An independent investigation into the care and treatment of a mental health service user Mr S

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Contents

Acknowledgments to the families of Mr S and Mrs S.

Caring Solutions would like to offer their deepest sympathies to the family of Mrs S. It is our sincere wish that this report does not contribute further to their pain and distress.

Caring Solutions also wish to thank both Mr S and members of his family for agreeing to meet with Caring Solution's investigation team, their contribution has been of great assistance to enable a greater understanding of the events that led up to the incident in April 2014.

Acknowledgement of participants:

Caring Solutions investigation team would like to acknowledge the contribution and support given by staff from Lancashire Care Foundation NHS Trust and Lancashire Constabulary during the course of this investigation. Their assistance has provided us with a more comprehensive understanding of the pertinent issues in this case.

Executive summary

In April 2016 NHS England (North) commissioned Caring Solutions to undertake an independent investigation into the care and treatment of Mr S, the events that led up to the death of Mrs S and to consider if the incident was predictable[1] or preventable.[2]

Summary of Incident:
On 29 of April 2014, at approximately 16:30, Mr S arrived at one of Lancashire Care NHS Foundation Trust's (LCFT) satellite mental health units and disclosed that he had killed his ex-wife at their home. A post-mortem concluded that Mrs S died of asphyxiation. Mr S pleaded guilty to the murder of his ex-wife and was given a life tariff with a minimum sentence of 14 years.

Mr S was last seen, on 24 April 2014, at his home by his care coordinator from LCFT Complex Care and Treatment Team (CCTT). At the time Mr S had the following mental health diagnoses: post-traumatic stress disorder (PTSD), depression and an anxiety disorder.

From January 2014 Mr S had several emergency hospital admissions due to him experiencing acute abdominal pains.

Summary of background information:

Mr S's psychiatrist history: Mr S reported that throughout his childhood he experienced significant emotional and physical abuse and neglect. From the age of 12 years Mr S had a number of convictions for assaults and criminal activities. Mr and Mrs S couple divorced in 1987 but remained living in the same accommodation. After the death of their teenage daughter, from a drug overdose, Mr S begun to experience significant mental health issues and that his ex-wife increasingly assumed the role of his carer.

In 2002, 2003, 2004 and 2009 Mr S was sporadically presenting himself, to his GP reporting that he was suffering on-going symptoms of anxiety and depression which he thought were related to his daughter's death.

Mrs S psychiatric history: In 2013 Mrs S was referred to an Improving Access to Psychological Therapy (IAPT) counsellor where she disclosed incidents of historical and recent incidents of domestic violence and that she was fearful of her

[1] Predictability is "the quality of being regarded as likely to happen, as behaviour or an event". We will identify if there were any missed opportunities which, if actioned, may have resulted in a different outcome. An essential characteristic of risk assessments is that they involve estimating a probability. If a homicide is judged to have been predictable, it means that the probability of violence, at that time, was high enough to warrant action by professionals to try to avert it. . Predictability

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

ex-husband who she reported had said that he "would kill her if she left and she believed him."[3]

The IAPT therapist suggested to Mrs S that such was her concern for her safety that she wanted to report the most recent incident to the LCFT's adult safeguarding team. Mrs S refused to give her permission but she did agree that the therapist could contact them for advice. The adult safeguarding team advised the IAPT therapist that as Mrs S had "capacity she was in effect choosing to stay in a risky situation which [was] her right." [4] The IAPT therapist's discharge letter, in which she outlined both her concerns about Mrs S's safety and the history of domestic violence, was sent with Mrs S's permission to both Mr S's GP and Mr S's CCTT care coordinator.

Mrs S's carer's assessment: On 30 May 2013 Mrs S had a carer's assessment which was undertaken by Mr S's care coordinator. During the assessment Mrs S did not disclose any information about the history of domestic violence. Following this assessment Mrs S was referred to the third sector organisation that was, at the time, commissioned by the Local Authority to provide carers support in the locality.[5]

The last face to face meeting as Mrs S was on 14 February 2014. Four days before her death (25 April 2014) she phoned her support worker reporting that she was finding her ex-husband's on-going physical health issues extremely difficult to manage and requested an appointment. It is not evident if an appointment was offered but the support worker advised Mrs S to try and have some respite time.

Mr S's involvement of community mental health services from 2012: Mr S was referred by his GP to the Single Point of Access (SPoA) for an assessment. He was subsequently referred to CCTT and allocated a care coordinator who visited him at his home. Mr S was also being reviewed by the CCTT's psychiatrist.

Psychology intervention: Mr S was also referred to a psychologist and was initially seen, with Mrs S, on 8 August 2013. Apart from two sessions,[6] when the psychologist saw Mr and Mrs S individually, they were seen together until 10 January 2014. The focus of the therapy was on reducing Mr S's anger and aggression and supporting him to develop alternatives strategies in order to manage his complex feelings.

[3] Progress notes 26 April 2013

[4] Progress notes 8 March 2013

[5] Since this incident the service has been recommissioned to another third sector organisation

[6] 24 September and 3 October 2013

On several occasions Mr and Mrs S disclosed to the psychologist both historic and recent incidents of domestic violence, coercive and controlling behaviours: for example Mrs S reported "that she has not dismissed the possibility that [her ex-husband] might kill her if he is not able to control his temper."[7] On another occasions Mrs S reported that her ex-husband "usually smashed objects when he got too angry, but he did not attack her. However, she stated that there [were] times when she felt unsafe, especially when [he] grabbed her or when he became angry."[8] The psychologist showed Mr and Mrs S several techniques that she suggested they could utilise in order to defuse situations that had the potential of violence and/or intimidation. On several occasions the couple reported that they had found these techniques useful.

The psychologist informed Mr and Mrs S that it was her intention to inform Mr S's care coordinator of their disclosures regarding domestic violence. On two occasions she emailed [9] the care coordinator outlining a summary of the couple's disclosures of domestic violence.

Mr S's physical health: from January 2014 it was being documented by the GP, care coordinator and his psychologist that Mr S was becoming increasingly concerned about his physical health. He also was admitted three times to hospital as an emergency admission. Despite numerous diagnostic tests being undertaken no aetiology[10] was identified. On several occasions both the doctors and the care coordinator suggested to Mr S that his symptoms may have been either due to functional abdominal pain syndrome[11]or were psychological but Mr S repeatedly refused to consider either as possible cause.

During this period Mr S was expressing to his care coordinator and CCTT's psychiatrist his increasing health anxieties and frustrations that his ex-wife was not taking his symptoms seriously. In a summary letter[12] written by the consultant psychiatrist to the GP it was documented that Mr S "was very preoccupied about his physical health. He was frustrated and appeared angry on occasions especially when he was interrupted by his ex-wife."[13]

[7] Care notes 11 October 2013

[8] Mr S's care notes 16 September 2013

[9] This commination was not dated, not clear if it was an email

[10] Aetiology, set of causes, or manner of causation of a disease or condition

[11] Functional abdominal pain syndrome (FAPS) is a condition of abdominal (belly) pain that is long-term or keeps coming back. The pain is not linked with changes in bowel pattern – constipation and/or diarrhoea. It occurs because of abnormal functioning of nerve impulses in the abdomen and brain. The nerves become overly sensitive FAPS.

[12] 7 March 2014

[13] Correspondence from CCTT consultant psychiatrist 7 March 2014, p2

Findings:

Domestic Violence: During the couple's involvement with secondary mental health services they were disclosing a number of significant risk indicators of potential domestic abuse: for example Mrs S was reporting that she was becoming increasingly "isolated and was not getting any practical and/or emotional support from their family, friends."[14] Mr S was observed treating his ex-wife "with a lack of respect or courtesy." Mrs S also disclosed recent incidents of her ex-husband "engaging in abusive, aggressive and controlling behaviour"[15]and on more than one occasion she disclosed that she was fearful for her life.

The care coordinator reported to Caring Solution's investigation team that she had been aware that there was some historical domestic abuse and that their relationship was very complex. She also reported that given the significant time that has elapsed since the incident she was unable to recall receiving either the emails from the psychologist or the IAPT therapist's discharge letter. She had observed that in the months leading up to the incident Mr S's physical health concerns had placed considerable pressure on Mrs S. However as she had never witnessed any evidence of domestic violence she did not inquire or have any particular concerns about Mrs S being at risk.

LCFT's Domestic Abuse Policy, [16]which was in place at the time of the incident, directed that:

> ""Identifying domestic abuse is a routine part of health assessment… By ensuring routine enquiry is carried out LCFT staff will give victims the opportunity to disclose and help them to have the confidence that they will be believed... All disclosures of domestic abuse should be taken seriously… [practitioners] must be aware of and understand the indicators which lead to domestic abuse …also be aware that often a victim may not realise the extent of risk and may minimise the actual risk factors. Health practitioners should use the CAADA DASH[17] Risk Assessment to assess level of risk."[18]

Apart from the IAPT therapist no other involved clinician sought advice or guidance from the Trust's Safeguarding Department, nor was there any consideration given, by the practitioners who had been aware of either the historic or more recent

[14] Adass Carers and Safeguarding Adults –Working together to improve outcomes April 2011, p 11 ADASS

[15] Adass Carers and Safeguarding Adults –Working together to improve outcomes April 2011, p 11 ADASS

[16] LCFT's Domestic Abuse Policy Incorporating Forced Marriage, Honour Based Abuse and Female Genital Mutilation April 2011

[17] CADDA is now referred to SAFELIVES

[18] LCFT's Domestic Abuse Policy Incorporating Forced Marriage, Honour Based Abuse and Female Genital Mutilation August 2013, p14

incidents of domestic violence, to utilising a domestic violence risk assessment such as CAADA DASH.[19]

Research into the identification of potential victims and perpetrators of domestic violence within the complex dynamics of the caring relationship suggests that "carers can often become hidden victims of abuse."[20] It is also suggested that:

"the challenges that face professionals in identifying, reporting and responding to those carers who at risk can be complex but the recognition of risk of harm or potential harmful behaviour is critical to the prevention and protection of the carers."[21]

Caring Solution's investigation team was informed that CCTT's staff are required to complete Safeguarding Training Level 3. When an involved practitioner was asked about the level of safeguarding training she had received she reported that she was unable to recall. [22] Although it is acknowledged that this is feedback from one individual it was a concerning comment and may be indicating that there is an underpinning deficit in supporting trainees to evaluate, consolidate and embed their learning from training into their practice. We would, therefore, suggest that LCFT should consider introducing a process for evaluating the effectiveness of their training, for example the Kirkpatrick Model.[23]

Risk assessments and risk management: Two Safety Profiles were completed by CCTT care coordinator: The initial profile (11 February 2013) assessed that Mr S's risk to others, treatment /illness related risk and social circumstances were "medium." The next Safety Profile (3 December 2013) concluded that there was no current risk of Mr S "harming others" and all his risks had all been reduced to "low."

LCFT's Clinical Risk Policy at the time stated that:

"Risk assessment can, therefore, be described as a dynamic process based on an estimation of the likelihood and severity of particular adverse events occurring under particular circumstances within a specified period of time. It is the gathering of information about clinical presentation, risk behaviour and risk history, and an analysis of the potential outcomes of identified behaviour. The nature, frequency, and severity of the risk behaviour must all be considered."[24]

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[19] The purpose of the Dash risk checklist is to give a consistent and simple tool for practitioners who work with adult victims of domestic abuse in order to help them identify those who are at high risk of harm and whose cases should be referred to a MARAC meeting in order to manage their risk CAADA DASH

[20] Adass Carers and Safeguarding Adults –Working together to improve outcomes April 2011, p 11 ADASS

[21] Adass Carers and Safeguarding Adults –Working together to improve outcomes April 2011, p 12 ADASS

[22] Reported that annually they have 30 days training plus Continual Professional Development (CPD)

[23] The Kirkpatrick Model

[24] LCFT Clinical Risk Management Policy January 2012 , p 6-7

In the review of Mr S and Mrs S's historical and current circumstances, that was known by some of the involved practitioners, it is evident that Mr S had many of the risk factors that were identified within LCFT's Clinical Risk Management Policy: for example his demographic, background history, psychological and psychosocial factors, current context .[25] It was also known that Mr S's violent behaviour was directed towards one person, his ex-wife. Yet despite this guidance Mr S was assessed at low risk in regard to potential risk of harm to Mrs S and others.

The Royal College of Psychiatrist suggest that:

"The basis of all violence risk assessment is that past behaviour is the best guide to future behaviour. It follows that the most important part of risk assessment is a careful history of previous violent behaviour and the circumstances in which it occurred." [26]

The College also suggests that if in an assessment of the patient there is concern regarding their risk of harm to others it should "trigger a more structured risk assessment process, with the use of an assessment tool that is appropriate for the group, such as a HCR-20 assessment.[27] As none of Mr S's assessments indicated that this was a significant potential risk of domestic violence there was no consideration that a more in depth assessment was required. Nor was there any consideration of referring the case either to the independent domestic advisors, who worked closely with the police, or to Multi-Agency Risk Assessment Conferences (MARAC).[28]

Based on Caring Solution's findings it was concluded that despite the numerous disclosures that were being made by both Mr and Mrs S the safety profiles clearly failed to adequately identify the extent of possible future risks of harm to Mrs S. As a consequence it failed to establish a relevant risk management and crisis plan for either Mr S.

There was also no evidence that either the psychologist or Mr S's GP were invited to contribute to the risk assessment or subsequent reviews. Despite LCFT's policy directing that:

[25] LCFT Clinical Risk Management policy, January 2012, p14-15

[26] Rethinking risk to others in mental health services Royal College of Psychiatrists London 2016, p24 Rethinking risk

[27] HCR-20 V3 is a comprehensive set of professional guidelines for the assessment and management of violence riskHCR-20

[28] A MARAC is a meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs), probation and other specialists from the statutory and voluntary sectors MARAC .

"Effective communication and sharing information within the mental health team, with other relevant practitioners (including General Practitioners) and between agencies is essential, and information sharing arrangements must be documented."[29]

Care planning: as part of Mr S's initial assessment with CCTT a care plan was completed on 28 March 2013 by the CCTT care coordinator, it was reviewed on 3 December 2013. Both Mr and Mrs S were involved in these assessments. LCFT's Care Programme Approach Policy (July 2013) that was in place at the time emphasised that the:

"Two central components of the CPA are the role of the care co-ordinator who has overall responsibility for the coordination of the assessment and care planning processes in partnership with the Service User and Carer, and multidisciplinary team working… Collaboration and communication about risk are vitally important components of good and safe practice."[30]

Again despite this directive there was no evidence that the psychologist and/or the GP were asked to contribute to either the initial and subsequent care planning reviews.

Hospital Discharge Summaries: Caring Solution's investigation team were informed that at the times and currently patients' discharge summaries, from an acute inpatient admission, are only sent to their primary care service.

In this case Mr S's GP did not communicate the information, such as Mr S's medication regime, to either his CCTT's care coordinator or his consultant psychiatrist. The care coordinator also reported that she had not liaised with the GP but had relied on information being provided by Mr and Mrs S.

Although there was evidence that LCFT's CCTT sent letters to the GP after each of Mr S's outpatient's appointment and on his discharged from the psychologist. The GP, who mainly saw Mr and Mrs S in the months leading up to the incident, reported to Caring Solution's investigation team that in Mr S's case, and in general, the surgery does not have any direct communication with care coordinators from the community mental health service.

Caring Solution's investigation team concluded that with a patient such as Mr S, who was presenting with such a complex profile and who was being discharged from inpatient admission with a significant combination of medication, that it is of the utmost importance that information is shared between all involved agencies. In

[29] LCFT Clinical Risk Management policy, January 2012, p6

[30] LCFT Care Planning Approach Policy July 2013, p 5 and 9

this case it would have enabled a more coordinated and informed care to be provided to Mr S. It would also have enabled the CCTT's care coordinator and consultant psychiatrist to assess and consider Mr S's emerging needs in order to identify any new potential risks factors: for example the effects Mr S's medication was having on his impulse control and anger management towards others especially his ex-wife.

It is also suggested that the GP, with the patient's consent, should be providing the care coordinator with a copy of any discharge summaries that they receive.

Lancashire Multi-Agency Carers Strategy (2013-2015)[31] that was in place at the time outlined all services' commitment to provide a comprehensive provision of carer's services that provide emotional, practical, financial, peer and educational support.

In the review of both the initial carer's assessment and the on-going support provided to Mrs S there was little evidence of any ongoing assessments being undertaken, nor was she offered any other carer's services apart from the monthly meetings with the support worker. The evidence also indicated that there was no review process undertaken.

Since the incident a revised carer's assessment (common assessment framework) form has been introduced. The assessment now askes the carers "Have you ever felt distressed or in danger due to the behaviour of the person you care for?" This focused question will hopefully enable carers, such as Mrs S, to feel able to disclose information. However, based on the review of the local strategies that currently exist it remains unclear that once such a disclosure has been made who/or which agency has the responsibility for assessing and monitoring the potential risks.

One of the recommendations of this investigation is that when there has been a disclosure of potential or historic abuse that a 'keeping safe plan' is developed and that it should be reviewed on a regular basis and certainly when the carer or other agencies reported any change in their situation that may affect any potential risk(s) factors.

Review of Lancashire Care NMS Foundation Trust's internal investigation: Following this incident LCFT was required to complete an Independent Management Review (IMR) which was submitted to the Domestic Homicide Review panel. Caring Solution's investigation team concluded that LCFT satisfied all the DHR's keys lines of enquiry and their IMR recommendations were proportionate and comprehensive.

[31] Lancashire Multi-Agency Carers Strategy 2013-2015 Carers Strategy

LCFT's IMR made four recommendations: from the evidence provided to the Caring Solution's investigation team it was evident all the action plans have been fully implemented.

LCFT's Head of Risk, Safety and Quality Governance also provided evidence that since this incident there have been significant improvements with regard to the commissioning of serious incident investigations, DHRs, complaints and the monitoring of action plans.

Predictability and preventability: Predictability: Caring Solutions investigation team concluded that it was predictable or highly likely, that some form of violence and/or aggression would continue within Mr and Mrs S's relationship. However, what was not predicable was that the violence would, on that day, escalate to the extent that Mr S would take the life of Mrs S.

Preventability: It was evidence that on numerous occasions Mr and Mrs S were disclosing to various agencies, both individually and as a couple, that incidents domestic violence continued to remain a significant feature within their relationship. However there was a consistent failure on the part of the involved practitioners to document and/ or consider the potential risk(s) within Mr S's safety profile and care plans.

Despite this deficit being of great concern Caring Solution's investigation team have concluded that even if the individual practitioners had acted responsively to the information that was available given the complexities of the relationship and the fact that Mrs S clearly had capacity to make the decision to remain in the relationship the involved practitioners did not have the means to prevent the incident. Therefore it is concluded that the death of Mrs S was not preventable.

Concluding Comments: It was evident to Caring Solution's investigation team that the individual practitioner's involved in providing care to Mr and Mrs S were very committed in trying to support this couple. However it was evident that the treatment plan, which involved a combination of medication, psychological and care support, was largely ineffective. The true extent of both Mr and Mrs S's historic and recent emotional, psychological and physical abuse remained only partially understood but the evidence clearly indicated that it was a very complex relationship.

A recent Home Office Domestic Homicide Review [32](December 2016) presented an analysis of the following trends:

[32] HO Domestic Violence Review

"Mental health issues were present in 25 of the 33 intimate partner homicides…Risk assessment was the next most commonly occurring theme... Communication and information sharing between agencies was identified as an issue in 25 out of 33 (76%)… professionals were noted as having lacked 'professional curiosity' or taken things at face value."[33]
Clearly during the course of Caring Solutions' investigation there was ample evidence of all of the above issues. Although none of the deficits have been identified as root causes they were all contributing factors to the deficits in the assessments of the potential risks of domestic violence within this vulnerable couple's complex relationship.

Recommendations

Lancashire County Council, Lancashire Care NHS Foundation Trust, Clinical Commissioning Group and other third sector providers.

Recommendation 1: Agencies who are currently responsible for undertaking carer's assessment and providing carers services need to review their current protocols for:

- Responding to disclosures of actual or potential risk of abuse of carers.
- Identifying in what circumstances would there be an escalation of information sharing.
- A review of the allocation and role of the care coordinator to identify their responsibilities for liaising with other involved services as part of both the initial assessment and during the review process.

