Wiltshire Joint Domestic Homicide and Mental Health Homicide Investigation

EXECUTIVE SUMMARY OF THE OVERVIEW REPORT

Into the homicide of Adult A 18th April 2014

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Section One: Introduction

1.1 This Domestic and Mental Homicide Review examine the circumstances surrounding the death of Adult A (pseudonym) in a small village in Wiltshire on 18th April 2014.

1.2. **Incident**

At 1344 hours, on Friday 18th April, 2014, a telephone call was received by Wiltshire Police Control Room from Adult J (pseudonym) stating that he had killed his wife with a knife.

At 1347 hours, two Police Officers attended the address. Adult J was sat on the doorstep with traces of blood on his clothing.

As the officers approached Adult J, he said: “I’ve killed my wife”.

The officers entered the address and found Adult A sat against a wall in the dining room. There was a single puncture wound to her chest, and some blood on the floor near to where she was sitting.

Adult J was subsequently arrested on suspicion of murder, the next day he was charged with the murder of Adult A and was remanded in custody, prior to being sectioned and transferred to a mental health hospital.

Adult J pleaded guilty to Adult A’s manslaughter at Crown Court in January 2015 and was later given a Restriction Order under Section 41 of the Mental Health Act 1983. The order restricts Adult J’s discharge, transfer or leave of absence from a secure hospital without the consent of the Secretary of State.

A postmortem on Adult A found that a single stab wound had been sustained to the upper left side of her chest which had transfixed the heart.

Section Two: The Review Process

2.1. This summary outlines the process undertaken by the Wiltshire Domestic and Mental Health Homicide Review Panel in reviewing the murder of Adult A.

2.2. A Domestic Homicide Review (DHR) was recommended and commissioned by the Wiltshire Community Safety Partnership in line with section 9 of the Domestic Violence, Crime and Victims Act 2004 and the expectations of the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews 2011. The Home Office was informed of the intention to conduct a DHR on the 7th May 2014.

2.3. As the circumstances of the homicide also meet the requirements for an independent investigation into mental health homicides as per The Health Service Guidance 94(27) (as amended), NHS England have agreed with the Wiltshire Community Safety Partnership to hold a joint independent Review as it was acknowledged that as the facts and aims would be the same, i.e. to identify what lessons should be learnt by agencies (if any) and what recommendations are required to address them.

2.4. The process began on 8th July 2014 with an initial Review Panel meeting of agencies that potentially had contact with Adult A and her husband Adult J, prior to Adult A's death.

2.5 Adult A's and Adult J's three sons were contacted at the start of the Review and were kept informed throughout the Review by the Chair. The sons who were in contact with the Homicide Support Service were also provided with details of the charity AAFDA.

2.6. The three sons were notified of the Review's final report and one, representing the family, expressed his disappointment with the conclusions of the Review.

2.7. The agencies participating in this Review are:-

- Army Provost Marshal*
- Avon & Wiltshire Mental Health Partnership NHS Trust (AWP)*
- NHS England
- NHS Wiltshire CCG
- National Probation Service
- Salisbury Plain Health Partnership*
- Wiltshire Police*
- IDVA Service Victim Support

2.8. Agencies were asked to give chronological accounts of their contact with the perpetrator and victim prior to the homicide. Where there was no involvement or insignificant involvement, agencies advised accordingly. In line with the Terms of

Reference, the DHR has covered in detail the period from 1st January 2012 to 18th April 2014, although the Army and Health Services have included relevant contacts prior to 2012.

2.9. Nine agencies were contacted about this Review. Five have responded as having had no contact with the family.

2.10. Four have responded with information indicating some level of involvement with the family and have completed either an Individual Management Review (IMR) or a report. They are identified with an * in paragraph 2.6 above. It should be noted that the contacts with Wiltshire Police were minor and not relevant to this case, other than the contacts post the homicide.

Section Three: The Facts

3. A summary of the facts obtained from IMRs, reports and from the family is as follows:

3.1. In 1962 at the age of 16, Adult J had joined the British Army as a boy soldier. He was in the Army for 31 years, serving in several different parts of the world. He retired as a Major in 1993 and then established his own business selling Army memorabilia.

