families, ICB, and Providers

4.2 A final report that is easy to read and follow with a set of measurable and co-produced patient safety actions (NHS England style guide to be followed).

4.3 At the end of the review, to share the report with the Provider and meet the relevant families to explain the findings of the review and engage the ICB with these meetings where appropriate.

4.4 A final presentation of the review to NHS England, ICB, Provider Board, and to staff involved in the incident as required.
4.5 A briefing document of key learning points that can be published and shared with the Regions, ICBs, and Providers.
4.6 The investigator will deliver learning events/workshops for the Provider, staff, and commissioners if appropriate.

**5.Other**

5.1 Should the families formally identify any further areas of concern or complaint, about the care received or the final report, the investigation team should highlight this to NHS England for escalation and resolution at the earliest opportunity.

## APPENDIX 4

## Methodology

174. A comprehensive review was undertaken of the clinical records including previous reports, assessments, notes, and related correspondence.

175. All parties were offered the opportunity to check this report for factual accuracies.

176. As per Psychological Approaches' internal protocols, a confidential peer review of this report also took place.

177. This homicide was also subject to a Domestic Homicide Review (DHR) which was completed and sent to the Home Office DHR Quality Assurance Panel. These responded on the 23/10/24 requesting additional development in 7 areas before signing the review off. Prior to the commencement of this investigation, the author of this report was given access to the draft DHR report in order to build on its findings[12] and has seen the response by the Home Office QA Panel.

Documentation Reviewed

| Document | Organisation | Date Range |
|---|---|---|
| | | |
| The Care Programme Approach (National policy outgoing) | | 2022 |
| The community mental health framework for adults and older adults (National policy incoming) | | 2022 |
| Supporting adult carers NICE guideline [NG150 | NICE | |
| Violence and aggression: short-term management in mental health, health, and community settings [NG10] | NICE | |
| Psychosis and schizophrenia in adults: prevention and management [CG178] | NICE | |

[12] https://www.gov.uk/government/publications/revised-statutory-guidance-for-the-conduct-of-domestic-homicide-reviews

| Staff Interviewed | Position | Organisation |
|---|---|---|
| Service Manager, Mental Health Liaison Team, Queen Alexandra Hospital | | Southern Health NHS Foundation Trust |
| Consultant Old Age Psychiatrist, Mental Health Liaison Team, Queen Alexandra Hospital | | Southern Health NHS Foundation Trust |
| Head of Nursing – Adult MH Community Teams | | Southern Health NHS Foundation Trust |
| Acting Clinical Manager - CRHTT | | Solent NHS Trust |
| Access Service Manager. Previous position - Service Manager for CRHTT and A2i (March 2020 – August 2023) | | Solent NHS Trust |
| Senior Health Care Support Worker – CRHTT | | Solent NHS Trust |
| Head of Psychological Professions and Consultant Psychologist.<br><br>Previously in charge of all psychological services plus senior management role for the MH services for Quality Assurance in psychological therapies | | Solent NHS Trust |
| Previously held Position of:<br>In-patient Services Manager & Clinical Matron | | Solent NHS Trust |
| Operational Lead for Talking Change Service | | Solent NHS Trust |
| Locum Consultant Psychiatrist.<br>Summer of 2022 (Inpatient services) | | Formally with Solent NHS Trust |
| Charge Nurse the Orchards<br>Senior Nurse, (Charge Nurse) Hawthorn ward, where CSH was admitted | | Solent NHS Trust |
| CBT Therapist | | Solent NHS Trust |
| Previously Registered Nurse CRHTT | | Solent NHS Trust |
| Secretary A2I service | | Solent NHS Trust |
| Named nurse, Brooker ward 1 | | Solent NHS Trust |

| | | |
|---|---|---|
| Named nurse, Brooker ward 2 | | Solent NHS Trust |
| Staff We were unable to interview | Position | Organisation |
| Consultant Psychiatrist<br>Crisis Resolution Home Treatment Team (CRHTT), | | Formally with Solent NHS Trust |
| Staff who provided organisational support and information. | Position | Organisation |
| Patient Safety Specialist – Operational Lead<br>Quality and Governance Team | | Solent NHS Trust |
| Quality & Safety Manager (Legacy Solent) | | Solent NHS Trust |
| Interim Associate Director of Safeguarding | | IW/PHU Trusts |

# APPENDIX 5

## Our Ethos and Our Team

Psychological Approaches is a community interest company delivering a range of consultancy in collaboration with mental health and criminal justice agencies. Our focus is on the public and voluntary sector, enabling services to develop a workforce that is confident and competent in supporting individuals with complex mental health and behaviour (often offending) that challenges services. We have a stable team of six serious incident investigators, and offer a whole team approach to each investigation, regardless of the specific individual or panel chosen to lead on the investigation. Our ethos is one of collaborative solution-seeking, with a focus on achieving recommendations that are demonstrably lean – that is, achieving the maximum impact by means of the efficient deployment of limited resources.

## Independent Investigation Team Members

**Panel Chair - Mr John Enser, (RMN/RGN – DiP in Management / MSc in Health Services Management)**

John is a registered mental health and general nurse. He has 40 years' experience; initially in clinical practice, before moving into middle and senior management roles. For 10 years, he was an executive member of the Forensic Psychiatric Nurses Association (FPNA). John has designed and developed many new services including in-patient services, prison mental health and primary care, police and court liaison services and community. Inevitably, this has involved working with multiple agencies and reviewing incidents when things have gone wrong as part of the governance and assurance framework. Independently, and as a Director for Psychological Approaches, he has carried out reviews of other services which were experiencing difficulties and led on "deaths in custody" reviews. He previously was an Honorary Lecturer at Canterbury Christchurch University and has an MSc in Health Services Management.

**Dr Deborah Brooke, Psychiatric advisor to the panel**
Deborah is a Consultant Psychiatrist with over 40 years in the NHS.

Deborah qualified at Guy's, and trained in general practice in Nottingham, becoming interested in the problems of alcoholics. She trained in psychiatry in London, undertaking research at the Institute of Psychiatry before joining Oxleas NHSFT in 1996 as a consultant forensic psychiatrist. She retired from this post in 2016 and worked in an NHS service for sick doctors until 2022. She continues as the Appraisal Lead for Oxleas.

She has extensive experience in ensuring quality in postgraduate medical education and appraisal and has had a regulatory role for over fifteen years with the fitness to practice procedures – first as medical examiner and supervisor for the General Medical Council, then as a panellist for the Medical Practitioners' Tribunal Service.

Deborah has published research in both addictions and forensic psychiatry.

**Lisa Dakin, RNLD/RMN, MSc in Forensic Mental Health**

A learning disability and mental health inpatient, prison, and community specialist. Lisa is a Mental Health & Learning Disability Nurse Consultant and specialist in secure inpatient and prison healthcare, with over 30 years of experience working as a nurse leader in forensic & prison mental health and learning disability services. She was formerly Head of Nursing and Associate Clinical Director for Forensic & Prison services in a large NHS Trust. Lisa has considerable experience of independent incident investigations across complex mental health care pathways, including acute, forensic, prison and community services. Lisa has undertaken a number of Mental Health Homicide Reviews (MHHR) on behalf of NHS England, including those conducted in parallel with Domestic Homicide Reviews (DHR). Lisa has an MSc in forensic mental health and undertook postgraduate training in leading & managing partnership working. She has recently completed Healthcare Safety Investigation Branch (HSIB), Safety Investigation Training at level 2.