Lancashire County Council, Lancashire Care NHS Foundation Trust, Clinical Commissioning Group and third sector providers.

Recommendation 2: In order to standardise and improve the quality of assessments and reviews of carer's needs and risks, consideration should be given to introducing one set of assessment and review proformas that are used by all carer's services within Lancashire.

Lancashire County Council, Lancashire Care NHS Foundation Trust, Clinical Commission Group and third sector providers.

Recommendation 3: Consideration should be given to introducing a "keeping safe plan" within all support plans which also addresses the carer's possible fears around care alternatives for the person they are caring for and the consequences that may arise if action is taken.

[33] Home Office Domestic Homicide Review December 2016, p3-9

Lancashire Care NHS Foundation Trust and Clinical Commissioning Group.

Recommendation 4: In order to improve information sharing between primary care and Lancashire Care NHS Foundation Trust's community mental health services consideration should be given to strengthening a joint information sharing protocol. Such a protocol should identify both agencies' responsibilities for:

- Information sharing following a patient's discharge from an acute inpatient admission.
- Joint responsibility for on-going communication between a patient's primary care and care coordinator.
- Involvement of primary care in a patient's care planning reviews by mental health services.

Lancashire Care NHS Foundation Trust and N Compass.

Recommendation 5: In order to evaluate whether the issues and deficits highlighted within this report are systemic within Lancashire Care NHS Foundation Trust's Complex Care and Treatment Team and/ or the N Compass service; both should consider undertaking an audit of a number of patients involved with both services. This audit should also include a review of the current interagency information sharing protocol and involvement in care planning and care planning reviews.

Lancashire Care NHS Foundation Trust.

Recommendation 6: Lancashire Care NHS Trust should consider introducing an alert system on their Electronic Care Record System which alerts the clinician when new correspondence has been unloaded onto a patient's records.

Lancashire Care NHS Foundation Trust.

Recommendation 7: A quality audit should be undertaken of care plans and safety profiles and reviews completed by the Complex Care and Treatment Team to ascertain if practitioners are accurately identifying and assessing the levels of risk(s). Where deficits are identified with specific practitioners then the appropriate training and management guidance should be provided.

Lancashire Care NHS Foundation Trust.

Recommendation 8: Lancashire Care NHS Foundation Trust should review its

current guidelines within their Safeguarding Policy to ensure that it provides clear directives as to when and in what circumstances staff should be consulting the Trust's safeguarding team to seek advice and guidance.

Lancashire Care NHS Foundation Trust.

Recommendation 9: The members of both the Complex Care and Treatment Team and psychologist who were involved in this case should receive additional training on their role, responsibilities and actions that is expected to be taken when there has been a disclosure and/or report from another service of either historical and/or recent incidents of domestic abuse.

Lancashire Care NHS Foundation Trust.

Recommendation 10: An audit should be undertaken within the Complex Care and Treatment Team, including the psychologist team, to highlight any current cases where domestic abuse maybe a feature to ensure that staff are:

- Taking the appropriate and proportionate action is being taken.
- Seeking the appropriate guidance from Lancashire Care NHS Foundation Trust's safeguarding team and their senior managers and supervisors.
- Awareness of when to utilise assessments, such as CAADA DASH.

Lancashire Care NHS Foundation Trust.

Recommendation 11: In order to ensure that there is a process utilised to evaluate, maximise and demonstrate the value of its training programme to both the trainee and the organisation Lancashire Care NHS Trust should consider adopting a recognised training evaluation tool such as the Kirkpatrick Model.

1 Offence

1.1 On 29 of April 2014, at approximately 16:10, Mr S drove to his nephew's house; he posted his car keys and wallet through the letter box. He then walked to one of Lancashire Care NHS Foundation Trust's (LCFT) satellite mental health units.

1.2 At approximately 16:30 Mr S arrived at the unit reportedly in a distressed state. He initially disclosed to a primary care mental health practitioner and then to a social worker and consultant psychiatrist that he had killed his ex-wife at their home. Mr S also reported that he was experiencing severe abdominal pains.

1.3 The unit contacted the emergency services who attended the home of Mr and Mrs S. The body of Mrs S was discovered in one of the bedrooms of the property.

1.4 A Home Office post-mortem concluded that Mrs S died of asphyxiation.

1.5 Mr S was arrested and subsequently pleaded guilty to the murder of his ex-wife.

1.6 At the time of Mr S's arrest toxicology tests indicated that the medication[34]he was being prescribed were within expected therapeutic levels.

1.7 Mr S was given a life tariff with a minimum sentence of 14 years before he would be eligible for parole.

1.8 During the week before the incident a friend reported[35] that both Mr and Mrs S were at "the end of their tether with his illness."[36] She also reported that on the Friday before the incident she had become particularly concerned about Mr S as she had received a "frantic' phone-call from him saying that he was in unbearable pain."[37] During the phone call she had heard Mrs S in the background shouting.

1.9 This friend also reported that she had made two telephone calls to the mental health services to highlight her concerns about both Mr and Mrs S. There were no documented records of these calls within Mr S's patient records.

[34] Dihydrocodeine, fentanyl Diazepam, Bisoprolol Amitriptyline

[35] Domestic Homicide Report , p46

[36] Domestic Homicide Report, p46

[37] Domestic Homicide Report, p46

1.10 Mr S was last seen on 24 April 2014 at his home by his care coordinator from LCFT's Complex Care and Treatment Team (CCTT), Mrs S was present. At one point during the visit Mr S became verbally aggressive towards Mrs S, accusing her of not understanding his on-going physical pain and his health anxieties.

1.11 From January 2014 Mr S had several emergency admissions to hospital due to him experiencing acute abdominal pains. Despite numerous diagnostic tests no aetiology[38] was found.

1.12 On 25 April 2014 Mrs S had telephoned her support worker from the carer's support service to arrange an appointment, she disclosed that she needed support because of her ex-husband's continual health anxieties. Her support worker advised Mrs S to February

1.13 try and take short respite time away from her ex-husband.

1.14 Mr and Mrs S divorced in 1987 but they remained living in the same accommodation. At the time of her death Mrs S had assumed the role of carer to her ex-husband.

1.15 Both Mr and Mrs S repeatedly reported to agencies that after their teenage daughter died of a drug overdose in 2001 Mr S had begun to experience significant mental health symptoms. He was diagnosed with post-traumatic stress disorder (PTSD), depression and an anxiety disorder.

2 Independent investigation

Approach to the investigation

2.1 From 2013 NHS England assumed overarching responsibility for the commissioning of independent investigations into mental health homicides and serious incidents. On 1 April 2015 NHS England introduced its revised Serious Incident Framework[39] which aims:

> "To facilitate learning by promoting a fair, open and just culture that abandons blame as a tool and promotes the belief that an incident cannot simply be linked to the actions of the individual healthcare staff involved but rather the system in which the individuals were working. Looking at what was wrong in the system helps organisations to learn lessons that can prevent the incident recurring."[40]

[38] Aetiology, set of causes, or manner of causation of a disease or condition

[39] NHS Serious Incident

[40] NHS Serious Incident p10

2.2 The following criteria for the commissioning of an independent investigation within the Serious Incident Framework is:

> "When a homicide has been committed by a person who is or has been in receipt of care and has been subject to the regular or enhanced care programme approach, or is under the care of specialist mental health services in the 6 months prior to the event."[41]

2.3 The framework also cites that a standardised approach to the investigation of such incidents is to:

> "Ensure that mental health care related homicides are investigated in such a way that lessons can be learned effectively to prevent recurrence. Facilitate further examination of the care and treatment of the patient in the wider context and establish whether or not an incident could have been predicted or prevented, and if any lessons can be learned for the future to reduce the chance of recurrence. Ensure that any resultant recommendations are implemented through effective action planning and monitoring by providers and commissioners."[42]

2.4 In April 2016 NHS England (North) commissioned Caring Solutions to undertake an investigation into the events that led up to the homicide of Mrs S on 29 April 2014.

Purpose and scope of the investigation

2.5 The full Terms of Reference (ToR) for this investigation are located in appendix B.

2.6 Briefly the aim of this investigation is to :

- "Undertake a proportional review of the care, treatment and services provided by the NHS and other relevant agencies from (Mr S's) first contact with mental health services to the time of the offence.
- Consider the appropriateness of the care and treatment pathways in line with national standards, best practice and the Trust's policies.
- To review the communication between agencies and services with regard to the assessment of risks and information sharing.
- Examine the effectiveness of (Mr S's) risk assessments and care plans.

[41] NHS Serious Incident p47

[42] NHS Serious Incident p48

- To consider whether the incident on 29 April 2014, which led to the death of Mrs S, was predictable[43] or preventable.[44]

- Provide support to Lancashire Care NHS Foundation Trust and their commissioners (CCG) to develop robust, outcome focussed action plans based on the report's recommendations."

2.7 The overall aim of this investigation is to identify common risks and opportunities, to improve patient safety and to make recommendations regarding both organisational and system learning.

2.8 The ToR has also asked that Caring Solutions reviewed and comment on LCFT's Individual Management Review (IMR),[45] which was completed for the Domestic Homicide Review (DHR), in order to ascertain if:

- The internal investigation satisfied the key lines of enquiry set by the Domestic Homicide Review Chair.

- Recommendations were appropriate and comprehensive.

- Identified actions had been effectively implemented.

2.9 The supplementary TOR also requested that Caring Solutions support both LCFT and NHS England (North) commissioner to:

> "Develop robust, outcome focussed action plans based on the report's recommendations…. Support the commissioners to develop a structured plan to review implementation of the action plan. This should include a proposal for identifying measurable change and be comprehensible to service users, carers, victims and others with a legitimate interest"

2.10 Prior to the publication of this report we intend to meet with LCFT and other stakeholders, N-compass, Lancashire County Council (LCC) and Clinical Commissioning Group (CCG), in order to support them to develop an action plan(s) that addresses the findings of this report.

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[43] Predictability is the quality of being regarded as likely to happen, as behaviour or an event". We will identify if there were any missed opportunities which, if actioned, may have resulted in a different outcome. An essential characteristic of risk assessments is that they involve estimating a probability. If a homicide is judged to have been predictable, it means that the probability of violence, at that time, was high enough to warrant action by professionals to try to avert it.

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

[45] IMR is an account of an agency's role in how they dealt with a particular case. The aim of an IMR is to allow agencies to look openly and critically at individual and organisational practice and the context within which people were working to see whether the homicide indicates that changes could and should be made; identify how those changes will be brought about; and, identify examples of good practice within agencies. IMR

2.11 After the report has been published Caring Solutions will agree with NHS England (North) the timetable and format to review the stakeholders' implementation of their action plans.

Caring Solutions investigation team

2.12 Caring Solutions (UK) Ltd is a mental health and learning disability consultancy company who has extensive experience in undertaking complex investigations following serious incidents and unexpected deaths within health and social care sectors.

2.13 The lead investigator for this case was Grania Jenkins. Grania is a senior mental health care, performance and quality professional who has worked in primary, secondary and third sectors. Grania has extensive experience of undertaking investigations into suicides and unexpected deaths, critical and serious incidents, complaints, cases of gross misconduct as well as Root Cause Analysis investigations and thematic reviews. Since 2014 Grania has being the lead investigator for homicide investigations under NHS England's Serious Incident Framework.

2.14 Dr Michael Rosenberg provided expert psychiatric advice to the panel. Dr Rosenberg was previously the Consultant Psychiatrist for an Inpatient Triage, service, Medical Director and Chief Executive for an NHS Foundation Trust. Dr Rosenberg is an approved doctor under Section 12(2) of the Mental Health Act 1983 and has extensive experience of investigating critical incidents. He has completed a large number of external reviews into services including independent homicide investigations on behalf of Caring Solutions (UK) Ltd.

2.15 The report was peer reviewed by Maggie Clifton Caring Solutions Investigations Manager. Maggie is a social scientist, specialising in qualitative research in health and social policy and a general manager with extensive experience working in both the voluntary and NHS sectors.

2.16 For the purpose of this report, the investigation team will be referred to in the first person plural.

Domestic Homicide Report

2.17 Following this incident a Domestic Homicide Review (DHR) was commissioned by Chorley and South Ribble Community Safety Partnership.

2.18 The DHR was completed and submitted to the Home Office on 15 September 2015.

2.19 Where the following report references information that has been obtained from the DHR it is cited within the respective footnote.

Methodology

2.20 Root Cause Analysis (RCA)[46] methodology has been utilised within this report to review the information obtained throughout the course of this investigation.

2.21 RCA is a retrospective multidisciplinary approach designed to identify the sequence of events that lead to an incident. It is an iterative[47] structured process that has the ultimate goal of the prevention of future adverse events by the elimination of latent errors.

2.22 RCA provides a systematic process for conducting an investigation, looking beyond the individuals involved and seeking to identify and understand the underlying system features and the environmental context in which an incident occurred. It also assists in the identification of common risks and opportunities to improve patient safety and informs recommendations regarding organisational and system learning.

2.23 The prescribed RCA process includes data collection and a reconstruction of the event in question through record reviews and participant interviews.

2.24 Where relevant we have referred to national and local policies and guidelines, to the various Department of Health (DH) Best Practice[48] guidelines and to the relevant NICE[49] guidance.

2.25 As far as possible we have tried to eliminate or minimise hindsight or outcome bias[50] in our investigation. We analysed information that was available to primary and secondary care services at the time. However, where hindsight has informed our judgments this has been identified.

Interviews

2.26 As part of this investigation we interviewed the following LCFT's practitioners:

- Complex Care Treatment Team (CCTT) Care Coordinator.

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[46] Root Cause Analysis (RCA) is a technique and process that helps answer the question of why a problem may have occurred. It seeks to identify the origin of a problem using a specific set of steps, with associated tools, to find the primary cause of the problem Root Cause Analysis

[47] Iteration is the act of repeating a process with the aim of approaching a desired goal, target or result

[48] DH (March 2008), Refocusing the Care Programme Approach Policy and Positive Practice and Code of Practice Mental Health Act 1983 (revised) CPA

[49] NICE: National Institute for Health and Care Excellence NICE

[50] Hindsight bias is when actions that should have been taken in the time leading up to an incident seem obvious because all the facts become clear after the event. This leads to judgment and assumptions around the staff closest to the incident. Outcome bias is when the outcome of the incident influences the way it is analysed. For example, when an incident leads to a death, it is considered very differently from an incident that leads to no harm, even when the type of incident is exactly the same. When people are judged one way when the outcome is poor and another way when the outcome is good, accountability may become inconsistent and unfair. (NPSA 2008) NPSA

- CCTT Social Worker.
- Locality Manager Single Point of Access and CCTT.
- Consultant psychiatrist from Single Point of Access and CCTT.
- Clinical Psychologist.
- Head of Risk, Safety and Quality Governance.
- Staff Nurse.
- Head of Quality Improvement and Experience.
- Associate Director of Quality and Experience.
- Associate Director for safeguarding: (telephone interview).
- Investigation and Learning Specialist author of the IMR (telephone interview).
- Director of Carers Support Service (telephone interview).

2.27 We undertook a telephone interview with Mr S's last primary care physician (GP).

2.28 We met with a member of Lancashire Constabulary.

2.29 Caring Solution's interviews are managed with reference to the National Patient Safety Agency (NPSA) investigation interview guidance[51] and adhere to the Salmon/Scott principles.[52]

2.30 We had access to the following:

- Mr S's LCFT's clinical records.
- Mr S's primary care notes.
- Mrs S's LCFT's Improving Access to Psychological Therapies programme (IAPT) notes.
- Mrs S's carers assessment (30 May 2013).
- Police's investigation and arrest records (redacted).
- Post arrest assessment.

[51] National Patient Safety Agency (2008) Root Cause Analysis Investigation Tools: Investigation interview guidance NPSA

[52] The 'Salmon Process' is used by a public inquiry to notify individual witnesses of potential criticisms that have been made of them in relation to their involvement in the issue under consideration. The name derives from Lord Justice Salmon, Chairman of the 1996 Royal Commission on Tribunals of Inquiry, whose report, amongst other things, set out principles of fairness to which public inquiries should seek to adhere Salmon/Scott

- Court transcripts.
- Bolton NHS Foundation Trust Notes.
- Domestic Homicide Review Report.

2.31 We also referred to the relevant LCFT and other stakeholders' policies which were in place at the time and also those that have subsequently been reviewed.

Anonymity

For the purpose of this report:

2.32 The identities of all those who were interviewed have been anonymised and they will be identified by their professional titles.

2.33 The patient is referred to as Mr S and the victim as Mrs S.

Structure of the report

2.34 This report has been divided into various sections. Where it is required, some sections have an arising issues and commentary subsection, which provides additional information that we have obtained and/or a commentary and analysis of the issues that have been highlighted within that section.

2.35 At the end of each section there are the associated recommendations. There is also a full list of all the recommendations in section 12.

2.36 We have provided a full chronology in appendix B from the point Mr S presented to community mental health services on 8 March 2012 to the incident (29 of April 2014).

Involvement of Mr S and members of the families

2.37 NHS's Serious Incident Framework directs that all investigations should:

> "Ensure that families (to include friends, next of kin and extended families) of both the deceased and the perpetrator are fully involved. Families should be at the centre of the process and have appropriate input into investigations."[53]

2.38 As part of all Caring Solutions investigations we will always try to obtain the views of the patient and the families of both the victim and the perpetrator, not only in relation to the incident itself but also their wider thoughts regarding where improvements to services could be made in order to prevent similar incidents from occurring again.

[53] NHS England, Serious Incident Framework. Supporting learning to prevent recurrence, p48

2.39 We met with both Mr S and one of his siblings on one occasion. Unfortunately we have been unable to locate any of members of Mrs S's family.

2.40 We have been extremely grateful for the information they provided, as it has been essential in assisting us to develop the chronology of events that led up to the incident itself. They also provided valuable background information on the lives of both Mr S and Mrs S which was not known to services at the time of the incident.

2.41 It is our intention to offer the family of Mr S the opportunity to be provided with a copy of our report, and if they wish both NHS England (North) lead and Caring Solutions lead investigator will meet with them to provide verbal feedback on the report's findings and recommendations.

2.42 We will also offer Mr S copy of our report, and if he wishes both NHS England (North) lead and Caring Solutions lead investigator will meet with him to provide feedback on the report's findings and recommendations.

3 Background Information

Childhood, family and schooling

3.1 Mr S was the youngest of three children. His biological father was a bus driver who lived with the family until Mr S was seven years old at which point his parents divorced.

3.2 Following their parent's divorce Mr S and at least one sibling lived with their mother and had little further contact with their biological father.

3.3 Mr S reported that during his childhood his mother suffered from mental health difficulties and that on at least one occasion she received Electroconvulsive Therapy (ECT)[54] for manic depression.

3.4 After her divorce Mr S's mother had a number of short term relationships and re-married six times during Mr S's childhood and adolescence.

3.5 Mr S reported that as a child he had witnessed many incidents of domestic violence between his parents and that he had been physically abused by his mother and her partners.

3.6 Mr S also reported that he had, on more than one occasion, physically attacked his mother.[55]

[54] Information documented in correspondence between consultant psychiatrist and GP, 21 December 2012, p2 ECT

[55] CCTT assessment 29 January 2013

3.7 Both Mr S and one of his older siblings, who we interviewed, described their childhood as being one of extreme poverty, poor housing and parental neglect. Mr S recalled that after his older sibling moved out of the family home he was frequently left alone, often locked in a room, whilst his mother went out. He described feeling "frightened, isolated and "unloved" [56] during his childhood.

3.8 Mr S recalled that he had a very unsettled childhood due to his mother and her respective partners moving to a number of different areas, therefore he was continually changing schools.[57] As a consequence he reported that he had no close friends and that he was often bullied at both his junior and senior schools. Mr S also reported that he was involved in physical violence towards others pupils.