3.2. Adult A and Adult J had been married for 44 years; they had three sons, who are all adults in their 30s and 40s. All three describe their parents as being a happy loving couple. They were categoric that there had never been any previous domestic abuse between Adult J and Adult A. They did state that their father was strict with them as they grew up.

3.3. One of Adult J and Adult A's grandsons lived with them from the age of 11. He was aged 21 at the time of the incident. In his opinion the house was a very happy one, he never heard his grandparents arguing.

3.4. Adult J was first diagnosed with depression in 1989 while he was still in the Army following a two year attachment in Oman. Matters were discussed with his wife, Adult A, who made it clear there were no particular worries about the home, their finances, or the behaviour of their children.

3.5. Initially Adult J was prescribed medication, however he failed to comply with the prescription and his general state had continued to deteriorate. Consequently he was admitted to a military hospital. Medication was discontinued and he was placed on a course of Electro-Convulsive Therapy (ECT), to which he responded "extremely well". He had also been placed on amitripyline 150 mg nightly. He was discharged in February 1990 and arrangements were made for him to be followed up as an outpatient.

3.6. In 1993 Adult J was admitted to a hospital in Salisbury following an overdose of paracetamol tablets. He was diagnosed with depression and continued to experience suicidal thoughts during this admission. Whilst there was some initial improvement he later became more depressed and his medication was increased. As he remained depressed, he was given four sessions of (ECT). He became more motivated and cheerful. He was discharged from hospital, to continue taking paroxetine daily.

3.7. Between 1995 and 2003 Adult J had five further severe depressive episodes, each of which resulted in hospital admissions and courses of ECT to which he responded positively.

3.8. In October 2005, he reported that he felt low, having stopped taking his medication and he was advised to increase his prescription to paroxetine 50mg and lithium 800mg. He improved without requiring admission to hospital or ECT.

3.9. Between 2005 and 2014 Adult J remained stable on medication, with no mental health issues although his medical notes do refer to compliance problems regarding him regularly taking his medication.

3.10. On 31st March 2014 Adult J attended his GP surgery, accompanied by Adult A. He said he was again suffering an episode of depression. He admitted he had reduced taking his medication of paroxetine to alternative days and had only been taking them sporadically over the past few months. An appointment was made to review him regarding his depression in two weeks.

3.11. On the 4th April 2014, Adult J had a telephone consultation with his GP. He explained that he had started taking his paroxetine, regularly again, but they did not seem to be as effective. He said he takes them each morning but he is struggling to sleep and feeling unsteady on his feet. His GP prescribed amitriptyline at night and gave him a follow-up appointment in ten days.

3.12. Three days later, on 7th April, after a telephone consultation, arrangements were made for Adult J to be seen at the surgery later that morning. His medical record notes state “he was on paroxetine for years and stable on this, now worried he will harm himself or harm his wife? refer to PCLS (Primary Care Liaison Service) / restart antidepressants/booking for a review/consider for crisis team today depending on how he presents”

3.13. Half an hour later, at about 9.50am, Adult J was seen at the GP surgery by a doctor. The records show that “he was depressed and agitated”. It was noted that he had “a history of major depression, requiring ECT and that he had a history of overdose. The case was discussed with the PCLS. The dangers of prescribing amitriptyline was pointed out, due to the risk of overdose. It was stopped and diazepam prescribed. PCLS will review him hopefully this week. Number given to patient in case of crisis. I will review patient next week.”

3.14. At 11.45am on 7th April 2014 Adult J’s referral was made by telephone to PCLS requesting “a triage level of timeliness”. At 2.32pm information from the GP records was downloaded by the surgery. It is not known what time this was faxed to the PCLS team. Later the same day, at 6.09 pm, the PCLS/Intensive team nurse telephoned Adult J and he was offered routine assessment in approximately three weeks.

3.15. On the morning of the 8th April 2014 the information from the GP was uploaded on to RiO (the Avon and Wiltshire Mental Health Partnership’s electronic record system).

3.16. On 10th April the PCLS manager received a telephone call from Adult J, who sought information re medication. No new concerns were identified.

3.17. On 11th April Adult A telephoned to speak to a GP, being concerned that her husband would soon run out of diazepam. It was explained to her that this was not a regular medication but had been given to establish a sleeping pattern.