Training and employment

3.9 Mr S left school at the age of 16 years without any formal qualifications. He was employed in several short term unskilled positions and then he was employed for several years, by one company, initially as a petrol pump attendant and then as a tyre fitter. He reported that he had enjoyed this work.[58]

3.10 Mr S reported that in his early twenties he had applied to be a prison warden but failed the initial exam. From this point he then worked for various friends and associates as a door man and security guard at night clubs but that often these positions were terminated due to either him moving from the area or his ongoing drinking difficulties.[59]

3.11 Following his daughter's death in 2001 Mr S ceased all employment and he and his ex-wife were on benefits until the incident in April 2014.

3.12 When he left school Mr S recalled that he had developed a keen interest in rugby and that he had played semi-professionally with a local club. He reported that after his marriage to Mrs S (1979) he had given up this sport.

[56] Psychological assessment 18 March 2016 p3

[57] Psychological assessment 18 March 2016 p3

[58] Psychological assessment 18 March 2016 p3

[59] Psychological assessment 18 March 2016 p3

Substance misuse

3.13 Mr S consistently denied having ever taken illicit substances; however he did disclose to various agencies that his alcohol consumption increased after his marriage and the birth of his daughter (1984).

3.14 Mr S disclosed that he had started to drink alcohol as it had "improved his confidence."[60] He also disclosed that he thought that his excessive drinking was a way of managing his memories and anger relating to his unhappy childhood .[61] Mr S recalled that he was drinking on a daily basis but if he did not have access to alcohol he denied ever experiencing symptoms of physical dependence.

3.15 Mr S frequently acknowledged that his drinking would make him impulsive, aggressive and at times violent. Both Mr S and Mrs S identified that his drinking was a significant contributing factor to the historic incidents of domestic violence within their marriage. However during periods of abstinence Mr S's aggressive behaviour reduced and their relationship improved until he began drinking alcohol again.

3.16 In 2012, when Mr S was assessed by community mental health service, he reported that since 1998 he had been entirely abstinent from alcohol as he had recognised the detrimental impact that his drinking was having on both his mental and physical health.

Mr S's contact with the criminal justice system

3.17 Mr S disclosed that at the age of 12 he had become "fascinated with air rifles,"[62]that he would often shoot animals and had "enjoyed watching them die."[63] He also reported that on occasions he had shot at people and recalled that "he used to feel good about this."[64] Mr S reported that he had been arrested and subsequently found guilty for the offence of shooting at a person and received a fine.

3.18 Mr S also reported that during his childhood and adolescence he had started a number of fires in both fields and buildings. On one occasion he had set fire to a garage, was arrested and received a police caution.

3.19 Between 1974 and 1989 Mr S had five criminal convictions:

[60] ADHD assessment completed by Adult and Older People's Mental Health Division 23 May 2013, p2

[61] Psychological assessment 18 March 2016, p4

[62] Correspondence from consultant psychiatrist to GP 21 December 2012

[63] Correspondence from consultant psychiatrist to GP 21 December 2012

[64] Psychology session 16 December 2013

- 10 July 1974, aged 15 years, he was convicted of actual bodily harm and was fined £10.
- 22 March 1984, aged 25, he was convicted of using threatening, abusive or insulting words/behaviours and was fined £100.
- When Mr S was 26 years old he was imprisoned for four months for a drink driving offence and assaulting a police officer.
- In 1987 Mr S, aged 27 reported that he became involved in a gang and was involved in criminal activities and violence towards others.
- 2 October 1987 Mr S was convicted of Grievous Bodily Harm (GBH) and was sentenced to 120 days imprisonment. [65]

3.20 Following the death of Mr S's daughter he was arrested for alleged kidnap of the drug dealers who he believed had been supplying drugs to his daughter. Mr S was remanded in custody for five months, the charge was later withdrawn and he was released from prison.

3.21 Mr S was not involved with the police again until 20 June 2011 when a neighbour called the police reporting their concerns about raised voices coming from the home of Mr and Mrs S. When police attended the address Mr and Mrs S reported that they were having a heated discussion about moving house. The police did not log this as a domestic dispute and no further action (NFA) was taken.

3.22 On 2 October 2011 Mr S was accused of head-butting a neighbour and damaging property during a disagreement over a garden fence, he was not prosecuted.

3.23 During 2012 police responded on several occasions[66] to Mr S complaining about incidents of noise nuisance by his neighbours.

3.24 In response to these incidents the police made three referrals to the Public Protection Unit;[67] the initial risk assessment of both Mr and Mrs S's was that they were 'medium' risk (21 October 2013), this was subsequently reduced to 'low' risk (20 January 2013). Mr S's mental health issues were identified within the police's referrals.

3.25 Throughout 2013 the Police Community Support Officer (PCSO) undertook a number of unscheduled welfare checks on Mr and Mrs S. The last visit was on 19 October 2013.

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[65] Information provided by Mr S in a psychological assessment 18 March 2016, p5

[66] 19 August 2012 and 24 November 2012

[67] Public Protection unit now Multi Agency Public Protection Arrangements (MAPPA) MAPPA

3.26 Mr S reflected in a psychological session in 2013[68] that he "felt remorse for having done some nasty things in the past."[69] He also suggested that he had been wondering whether, because of his mother and his childhood experiences, he had a "genetic predisposition to not being able to control his anger and aggression."[70]

Relationship history

It is our intention to discuss the complexities of Mr S and Mrs Ss' relationship throughout this report so this section will focus on their relationship up until the point of their daughter's death in 2001.

3.27 Mr S described his relationship with Mrs S as his only significant relationship in his adult life. They met at a local rugby club when Mr S was 18 years old and married in 1979.

3.28 After their marriage the couple initially moved in with Mr S's mother who he reported had "bullied"[71] his wife. After two years of marriage the couple separated but then resumed their relationship after Mr S's mother moved.

3.29 Mrs S alleged[72] that when their daughter was 4 months old her husband had attacked her, kicking her in the face, knocking some of her teeth out and she had sustained significant facial injuries. During the attack Mrs S had fallen and was unconscious for a prolonged period of time, she recalled that her husband did not take her to hospital but to his mother's house.

3.30 Both Mr and Mrs S disclosed numerous incidents of domestic violence as well as coercive and controlling behaviours on the part of Mr S within their marriage. Mrs S reported that after their divorce in 1997 that she and her daughter had moved for a year into a women's refuge but that she had eventually returned to live with him.

3.31 On another occasion Mrs S reported that she had secured alternative housing for herself and their daughter but continued to facilitate access visits for Mr S to meet with his daughter. During one of these meetings Mr S had followed her and found where she was living and she again returned to live with him. Mrs S also reported that on several other occasions she had tried to end their relationship but either Mr S or their daughter persuaded her to return to the relationship.

[68] Psychology session 16 December 2013

[69] Psychology session 16 December 2013

[70] Psychology session 16 December 2013

[71] Psychological assessment report 18 March 2016, p3

[72] Mrs S's first counselling session 30 November 2012

3.32 Mrs S reported that after the death of their daughter (2001) she stopped trying to leave her ex-husband. By the time Mr S presented himself to his GP in 2011 it was noted that the couple were not in an intimate relationship but Mrs S had assumed the role of a carer for her ex-husband.

3.33 In 2013 Mrs S disclosed, to a IAPT counsellor, that she continued to be fearful of her ex-husband as:

> "When he was angry he [would] takes it out on her verbally. She was never sure what to expect of [Mr S's] moods… [He] was unpredictable and she was not sure if he would not hurt her…she was very afraid to leave him as she feared he would find her and kill her."[73]

Parental responsibilities

3.34 In 1981 during Mrs S's first pregnancy she left Mr S, at 32 weeks of her pregnancy and subsequently gave birth to a stillborn baby. After this Mrs S returned to live with her husband and his mother.

3.35 In 1984 Mrs S gave birth to a baby girl. Initially they reported that their daughter was doing well at school but at the age of 14 she began to associate with drug users and she then began a relationship with a known drug dealer.[74] She moved out of the family home and her parents had concerns that she may have been engaging in prostitution.

3.36 Mr S reported that he had contacted the police to report his concerns about his daughter and that they had also locked her in her bedroom, both to try and stop her from associating with this group and to detox her from heroin. Mr S also reported that when he had confronted his daughter's boyfriend he was threatened with a knife.

3.37 The family then moved from the area and for a period of time both Mr and Mrs S reported that they had believed that their daughter was drug free. However she began a relationship with a heroin user.

3.38 In July 2001, on the day that the family were again moving house, Mr and Mrs S found their daughter collapsed in the bathroom of their home.

3.39 She was pronounced dead and the cause of her death was a heroin overdose.

3.40 Both Mr and Mrs S often reported that the death of their daughter had a profound and continuing effect on both of them. Mr S reported that he had

[73] Psychology session 24 September 2013

[74] Psychology session 16 December 2013

been diagnosed with Post Traumatic Stress Disorder (PTSD) in 2001: he received some mental health and psychological support which he reported had not been helpful.

3.41 In 2012 Mr S reported, during his initial assessment with mental health services, that he continued to feel intense anger towards the individuals that he held responsible for his daughter's death and that he was still experiencing vivid flashback images of finding his daughter dead.

4 Mrs S

Information identified within this section is based on information obtained from the DHR, Mrs S's Improving Access to Psychological Therapies (IAPT) sessions[75] (30 November 2012 to 17 May 2013) and Mr S's patient records.

Familial history

4.1 Mrs S reported[76] to her IAPT counsellor that she had one sibling who was thirteen years older than her. Also that as a child she had been very close to her father who had chronic heart disease and at the time of his death he had been waiting for a heart operation. She reported that after her marriage to Mr S she became increasingly estranged from both her family and her friends.

Primary care involvement

4.2 On 4 May 2011, Mrs S attended her GP reporting that she was experiencing rib pain and had an ankle injury. The GP recorded that the ankle was "much bruised,"[77] but there is no record to indicate if Mrs S was asked how she had sustained these injuries.

4.3 In June and July 2011 Mrs S presented herself several times to her GP reporting that she was suffering with insomnia and stress which she disclosed were due to the on-going difficulties with their neighbours and her ex-husband's behaviour towards them.

4.4 Mr S accompanied his ex-wife to several of her GP appointments and it was documented that on one occasion he became verbally aggressive whilst talking to the GP about their neighbours. They requested that the GP wrote to the housing department in support of their transfer request due to the on-

[75] Improving Access to Psychological Therapies (IAPT) programme began in 2008. IAPT services provide evidence based treatments for people with anxiety and depression, include talking therapies IAPT

[76] 4 January 2013

[77] DHR,p25

going detrimental effects their difficulties with the neighbours was having on Mr S's mental health.

4.5 In August 2011 Mrs S was assessed by her GP as having low mood and paroxysmal nocturnal dyspnoea (PND).[78]

4.6 In January 2012 Mrs S disclosed to her GP that her husband was "controlling, depressed and that she was concerned that he may harm her but that this had not occurred for many years."[79] The GP gave Mrs S the telephone number of the local Domestic Violence Service and advised her to attend the A&E service if Mr S became violent.

4.7 In December 2012, Mrs S again presented to her GP reporting that she was experiencing symptoms of depression. The GP undertook a mental health screening questionnaire (PHQ-9), Mrs S scored 17/27[80] and was referred to community mental health services who undertook a telephone triage assessment (4 April 2012). The outcome of the assessment was that Mrs S was experiencing "unresolved grief following the death of her daughter"[81] and she Mrs S was referred to IAPT services for counselling.

Improving Access to Psychological Therapies (IAPT)

4.8 At the time when Mrs S was referred to IAPT services she reported that she had been living with her ex-husband for fourteen years and although they were living together they were not in an intimate relationship. She also reported that due to her ex-husband's mental health difficulties she had assumed the role of a carer and was in receipt of a carer's allowance.

4.9 Mrs S's IAPT counselling commenced on 30 November 2012: during the first session Mrs S disclosed that she felt "completely trapped and isolated …She said that [Mr S] was unable to control his anger…. He has said that he will kill her if she leaves and she believes him."[82]

4.10 In subsequent sessions Mrs S made further disclosures reporting that although her ex-husband had not recently been violent she still felt that she could not "trust him and still feared that he [would] attack her.[83]

[78] Paroxysmal nocturnal dyspnea or paroxysmal nocturnal dyspnoea (PND) refers to attacks of severe shortness of breath and coughing that generally occur at nigh PND

[79] GP notes 24 January 2012, a score of 17 indicates moderate to severe depression

[80] DHR, p26

[81] Progress notes 4 April 2012

[82] Progress notes 30 November 2012

[83] Progress notes 14 December 2012

4.11 It was documented that Mr S would always bring his ex-wife to the IAPT and would wait in the reception area often becoming agitated and seeking reassurance from the reception staff.[84]

4.12 During a session on 8 March 2013 Ms D disclosed to the IAPT therapist that there had been a recent incident where Mr S had kicked a garden chair at her, she sustained a large bruise on her leg which she showed the therapist. Mrs S also reported that since his medication had increased he had become more agitated, volatile and verbally aggressive towards both her and a neighbour.

4.13 The IAPT therapist reported to Mrs S that such was her concern about her safety that she wanted to report the incident to the Trust's safeguarding team. Mrs S refused to give her permission but she did agree that the therapist could contact the safeguarding team for their advice.

4.14 The adult safeguarding team advised the IAPT therapist that as Mrs S had "capacity she was in effect choosing to stay in a risky situation which [was] her right." [85] They suggested that if Mrs S wished they would meet with her to discuss her options.

4.15 The IAPT therapist phoned Mrs S to explain what the safeguarding team had reported. She also suggested that if Mrs S wished to meet them in order to prevent her ex-husband knowing they would ensure that the appointment letter looked like a medical appointment. She also provided Mrs S with the contact details of the Domestic Abuse Helpline.

4.16 After this disclosure Mrs S continued to attend her IAPT sessions where she reported on several other occasions that her ex-husband had been verbally aggressive towards her and that she was feeling increasingly isolated. She also expressed her concern that Mr S was "out of control and that she [felt] scared of him."[86]

4.17 Mrs S also reported that following one particular incident, when Mr S had been verbally aggressive, she had been tempted to call the Domestic Violence Helpline.[87] However, she had decided against it as she felt that she was to "blame for her daughter's death and therefore she deserved to be punished so she stayed with [Mr S]."[88]

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[84] Letter from IAPT therapist to GP and copied to care coordinator 21 May 2013

[85] Progress notes 8 March 2013

[86] Progress notes 10 May 2013

[87] 26 April 2013,

[88] Progress notes 26 April 2013

4.18 Mrs S also disclosed that her ex-husband had said that he "would kill her if she left and she believed him; reported being trapped so long that she felt like she had no sense of who she truly is and she would be afraid she could not build a life for herself."[89]

4.19 The IAPT contract was for 12 weeks and during the tenth session the therapist began to discuss with Mrs S about what support was available to her after their contact ceased. In their discussion (17 May 2013) about the women's centre Mrs S reported that as her ex-husband always insisted on accompanying her to all her appointments, including her hairdresser's appointments, and as he would not be allowed into the women's centre she would not be able to attend.

4.20 At this session the IAPT therapist also discussed with Mrs S the contents of the discharge letter that she intended to write to her GP and her ex-husband's care coordinator. The discharge letter[90] commented on the complex relationship and noting that Mr S had a:

"History of violence: that [Mrs S was] frightened of him at times as he had been violent towards her, recently badly bruising her leg and pulling her back as she climbed the stairs…she has difficulty even having a telephone conversation away from [Mr S]."[91]

4.21 The IAPT therapist also reported that such had been the level of her concerns about Mrs S's safety that she had sought advice from the Trust's safeguarding department and she outlined the advice they had given her. She also reported that if in the future Mrs S made the decision to leave her ex-husband that she had provided her with information regarding local domestic violence services and the support that was available to her. The IAPT therapist reported that Mrs S had given her permission for a copy of the letter to be sent to Mr S's care coordinator so that "she would be aware of the issues." [92] She concluded by stating that a "time limited service [was] not sufficient as [Mrs S] needed longer term support."[93]

4.22 No action was taken to provide further on going psychological support for Mrs S.

[89] Progress notes 26 April 2013

[90] 21 May 2013

[91] IAPT discharge letter 21 May 2013 , p1

[92] IAPT discharge letter 21 May 2013 , p2

[93] IAPT discharge letter 21 May 2013 , p2

Carers assessment

4.23 On 30 May 2013 Mrs S had a carer's assessment which was undertaken by Mr S's care coordinator from CCTT.

4.24 The carer's assessment documented that Mrs S had the following physical health diagnoses: heart disease, angina, heart failure, pernicious anaemia[94] and an underactive thyroid.

4.25 During the assessment Mrs S did not disclose any information about the history of domestic violence or her fears, which she had recently disclosed to her IAPT therapist. It was however documented within the carer's assessment that Mrs S disclosed that her ex-husband "believed if she was not spending time with him [Mr S] felt that she [was] plotting things behind his back."[95]

4.26 In the section "What assistance might you find useful in you role as a carer" section Mrs S reported that "she has to give 24 hrs care to [Mr S] and [she] would like a break."[96]

4.27 Following this assessment Mrs S was referred to the third sector organisation that was, at the time, commissioned by the Local Authority to provide carers support in the locality.[97]

4.28 Mrs S met her carer's support worker monthly, from 19 September 2013 to 13 February 2014.

4.29 At the initial meeting with her carer's support worker it was documented that Mr S "was extremely unpredictable but posed no risk to workers." [98] The risk assessment section documented no identified risks.

4.30 The content of the sessions with the carer's support worker documented that the focus was on Mr S's increasing physical health difficulties and that "advice and emotional support given." Mrs S disclosed in two sessions (6 November 2013 and 14 January 2014) that she felt she needed some respite but felt that she was unable to leave her ex-husband even for a short break.

[94] Pernicious anaemia

[95] Carers assessment 30 May 2013

[96] Carers assessment 30 May 2013

[97] Since this incident the service has been recommissioned to another third sector organisation

[98] Record of contact 19 September 2013

4.31 During a session (14 February 2014) Mr S reported that “it had come to light that [Mr S] had not been taking his Olanzapine as he has been very short tempered.”[99]

4.32 This was the last face to face meeting with the carer’s support worker as Mrs S cancelled the next scheduled appointment (13 March 2014) as she informed the support worker that she had to accompany her ex-husband to a hospital appointment.

4.33 On 25 April 2014 Mrs S rang her support worker to report that she was finding her ex-husband’s on-going health issues extremely difficult to manage and requested an appointment. It is not evident within the notes if an appointment was offered but the support worker advised Mrs S to try and have some respite time.

Arising issues, comments and analysis

4.34 The care coordinator reported to Caring Solutions’ investigation team that due to the significant time that has elapsed since this case she was unable to recall receiving any information from either the IAPT therapist regarding her concerns about Mrs S’s safety and the recent issues of domestic violence.

4.35 The care coordinator recalled that although she had been aware that there was some historical domestic abuse and that Mr and Mrs S’s relationship was very complex. However she had never seen any evidence of domestic violence nor had Mrs S disclosed to her any concern about her safety.

4.36 She reflected that in many ways the couple were both very “co-dependent on each other.” Also during her involvement with Mr S she had developed a significant relationship with Mrs S and that during her home visits she would try and spend some time alone with her, they would often have a cup of tea together. The care coordinator also reported that “at no time did [(Mrs S] present saying that, I’m fearful for my life… and she would have told me that… [Mrs S] was very open with me, very honest with me.”

4.37 The care coordinator also reported that in the months leading up to the incident she had observed that Mr S’s increasing physical health concerns had placed considerable pressure on Mrs S. That it was evident that she was finding his continual hospital admissions, behaviour, anxieties and frustrations increasingly difficult to manage.

4.38 We noted that at the time the carer’s assessment was completed by Mr S’s care coordinator the IAPT discharge letter, which outlined both the disclosures made by Mrs S regarding historic and recent incidents of

[99] Record of contact 13 February 2014

domestic violence and also the therapist's concern about Mrs S's safety, had been received by both the GP and care coordinator.

4.39 The Lancashire Multi-Agency Carers Strategy (2013-2015)[100] that was in place at the time states that:

> "Carers will be respected as expert care partners and will have access to integrated and personalised services that they need to support them in their caring role… Carers will be able to have a life of their own alongside their caring role."[101]

4.40 This strategy's aims and commitment to the provision of services for carers also underpinned Lancashire Care NHS Trust's Carers Strategy at the time which identified the role of care coordinator as being fundamental in the ongoing assessment and support of carers and that:

> "Flexible response, with carefully weighed judgements tailored to the Individual's situation, professionals should communicate with each other effectively to ensure carers and those they care for have a seamless service" [102]

Both strategies outlined the commitment to providing a comprehensive provision of carer's services in the area to provide emotional, practical, financial, peer and educational support.

4.41 In our review of the carer's assessment and support provided to Mrs S there was no documented evidence of either any ongoing assessments being undertaken or her being offered any other services except the monthly meetings with the support worker. The evidence also indicates that there was no review process being undertaken to assess either Mrs S's developing risks and/or needs, despite it being recognised by all those involved that she was experiencing increasing difficulties in managing her ex-husband's behaviour and ill health from January 2014.

4.42 We were provided with a copy of the revised carers assessment (common assessment framework) form that has, since this incident been introduced. We noted that there is now a question that asks: "Have you ever felt distressed or in danger due to the behaviour of the person you care for?" This focused question will hopefully enable carers, such as Mrs S, to feel able to disclose information.

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[100] Lancashire Multi-Agency Carers Strategy 2013-2015 Carers Strategy

[101] Lancashire Multi-Agency Carers Strategy 2013-2015 p 11 -p15 Carers Strategy

[102] Lancashire NHS Trust Carers Strategy p 6 –p9 Lancashire NHS Strategy

4.43 However, based on our review of the local strategies that currently exist it remains unclear that once such a disclosure has been made who/or which agency has the responsibility for assessing and monitoring the potential risks? We would also suggest that when there has been a disclosure of potential or historic abuse that a 'keeping safe plan' is developed. Such a plan should be reviewed on a regular basis and certainly when the carer or other agencies report any change in their situation that may affect their risk and/or safety.

4.44 We would suggest that, in order to improve the current processes consideration should be given to developing a single framework of proformas which includes a risk assessment and support plan with review processes that would be utilised by all carer's services within Lancashire. This would not only standardise the process but also avoid duplication of assessments if the carer is referred to multiple services.

4.45 It was also documented that Mrs S was often disclosing to her support worker that she needed a break but there is no evidence that she was provided with practical assistance or information about what services were available to assist her, as a carer, to take a break.

4.46 The letter from the IAPT therapist advised that Mrs S was "inhibited from being honest if [Mr S] is with her for fear of his reaction." [103] Despite this information, apart from informal chats with the care coordinator and one session with the psychologist, Mrs S was always seen with her ex-husband. There was also no evidence that she was ever asked to contribute to his CPA reviews. Lancashire Multi Agency Carers Strategy (2013-2015) agencies should:

"Make clear to carers that they can communicate with professionals privately (e.g. sending in written information prior to a meeting) and to ensure that the carer's own confidentiality is respected."[104]

4.47 In our discussions with the CCTT practitioners regarding what services might have been available to Mrs S we were advised that she would not have met the criteria threshold for access to community mental health services who: "provide a service to adults who need assessment and treatment of mental health disorders which due to their severity or complexity cannot or have not responded successfully to treatment in IAPT services."[105] This led us to ask what service would have been available to Mrs S and why was there no

[103] IAPT letter to GP 21 May 2013

[104] Lancashire Multi-Agency Carers Strategy 2013-2015 p 11 -p15 Carers Strategy

[105] LCFT Community Mental Health Teams Standard Operating Procedure 2014

consideration given by the clinicians involved, to discuss with Mrs S that she could be re-referred to the IAPT, as was suggested within the IAPT discharge letter? It was from the point that she was discharged from IAPT that she was only seen by mental health services in conjunction with her ex-husband whose needs were the primarily focus. This we suggest was a significant and concerning deficit in the support of this vulnerable couple and did not reflect the LCFT and the local authorities' commitment to provide seamless and comprehensive services for carers such as Mrs S.

4.48 During the course of our investigation we were also informed that the carer's service has been recommissioned to another third sector organisation N-compass.[106] As both the previous and current third sector carer's organisation do not have access to the Trust's patient records nor was any information about the issues and complexities of Mr and Mrs S relationship forwarded to them they had been unaware of either the historical or recent issues of domestic violence. This lack of information sharing was of concern to the investigation team and it clearly highlights how essential it is for information sharing to occur between all sectors to enable the appropriate support to be provided and to ensure that potential risk(s), to both carers and those being cared for, are being proportionally assessed and monitored.

Lancashire County Council, Lancashire Care NHS Foundation Trust, Clinical Commissioning Group and other third sector providers.

Recommendation 1: Agencies who are currently responsible for undertaking carer's assessment and providing carers services need to review their current protocols for:

- Responding to disclosures of actual or potential risk of abuse of carers.
- Identifying in what circumstances would there be an escalation of information sharing.
- A review of the allocation and role of the care coordinator to identify their responsibilities for liaising with other involved services as part of both the initial assessment and during the review process.

[106] N-compass

Lancashire County Council, Lancashire Care NHS Foundation Trust, Clinical Commissioning Group and third sector providers.

Recommendation 2: In order to standardise and improve the quality of assessments and reviews of carer's needs and risks, consideration should be given to introducing one set of assessment and review proformas that are used by all carer's services within Lancashire.

Lancashire County Council, Lancashire Care NHS Foundation Trust, Clinical Commissioning Group and third sector providers.

Recommendation 3: Consideration should be given to introducing a "keeping safe plan" within all support plans which also addresses the carer's possible fears around care alternatives for the person they are caring for and the consequences that may arise if action is taken.

5 Mr S's physical health

5.1 From January 2010 to the incident (April 2014) Mr and Mrs S were registered with three different primary care services.

5.2 From January 2010 Mr S was regularly presenting himself to his GP with stomach and chest pains, breathing difficulties, dizziness and general health anxieties. Blood screens and an echocardiogram[107]identified no apparent physical aetiology.[108]Mr S was also referred to both neurological and gastrointestinal clinics and following more tests it was concluded that Mr S's symptoms were likely to have been caused by his generalised health anxieties, depression and Post Traumatic Stress Disorder.

5.3 In 2012 Mr S's GP noted that he was "angry and upset" [109] due to his on-going difficulties with his neighbours. The GP wrote a number of letters to the Housing Department supporting the couple's transfer application, citing that Mr S's difficulties with his neighbours was having an adverse effect on his mental and physical health.

[107] Echocardiograms: ultrasound test that uses high-pitched sound waves that are sent through a device called a transducer. The device picks up echoes of the sound waves as they bounce off the different parts of the heart Echocardiogram

[108] Aetiology: the cause, set of causes, or manner of causation of a disease or condition aetiology

[109] 30 January 2012, 8 March 2012

5.4 From January 2014 it was being documented by the GP, care coordinator and his psychologist that Mr S was becoming increasingly concerned about his physical health. Throughout February and March 2014 the GP saw or had telephone contact with Mr S on seven occasions.[110]

5.5 On 13 February 2014, following an appointment with his GP, Mr S was admitted to hospital. He was discharged following diagnostic tests which again detected no physical abnormalities.

5.6 Mrs S would often accompany her ex-husband to his GP appointments and in 2014 there were two occasions (28 February and 31 March 2014) when she contacted the GP to discuss her increasing concerns about her ex-husband's health issues and the difficulties she was experiencing supporting him.

5.7 On 1 March 2014 Mr S presented at an Accident and Emergency Department reporting that he was experiencing chest and abdominal pains which he had been suffering since January 2014. He also informed the admitting doctors that he had previously been admitted to hospital in another Trust for similar symptoms.

5.8 Mr S was admitted to a ward for pain management and further tests. He was initially prescribed oxycodone[111] for pain relief. Following a review by the pain management team [112] this medication was changed to Oramorph 10-20mgs[113] PRN.[114]

5.9 Whilst Mr S was an inpatient it was documented on several occasions that he was "extremely anxious, low in mood and agitated."[115] It was also documented that Mr S was adamant that he had a serious underlying condition that was causing his symptoms and demanded that further tests be undertaken, refusing to have these tests as an outpatient.

5.10 During Mr S's admission on 2 March 2014 it was documented that Mrs S had expressed her concerns[116] to the ward doctor about how they would manage at home if her ex-husband was discharged. She also reported that prior to the admission he had been expressing suicidal thoughts. On the 18 March

[110] 6 February, 10 February, 21 February, 6 March (telephone consultation with Mrs S), 13 March, 20 March, 21 March.

[111] Oxycodone is an opioid pain medication used to treat moderate to severe pain Oxycodone

[112] 7 March 2014

[113] Oramorph

[114] PRN when necessary

[115] Medical notes 3 March 2014

[116] 2 March 2014

2014 the ward doctor rang the CCTT requesting an update on Mr S's mental health.

5.11 During this admission a colonoscopy[117] and CT scan[118] were performed, both identified no abnormalities. The doctors discussed with Mr S that his symptoms may be either due to functional abdominal pain syndrome[119] or that they were psychological. It was documented that Mr S refused to consider either as possible reasons for his ongoing symptoms.

5.12 Following these diagnostic procedures Mr S went on weekend leave and on his return to the ward he was discharged (19 March 2014). His discharge medication regime was:

- Buscopan[120] 20 mg.
- BuTrans Patch[121] 5 micrograms (one weekly change).
- Omeprazole[122] 20 mg.
- Oxycodone hydrochloride 2.5. -5mg (PRN).
- Paracetamol 1 gram.
- Sertraline[123] 50 mg.
- Diazepam[124] 2mg.

5.13 He was referred for an outpatient oesophago-gastroduodenoscopy (OGD).[125]

5.14 On 31 March Mrs S had a consultation with the GP reporting her concerns about her ex-husband's on-going health issues. She also reported that there

[117] Colonoscopy is a test that allows the doctor to look at the inner lining of large intestine (rectum and colon)

[118] CT scan (or CAT scan) stands for computerised (axial) tomography scan uses x-rays to build a three-dimensional picture of the inside of the body.

[119] Functional abdominal pain syndrome (FAPS) is a condition of abdominal (belly) pain that is long-term or keeps coming back. The pain is not linked with changes in bowel pattern – constipation and/or diarrhoea. It occurs because of abnormal functioning of nerve impulses in the abdomen and brain. The nerves become overly sensitive FAPS.

[120] Buscopan antispasmodics, which are used to relieve painful colicky aching and spasm in the bowel Buscopan

[121] BuTrans patches contain a reservoir of buprenorphine that passes slowly from the patch through the skin and into the bloodstream Bu Trans

[122] Omeprazole proton pump inhibitors. Used to treat symptoms of gastroesophageal reflux disease (GERD) Omeprazole

[123] Sertraline is an antidepressant in a group of drugs called selective serotonin reuptake inhibitors (SSRIs) used to treat depression, obsessive-compulsive disorder, panic disorder, anxiety disorders, post-traumatic stress disorder (PTSD) Sertraline

[124] Diazepam (Valium) is a benzodiazepine medicine used to treat anxiety, depression Diazepam

[125] Gastroscopy is a procedure where a thin, flexible tube called an endoscope is used to look inside the oesophagus (gullet), stomach and first part of the small intestines ODG

had been some issues with the care that Mr S had received during his last admission and that Patient Advice and Liaison Service (PALS) [126] were involved. This was the last contact the GP had with either Mr or Mrs S.

5.15 Mr S reported to us that his ex-wife was in charge of dispensing his medication but that he was aware of the correct dosage and was fully compliant with his medication.

Arising issues, comments and analysis

5.16 From January 2014 Mr S's increasing anxieties and distress regarding his physical health was clearly affecting his mental health and the care coordinator reported that this was placing additional stress on Mrs S and her relationship with her ex-husband.

5.17 Apart from one occasion, when the ward doctor directly contacted the CCTT (18 March 2014), there was no further contact.

5.18 The GP who saw Mr and Mrs S, mostly in the months leading up to the incident, reported to us that both in Mr S's case, and in general, the surgery does not have any direct communication with care coordinators from the community mental health service. Also they had not been invited to contribute to Mr S's care planning reviews.

5.19 The LCFT's Clinical Risks Management policy that was in situ at the time stated that:

"Effective communication and sharing information within the mental health team, with other relevant practitioners (including General Practitioners) and between agencies is essential, and information sharing arrangements must be documented."[127]

5.20 We were informed by Mr S's GP that a patient's discharge summary from an acute inpatient admission is only sent to the patient's primary care service. The care coordinator confirmed that neither she nor the consultant psychiatrist had been made aware of Mr S's discharge medication regime from his acute hospital admissions and that they had relied on information being provided by Mr and Mrs S. Although there was evidence that LCFT's CCTT service sent letters to the GP after each outpatient's appointment and when Mr S was discharged from the psychologist. There was no evidence of any further communication instigated by either Mr S's primary or secondary mental health services.

[126] Patient Advice and Liaison Service (PALS) offers confidential advice, support and information on health-related matters. They provide you information about complaints procedure PALS

[127] LCFT Clinical Risk assessment and Management in mental Health Services Policy January 2012, p6

5.21 We would suggest that with a patient such as Mr S, who was presenting with such a complex profile and who was being discharged from an inpatient admission with a significant combination of medication, that it is of the utmost importance that information is shared between all involved agencies. This would have enabled a more coordinated and informed care to have been provided to Mr S.

5.22 It also would have enabled CCTT to have been able to assess Mr S's emerging needs and to identify any new potential risks factors: for example the effects Mr S's medication was having on his impulse control and anger management towards others especially his ex-wife.

5.23 In order to improve information sharing between primary and secondary care of complex patients, such as Mr S, we would suggest that in future there is on-going direct communication between care coordinators and the patient's GP. Additionally we would suggest that the patient's GP is always invited to contribute to care planning reviews and risk reviews.

5.24 It has not been possible to assess whether the deficits that we have highlighted, with regard to the lack of information sharing and communication between primary care and CCTT and the failure to involve the GP in Mr S's care planning process, is a systemic issue or isolated to this particular case. Therefore we suggest that LCFT commissions an audit of similar patients being managed by the CCTT.

5.25 We also suggest that the GP, with the patient's consent, should be providing the care coordinator with a copy of any discharge summaries that they receive. We also suggest that a protocol is developed that clearly identifies that both agencies having joint responsibility for information sharing, in order to ensure that there is consistency with regard to information sharing between the primary care services and LCFT's community mental health services.

Lancashire Care NHS Foundation Trust and Clinical Commissioning Group

Recommendation 4: In order to improve information sharing between primary care and Lancashire Care NHS Foundation Trust's community mental health services consideration should be given to strengthening a joint information sharing protocol. Such a protocol should identify both agencies' responsibilities for :

- Information sharing following a patient's discharge from an acute inpatient admission.
- Joint responsibility for on-going communication between a patient's primary care and care coordinator.

- Involvement of primary care in a patient's care planning reviews by mental health services.

Lancashire Care NHS Foundation Trust and N Compass

Recommendation 5: In order to evaluate whether the issues and deficits highlighted within this report are systemic within Lancashire Care NHS Foundation Trust's Complex Care and Treatment Team and/ or the N Compass service; both should consider undertaking an audit of a number of patients involved with both services. This audit should also include a review of the current interagency information sharing protocol and involvement in care planning and care planning reviews.

6 Mr S's psychiatric history

Please also refer to Chronology in appendix C.

6.1 In 2001 Mr S's GP referred him to community mental health services: during the assessment (23 August 2001) Mr S disclosed that since the death of his daughter he had become "more irritable and argumentative especially towards his wife and he [was] verbally abusive."[128]

6.2 The assessment concluded that Mr S was experiencing "acute grief reaction and symptoms suggestive of post-traumatic stress disorder" related to the death of his daughter. The GP was advised to stop prescribing Mr S the antidepressant Dothiepin[129] and that a referral would be made for short term counselling.

6.3 Mr S was reviewed again on 17 October 2001, where it was documented that since the last assessment Mr S's GP had been prescribing him diazepam (5mgs).

6.4 Mr S was provided with individual counselling and was also advised to contact a local bereavement agency for additional support. However by February 2002 Mr S reported that he had disengaged with his counsellor as he did not feel that their support had been beneficial to him.

6.5 Throughout 2002, 2003 and 2004 Mr S's GP notes indicated that he was sporadically presenting himself, reporting that he was suffering on-going symptoms of anxiety and depression.

[128] Letter to Mr S's GP from SHO Community Mental Health Team, 29 August 2001

[129] Dothiepin

6.6 Mr S had no further contact with mental health services until October 2009 when a volunteer counsellor, who was seeing Mr S, wrote to the GP reporting that she had just received a telephone call from Mr S who was in a:

> "hyper vigilant state and [that he was] a very angry, aggressive and extremely wound up man who wanted [the counsellor] to alert the police to his state of mind as he was aware that he may do something that he may well regret to his neighbours."[130]

6.7 The counsellor also noted that she had informed Mr S that she would be reporting her concerns about his "emotional health especially as [she] could hear his wife in the background saying she was frightened of him"[131] to his GP. There was no documented evidence of any action being taken in response to the concerns raised by the counsellor.

6.8 The counsellor also reported that Mr S was, at the time, waiting for an assessment by the Cognitive Behavioural Therapy (CBT) team.[132] The notes indicated that on 17 March 2010 Mr S was subsequently discharged from the CBT waiting list as he declined to attend two assessment appointments.

6.9 On 7 June 2004 Mr S again presented himself to his GP with symptoms of anxiety and depression, again citing the death of his daughter as the cause. The GP prescribed amitriptyline.[133]

Involvement of community mental health services from 2012

Single Point of Access (SPoA):

6.10 Mr S next presented to his GP in March 2012 and he was referred to the SPoA for a mental health assessment.

6.11 After several missed appointments Mr S was seen by a Community Psychiatric Nurse (CPN) on 3 August 2012. At this initial assessment it was suggested that Mr S was experiencing Post-Traumatic Stress Disorder (PTSD), and that he was exhibiting symptoms of depression and anger. It was also documented that Mr S was frequently involved in on-going disputes with his neighbours who were causing additional stress and anxiety.

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[130] Letter to GP 27 October 2009

[131] Letter to GP 27 October 2009

[132] CBT

[133] Amitriptyline belongs to a group of medicines call tricyclic antidepressants used as a depression treatment Amitriptyline

6.12 Mr S was reviewed on two further occasions by SPoA (3 August 2012 and 25 September 2012). During these assessments Mr S frequently described himself as being angry, irritable, isolated and anxious.

6.13 Mr S was accompanied by his ex-wife at all the assessments; they both reported that they believed that his difficulties were rooted in his past experiences as a child and the circumstances surrounding the death of their daughter. They also believed that Mr S's symptoms were being further exacerbated by the difficulties he was experiencing with his neighbours, his intolerance to noise and that he had, historically and currently, used his anger and intimidation as a coping mechanism.

6.14 The assessment letter sent to Mr S's GP noted that "one problem that [Mrs S] mentioned and I experienced is the anger he expresses which can be quite intimidating (although he reassures me he was not intending action on this)."[134]

6.15 Mr S was reviewed by a consultant psychiatrist on 18 December 2012: the mental health state examination concluded that Mr S was suffering from PTSD and Mixed Anxiety Depressive Symptoms. The psychiatrist suggested that based on the historical information which Mr S had disclosed he appeared:

"To have symptoms of Adult ADHD[135] which will need further exploration - he demonstrated Conduct Disorder[136] in the past as well as some Anti-Social Personality Traits.[137]

6.16 A plan of care included a referral for Post-Traumatic Stress Counselling, an assessment to exclude Attention Deficit Hyperactivity Disorder and supportive therapy from the Continuing Care and Treatment Team (CCTT).