3.18. At 2.53 pm on 14th April 2014 Adult A telephoned the GP surgery to raise her concerns that there had been no major intervention the previous week, Adult J had received a telephone call and was advised to do exercise and get out of the house for a walk. Consequently the GP telephoned the PCLS manager and explained the deterioration in Adult J’s mental health. At 5pm the same day, two nurses from Avon and Wiltshire Mental Health Partnership’s Intensive Team met with Adult J and Adult A. They completed an assessment including a risk assessment and

agreed a plan for home assessment, including a medical review from a Consultant Psychiatrist.

3.19. Adult A and Adult J were seen by the Intensive Team Consultant Psychiatrist for a medical review. The notes show “a continuation of the home treatment plan, a review of medication, a change was offered but declined as was an ECT. A provisional appointment was made for an ECT assessment so that it could be quickly arranged if Adult J changed his mind”.

3.20. On16th April a home visit was made to Adult J and Adult A by a PCLS and Intensive Team nurse. Support was offered and a care plan was agreed and signed.

3.21. On 17th April 2014 an Intensive Team nurse again made a home visit. Adult J was taken out for a walk and Adult A was spoken to on their return.

3.22. At 11.30am on 18th April 2014 two Intensive Team nurses made a home visit. One took Adult J for a walk while the other stayed and spoke to Adult A about her needs. Before leaving, the nurses spoke to Adult J and Adult A together. At 1.20pm the same day one of the nurses telephoned Adult A to arrange the next visit and to confirm the following week’s support of Adult J. She raised no concerns and sounded calm.

3.23. At about 1.40pm the Avon and Wiltshire Mental Health Partnership and the Police received calls from Adult J stating he had killed his wife. The summary of the incident is set out in paragraph 1.2 of this report.

Section Four: Terms of Reference

The joint review will look into the circumstances surrounding the death of Adult A on Friday 18th April 2014.

4.1 **Purpose of the Reviews**

4.1.1 The purpose of the Domestic Homicide Review is to:

- Ensure the review is conducted according to best practice, with effective analysis and conclusions of the information related to the case.
- Establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and support victims of domestic violence including their dependent children.
- Identify clearly what those lessons are, both within and between agencies, how and within what timescales they will be acted on and what is expected to change as a result.
- Apply these lessons to service responses including changes to policies and procedures as appropriate; and

  Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

4.1.2 The purpose of the Mental Health Homicide Investigation is that:-

- Independent investigations are intended to examine the care and treatment of patients and establish whether or not a homicide could have been predicted or prevented and if any lessons can be learned for the future to reduce the chances of reoccurrence of a similar incident.
- This process will also increase public confidence in statutory mental health service providers.
- By undertaking independent investigations and the publication of the findings will ensure that Trusts/Providers implement the report's recommendations and action plans.
- The reports are appropriately shared with other providers and commissioners so that they take account of the lessons learnt and put mitigations in place to reduce the chances of similar incidents from occurring in their own services.

* Commissioners are expected to play an active role in ensuring that the services they purchase are of a high standard, in line with the NHS Standard Contract. Commissioners must be satisfied and assured with the level and standard of service they commission and can make unannounced visits to check, ascertain and assure themselves of the quality of services patients are receiving.

* The role of families and carers (which includes next of kin, friends and extended families) of both the deceased and the perpetrator is central. Families should be treated fairly, with respect and dignity and seen as central to undertaking independent investigations. This is in line with the Department of Health's "No decision about me, without me", the NHS Constitution and s13H of the NHS Act 2006 (as amended).

4.2 **Overview and Accountability**

4.2.1 The decision for Wiltshire to undertake a Domestic Homicide Review (DHR) was taken by the Chair of the Wiltshire Community Safety Partnership on the 6th May 2014 and the Home Office informed on 7th May 2014. The decision to hold a Mental Health Homicide Review was taken by Regional Homicide Group – NHS England South on 26th June 2014. In recognition of national good practice, the decision was taken to undertake a combined review.

4.2.2 In accordance with statutory guidance where practically possible both DHRs and MHHRs should be completed within 6 months of the decision made to proceed with the review. In this case a decision has been made to adjourn the completion of the joint review until after the conclusion of any criminal proceedings.

4.2.3 This joint review which is committed, within the spirit of the Equalities Act 2010, to an ethos of fairness, equality, openness, and transparency, will be conducted in a thorough, accurate and meticulous manner.