6.17 In the consultant psychiatrist's letter to the GP it documented Mr S's psychosocial history, including his childhood experiences, his involvement during his adolescence with the judicial services and the current social isolation that both Mr S and his ex-wife were experiencing due to his "aggression and behaviour".[138] Additionally it noted that both Mr and Mrs S

[134] Letter from assessor to GP 26 September 2012

[135] Adult attention-deficit/hyperactivity disorder (ADHD) is a mental health disorder that includes a combination of persistent problems, such as difficulty paying attention, hyperactivity and impulsive behaviour. Adult ADHD can lead to unstable relationships, poor work or school performance, low self-esteem, and other problems. ADHD

[136] Conduct disorder (CD) is a mental disorder diagnosed in childhood or adolescence that presents itself through a repetitive and persistent pattern of behaviour. Conduct Disorder

[137] Antisocial personality disorder may: exploit, manipulate or violate the rights of others. Lack concern, regret or remorse about other people's distress. behave irresponsibly and show disregard for normal social behaviour Antisocial personality disorder

[138] Letter from consultant psychiatrist to GP 18 December 2012

had disclosed information regarding the history of domestic violence in their relationship. It noted that when Mr S:

"Was under the influence of alcohol he would beat [Mrs S] up. However even though he has stopped alcohol that the last time he assaulted her [was] about four years ago" [139] The letter went on to comment that Mr S had:

"A very supportive partner who has stuck with him since 1978 despite him being aggressive towards her. She continues to support him due to him losing all his friends and family because of his aggressive nature."[140]

6.18 As part of the assessment Mr S completed a Wender Utah Attention deficit hyperactivity disorder (ADHD) screen tool, [141] he scored 60/100. The consultant psychiatrist requested that the GP apply to their Primary Care Trusts[142] for funding for Mr S to be fully assessed at the ADHD centre.

6.19 The consultant psychiatrist concluded that Mr S required a further assessment by CCTT. She reported that she had suggested to Mr S that he be prescribed antidepressant medication and had provided him with information about several selective serotonin reuptake inhibitors (SSRIs) antidepressant medications (Sertraline, Fluoxetine and Citalopram).[143]

6.20 The consultant psychiatrist advised the GP that this proposed care plan would need to be approved by the SPoA case manager but as far as she was concerned he did not required any further psychiatric involvement.

Continuing Care and Treatment Team (CCTT).

6.21 Mr S was referred to the CCTT on 10 January 2013: at his first appointment (29 January 2013) it was documented that Mr S:

"Described a violent relationship with [his wife] while they were married, when he frequently subjected her to domestic violence. [He] also stated he [had] hit his wife at times, both of which he stated he was extremely remorseful and guilty for… [Mrs S] stated that there was no longer any violence but that [her ex-husband] can make threats when very agitated; however, he did not act upon them."[144]

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[139] Letter from consultant psychiatrist to GP 18 December 2012

[140] Correspondence to GP from consultant psychiatrist Single Point of Access 21 December 2012, p 3

[141] The Wender Utah Rating Scale (WURS) is used to retroactively assess ADHD symptoms Wender Utah

[142] Primary care trusts (PCT) were abolished on 31 March 2013 as part of the Health and Social Care Act 2012, with their work taken over by clinical commissioning groups (CCG).

[143] SSRI selective serotonin re-uptake inhibitors or serotonin-specific reuptake inhibitors (SSRIs) antidepressants used in the treatment of major depressive disorder and anxiety disorders SSRI.

[144] Mr S's care notes 29 January 2013

6.22 Following a CCTT's team discussion Mr S was referred to the psychology service (15 February 2013).

6.23 Mr S was reviewed again, with his ex-wife, by the CCTT's consultant psychiatrist on 28 March 2013. In the consultation Mrs S discussed her on-going concerns about her ex-husband's "aggressive outbursts."[145]

6.24 During this period Mr S's appointed care coordinator was off on sick leave for over two months, home visits resumed on 20 May 2013. At this visit it was noted that Mr S was "very agitated high levels of stress and anxiety. His mental health was unstable and unsettled. [He was] using inappropriate language throughout home visit and was unable to stay calm."[146]

6.25 On 23 May 2013 Mr S underwent an ADHD assessment: the assessment concluded that Mr S had "Post Traumatic Stress Disorder and that is in the background of lifelong Autistic Spectrum, namely Asperger's Syndrome."[147] He was discharged from the clinic but the GP was advised to approach the CCG for funding for an Autism Spectrum Disorder assessment.

6.26 At a CCTT medication review (28 June 2013) the consultant psychiatrist discussed prescribing Olanzapine[148] with Mr S and after an ECG[149] this medication was commenced (7 July 2013). In a subsequent review (3 September 2013) Mr S reported that this medication had been helpful.

6.27 During this period the care coordinator was documenting that her discussions with Mr S were focused on his on-going difficulties with his neighbours and a recent pest infestation.

6.28 The CCTT's consultant psychiatrist next reviewed Mr S on 16 December 2013: in this session Mr S talked about the physical symptoms he was experiencing. It was suggested to him that they may be due to the prolonged stress and anxiety that Mr S had experienced.

6.29 Mr S's safety profile was updated following this review and his risk to others was rated as low.

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[145] Mr S's care notes 23 March 2013

[146] Mr S's care notes, 20 May 2013

[147] Asperger Syndrome (AS) is a neurobiological disorder on the higher-functioning end of the autism spectrum Asperger's Syndrome

[148] Olanzapine is an atypical antipsychotic Olanzapine

[149] ECG an electrocardiogram to check heart's rhythm and electrical activity ECG

6.30 Mr S was discussed at the CCTT's multidisciplinary team (MDT) meeting on 27 February 2014; the care coordinator reported that Mr S was presenting with more concern about his physical health problems than his mental health. Also that he had stopped taking his prescribed medication, Olanzapine, due to weight gain and his insomnia. It was also reported that due to Mr S's pain levels he was becoming increasingly verbally aggressive and that Mrs S was finding it difficult to manage.

6.31 Mr S was again reviewed by the CCTT's consultant psychiatrist and his care coordinator on 7 March 2014: Mr S reported that he had stopped taking Olanzapine and the psychiatrist suggested that he commence Sertraline (50mg),[150] Mr S agreed.

6.32 In a summary letter. [151] written by the consultant psychiatrist, to the GP it was documented that Mr S "was very preoccupied about his physical health. He was frustrated and appeared angry on occasions especially when he was interrupted by his ex-wife."[152]

6.33 Mr S's care coordinator continued to visit Mr and Mrs S and the main topic discussed was his physical health. She also maintained telephone contact with Mrs S to obtain updates on Mr S's hospital admissions.

6.34 On the last home visit by the care coordinator (25 April 2014), which was 2 days before the incident, it was documented that Mr S presented in a very distressed state, reporting that he was continuing to experience ongoing acute physical symptoms. When it was suggested to him by the care coordinator that his physical issues may be psycho-somatic and related to his ongoing psychological issues it was documented that he would not consider any possible connection.

6.35 Mrs S was present during this home visit and it was documented that Mr S became verbally aggressive towards her and he asked her to leave the room, shouting "that she didn't understand the extent of his physical pain."[153]

6.36 Mr S also reported that he had not been taking his antidepressant sertraline. Following this visit the care coordinator arranged an appointment with the consultant psychiatrist (2 May 2014) which Mr S agreed to attend.

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[150] Sertrali*n*e is an antidepressant in a group of drugs called selective serotonin reuptake inhibitors (SSRIs) prescribed to treat depression, obsessive-compulsive disorder, panic disorder, anxiety disorders, post-traumatic stress disorder (PTSD) Sertraline

[151] 7 March 2014

[152] Correspondence from CCTT consultant psychiatrist 7 March 2014, p2

[153] Care notes 25 April 2014

6.37 The care coordinator also documented that she had advised Mrs S to contact her support worker so that she could receive some additional support.

7 Psychology intervention

7.1 Mr S was referred to a psychologist by the CCTT's consultant psychiatrist. Mr and Mrs S were initially seen on 8 August 2013.

7.2 Apart from two sessions,[154] when the psychologist saw Mr and Mrs S individually, they were seen as a couple until 10 January 2014. It was reported to Caring Solution's investigation team that Mr S was the patient and his ex-wife was attending to provide him with support.

7.3 The focus of the therapy was on reducing Mr S's anger and aggression, supporting them as a couple in developing strategies to manage their complex feelings and increasing Mrs S's safety and independence, as well as improving their social lives.

7.4 During a session on 16 September 2013 Mrs S disclosed that "she [had] been the victim domestic violence during her marriage"[155] The psychologist asked Mrs S "whether she felt safe at home with [Mr S] given the history of domestic violence." [156]Mrs S replied that her ex-husband "usually smashed objects when he got too angry, but he did not attack her. However, she stated that there [were] times when she felt unsafe, especially when [he] grabbed her or when he became angry."[157] It was documented that Mr S acknowledged his ex-wife's concerns and reported that:

"He was concerned about his angry outbursts and what he could do without meaning it… [Mr S] stated that although he wanted to be able to behave better towards [Mrs S) he was not sure he could trust himself. He stated that he did not intend to harm [his wife] but he could not be sure he could control his outburst and stop himself from harming her if he ever found himself holding an object that could inflict harm (i.e. knife) whilst being angry."[158]

7.5 After these disclosures the psychologist advised Mrs S to either call the police or leave the house if she felt threatened. It was at this point that the couple agreed that they would see the psychologist separately for one session.

[154] 24 September and 3 October 2013

[155] Mr S care notes 16 September 2013

[156] Mr S care notes 16 September 2013

[157] Mr S care notes 16 September 2013

[158] Mr S care notes 16 September 2013

7.6 During Mrs S's individual session[159] she disclosed that her ex-husband had been both physically and emotionally abusive towards her but "that if she was to leave [her ex-husband] she would not know where to start in her life, as this situation is familiar to her."[160] She also disclosed the incident that she had reported to the IAPT when her ex-husband had kicked a table at her and although there had been no more physical violence towards her he continued to be verbally abusive towards her and that she was "still scared" [161]of him.

7.7 In Mr S's individual session (3 October 2013) with the psychologist he reported that he wished to be more in control of his anger and that he had "managed to refrain from being physically aggressive towards"[162] his ex-wife.

7.8 After these individual sessions the psychologist informed Mr and Mrs S that it was her intention to inform Mr S's care coordinator of their disclosures regarding domestic violence.

7.9 The psychologist emailed[163]Mr S's care coordinator informing her that she had completed her assessment and that she intended to see Mr and Mrs S together. She also provided a summary of the couple's historic domestic violence and stated that Mrs S had told her that "she still feels scared at times when [Mr S] becomes angry and shouts and grabs her."[164]

7.10 The psychologist subsequently discussed Mr and Mrs S's case in her supervision[165] where it was agreed that she would continue monitoring and exploring the potential risks of domestic violence within their relationship.

7.11 The risk assessment that was completed by the psychologist after the disclosures documented that the "risk: [Mr S] feels able to stop himself from physically hurting [Mrs S].[166]

7.12 The psychologist assessed that Mr S had a Depression, Anxiety and a Stress Scale (DASS)[167] of 21, which indicated that he was suffering extremely severe depression, anxiety and stress.

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[159] 24 September 2013

[160] Mr S care notes 24 September 2013

[161] Care notes 24 September 2013

[162] Care notes 3 October 2013

[163] This commination was not dated, not clear if it was an email

[164] Correspondence between psychologist and care coordinator, not dated

[165] 17 September 2013

[166] Care notes 3 October 2013

[167] DASS is a 42-item self-report instrument for measuring depression, anxiety and tension/stress DASS.

7.13 It was documented by the psychologist that the overarching theme and focus of the sessions were Mr S's continual ruminations that he believed that his problems were related exclusively to both the death of his daughter and his difficult childhood. The psychologist also noted[168] that as Mr S had a very limited repertoire of coping strategies it was not appropriate to refer him for post traumatic therapy.

7.14 In a session on 11 October 2013 Mrs S reported to the psychologist "that she has not dismissed the possibility that [her ex-husband] might kill her if he is not able to control his temper."[169]

7.15 At this session both Mr and Mrs S agreed with the psychologist that to reduce the risk to Mrs S's safety during their arguments they would both remain 6 feet away from each other. Mr S agreed that when he started becoming agitated he would maintain a distance from Mrs S. They also both agreed when they felt angry or agitated to allow each other time to be alone. They reported in future sessions that these techniques had been helpful in order to defuse some of their points of conflict.

7.16 In a session (22 November 2013) Mrs S disclosed that "she felt imprisoned and isolated" and that the previous week Mr S had become agitated, grabbed her and started shouting at her.[170] Mr S acknowledged that he was still finding it "difficult to manage his anger and he found his feelings escalating abruptly."[171] They both reported that they had utilised the strategies that they had agreed in order to defuse the situation.

7.17 Following this session the psychologist assessed that there were no identified increased risks as both Mr and Mrs S "appeared to becoming increasingly more able to facilitate each other's safety by making progress on maintaining physical distance and time out during conflict."[172]

7.18 In a session on the 5 December 2013 Mrs S reported that during a conflict the previous day Mr S had grabbed her. Mr S acknowledged that this was not acceptable behaviour and also disclosed that on "occasions when he disagreed with [Mrs S's] decisions he tried to prevent her from doing what she felt she needed to do (e.g. having an intrusive medical examination that her doctors thought was necessary)."[173] Mr S also disclosed his criminal

[168] Care notes 30 October 2013

[169] Care notes 11 October 2013

[170] Care notes 22 November 2013

[171] Care notes 22 November 2013

[172] Care notes 22 November 2013

[173] Care notes 5 December 2013

history to the psychologist and it was noted that he did express some remorse for his actions.

7.19 Mr S was often disclosing in the sessions his emotional and physical dependency on his ex-wife and that when she was not with him "he [felt] unsafe. He also felt that [Mrs S] was a substitute for the mother that he never had."[174]

7.20 From the next session,[175] until the psychology sessions ended (24 January 2014), Mr S increasingly focused on his concerns and anxieties relating to his physical health issues.

7.21 During a session on 10 January 2014 Mrs S reported that she felt "suppressed and "imprisoned in their relationship and she stated that past experience has taught her to be apprehensive when [Mr S became] quiet, as she has learnt to expect a blow up."[176]

7.22 It was at this session that Mr and Mrs S were informed by the psychologist that she was leaving her post: they discussed the possibility of seeing another psychologist but Mr S refused stating that he did not wish to discuss his difficulties with another professional.

7.23 This was the last time the psychologist saw Mr and Mrs S as the subsequent two scheduled sessions were cancelled by Mrs S due to her ex-husband's ill health. During one of these telephone calls Mrs S disclosed to the psychologist that she was concerned that this support was ending.

8 Arising issues, comments and analysis

This section looks at the following areas which were identified within the ToR:

"Review the adequacy of risk assessments, including the risk to of harm to others and review the implementation and effectiveness of the Trust's safeguarding processes with particular reference to domestic violence.
Review the appropriateness of the treatment of the service user in the light of their identified health and social care needs, identifying both areas of good practice and areas of concern including any areas of future risk.

[174] Care notes 22 November 2013

[175] 16 December 2013

[176] Care notes 10 January 2014

Review and assess the Trusts compliance with local policies, national guidance and relevant statutory obligations including Care Programme Approach and Safeguarding Processes."[177]

Risk assessments and risk management

8.1 Two Safety Profiles were completed by CCTT care coordinator (11 February 2013 and 3 December 2013).

8.2 The initial Safety Profile documented in the risk history section that Mr S "has in the past been a perpetrator of domestic violence. [Mr S's] wife (victim) at the time is now his carer." It was also noted that Mr S "has in the past been a violent man. [Mr S] reports to have been surrounded by violence all his life… [Mrs S] confirms that [Mr S] is no longer violent but can at times threaten violence."[178]

8.3 The Formulation and Management Outcome identified the following issues:

- "Lack of impulsive control: "[Mr S] has acted impulsively out of frustration in the past and this has often led him [to] be violent.
- Uncooperative: [Mr S] struggles to communicate with others and can be uncooperative and angry in his response.
- Evidence of rootlessness/detachment: Mr S does not display attachment to places and people. [Mr S] has no contact with family and friends.
- Difficulties communicating needs: [Mr S] struggles to communicate with others. [Mr S] has always struggled to communicate since childhood. However this has greatly increased since the death of his daughter and subsequent chain of events."

8.4 This Safety Profile (3 December 2013) concluded that Mr S's risk to others, treatment /illness related risk and social circumstances were "medium." This Profile was undertaken after the psychologist had communicated her concerns to the care coordinator about both historical and recent incidents of domestic violence within the couple's relationship.[179] In one of the emails, sent by the psychologist, it was noted that "concerns that were raised in relation to [Mrs S's] safety when [Mr S) becomes angry and aggressive." [180]

[177] NHS ToR p1

[178] 11 February 2013

[179] The psychologist had emailed the care coordinator on two occasions 16 and 24 September 2013

[180] Email from psychologist 16 September 2013

8.5 The Safety Profile concluded that there was no current risk of Mr S "harming others" All Mr S's risks had all been reduced to "low."

8.6 It was also noted that the Formulation and Management Outcomes section was not completed on this review.

8.7 The rational for this reduction in Mr S's level of risk is unclear especially in light of the fact that additional information had been provided about recent incidents of domestic abuse and intimidation and their concerns about Mrs S's future safety which had been provided by the clinical psychologist. Nowhere were her concerns documented or considered.

8.8 LCFT's Clinical Risk Policy at the time stated that the context of risk assessments was:

"The likelihood of an event happening with potentially beneficial or harmful outcomes for self and others" (Sainsbury Centre for Mental Health, 2000). Risk assessment can, therefore, be described as a dynamic process based centring on an estimation of the likelihood and severity of particular adverse events occurring under particular circumstances within a specified period of time. It is the gathering of information about clinical presentation, risk behaviour and risk history, and an analysis of the potential outcomes of identified behaviour. The nature, frequency, and severity of the risk behaviour must all be considered."[181]

8.9 If one reviews Mr S and Mrs S's historical and current circumstances, that was known by the involved practitioners, it is evident that Mr S had many of the risk factors for violence that were outlined within LCFT's Clinical Risk Management Policy. These were:

- Demographics: he was male, lack of social support.
- Background history**:** childhood maltreatment, history of violence, first violent at young age, history of childhood conduct disorder.
- Clinical history: non-compliance with medication.
- Psychological and psychosocial factors: anger, impulsivity, suspiciousness, lack of insight.
- Current 'context': threats of violence, interpersonal discord/instability.[182]

[181] LCFT Clinical Risk Management Policy January 2012 , p 6-7

[182] LCFT Clinical Risk Management policy, January 2012, p14-15

It was also known that Mr S's aggressive behaviours were directed towards one person, his ex-wife. Yet despite this guidance Mr S was assessed at low risk in regard to his potential risk of harm to Mrs S and others.

8.10 The Royal College of Psychiatrist suggest that:

> "The basis of all violence risk assessment is that past behaviour is the best guide to future behaviour. It follows that the most important part of risk assessment is a careful history of previous violent behaviour and the circumstances in which it occurred. On an individual level, a detailed understanding of the patient's mental state, life circumstances and thinking is a major contributor to the prevention of harm. … A critical function is to stratify people into a group (low, medium or high risk), which will help dictate the appropriate risk management strategy.[183]

8.11 They reiterate the importance of longitudinal risk assessments being undertaken that includes a combination of "statistical data with clinical information in a way that integrates historical variables, current crucial variables and contextual or environmental factors."[184] Additionally any "concerns raised by families should be responded to and in principle, their concerns should also automatically trigger a more structured risk assessment.

8.12 The College also suggests that if in an assessment of the patient there is concern regarding their risk of harm to others it should "trigger a more structured risk assessment process, with the use of an assessment tool that is appropriate for the group, such as a HCR-20 assessment [185] and avoiding the notion that one size fits all."[186] As none of Mr S's assessments indicated that this was a significant potential risk of domestic violence there was no consideration that a further more in depth assessment was required. Nor was there any consideration of referring the case either to the independent domestic advisors, who worked closely with the police, or to the local Multi-Agency Risk Assessment Conferences (MARAC).[187]

8.13 With regard to risk management: LCFT policy at the time stated:

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[183] Rethinking risk to others in mental health services Royal College of Psychiatrists London 2016, p24 Rethinking risk

[184] Rethinking risk to others in mental health services Royal College of Psychiatrists London p38

[185] HCR-20 V3 is a comprehensive set of professional guidelines for the assessment and management of violence riskHCR-20

[186] Rethinking risk to others in mental health services Royal College of Psychiatrists London p38

[187] A MARAC is a meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs), probation and other specialists from the statutory and voluntary sectors MARAC .

"The formulation provides a clear explanation of how specific risk behaviours arise in an individual given the presence and relevance of various conditions, which have been identified as risk factors. It should further indicate interventions or responses which are likely to reduce (or increase) the likelihood of the specific risk behaviour(s) occurring and is consequently key to subsequent risk management planning. It includes predisposing, precipitating, perpetuating and protective factors. The risk management plan will provide a record of relevant interventions, the staying well plan (crisis / contingency plan) and, where relevant, advance statements. The plan includes actions that will be taken, an allocation of individual responsibilities, and all those involved in providing treatment and support, including the service user, family, friends and/or carers."[188]

8.14 Based on our findings we concluded that despite the numerous disclosures that were being made by both Mr and Mrs S the safety profiles clearly failed, in our opinion, to adequately identify the extent of possible future risks of harm to Mrs S. As a consequence it failed to establish a relevant risk management and crisis plan for either Mr or Mrs S. Nor was there any evidence that neither the psychologist or Mr S's GP were invited to contribute to the safety profile and subsequent reviews this was despite LCFT's policy directing that: "Effective communication and sharing information within the mental health team, with other relevant practitioners (including General Practitioners) and between agencies is essential, and information sharing arrangements must be documented."[189]

8.15 As we have reported, the care coordinator reflected, during her interviews with the investigation team, that due to the time lapse since this case she was unable to remember if she had seen the letter from the IAPT or the emails and discharge summary from the psychologist. Although she suggested the IAPT letter would have been uploaded onto Mrs S's notes which she did not have access to.

8.16 It was reported to us by the CCTT locality manager, who completed an initial post incident report for LCFT that she had been unable to track who had reviewed the IAPT correspondence. However, she reported that since this incident a new process that has been introduced for monitoring and uploading incoming correspondences to the CCTT. She reported that the new system facilitates " a clear audit trail" and that any future investigation would now be able to identify who and when external correspondence has been received and when it has been uploaded onto the patient's Electronic Care Record (ECR). However she reported that currently there is no alert system in place

[188] LCFT Clinical Risk Management policy, January 2012, p6

[189] LCFT Clinical Risk Management policy, January 2012, p6

on the ECR to indicate if external correspondence has been uploaded. Therefore it was agreed that there was still the possibility that a letter could be overlooked as they are stored within the ECR in another file that has to be opened by the reader. We would suggest that in order to mitigate again this possibility LCFT should consider introducing an alert system that notified the clinician when a new letter has been uploaded.

Lancashire Care NHS Foundation Trust

Recommendation 6: Lancashire Care NHS Trust should consider introducing an alert system on their Electronic Care Record System which alerts the clinician when new correspondence has been unloaded onto a patient's records.

8.17 With regards to email correspondence that are sent to CCTT's practitioners; the locality manager reported that staff are directed to either cut and paste or summarise the contents of the email on to the patient's ECR.

Care planning

8.18 As part of Mr S's CCTT's initial assessment with CCTT a care plan was completed by the CCTT's care coordinator and consultant psychiatrist on 28 March 2013. A Health and Safety Needs assessment (18 February 2013) was also completed. The later was completed by a social worker and care coordinator and was the only Health and Safety Needs assessment completed. Both Mr and Mrs S were involved in these assessments.

8.19 In the care plan it was documented that Mrs S had reported that her ex-husband has "a long history of having a prickly moody side of him and she described waking up not knowing whether to say something to him or not and over the last few years things have got worse."[190]

8.20 This care plan also documented, in the unmet needs section, that the carer (Mrs S) did not have any needs and that a carer's assessment was "not appropriate."[191]

8.21 The next care plan review completed by the care coordinator was on 11 March 2013.

[190] Care plan 28 March 2013

[191] Care plan 28 March 2013

8.22 Mr S's care plan was again reviewed on 3 December 2013 by a different CCTT consultant psychiatrist and the care coordinator. Mr S's Safety Profile was reviewed after the meeting.

8.23 This review occurred after the care coordinator had received several emails from the psychologist regarding her concerns about the historical and potential current violence within Mr and Mrs S's relationship. This information was not recorded either in the care plan nor the safety review, and as we have already identified Mr S's risk was downgraded to low with regard to his risk to others.

8.24 The next and last care plan review before the incident was completed by the care coordinator on 24 March 2014. This was during a period when Mr S was experiencing health issues and anxieties and was being admitted to hospital. Apart from the review documenting that Mr S was "currently unwell with gastro problems;"[192] there was no further reference to this issue or any identification of support needs that Mr S may have had in relation to what we have now ascertained from other sources, was an extremely stressful time for both Mr and Mrs S. This was also after both psychologist 's involvement had ended and the discharge letter, which was copied to the care coordinator, that made reference to the physical violence and verbal aggression" within Mr and Mrs S's relationship.

8.25 We reviewed Mr S's care plans with reference to LCFT's Care Programme Approach Policy (July 2013) that was in place at the time. The policy emphasised that the:

"Two central components of the CPA are the role of the care co-ordinator who has overall responsibility for the coordination of the assessment and care planning processes in partnership with the Service User and Carer, and multidisciplinary team working… Collaboration and communication about risk are vitally important components of good and safe practice."[193]

Despite this directive that care planning and subsequent reviews should be collaborative with both the patient and other involved practitioners, there was no evidence that the psychologist and/or the GP were asked to contribute to Mr S's care plan reviews.

8.26 The policy also directs that one of the key standard of CPA is that:

"The assessment must include reference to risk, safeguarding… A formal risk assessment must be completed and recorded at initial assessment. On-going

[192] Care plan 23 March 2014

[193] LCFT Care Planning Approach Policy July 2013, p 5 &9

risk assessment will be carried out for all Service Users and this will continue to inform the care planning process. Any new information gained which highlights any previously unidentified risk or escalation of known risk will result in a further formal risk assessment being documented."[194] This care plan will include actions to address their identified needs, who are involved in actions to meet those needs, their relapse signature and management of risk including contingency/crisis arrangements."[195]

8.27 As we have already identified neither the care plan nor safety profile reviews made reference to or considered the information that had been received by both the psychologist and the IAPT counsellor with regards to the disclosures that there had been recent incidents of domestic violence and that Mrs S had expressed her concerns about her safety. Also we could not find any evidence to indicate if a crisis or contingency plan was developed for Mr S. The policy directs that practitioners should develop and utilise these plans to "identified risks and actions to minimise these risks."[196]

8.28 Again we have to ask why there were repeated failures to comply with LCFT's Care Planning Approach Policy which:

"Emphasises the need for a focus on delivering person-centred mental health care and also repeats that crisis, contingency and risk management are an integral part of the assessment and planning processes." [197]

8.29 In our review of both Mr S's safety profiles and the care plan reviews we have considered if the failures we have identified were due to:

- A lack of professional curiosity.
- A lack of adequate training and/or supervision.
- The considerable pressure and work load that all the community based practitioners were reported to us that they were experiencing.
- A systemic culture within the CCTT team.
- And /or a combination of all these factors.

[194] LCFT Care Planning Approach Policy July 2013, p7

[195] LCFT Care Planning Approach Policy July 2013, p8

[196] LCFT Care Planning Approach Policy July 2013, p8

[197] LCFT Care Planning Approach Policy July 2013, p5

8.30 Clearly as this incident occurred in 2014 a number of changes have occurred within the CCTT with regard to the training that LCFT staff have received, the management structure and policies that have been reviewed.

8.31 We asked the current CCTT's locality manager, who was at the time of this incident supervising the care coordinator, about her recollection of Mr and Mrs S: she reported that as far as she was able to recall the care coordinator had reported that "there was no signs or evidence to suggest that there was any current risks [Mrs S] and that [she] was getting her own interventions separate from the service user… [The care coordinator] was talking about Mr S being discharged from the service because everything seemed to be going in the right direction, from her interventions and the interventions that he'd received from the psychologist."

8.32 The care coordinator also reported that, at the time, only cases which were identified as being at particularly high risk or in crisis would have been discussed at a Clinical Review Meeting. However, since this incident staff are now allocated specific review meetings where they are required to present all their patients. This enables both the clinical and managerial team to have an overview of all patients and also provides supervision and guidance. Additionally these meetings have allocated time where staff can discus particular patients who are causing concern or who are in crisis.

8.33 We were informed that all practitioners within the CCTT have regular individual clinical supervision where their patients are discussed in detail.

8.34 The locality manager also reported that when she assumed her role she had identified that there were systemic quality issues within the team with regard to care planning and the lack of SMART [198] outcomes being identified. To address these issues she has facilitated a number of team training sessions.

8.35 Clearly there has been some positive changes within the CCTT: however the locality manager reported to us that due to time constraints and the number of patients who are high risk and/or in crisis those who are presenting with lower risks, such as Mr S, would not have their safety profiles or care plans routinely reviewed by the management team.

8.36 We would suggest that in order to ascertain if the deficits we have identified within Mr S's care plans and safety profiles are either a systemic issue within the team or particular to this case we would recommend that a quality audit of a random sample of CCTT safety assessments and reviews is undertaken. If deficits and inconsistencies are identified then consideration should be given

[198] SMART specific, measurable, attainable, realistic and timely

to providing training/mentoring to either particular care coordinators and/or the team.

Lancashire Care NHS Foundation Trust

Recommendation 7: A quality audit should be undertaken of care plans and safety profiles and reviews completed by the Complex Care and Treatment Team to ascertain if practitioners are accurately identifying and assessing the levels of risk(s). Where deficits are identified with specific practitioners then the appropriate training and management guidance should be provided.

Information Sharing

8.37 At the time Mr and Mrs S's records were kept on different electronic patient records systems, since this incident the two systems have been amalgamated. However, unless there was a particular cause for concern, for example a safeguarding concern, family members' records would not be routinely accessed by staff from other services within the LCFT.

8.38 Apart from outpatient summaries and also letters of support to the housing office there was no written evidence to indicate any of LCFT's practitioners involved with Mr and Mrs S made contact with other external agencies: for example the carer's agency who was providing carers support to Mrs S.

8.39 In the DHR the carers agency reported that they" no knowledge of any domestic abuse or safeguarding issue concerning [Mrs S] prior or during their involvement." [199] In the light of this incident they identified that they needed to improve:

> "Effective sharing of information between agencies and themselves and that any possible risks of domestic abuse must be identified at the earliest opportunity, i.e. at point of referral." [200]
>
> To address this issue they have now implemented that "a separate section has now been added to their initial referral form for this information to be documented by the referrer.[201]

8.40 Apart from outpatients letters there was no direct communication between Mr and Mrs S's GP and LCFT's practitioners regarding concerns about Mrs S's safety as neither agency perceived the risk to be high enough.

[199] DHR, p56

[200] DHR, p43

[201] DHR, p43

8.41 LCFT's Carers Strategy at the time states its commitment to "increasing the integration of NHS, Local Authority and third sector services supported by the Common Assessment Framework which allows sharing of information."[202]

8.42 Additionally one of LCFT's recommendations from their IMR was "to support staff to escalate the concerns of domestic abuse by completing CAADA forms or by information sharing with other agencies."

8.43 Clearly the Carer's Strategy addresses the initial assessment process but this case has highlighted that information sharing must, within the boundaries of confidentiality, be improved by all the sectors involved in order to ensure the safety and wellbeing of carers and those they are caring for.

8.44 We will be reviewing the progress LCFT has made with regard to the action plan that arose out of the findings of the DHR in section 9 of this report.

Domestic Violence

8.45 Clearly within our investigation there was ample evidence that indicated that Mr and Mrs S were repeatedly disclosing there had been a significant number of both historic and recent incidents of domestic violence and intimidation. For example Mrs S was reporting that she was becoming increasingly "isolated and was not getting any practical and/or emotional support from their family, friends."[203] Mrs S was also disclosed that her ex-husband "was engaging in abusive, aggressive and controlling behaviours."[204] Additionally it was documented that Mr S had been observed treating his ex-wife "with a lack of respect or courtesy… refusing to be left alone by day or by night." During one of the psychology sessions it was documented that Mrs S had reported that her ex-husband had "excessive control over her life, especially at an emotional level." [205] She also disclosed that she had "not dismissed the possibility that [Mr S] might kill her if he is not able to control his temper."[206]

8.46 All these disclosures should have been recognised as significant risk indicators of potential current and future domestic abuse. We would also suggest that even without their actual disclosures practitioners should have been alerted to the fact that this couple were in a very complex relationship: Mrs S had tried several times (unsuccessfully) to leave a violent and abusive marriage; the tragic death of their daughter and that Mrs S was providing

[202] LCFT;s Carers Strategy , p 8-9

[203] Adass Carers and Safeguarding Adults –Working together to improve outcomes April 2011, p 11 ADASS

[204] Adass Carers and Safeguarding Adults –Working together to improve outcomes April 2011, p 11 ADASS

[205] 11 October 2013

[206] 11 October 2013

constant care to her ex-husband who was experiencing significant mental health issues. Mrs S was also, at the time CCTT became involved, in poor physical health.

8.47 We would suggest that both Mr and Mrs S should have been reviewed as adults at risk and given the amount of disclosures, regarding historical and recent domestic violence within their relationship, this should have triggered and informed a Coordinated Action Against Abuse (CAADA) assessment.[207]

8.48 Additionally research into the identification of potential victims and perpetrators of domestic violence within the complex dynamics of the caring relationship identified that "carers can often become hidden victims of abuse."[208] It is suggested that "the challenges that face professionals in identifying, reporting and responding to those carers who at risk can be complex but the recognition of risk of harm or potential harmful behaviour is critical to the prevention and protection of the carers."[209]

8.49 LCFT's Domestic Abuse Policy, which was in place at the time of the incident,[210] directed that:

"Identifying domestic abuse is a routine part of health assessment… By ensuring routine enquiry is carried out LCFT staff will give victims the opportunity to disclose and help them to have the confidence that they will be believed... All disclosures of domestic abuse should be taken seriously."[211]

8.50 Apart from the IAPT therapist no other involved clinician (IAPT) appeared to have sought further advice or guidance from the Trust's Safeguarding Department in regard to couple's on-going disclosures. The Trust's policy at the time states that one of the functions of the Safeguarding Team is to "provide advice and support."[212] In this case we would suggest that when Mrs S was disclosing her concerns and reported incidents the CCTT's practitioners and the psychologist should have been seeking the on-going advice and support from the Safeguarding Team. Additionally apart from the IAPT discussion with the safeguarding team there was no further

[207] CAADA information and CAADA assessment was available on LCFT safeguarding website. the assessment identifies potential risks to the victim

[208] Adass Carers and Safeguarding Adults –Working together to improve outcomes April 2011, p 11 ADASS

[209] Adass Carers and Safeguarding Adults –Working together to improve outcomes April 2011, p 12 ADASS

[210] LCFT's Domestic Abuse Policy Incorporating Forced Marriage, Honour Based Abuse and Female Genital Mutilation April 2011

[211] LCFT's Domestic Abuse Policy Incorporating Forced Marriage, Honour Based Abuse and Female Genital Mutilation April 2011 p14

[212] LCFT's Domestic Abuse Policy Incorporating Forced Marriage, Honour Based Abuse and Female Genital Mutilation August 2013, p9

consideration or assessment of Mrs S's capacity with regard to her decision making to stay in the relationship with Mr S. despite her on-going fears.

8.51 LCFT safeguarding policy advises its staff that:

> "adults sometimes have complex interpersonal relationships and may be ambivalent, unclear or unrealistic about their personal circumstances… all staff within their area of responsibility are aware of, respond to instances of suspected or actual abuse and have contact details for safeguarding and protecting lead professionals within the organisation. Clinical practice takes a proactive approach to protecting and safeguarding children and adults."[213]

All the practitioners reported to us that they had been aware that Mr and Mrs S's relationship clearly fitted the profile of a complex interpersonal relationship. However despite this emerging picture, apart from the IAPT, none of the involved practitioners took any proactive action to:

- See Mrs S alone on an on-going basis in order to ascertain further information from her and to assess her support needs and potential risks of being a victim of future domestic violence.
- Apart from the psychologist teaching the couple a defusing strategy no practitioner was supporting her "to identify and make informed choices about how to manage the potential risk of future harm... how to manage potential risk of significant harm. To reinforce her resilience and self-care capacity and to advise her of the support carer's [and local domestic violence service] might be able to provide."[214]
- No practitioners were utilising the information that they were aware of regarding the historic and recent incidents of domestic violence to inform Mr S's risk reviews.

8.52 Nor does there appear to have been any consideration given by any of the involved practitioners to utilising a domestic violence risk assessment such as CAADA DASH.[215] This is despite LCFT's Domestic Abuse Policy directing that its staff "must be aware of and understand the indicators which lead to domestic abuse …also be aware that often a victim may not realise the extent

[213] LCFT Safeguarding Policy 2015 p 5 and p13

[214] Adass Carers and Safeguarding Adults –Working together to improve outcomes April 2011, p 11 ADASS

[215] The purpose of the Dash risk checklist is to give a consistent and simple tool for practitioners who work with adult victims of domestic abuse in order to help them identify those who are at high risk of harm and whose cases should be referred to a MARAC meeting in order to manage their risk CAADA DASH

of risks and may minimise the actual risk factors. Health practitioners should use the CAADA DASH[216] Risk Assessment to assess the level(s) of risk."[217]

8.53 No practitioner sought Mrs S's permission to share her disclosures with the carers support agency. This agency was seeing Mrs S alone and therefore was in a position to discuss, without the presence of Mrs S's ex-husband, what her options were and what support she felt she could access.

8.54 It was reported to the Caring Solution's investigation team that Lancashire Care NHS Foundation Trust provides regular briefings and training to all its practitioners. However in light of the evidence that we have identified of a lack of any proactive action being taken in response to Mr and Mrs S's disclosures we would recommend that LCFT provide further directives to CCTT in regard to under what circumstances its staff should be consulting the Trust's safeguarding team and what assessments they should be undertaking when there has been a disclosure of domestic violence.

8.55 Members of the CCTT, who were involved in this case, should also receive additional training on their role, responsibilities and actions that need to be taken when there has been a disclosure and/or report from another service of either historical and/or recent incidents of domestic abuse.

8.56 We would also suggest that, in order to ascertain if this lack of response and action is a systemic issue within the CCTT, LCFT should consider undertaking a review of the current cases being managed within this team where historic and/or recent incident of domestic abuse have been disclosed.

8.57 The NICE Guidelines (February 2014) Domestic Violence & Abuse[218] at the time directed that front line staff "need to access specific training on domestic abuse in order to identify it and provide an effective response". LCFT Domestic Abuse Policy stated that:

"All new starters within LCFT must attend the Mandatory Induction Training. Reference to domestic abuse is contained within the Safeguarding section of the Induction Training … Clinical staff will be offered domestic abuse and forced marriage awareness sessions which will equip them with the knowledge to recognize and respond to issues of domestic abuse."[219]

[216] CADDA is now referred to SAFELIVES

[217] LCFT's Domestic Abuse Policy Incorporating Forced Marriage, Honour Based Abuse and Female Genital Mutilation August 2013, p14

[218] NICE guidelines

[219] LCFT's Domestic Abuse Policy Incorporating Forced Marriage, Honour Based Abuse and Female Genital Mutilation p15

8.58 We were informed that CCTT staff are required to completed Safeguarding Training Level 3, however when we asked a clinician about the training she reported that she was unable to recall the level of safeguarding training she had received.[220] Although this was a concerning comment we do acknowledge that this is feedback from one particular individual and it is difficult to assess the extent to which there might be a deficit in the CCTT with regard to how learning is evaluated, consolidated and embed into practice. We would, therefore, suggest that LCFT should consider introducing a process for evaluating the effectiveness of their training, for example the Kirkpatrick Model.[221]This is utilised to evaluate the value of any type of training, formal or informal, across the following four levels:

- **Level 1 Reaction**: the degree to which participants find the training favourable, engaging and relevant to their jobs.
- **Level 2: Learning:** the degree to which participants acquire the intended knowledge, skills, attitude, confidence and commitment based on their participation in the training.
- **Level 3: Behaviour:** the degree to which participants apply what they learned during training when they are back on the job.
- **Level 4: Results:** the degree to which targeted outcomes occur as a result of the training and the support and accountability package.

Lancashire Care NHS Foundation Trust.

Recommendation 8: Lancashire Care NHS Foundation Trust should review its current guidelines within their Safeguarding Policy to ensure that it provides clear directives as to when and in what circumstances staff should be consulting the Trust's safeguarding team to seek advice and guidance.