4.3 **The Review will consider:**

4.3.1 Each agency's involvement with the following from 1st January 2012 and the death of Adult A on 18th April 2014. Other than Army and Health Services which will include all relevant health issues prior to that period.

a) Adult A - 64 years of age at time of her death of Wiltshire
b) Adult J - 68 years of age at date of incident of Wiltshire

4.3.2 Whether there was any previous history of violent behaviour by the perpetrator towards himself, the deceased, their children or grandchildren, and whether this was known to any agencies.

4.3.3 Whether family, friends or colleagues want to participate in the review. If so, ascertain whether they were aware of any abusive or violent behaviour or concerns about the perpetrator's mental health to himself, the victim, their children or grandchildren, prior to the homicide.

4.3.4 Whether, in relation to the family members, were there any barriers experienced in reporting abuse or violence or accessing information and support for Adult J's mental health?

4.3.5 Could improvement in any of the following have led to a different outcome for Adult A considering: -

a) Communication and information sharing between all services

b) Information sharing between services with regard to the safeguarding of adults and children
c) Communication within services
d) Communication between health services and the family regarding Adult J's mental health
e) Communication to the general public and non-specialist services about available specialist services, including transfer of health records to the NHS

4.3.6 Whether the work undertaken by services in this case are consistent with each organisation's:

a) Professional standards in line with statutory guidance and best practice
b) Domestic abuse policy, procedures and protocols

4.3.7 The response of the relevant agencies to any referrals relating to Adult A concerning domestic abuse or other significant harm from 1st January 2012 and her death on 18th April 2014. Other than Army and Health Services who will include any relevant health issues prior to that period. It will seek to understand what decisions were taken and what actions were carried out, or not, and establish the reasons. In particular, the following areas will be explored:

a) Identification of the key opportunities for assessment, decision making and effective intervention in this case from the point of any first contact onwards with victim, perpetrator, their children or grandchildren.

b) Whether any actions taken were in accordance with assessments and decisions made and whether those interventions were timely and effective.

c) Whether appropriate services were offered/provided and/or relevant enquiries made in the light of any assessments made

d) The quality of any risk assessments undertaken by each agency in respect of Adult A and Adult J

4.3.8 Where an organisation has thresholds which must be reached prior to a particular intervention or treatment being considered, are those thresholds set appropriately and applied correctly.

4.3.9 Whether practices by all agencies were sensitive to the ethnic, cultural (being a war veteran), linguistic and religious identity of the respective family members and whether any specialist needs on the part of the subjects were explored, shared appropriately and recorded.

4.3.10 Whether issues were escalated to senior management or other organisations and professionals, if appropriate, and completed in a timely manner.

4.3.11 Whether, any training or awareness raising requirements are identified to ensure a greater knowledge and understanding of domestic abuse processes and/or services.

4.3.12 Specifically relating to health issues:

- To evaluate the mental health care and treatment Adult J received including the adequacy of risk assessment, management and care planning.

- To review if the treatment pathway and options were appropriate, adequate and in line with NICE guidance and best practice.
- To understand any potential effect of changes in medication may have had? And what monitoring was in place.
- To understand the assessment decision that was made not to admit Adult J? What plans were put in place?
- Identify care or service delivery issues along with the factor that might have contributed to this incident including engagement with services and staff.
- To review if Adult J's war veteran status was considered and if he was offered access to specialist services.
- The Chair and Panel agreed that if the family consent and understand the needs for confidentiality, health service organisations can contact family members during this investigation, in line with Department of Health best practice guidance.

4.3.13 The review will consider any other information that is found to be relevant.

Section Five: Key issues arising from the Review

5.1 The Review provides an opportunity to analyse all of the information obtained from agencies and from family and friends. It is clear that Adult A and Adult J's relationship was a close, loving one and there were never any incidents of domestic abuse known to their children, grandchildren or outside agencies. There were no relevant police records in relation to either of them. The key issues relate to Adult J's recurring bouts of depression and the treatment he was given, particularly from March 2014. These were also the topics that Adult A and Adult J's sons asked the Review to focus on; i.e. Adult J's depression and in particular, on the nature and timing of the treatment he received just prior to the homicide.