Lancashire Care NHS Foundation Trust.

Recommendation 9: The members of both the Complex Care and Treatment Team and psychologist who were involved in this case should receive additional training on their role, responsibilities and actions that is expected to be taken when there has been a disclosure and/or report from another service of either historical and/or recent incidents of domestic abuse.

[220] Reported that annually they have 30 days training plus Continual Professional Development (CPD)

[221] The Kirkpatrick Model

Lancashire Care NHS Foundation Trust.

Recommendation 10: An audit should be undertaken within the Complex Care and Treatment Team, including the psychologist team, to highlight any current cases where domestic abuse maybe a feature to ensure that staff are:

- Taking the appropriate and proportionate action is being taken.
- Seeking the appropriate guidance from Lancashire Care NHS Foundation Trust's safeguarding team and their senior managers and supervisors.
- Awareness of when to utilise assessments, such as CAADA DASH.

Lancashire Care NHS Foundation Trust.

Recommendation 11: In order to ensure that there is a process utilised to evaluate, maximise and demonstrate the value of its training programme to both the trainee and the organisation Lancashire Care NHS Trust should consider adopting a recognised training evaluation tool such as the Kirkpatrick Model.

9 Internal investigation and action plan

ToR asked the investigation to:
"Review the Trust's internal management review to identify:

- If the internal investigation satisfied the key lines of enquiry set by the Domestic Homicide Review Chair.
- If all key issues and lessons were identified.
- If recommendations are appropriate and comprehensive.
- If identified actions have been effectively implemented."[222]

9.1 Following this incident LCFT completed an IMR that was submitted to the Domestic Homicide Review's panel. At the time that the IMR was being undertaken the author was unable to interview involved staff due to the impending court case.

9.2 We were informed that as an IMR was to be completed the Trust made the decision not to complete an internal Root Cause Analysis investigation. It was

[222] ToR, p1

also reported to us that after the incident the locality manager for CCTT was involved in undertaking a review of the service's involvement that informed the chronology for LCFT's IMR.

9.3 The IMR provided the DHR with a comprehensive chronology of Mr and Mrs S's involvement LCFT's services from 8 March 2012 to the point when Mr S presented himself to the reception of a community mental health unit on 29 April 2014 reporting that he had killed his ex-wife.

9.4 With regard to the question asked by the DHR panel to LCFT "Were there effective and appropriate arrangements in place for risk assessment and escalation of concerns?"[223] The IMR author concluded:

"A Safety Profile [was] completed on 11 February 2013, [Mr S] scored medium risk for harm to others and illness related risk which included impulse control and incidents of domestic violence were recorded relating to his past violence. A further safety profile was completed on 3 December 2013. [Mr S] scored low for harm to others and illness related risks and there were no incidents of domestic violence recorded."[224]

However there was no commentary as to why Mr S had been downgraded to low risk. It also did not highlight that the review had taken place after the CCTT's care coordinator had received the two emails from the psychologist nor did it address why this information was not reflected in the subsequent safety profile review. If this had been highlighted we would have expected that the IMR would have made a particular recommendation regarding improving safety profiling and reviews in with the CCTT.

9.5 LCFT's IMR reported to the DHR panel that "in May 2014 a baseline assessment of compliance with the NICE guidance for Domestic Violence and Abuse (PH50) was undertaken. This identified areas to be strengthened and these will be included in the Trust's Safeguarding Priorities for the coming year."[225]

9.6 LCFT's IMR made four recommendations : here are the actions taken and summary of progress made to date (February 2016):

9.7 Recommendation 1:

[223] IMR, p13

[224] IMR, p13

[225] DHR, p37

“To support staff to escalate the concerns of domestic abuse by completing CAADA risk assessment and information sharing:

Outcome: to “increase awareness and timely multiagency approach in relation to domestic abuse to improve outcomes for victims.”

Key actions:

- “Issue Safeguarding Newsflash to all staff to remind them of their responsibilities in relation to domestic abuse.
- Briefing was sent to all staff via weekly bulletin. There was also an article presented in the July 2015 edition in the Trust Insight Magazine.
- Safeguarding Team to contact MARAC Development Officer and discuss how they can assist and support assessment of risk of domestic violence in LCFT staff work.
- Safeguarding Team Portfolio Group established to review progress against delivery of LCFT Domestic Abuse action plan.
- Safeguarding Team to attend all MARAC meetings.
- Safeguarding Team Portfolio Group established to review progress against delivery of LCFT Domestic Abuse action plan.
- Awareness raised of both the CAADA website and LCFT’s Safeguarding Intranet pages.
- Clinical risk training updated to include assessment of Domestic Abuse Clinical Risk Training. Handbook to be updated to include routine enquiry, safeguarding team’s contact details and categories of abuse.

Evidence:

- Discussion at team meetings and correspondence through Team Information Boards and team meeting minutes.
- Network audit of standards of Domestic Abuse practice.
- Recommendations submitted to Networks and assessments reviewed to be inclusive of routine enquiry.
- The Safeguarding Intranet Pages for Children and for Adults (within Domestic Abuse Section) have been uploaded - Safe Lives DASH risk containing information and useful links.

Outcomes:

- To increase awareness and timely multiagency approach in relation to domestic abuse to improve outcomes for victims.

All actions were reported to have been completed between March - September 2015.
Lead officers: Assistant director Nursing Safeguarding– cascaded to Service Managers via Network Governance Meetings.

9.8 Recommendation 2:

“Network reviews current safeguarding and refresher training for team members and ensure staff are attending training sessions as required for their role.

Outcomes:

- Enhance skills and knowledge to morally and professionally escalate concerns of domestic abuse.

- Domestic Abuse module under development as part of Phase 2 of LCFT Making Every Contact Count (MECC) programme. This will further support information regarding key public health messages relating to Domestic Abuse.”

Key actions:

- To identify and support staff to attend safeguarding training.

- Funding secured and x6 Domestic Abuse awareness sessions commissioned and facilitated. Further bids successful to secure and commission additional training and awareness sessions from AFTA thought theatre company.

- Domestic Abuse already within LCFT core mandatory Safeguarding training.

- Additional training programmes in place. X1 session per month facilitated re. the topics below:

  Domestic Abuse (half day).
  MARAC (half day).

Evidence:

- Key staff identified and attended training.

All actions completed “significant increase in training and awareness however this this will be ongoing.”

Lead officers: Service Managers.

9.9 Recommendation 3:

"Safeguarding Team will seek updated contact details for all Specialist Domestic Violence Services within the LCFT footprint to ensure staff are able to signpost and refer victims appropriately to Domestic Violence Services. Details to be available to all staff via Trust Intranet.

Outcomes:
Updated contact details available to all LCFT staff via safeguarding intranet pages.
Key actions:"

- Contact Lancashire Strategic Domestic Abuse partnership to gather local contact details.

- Leaflets for Blackpool, Lancashire and Blackburn areas are available on the Intranet pages under Domestic Abuse Section – this is in both the Adults pages and the Children's pages.

- Commissioned services details were circulated to staff across the Network and requested that all teams retained local contacts details.

Evidence:

- Updated contact details available to all LCFT staff via safeguarding intranet.

All action completed February 2015.
Lead officer: Assistant Director Nursing Safeguarding.

9.10 Recommendation 4:

"LCFT Safeguarding Team to lead a review of current Domestic Abuse Policy and Procedures and Safeguarding Training packages. Outcomes: Increased awareness and timely responses to domestic abuse therefore improving outcomes for victims of domestic abuse."

Key actions:

- Safeguarding Domestic Abuse Portfolio group to review and update LCFT Domestic Abuse Policy and procedures to ensure recommendations reflected within.

- Safeguarding Adults training package to be reviewed to be inclusive of awareness of Domestic Abuse and staff responsibilities.

Evidence:

- Updated current policy and procedures available to staff via Trust Intranet site.

- Updated training package delivered to reflect Policy and procedures and recommendations.

All actions completed March 2015.
Lead officer: Assistant Director Nursing Safeguarding.

9.11 We also met with LCFT's Head of Risk, Safety and Quality Governance who informed us and provided evidence of the significant changes and improvements within LCFT with regard to the commissioning of serious incident investigations, DHRs, complaints and the monitoring of action plans. These include:

- A centralised investigation team.
- The Quality Improvement Team provides support at the improvement planning stage.
- The internal commissioning processes are via the Safety Quality Governance Department and the Executive Serious Incident Review Panel.
- DHRs are monitored by the LCFT's Safeguarding Group.
- The IT system Datix is now the one repository for all investigations' action plans.
- The use of a dashboard such as: Quality Seal which provides live and current information that is accessible by all teams. It triangulates a range of information, such as incidents, complaints, risk information and also indicates actions that require completion.
- Business partners also required to report to Head of Risk, Safety and Quality Governance support networks to ensure and report on the implementation of action plans.
- The four Clinical Directors (Children and Families, Specialist Services, Adult Mental Health and Adult Community) attend Quality and Safety Sub Committee where investigations and actions plans are being monitored.
- Weekly 'The Pulse and monthly 'Quality Matters' bulletins: this is available to all LCFT staff and provides summary of findings from serious incidents. It is also used to highlight any emerging themes as they are arising during the serious incident investigations.
- Recently LCFT ran a number of workshops with staff to ascertain how to improve learning within the Trust.
- Convened "dare to share" events: recent agreement that each network will hold these events at least four a year each.

9.12 Caring Solutions investigation team were provided with evidence that indicated all the action plans have been implemented. They have concluded that based on this evidence that, apart from the issues identified within this section, LCFT has satisfied the DHR's keys lines of enquiry and their recommendations were appropriate and comprehensive.

10 Predictability[226] and preventability[227]

10.1 Throughout the course of this investigation, we have remained mindful of one of the requirements of NHS England's Terms of Reference, which was that we should consider if the incident which resulted in the death of Mrs S was either predictable or preventable.

10.2 Whilst analysing the evidence we have obtained, we have borne in mind the following definition of a homicide that is judged to have been predictable, which is one where "the probability of violence, at that time, was high enough to warrant action by professionals to try to avert it."[228]

Predictability

10.3 On many occasions both Mr and Mrs S disclosed that they had a long, complex and turbulent relationship, where there were many historic and more recent incidents and threats of domestic violence with Mrs S being the victim.

10.4 Both Mr and Mrs S had experienced the devastating loss of their daughter which led to both of them to experience mental ill health issues and increasing social and emotional isolation from their peers and their families. Although no longer in an intimate relationship Mrs S became her ex-husband's sole carer as well as suffering her own physical health issues.

10.5 Based on historic and recent reported incidents of violence, within Mr and Mrs S's relationship, there was ample evidence to indicate that Mr S's on-going impulsivity and aggression towards his ex-wife was likely to continue.

10.6 Therefore, the Caring Solution's investigation team concluded that it was predictable or highly likely, that some form of violence would continue. However we have concluded what was not predicable was that the violence

[226] Predictability is the quality of being regarded as likely to happen, as behaviour or an even". We will identify if there were any missed opportunities which, if actioned, may have resulted in a different outcome. An essential characteristic of risk assessments is that they involve estimating a probability. If a homicide is judged to have been predictable, it means that the probability of violence, at that time, was high enough to warrant action by professionals to try to avert it.

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

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

would, on that day, escalate to the extent that Mr S would take the life of Mrs S.

10.7 Additionally in the months leading up to Mrs S's death her ex-husband's health anxieties increased as did his frustration towards the medical profession who he felt failed to diagnose the aetiology of his physical symptoms. This placed increasing stress on the couple and during this period. Mr S was being prescribed a significant combination of strong pain relief that would have perhaps further reduced his tolerance and impulsivity.

10.8 Additionally the therapy that the couple received from the psychologist there was little evidence to indicate that it had any significant and lasting affect to reduce Mr S's impulsivity and anger issues in the months leading up to the incident.

Preventability

10.9 In our consideration of the preventability of this incident, we have asked ourselves the following two questions: based on the information that was known, were Mr S's risk factors and support needs being adequately assessed and addressed by the involved agencies? Additionally based on the information that was known at the time was the incident on the 15 April 2015 preventable?

10.10 A preventable incident is where there are 3 of the essential ingredients present: knowledge, legal means and the opportunity to stop an incident from occurring.

10.11 As our investigation revealed both Mr and Mrs S were disclosing to various agencies, both individually and as a couple, that incidents and their concerns about domestic violence remained a current feature within their relationship. On one occasion the IAPT did refer the case to the Trust's safeguarding team and the psychologist's concerns were also reported, via emails, to a member of the CCTT.

10.12 This information was also not documented within Mrs S's initial carer's assessment therefore the one agency, who was seeing her on a regular basis without the presence of her ex-husband, was not aware of the potential risks and concerns that Mrs S had been expressing.

10.13 Despite these issues being of great concern however, we have concluded that even if individuals had acted appropriately and responsively on the information that was available to them and instigated LCFT's Domestic Violence policy, the complexities of Mr and Mrs S's relationship and her

refusal to accept support and advise indicates that it was probably unlikely that she would have accepted any further interventions.

10.14 As Mrs S had capacity to make the decision to remain in the relationship with her ex-husband the involved practitioners did not have the means to prevent the incident.

10.15 We have therefore concluded that the death of Mrs S was not preventable.

11 Concluding Comments

11.1 Whilst it was evident to Caring Solutions investigation team that the individual practitioner's involved in providing care to Mr and Mrs S were very committed in their efforts to support this couple. However the treatment plan, which involved a combination of medication, psychological and care support, was largely ineffective. The true extent of both Mr and Mrs S's historic and recent emotional, psychological and physical abuse remained only partially understood and remained largely unresolved in what the evidence was clearly indicating was a very complex relationship between Mr and Mrs S.

11.2 In a recent Home Office Domestic Homicide Review [229](December 2016) presents an analysis of the following trends:

> "Mental health issues were present in 25 of the 33 intimate partner homicides…Risk assessment was the next most commonly occurring theme... Communication and information sharing between agencies was identified as an issue in 25 out of 33 (76%)… There were 24 cases (73% of those sampled) where victims or perpetrators presented to agencies with possible signs of domestic abuse and/or domestic violence but this was not recognised or explored further... Also noted was the issue of risk assessment processes not being properly understood or not being properly carried out… professionals were noted as having lacked 'professional curiosity' or taken things at face value."[230]

11.3 Clearly during the course of our investigation there was ample evidence of the above issues both in regard to Mr and Mrs S. Although we have concluded that none were the root cause of the death of Mrs S but they were all, we would suggest, contributing factors to the deficits in the assessments of the potential risks of domestic violence within this vulnerable couple's complex relationship.

[229] HO Domestic Violence Review

[230] Home Office Domestic Homicide Review December 2016, p3-9

12 Recommendations

Lancashire County Council, Lancashire Care NHS Foundation Trust, Clinical Commissioning Group and other third sector providers.

Recommendation 1: Agencies who are currently responsible for undertaking carer's assessment and providing carers services need to review their current protocols for:

- Responding to disclosures of actual or potential risk of abuse of carers.
- Identifying in what circumstances would there be an escalation of information sharing.
- A review of the allocation and role of the care coordinator to identify their responsibilities for liaising with other involved services as part of both the initial assessment and during the review process.

Lancashire County Council, Lancashire Care NHS Foundation Trust, Clinical Commissioning Group and third sector providers.

Recommendation 2: In order to standardise and improve the quality of assessments and reviews of carer's needs and risks, consideration should be given to introducing one set of assessment and review proformas that are used by all carer's services within Lancashire.

Lancashire County Council, Lancashire Care NHS Foundation Trust, Clinical Commission Group and third sector providers.

Recommendation 3: Consideration should be given to introducing a "keeping safe plan" within all support plans which also addresses the carer's possible fears around care alternatives for the person they are caring for and the consequences that may arise if action is taken.

Lancashire Care NHS Foundation Trust and Clinical Commissioning Group.

Recommendation 4: In order to improve information sharing between primary care and Lancashire Care NHS Foundation Trust's community mental health services consideration should be given to strengthening a joint information sharing protocol. Such a protocol should identify both agencies' responsibilities for:

- Information sharing following a patient's discharge from an acute inpatient admission.
- Joint responsibility for on-going communication between a patient's primary care

and care coordinator.

- Involvement of primary care in a patient's care planning reviews by mental health services.

Lancashire Care NHS Foundation Trust and N Compass.

Recommendation 5: In order to evaluate whether the issues and deficits highlighted within this report are systemic within Lancashire Care NHS Foundation Trust's Complex Care and Treatment Team and/ or the N Compass service; both should consider undertaking an audit of a number of patients involved with both services. This audit should also include a review of the current interagency information sharing protocol and involvement in care planning and care planning reviews.

Lancashire Care NHS Foundation Trust.

Recommendation 6: Lancashire Care NHS Trust should consider introducing an alert system on their Electronic Care Record System which alerts the clinician when new correspondence has been unloaded onto a patient's records.

Lancashire Care NHS Foundation Trust.

Recommendation 7: A quality audit should be undertaken of care plans and safety profiles and reviews completed by the Complex Care and Treatment Team to ascertain if practitioners are accurately identifying and assessing the levels of risk(s). Where deficits are identified with specific practitioners then the appropriate training and management guidance should be provided.

Lancashire Care NHS Foundation Trust.

Recommendation 8: Lancashire Care NHS Foundation Trust should review its current guidelines within their Safeguarding Policy to ensure that it provides clear directives as to when and in what circumstances staff should be consulting the Trust's safeguarding team to seek advice and guidance.

Lancashire Care NHS Foundation Trust.

Recommendation 9: The members of both the Complex Care and Treatment Team and psychologist who were involved in this case should receive additional training on their role, responsibilities and actions that is expected to be taken when there has been a disclosure and/or report from another service of either historical and/or recent incidents of domestic abuse.

Lancashire Care NHS Foundation Trust.

Recommendation 10: An audit should be undertaken within the Complex Care and Treatment Team, including the psychologist team, to highlight any current cases where domestic abuse maybe a feature to ensure that staff are:

- Taking the appropriate and proportionate action is being taken.
- Seeking the appropriate guidance from Lancashire Care NHS Foundation Trust's safeguarding team and their senior managers and supervisors.
- Awareness of when to utilise assessments, such as CAADA DASH.

Lancashire Care NHS Foundation Trust.

Recommendation 11: In order to ensure that there is a process utilised to evaluate, maximise and demonstrate the value of its training programme to both the trainee and the organisation Lancashire Care NHS Trust should consider adopting a recognised training evaluation tool such as the Kirkpatrick Model.

Appendix A – Terms of reference

Terms of Reference for Independent Investigations under NHS England's Serious Incident Framework 2015

Core Terms of Reference:

• Review the Trust's internal management review to identify:
• If the internal investigation satisfied the key lines of enquiry set by the Domestic Homicide Review Chair
• If all key issues and lessons were identified
• If recommendations are appropriate and comprehensive
• If identified actions have been effectively implemented,
• Undertake a proportional review of the care, treatment and services provided by the NHS and other relevant agencies from the service user's first contact with mental health services to the time of the offence
• Review the appropriateness of the treatment of the service user in the light of their identified health and social care needs, identifying both areas of good practice and areas of concern including any areas of future risk
• Review and assess the Trusts compliance with local policies, national guidance and relevant statutory obligations including Care Programme Approach and Safeguarding Processes
• Review the adequacy of risk assessments, including the risk to of harm to others and review the implementation and effectiveness of the Trusts safeguarding processes with particular reference to domestic violence
• Examine the effectiveness of the service user's care plan including the involvement of the service user and family
• Establish contact with both the families of those affected as fully as is considered appropriate, in liaison with the Police and other identified support organisations.
• Determine through reasoned argument the extent to which this incident was either predictable or preventable, providing a detailed rationale for the judgement
• Provide a written report to the Investigation Team that includes measurable and sustainable recommendations
• Based on overall investigative findings, constructively review any gaps in interagency working and identify opportunities for improvement
• Provide a written report to the NHS England North that includes measurable and sustainable recommendations.
• Assist NHS England in undertaking a brief post investigation evaluation.

Supplemental to Core Terms of Reference:

• Provide support to the provider and commissioner to develop robust, outcome focussed action plans based on the report's recommendations

• Support the commissioners to develop a structured plan to review implementation of the action plan. This should include a proposal for identifying measurable change and be comprehensible to service users, carers, victims and others with a legitimate interest

Appendix B – Chronology of involvement of community mental health services with Mr S from 8 March 2012 to April 2014

Date	Source	Event	Comment
08/03/12	LCFT Clinical Data System - Mindset (LCFT notes)	Mr S referred via Single Point of Access Team (SPOA): identified as suffering from Post-Traumatic Stress Disorder. He was referred for Cognitive Behavioural Therapy (CBT).	At the same time Mrs S was referred by GP to counselling service
15/5/2012	LCFT notes	Another referral received by SPOA (urgent).	
17/5/2012	LCFT notes	Referral discussed at the SPOA meeting. An appointment was sent for Mr S for initial assessment on 6 June 2012.	Identified that he was suffering from PTSD due to daughter's death. Problems with his neighbours, depression, anxiety, anger and socially isolated. He denied any harm to himself or others.
06/06/12	LCFT notes	Mr S DNA's appointment.	
11/06/12	LCFT notes	Mrs S contacted SPOA reporting that they had not received appointment letter. A further appointment sent 18 June 2012.	
13/06/12	LCFT notes	Mrs S cancelled appointment on 18 June 2013 due to Mr S having a hospital appointment. Rearranged for 3 August 2012.	
3/8/2012	LCFT notes	Mr S attended for an assessment accompanied by Mrs S.	It was agreed to review Mr S but no follow up was arranged
04/09/12	LCFT notes	T/C received by SPOA from Mr S requesting a follow up appointment.	T/C telephone call Unable to return call as using a disconnected number
18/09/12	LCFT notes	T/C made to Mr S: appointment made for 25 September 2012.	
25/09/12	LCFT notes	Mr S attended with Mrs S.	
01/11/12	LCFT notes	Referral made to SPOA Consultant.	Noted that this assessment needed two persons present due to Mr S's angry presentation.
08/11/12	LCFT notes	T/C with Mrs S re referral. 12 December 2012	Mr S reported police involvement due to dispute with neighbours
26/11/12	LCFT notes	Mrs S T/C contacted with SPOA: reported that there had been an escalation of incidents with neighbour. Requested earlier appointment for Mr S: 29 November 2012.	
29/11/2012	LCFT notes	SPOA assessment: no action taken Awaiting outpatient appointment with SPOA consultant.	
11/12/2012	LCFT notes	Review by SPOA consultant: recommended further assessments take place as Mr S suffering for PTSD and mixed anxiety and	Mrs S had started counselling. ADHD: Attention deficit hyperactivity disorder CCTT: complex care and treatment team

		depressive symptoms, poor sleep. It was noted he also had symptoms of Adult ADHD as he had demonstrated conduct disorder in the past as well as having anti-social personality traits. Referral made to CCTT for further assessment and support, PTSD Service, referral for an ADHD assessment (via the GP requesting funding from the CCG). Prescribed Sertraline.	Sertraline: antidepressant in a group of drugs called selective serotonin reuptake inhibitors
10/01/20113	LCFT notes	SPOA consultant psychiatrist: referral made to CCTT.	
29/01/2013	LCFT notes	Mr S assessed by CCTT: noted that Mr S had been prescribed by Citalopram 10mg: not as yet commenced course. Mr S disclosed previous domestic violence (DV) but reported no longer an issue. Mrs S: disclosed that she was experiencing difficult re her role as Mr S's carer and that she was in receipt of Step 3 services (counselling).	Citalopram antidepressant in a group of drugs called selective serotonin reuptake inhibitors. Possible prescribed by GP. Step 3: well-being support service
11/2/2013	LCFT notes	Risk assessment completed by CCTT: risk to self was rated low, risk to others rated medium.	noted that Mr S was no longer drinking alcohol
15/2/2013	LCFT notes	Discussion between the clinical psychologist and care coordinator: Mr S refused to attend Links group On referral list for psychological and mental health formulation assessments.	Links group: 12-session programme meeting : psycho education group
18/02/13	LCFT notes	Mr S seen by his care coordinator. Physical health check completed during the appointment.	Mrs S present: she reported that she was managing. Agreed to have a Carers assessment. Occurred May 2013
28/03/13	LCFT notes	Mr S assessed by psychiatrist: assessed that Mr S was not currently suitable for psychological impute at present. Plan to liaise with GP: re previous antidepressants. Mr S reported that he had recently being prescribed Citalopram and Amitriptyline. But has not taken either.	Mr S attended assessment Amitriptyline: tricyclic antidepressant used also to relieve the chronic (long-term) pain muscle relaxant
10/04/2013	LCFT notes	Mr S T/C to the duty worker. Requesting another care coordinator. Agreed to discuss when care coordinator returned to work (care coordinator off on sick leave).	
20/05/13	LCFT notes	Home visit by care coordinator: Mr S very agitated and distressed. Reported that he was not taking his medication.	

23/5/2013	LCFT notes and assessment letter	ADHD assessment.	
19/6/2013	LCFT notes	Home visit by care coordinator: Mr S reported that ADHD consultant in informed him he does not have a diagnosis of ADHD.	
20/6/2013	LCFT	Mr S seen by carer's support worker.	
28/06/2013	LCFT notes	Medication review with psychiatrist. Diagnosis: depression. Mr S reported that he had stopped taking the mirtazapine after two days. Mr S agreed to see psychologist. Risk assessed as low to others. Discussed prescribing Olanzapine.	Mirtazapine antidepressant used to treat major depressive disorder ECG required prior to prescribing Olanzapine
02/07/2013	LCFT notes	Mrs S T/C care coordinator: reporting that Mr S had a further altercation with neighbour. Police involved. Mr S requesting prescription of Olanzapine.	
04/07/2013	LCFT notes	Outpatient appointment with Mr S. Prescribed olanzapine initially 2.5mg to be increased to 5mg. Letter to GP: recommended GP to request funding from the Clinical Commissioning Group (CCG) for autistic spectrum disorder assessment.	Letter received from Adult ADHD service: Mr S may have Asperger's Syndrome, PTSD but not ADHD.
25/07/2013	LCFT notes	Home visit care coordinator: Mr S reported that they were applying for a house transfer due to ongoing difficulties with neighbours.	Mrs S reported receiving carers support
30/07/13	LCFT notes	Mrs S cancelled Mr S's appointment with psychologist due to "other commitments".	
08/08/2013	LCFT notes	Psychologist assessment: Both Mr and Mrs S present.	
16/08/2013	LCFT notes	Care coordinator sent letter supporting Mr S's housing application.	
29/08/2013	LCFT notes	Care coordinator home visit: Mr S reported that he had started his medication.	Mrs S reported she was still receiving carer's support
03/09/13	LCFT notes	Medication review: To continue on Olanzapine and a prescription of Olanzapine 2.5 mg nocte for 4 weeks. Outpatient clinic appointment in 3 months-times or sooner at care coordinator's request. Risk assessment completed.	
16/09/2013	LCFT notes	Clinical Psychology appointment: Mrs S reported stated there were times when she felt unsafe, especially	Mr S reported that he could not guarantee Mrs S's safety

		when Mr S grabbed her or when he became angry. Advised to contact the police when she felt unsafe, or to leave the house. Mr S was invited to an individual session the next week to discuss her own needs .The psychologist to e-mail the care coordinator to inform her of the conversation with Mrs and Mr S regarding DV in relation to domestic violence.	
24/09/2013	LCFT notes	Clinical Psychology appointment with Mrs S: she gave full disclosure of past and present DV. Report Mr S's he had not been physically violent towards her since he stopped drinking. But reported an incident 8 months ago; when Mr S had kicked a table at her, but she said that there have not been any more occasions of physical violence. Mrs S reported that she was still scared of Mr S. Follow up plan: to meet Mr S individually the following week and then return to joint sessions. The psychologist planned to inform the care coordinator of ongoing concerns of risks.	No risk assessment undertaken in response to letter.
30/09/2013	LCFT notes	Home visit by care coordinator.	
02/10/2013	LCFT notes	Psychologist: to record that Mr S's scores on the Depression, Anxiety and Stress Scale (DASS21) indicated extremely severe depression, anxiety and stress. Themes around worthlessness, hopelessness and agitation were present in his answers.	
03/10/2013	LCFT notes	Psychologist appointment: Mr S seen alone. Mr S acknowledged that he needed to take more responsibility in keeping Mrs S safe from his aggression and violence. Reported some childhood abuse.	

11/10/2013	LCFT notes	Psychologist appointment: Mr and Mrs S attended. Reported rat infestation. Mrs S explained she felt that Mr S had excessive control over her life, especially at an emotional level. Not able to leave him on his own as he would get into trouble. Risk and safety assessment: Mrs S reported that she felt scared of Mr S and was constantly wary of him. She also reported that she has not dismissed the possibility that Mr S might kill her if he is not able to control his temper. They agreed two strategies to reduce the risk to Mrs S: to stay 6 feet away from each other when they are having an argument /when Mr S starts becoming agitated. To allow each other time out when they feel angry or agitated.	
17/10/2013	LCFT notes	Care coordinator contacted council regarding rat infestation.	
18/10/2013	LCFT notes	Psychologist appointment: Mrs S reported that she felt under pressure and she told Mr S that her support was not unconditional and if he continued treating her badly she would leave.	
22/10/2013	LCFT notes	Care coordinator home visit: Mr S reported that he was taking his medication and it was having some significant effects.	
23/10/2013	LCFT notes	Psychologist appointment: Mrs S cancelled due to building work.	
30/10/2013	LCFT notes	Psychologist appointment: Female AA also reported an occasion when she tried to use time out Mr S followed her and grabbed her hand in order to gain her attention. She reported that although this incident did not lead to anything further, she felt scared. PTSD support discussed but that as Mr S had very limited coping strategies it was not appropriate.	
6/11/2013	DHR	Mrs S met with carers support worker.	
08/11/2013	LCFT notes	Psychologist appointment: some improvement report re Mr S's anger and being more sociable with family.	
13/11/2013	LCFT notes	Psychologist appointment: cancelled by Mr S. Car in garage	
21/11/2013	LCFT notes	Home visit care coordinator: discussed housing issues etc.	

22/11/2013	LCFT notes	Psychologist appointment: Mr S reported that he was still finding it difficult to manage his anger and he found his feelings escalating abruptly. Mrs S reported that previous week Mr S had become agitated and grabbed her and verbal aggression. Mr S reported that he wanted Mr S with him at all times, as he felt unsafe when she was not there. He may seek to find those he thought responsible for his daughter's death. Also thought that Mrs S was a substitute for the mother that he never had. Mrs S reported that she was happy to stay and continue living together, but that she felt "imprisoned" and isolated.	Risk: "no specific risk related concerns It was recorded that both Mr and Mrs S appeared to becoming increasingly more able to facilitate each other's safety by making progress on maintaining physical distance and time out during conflict
29/11/2013	LCFT notes	Psychologist appointment cancelled as Mr S was unwell.	
03/12/2013	LCFT notes	Medication review: Safety profile was completed, risk was rated as low although the Mr S reported ongoing difficulty with anger and Mrs S reported feeling scared and reported several incidents where he had grabbed her. Safety profile and risk review: risk low	The outpatient appointment was a CPA review
05/12/2013	LCFT notes	Psychologist appointment: Mr and Mrs S reported that they had an argument where Mr S grabbed her again. He admitted this was wrong. Mr S reported that on occasions when Mr S disagreed with female her decisions he tried to prevent her: e.g. having an intrusive medical examination that her doctors thought necessary.	Agreed a further 5 sessions
16/12/2013	LCFT notes	Psychologist appointment: discussed Mr S concerns about his physical health. Mr S reported that doctors had suggested that these symptoms could be stress related. They reiterated that they did not feel Mr S could be left alone even for an hour. He reported that he did not know how to deal with people on his own and he would try to take revenge for his daughter's death and he would be in trouble if left alone. He disclosed his criminal past history.	Risk assessed : no further concerns raised
19/12/2013	LCFT notes	Care coordinator home visit: both reported that they had been out to see friends and that their therapy had	

		help.	
10/01/2014	LCFT notes	Psychologist appointment: Mrs S reported that she felt “suppressed” and “imprisoned”, by Mr S. Does not feel she has freedom to behave the way she wants to at home, or visit her friends as much as she wants to. Discussed health issues: doctors unable to find a physical cause. Mr S refused to consider the possibility that his worry around his health might have psychological causes. Both reported that there have not been any incidents of aggression for weeks although Mrs S was reluctant to believe that this progress can be stable. She stated that past experience has taught her to be apprehensive when Mr S becomes quiet, as she has learnt to expect a “blow up”. Psychologist informed them that she was leaving. Therapist was leaving the team in mid-February 2013; Mr S reported that he did not want to talk to anyone else.	
14/01/2014	DHR	Mrs S met with carer's support worker.	
16/01/2014	LCFT notes	Care coordinator home visit: Mr S reported being excessively anxious about his health. Refusing to see his doctor. He was continually self-diagnosing himself with terminal illnesses and catastrophizing situations. Mrs S expressed her concerns that psychologist support was ending.	
17/01/2014	LCFT notes	Psychologist session: Mr S cancelled due to physical health.	
24/01/2014	LCFT notes	Psychologist session: Mr S reported his physical health concerns. Mrs S reported that she was worried that Mr S could be verbally aggressive again if there was a trigger. Discussed how Mrs S’s independence and how they could possibly facilitate. Continued therapy was not recommended as Mr S was not in a place where he could consider taking an active role in making more positive changes. Mrs S felt that therapy had helped them improve their everyday life and she was concerned about what would happen when therapy stopped. She	

		was informed that they could be re-referred if Mr S was ready to move on. Mrs S disclosed that before Mr S's referral to the CCTT, she was suicidal and was frequently thinking about ending her life. She also disclosed that after her daughter's death, she took an overdose which did not require hospital intervention. She reported that at some point she had stopped taking her heart medication some years ago, with the intention to harm herself. But subsequently re started them. She occasionally had thoughts about ending her life but she had no intentions to act on these thoughts. Mr S expressed that due to his physical health issues he had some thoughts that he wanted to die.	
31/01/2014	LCFT notes	Psychologist appointment: cancelled due to Mr S's physical health.	
06/02/2014	LCFT and GP notes	Psychologist appointment: cancelled by Mrs S due to Mr S's physical health. Mrs S reported that Mr S's on-going preoccupation and obsessive thoughts about his health had worsened. She reported feeling overwhelmed. Discussed coping strategies. Mr S was reminded that if they felt Mr S needed further psychological help, they could ask for a re-referral, provided that he was ready to move forward and identify goals for the future. GP appointment (attended with Mrs S): Mr S very anxious and was experiencing physical health issues: Agreed to undertake full blood screen.	
10/02/2014	GP notes	Mr S presented with acute stomach pains. GP referenced him to admission ward Mr S admitted to hospital with a 1 week history of vomiting, diarrhoea and abdominal pain. Discharged.	
13/02/2014	LCFT notes	Care coordinator appointment: she was informed that Mr S had attended his GP's with gastric pain and GP had referred him to A+E and an ultrasound scan and blood tests were completed. He was awaiting an endoscopy appointment. Mr S continued to report concerns	Metronidazole: anti-biotic used to treat infections caused by bacteria or parasites. Buscopan: antispasmodics, to relieve painful colicky aching and spasm in the bowel associated with Irritable Bowel Syndrome

		regarding his health. GP prescribed Buscopan and metronidazole for a possible intestine or gastric infection. Mr S reported that he had discontinued his olanzapine for the previous 7 days but had recommenced it (2 days prior the visit). Discussed his obsession due to his mother refusing to get medical help for him as a child. Mrs S reported she was still being supported by Carer's Support worker. Informed care coordinator that their psychology sessions had ended. Mr S requested a medication review with the CCTT consultant.	
21/02/2014	GP notes	Mr S present with anxiety regarding his physical health. Noted that he had restarted Olanzapine.	Olanzapine is an atypical antipsychotic
27/02/2014	LCFT notes	Medication review with consultant psychiatrist CCTT: Mr S appeared very preoccupied about his physical health. He was frustrated and appeared angry on occasions, especially when he was interrupted by Mr S during the consultation. He informed consultant that psychologist had ended. Prescribed: Sertraline 50mg od.	
6/03/2014	GP notes	GP telephone call (T/C) with Mrs S: Mrs S reported that Mr S was continuing to experience physical health issues (vomiting etc.). Reported that Mr S had cancelled colonoscopy but that she had rearranged it. GP provided advice.	Colonoscopy: looks at the inner lining of large intestine (rectum and colon)
8/03/214	DHR	Mr S was admitted to hospital via ambulance presenting 4/5 week history of vomiting, diarrhoea and abdominal pain.	
11/03/2014	DHR	Mr S was discharged from inpatient unit.	
12/03/2014	LCFT	Care coordinator home visit: On arrival Mr S was upstairs in bed complaining of excessive pain in his stomach/abdomen. Mrs S reported she had taken him to hospital on two occasions; tests had been completed with no conclusive results.	
12/03/2014	DHR	Mr S attended A&E with a 4/5 week history of vomiting, diarrhoea and abdominal pain.	
13/03/2014	GP notes	Home visit: on examination Mr S was	apyrexial: no fever

		apyrexial. Noted that "patient and wife at end of their tether." Requested ambulance to take Mr S to hospital.	
18/03/2014	LCFT	CCTT Duty Person received a call from a doctor at the hospital requesting information on Mr S's mental health. Information was provided but advised that Mr S's care coordinator would be better placed to give more in-depth information.	no indication that care coordinator contacted the hospitals
19/03/2014	GP notes	Mr S discharged from hospital.	
21/03/2014	GP notes	Home visit: GP requested ambulance to take Mr S to hospital.	
27/03/201	LCCT	Care coordinator home visit: Mr S had been discharged but reported that he was not happy with the care he had received and that intended to write a letter of complaint.	
31/03/2014	GP notes	Mrs S attended GP: discussion re Mr S's on-going health issues. She reported that she was upset re care Mr S had been receiving in hospital and that she was in contact with PALS.	PALS: The Patient Advice and Liaison Service
1/4/2014	BFT [231] notes	Mr A attended A&E with chest and abdominal pains. Admitted for pain relief and tests. Liaised with CCTT and previous A&E. Suggested that Mr S's symptoms were functional abdominal pain or psychological. Mrs S expressed her concerns about her husband if he was discharged.	
3/4/2014	BFT notes	Colonoscopy and CT undertaken: results normal.	
07/04/2014	LCFT and BFT notes	Care coordinator T/C to Mrs S: who advised that Mr S in hospital again. He was having gastro investigations due to the ongoing gastric pains. Acute Pain Team reviewed : Mr S reported that oxycodone and IV morphine not effected pain relief. Agreed to try Oramorph 10-20 mgs PRN.	Oxycodone is an opioid pain medication.
14/4/2014	BFT	Mr S discharged. discharge medication: Omeprazole 20 mg Buprenorphine 5 microgram BuTrans patches Diazepam: 2 mg x 3 daily paracetamol 1mg oral x 4 daily	Omeprazole protons pump inhibitor: to treat symptoms of gastroesophageal reflux disease (GERD) and other conditions caused by excess stomach acid. Buprenorphine BuTrans patches: contain a reservoir of buprenorphine that passes slowly from the patch through

[231] BFT Bolton NHS Foundation Trust

		Hyoscine butylbromide 20 mg oral, X 3.	the skin and into the bloodstream Diazepam: Valium. Hyoscine butylbromide is an antispasmodic medicine which is taken to relieve cramps in the stomach, intestines or bladder
25/04/2014	LCFT	Care coordinator home visit: Mr S continued to present as distressed over his ongoing physical health concerns. At one point Mr S became verbally aggressive towards Mrs S and asked her to leave the room, shouting that she did not understand the extent of his physical pain. Mr S reported that he was not taking his medication as he did not feel it was having any therapeutic effect, Next CCTT Outpatients Appointment was arranged for 2 May 2014. The care coordinator advised that Mrs A contact the carer support worker.	
26/4/2014	BFT	Mr S presented to A&E with same symptoms (chest and abdominal pains). Admitted.	
27/4/2014	BFT	Discharged from hospital.	
29/04/2014	LCFT	Incident occurred.	