5.2 Adult J had suffered from recurring episodes of depression from 1989 when he was first admitted to hospital and received ECT treatment. While his condition was mainly regulated with medication, he had, on occasions, failed to comply with medical direction, by not taking his medication regularly. Subsequently, on a further six occasions between 1993 and 2003, he was admitted to hospital and received ECT treatment, to which he responded positively. However, in October 2005, Adult J went to his GP feeling low, usually the first signs that his depression was returning. He said he had stopped taking his medication regularly as he had been feeling so well, his prescription was increased and he improved without hospital or ECT treatment.

5.3 Adult J's final episode of depression, which resulted in him stabbing his wife, first came to notice on 31st March 2014 is detailed in paragraphs 3.10 to 3.23 above.

The core points are:

- Adult J had a history of not taking his medication regularly when he felt well, and on eight occasions, from 1998 up to 2005, this resulted in the recurrence of acute depression.

- On seven of these previous episodes of depression he was admitted to hospital and given ECT treatment to which he responded positively. On the last occasion he responded to medication alone. This was recorded in his historic written medical record, which was not read by the AWP Intensive Team nurses prior to or while treating him.

- Adult J's GP prescribed amitriptyline to help him sleep but was informed by PCLS that there were risks in giving this medication to someone with Adult J's history of overdosing.

- Adult J's concerns, to his GP on 7th April 2014, that he may harm himself or harm his wife, while included in a fax to PCLS, was not communicated clearly to/through the PCLS to the Intensive Team. (The Avon and Wiltshire Mental Health Partnership NHS Trust IMR identifies staff shortages at the time as a possible reason).

- Initially it took too long for someone from the PCLS/Intensive Team to see him, (possibly because his needs were categorised as urgent not crisis).

When the seriousness of his depression was recognised he was then seen promptly and often.

- Intensive Team nurses had not received training in working with patients over 65, and did not recognise common age related characteristics. Adult J and Adult A were persuaded to agree to community/home based treatment rather that hospital admission and ECT treatment, although ECT treatment was later offered and rejected by Adult J. (Adult A and Adult J's family and friend have informed the Review that Adult J and Adult A felt pressurised into accepting home treatment rather than hospital admission and ECT treatment which they knew from experience worked).

5.4 One "Equality" issue was identified during the Review relating to Adult J's age and army veteran status. The Avon and Wiltshire Mental Health Partnership IMR author highlighted as a lesson learnt that Intensive Team staff had not received training in managing issues with older people. This is set out in more detail later in this Executive Summary.

Section Six: Lessons to be learned

6.1 The following agencies that had contact with Adult J and Adult A have identified the following lessons they have learnt during the Review. Neither the Army or police had any lessons to learn or recommendations to make.

6.2 **Avon and Wiltshire Mental Health Partnership NHS Trust**

6.2.1 Key information regarding risk in the summary of GP contacts sent to secondary services does not appear to have been reviewed or noted by the clinical teams involved

6.2.2 PCLS Team capacity: the team is not fully staffed either in terms of clinical staff or administrative staff and this has an impact on the teams' ability to provide urgent assessments and to ensure that the service operates smoothly

6.2.3 Intensive Team members reported that they have received no training in managing issues with older people although they have been working with this client group for some time. Individual staff were not confident in identifying some potentially important factors in the care of older adults with a functional illness, such as the tendency for them to be less likely to contact the team themselves and the slower response to anti-depressants in over 65's.

6.2.4 The old paper records were requested but not received by the Intensive Team before this incident occurred. This was a significant concern for the family. Review of these would have shown the service user's pattern of rapid decompensation. This would not have changed the management of his care (as he was seen so frequently), but it could have been helpful in alerting the team to the likely level of input needed. There was no information in these records that would have had an impact on the assessment of risk in this case. It appears that teams are less inclined to actively seek out old paper records or that they arrive more slowly since the advent of the RiO electronic record.

6.2.5 Service users and their families may accept the advice of clinical teams without challenging it, not because they are necessarily happy to do so, but because they trust 'the experts' to provide sound clinical advice. The Intensive Team is right to attempt to persuade service users and their families of the potential benefits of a service for which there is a strong evidence base, but it is easy to see how this can be interpreted as a pressure to agree to the treatment offered. The Root Cause Analysis chairs are clear that the team believed this service user and his wife were happy to accept the plan suggested to them by the team, but it may be helpful for the team to reflect on the family's feedback that this couple had significant reservations about the plan of which they were unaware.

6.3 **Salisbury Plain Health Partnership**

6.3.1 There is a risk of using amitriptyline to overdose, and it should not be used in patients who have a history of overdose, or if so, only with careful precautions taken to limit the risk.

6.3.2 There must be an effective audit trail in place for all documents leaving the GP surgery.

Section Seven: Conclusions

7.1 In reaching their conclusions the Review Panel has focused on the questions:

- Have the agencies involved in the Review used the opportunity to review their contacts with Adult A and Adult J in line with the Terms of Reference (ToR) of the Review and to openly identify and address lessons learnt?
- Will the actions they take improve the safety of domestic abuse victims and/or people with mental health disorders in Wiltshire in the future?
- Was Adult A's death predictable?
- Could/Should Adult A's death have been prevented?

7.2 The IMRs have been open and thorough. The organisations have used their participation in the review, to identify and address lessons learnt from their contacts with Adult A and Adult J in line with the Terms of Reference (ToR).

7.3 The Review Panel is satisfied that the agreed recommendations address the needs identified from the lessons learnt. Provided those recommendations are fully and promptly implemented, they will improve the safety of people suffering with mental health disorders, their families and friends. The Panel accepts there is no evidence of any domestic abuse occurring between Adult J and Adult A prior to this incident.

7.4 **Was Adult A's death predictable?**

7.4.1 Adult J was known to have deliberately self-harmed during some previous bouts of depression, but there is no indication that he had ever harmed any other person.

7.4.2 On 7th April 2014 Adult J had told his GP, during a telephone consultation that he was worried he may harm himself or his wife, this was taken seriously by his GP and he was seen at the surgery within half an hour of the telephone call consultation. There was no explicit record of him repeating these fears during the face to face consultation, but the GP did contact and discuss Adult J's severe depression with the Primary Care Liaison Service (PCLS). He also sent a fax containing the GP notes of the last three consultations to PCLS, although these notes were never brought to the attention of the treating team.

7.4.3 The GP told the PCLS that he had prescribed Adult J amitriptyline. The PCLS advised the GP that amitriptyline can be dangerous if taken in overdose by a person with depression who is a high risk of self-harm. Consequently Adult J's prescription was changed to diazepam. The Review Panel notes that the GP stated that he was fully aware of the risk when any patient overdosed on this particular medication. He considered this when writing the prescription but decided, at that consultation, that the patient appeared to be at low risk of taking an overdose. He acknowledged that he knew that the patient had overdosed in the past, but not for many years. As he was aware of the risks if used in overdose, a very low dose of the medication at 10 mg was prescribed, and the amount issued was limited to 28 days. At this dose the risk of cardiac problems in overdosage is minimal.

7.4.4 When Adult J and Adult A were seen on 14th April 2014 by the Avon and Wiltshire Mental Health Partnership's Intensive Team, a detailed risk assessment was

conducted which included questions relating to self-harm and risk to others. Adult J denied this was an issue when asked these explicit questions. Adult A was also interviewed and gave no indication of any concerns about her safety.

7.4.5 Adult A's and Adult J's relationship had always been perceived as strong and family members have been clear with the Review that there was never any indication of abuse or violence between them previously. The team treating Adult J also made comment on the strength of Adult J's and Adult A's relationship.

7.4.6 The panel notes that the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness states in its 2014 Annual Report that in the period 2002-2012 there were an average of 75 homicides by patients in the UK per year. Within this group, in England, people with affective disorders (including depression) accounted for only 13%. Intimate partner homicides accounted for only 20% of all homicides. Given the very large number of patients with depression at any one time (estimates vary, but as much as 20% of the adult population may be depressed at any one time, amounting to more than ten million people), the likelihood that any given patient with depression will commit homicide is clearly very low indeed. For this reason the panel accepts that in making an assessment of the risk that Adult J would be likely to harm others seriously, the starting point is that this risk would be very low indeed unless there were particular reasons to suggest otherwise. In Adult J's case, there was no history of violence to others; no history of drug or alcohol abuse, no suggestion of personality disorder or psychotic disorder, and nothing other than the single brief remark which he made to the GP at the first presentation to suggest that violence to others was likely in his case.

The Review Panel, after considering all of the information provided, concludes that Adult A's death was not predictable.

7.5 **Could/Should Adult A's death have been prevented?**

7.5.1 In considering if Adult A's death could have been prevented, the Panel accepts there has never been any indication, from a domestic abuse perspective, to suggest that Adult J would ever injure his wife in anyway.

7.5.2 Adult A's and Adult J's sons maintain that the decision to give their father community/home treatment was made on policy grounds or because of a lack of a hospital bed, rather than to meet their father's specific needs. They base this on the discussions they had with Avon and Wiltshire Mental Health Partnership NHS Trust personnel, who they met with on 31st July 2014. They say they had been told "they do not have the capacity to admit everyone". (See Appendix D). The family believes that if immediate action had been taken to admit Adult J to hospital and provide him with ECT treatment, he would have responded positively as he had on seven previous occasions and therefore their mother would still be alive.

7.5.3 The Panel acknowledges that If Adult J had been treated as an inpatient, Adult A's death would have been prevented at that time, as Adult J would have been in hospital. However that is not to suggest that the treatment provided to Adult J was inappropriate. The decision whether to manage Adult J using medication in the community, or to give ECT either as an outpatient or inpatient would have been a complex one, involving a balancing up of many factors. The independent medical adviser to the Review concluded his report with the opinion "When Adult J re-presented in 2014 it was reasonable to consider a trial of medication in his case,

especially as it was possible that paroxetine and/or lithium had helped him to stay well since about 2005. However, given his history of having needed ECT on seven occasions, there was a high likelihood that he would not respond to medication, and he would need ECT again."

7.5.4 Whilst lessons have been identified and will be addressed in line with the recommendations set out during this Review; Adult J's GPs on recognising the depth of his depression, treated him with care and referred him to the specialist service promptly. The AWP Intensive team, once the urgency of the referral was clear, attended to him on a daily basis and did their best to address complex issues; not least of which was identifying the most effective treatment for him, without knowing his full medical history.

7.5.5 Adult J had suffered from bouts of serious depression over a period of almost 25 years. His historic medical notes record that when he felt his mental health was declining, he consistently sought early medical help. On seven of eight such occasions, he was promptly admitted to hospital and responded positively to ECT treatment. On the eighth occasion, in October 2005, he reported that he felt low, having stopped taking his medication and he was advised to increase his prescription to paroxetine 50mg and lithium 800mg. He improved without requiring admission to hospital or ECT and was discharged from follow up on January 2007. He was then stable for several years until his depression in 2014.

7.5.6 The AWP Intensive Team did not have access to Adult J's historic paper medical records and were therefore not aware of his medical history. This was complicated by Adult J and Adult A telling them that he had had ECT twice in the past rather than the seven times he was treated with ECT (he repeated this later to the police).

7.5.7 The Intensive Team kept detailed notes on the RiO electronic note system which is widely used in psychiatric hospitals and which cannot be altered once validated. It was recorded on 14th April 2014 that he had asked for ECT treatment "as the only thing that works." The following day he was seen by a psychiatrist in hospital and the record of that meeting is summarised in Dr Hugh Series' report in Appendix B. It is apparent that ECT was being considered amongst the treatment options "We also talked about the option of ECT and to consider completing the work up in case there is not further improvement in his mental state….."

7.5.8 Prior to reaching a conclusion the Panel has asked the question: **should the treatment plan have been such as to ensure that Adult A's death was prevented?**

7.5.9 To do so, the Panel has considered if the risk assessments were adequate and therefore if home treatment was appropriate. There is clear evidence that full risk assessments were carried out by AWP practitioners at an early stage, but they were completed without the knowledge of all of the information that could have been available to them.

7.5.10 There is no record that during his first telephone referral, the GP informed PCLS about Adult J's fears of harming himself or his wife. The PCLS member of staff who took the call is clear this was not mentioned. Nevertheless this telephone call was followed up with a fax from the surgery which included the notes of Adult J's last three consultations, one of these being the consultation in which Adult J voiced his fears. This fax, which was received at AWP, was not brought to the attention of the practitioners treating Adult J.

7.5.11 It is also accepted that Adult J's full medical records which detailed his history of depression and the effectiveness of the treatment he received were not immediately accessible or read by the AWP PCLS or Intensive Teams who were responsible for Adult J's secondary care treatment.

7.5.12 There was clear duty on the PCLS admin team to ensure that information received from the GP surgery was uploaded into the hospital records promptly and for the clinician to have read it. In the Panel's view, the onus must be on each clinician to update him/herself from the records about what has happened since that person's last contact with the patient. The Panel notes that AWP has a policy requiring practitioners to familiarise themselves with a patient's history before completing risk assessments or treatment plans. In this case this did not happen.

7.5.13 If the practitioners had known the full extent of the use of ECT in the past in Adult J's case it might have made them more likely to advise switching to ECT sooner rather than later. However, even if the historical information had been available to them, this decision was not clear cut; on his previous relapse into depression, Adult J had recovered without needing ECT, and he had been well for a very long period without needing ECT. Adult J's own account to the clinical team, albeit inaccurate, was that he had not needed ECT for 20-25 years, although he had been on medication (see Appendix B for RiO note dated 7 April 2014).

7.5.14 The Review Panel is satisfied that the decision to treat Adult J at home was not based only on the availability of beds, as there is clear evidence that he was offered the opportunity to have inpatient treatment at a hospital further afield. He was also offered ECT treatment as an outpatient.

The Panel therefore concludes that while taking Adult J into hospital for treatment would have prevented Adult A's death at that time. The decisions made by the AWP practitioners were reasonable based on the information and policies available to them.

Section Eight: Recommendations

8.1 **National Recommendations**
There are no national recommendations identified

8.2 **Cross agency recommendations**

8.2.1 Primary and secondary health services in Wiltshire to work together to produce a referral template that is quick and easy to electronically complete at the GP surgery, whilst transferring all relevant clinical and social information to the secondary care service

8.2.2 For all involved organisations to review internal cultures to embed the spirit of organisational participation in future Domestic Homicide Reviews, improving information sharing to reassure families that organisations are supporting the Review process with transparency, integrity and fairness.

8.3.1 **Individual Agency Recommendations**

8.4 **Avon and Wiltshire Mental Health Partnership NHS Trust**

8.4.1 PCLS Team Recommendations

Ensure that there is a system in place for:

i) Routinely screening information that is sent to the team by referrers

ii) Ensuring that a record is made to indicate that this screening process has taken place, and to alert clinicians to new information, for example by recording its existence in the progress notes.

8.4.2 PCLS and Intensive Team Recommendations

i) Ensure that a paper copy of information sent to either team by referrers is filed in the 'blue folder' and that this folder is handed over to any team which subsequently takes over the care of the service user

ii) Ensure that a person's veteran status is highlighted in the Ex-British Armed Forces Indicator, under additional personal information, on RIO.

iii) Ensure that Team Members are familiar with the Veteran's Service website, so that they can suggest service users access it when appropriate

8.4.3 Delivery Unit Recommendations

i) Ensure that ageless services/teams are provided with appropriate training in the needs of both adults of working age and older adults with functional illnesses

ii) Review the staffing of the PCLS service to ensure that there are adequate numbers of substantive clinical and administrative staff

iii) Liaise with primary care services to review the process for sharing information at the point of referral to ensure that: Key information is highlighted and unnecessary information is not provided (as this may breach

the patient's confidentiality and may make significant information harder to identify)

8.4.4 Trust Recommendations

i) Review the process for obtaining paper records in the light of the feedback that this process has 'slowed down' since the advent of RIO and that teams are, therefore, less inclined to seek these out.

iv) Review whether the 'Working with Military Veterans' training should be made available again.

8.5 Salisbury Plain Health Partnership

8. 5.1 GPs should be reminded re the risk of prescribing amitriptyline when there is a risk of overdose. This reminder was given to all GPs at the internal serious incident report review meeting.

8.5.2 Patients who have previously overdosed should be searched for on the clinical system and a screen note added to their notes to act as a reminder prompt for the GPs when consulting with these patients. This happened shortly after the internal serious incident review meeting.

8.5.3. Administration team should follow all standard operating procedures, a reminder to this effect and review of the "Fax out" standard operating procedure took place shortly after the serious incident review meeting.

8.5.4. Since the incident it has been confirmed that the Intensive Team had frequent contact with the patient from 14th April 2014. None of these contacts were known about re date or time or content by the GP, and consideration should be given to improving communication from the Intensive Team/ AWP back to the GP regarding their involvement with patients.