Portsmouth CITY COUNCIL

Multi-Agency Homicide and Suicide Overview Report Into the Deaths of Anne and Martin in September 2022

Date approved:

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Independent Chair and Author

PS SAFEGUARDING LTD

Contents

Preface **2**

1.1 Introduction **4**

1.2 Case Summary **5**

1.3 Background Information about Anne and Martin **9**

1.4 Timescales **10**

1.5 Confidentiality **12**

1.6 Terms of Reference **13**

1.7 Methodology **14**

1.8 Involvement of Family, Friends, Neighbours and Wider Community **16**

1.9 Contributors to the Review **23**

1.10. The Review Panel Members **23**

1.11 Chair and Author of the Overview Report **24**

1.12 Parallel Reviews **24**

1.13 Equality and Diversity **25**

1.14 Dissemination **29**

2.1 The Facts **29**

2.2 Key Events from August 2021 to September 2022 ..... **31**

3.1 Analysis of Agency Involvement **40**

3.2 Analysis of Terms of Reference **58**

4.1 Conclusion **75**

5.1 Lessons to be Learnt **77**

5.2 Recommendations **78**

Acronyms **82**

Preface

The family and friends chose pseudonyms, which were used throughout the review. The only individuals identified are the chair and panel members.

The independent author and review panel send their deepest condolences to all those impacted by Anne and Martin's untimely passing and thank them for their involvement and support in this process.

The primary objective of this review is to permit the learning of lessons from the deaths of persons aged 16 or over who have or appear to have resulted from violence, abuse, or neglect by a person to whom they were related or with whom they had been in an intimate personal relationship or a member of the same household.

Professionals must understand what transpired in each situation for these lessons to be thoroughly and effectively digested.

The author thanked the panel and persons who submitted chronologies, reports, and materials for their time and cooperation.

The author expresses gratitude to the family and friends who assisted with the review to ensure that it appropriately portrayed the lives of Anne and Martin.

Family and Friends Dedication to Anne and Martin

"We are inexplicably devastated beyond belief- it's too hard to say how much we miss them. The world is not what it was without them behind us every step of the way, and it never will be, but we are determined to continue living life the way they taught us to. With confidence, kindness, and positivity."
Ethan & Taylor

"Anne was a strong and positive lady who was always there and supportive."
Tom

"Best couple in the world"
Bart and Gemma

"Martin and Anne were a fun, loving couple who did everything together and adored their children, whom they were very close to. Both were loyal friends who were always helping others, and the events of last September were a complete shock to us all."
Rose and Charlie.

"If I had a son, I'd want him to be Martin; I'm where I am because of him."
Shanella

"Martin was a true friend. The tragic loss of Martin and Anne is as unbelievable as it was on that day."
Mary

1.1 Introduction

1.1.1 The report was commissioned in December 2022 following the tragic death of Anne in September 2022. The Portsmouth Community Safety Partnership (CSP) received a referral from the Hampshire and Isle of Wight Constabulary (Police) on 15 September 2022. The case was discussed at a partnership meeting convened on 7 October 2022. The partnership panel found unanimously that the domestic homicide review criteria had been satisfied.

1.1.2 Adopted in 2011, Section 9(3) of the Domestic Violence, Crime, and Victims Act of 2004 added Domestic Homicide Reviews[1] (DHRs). Domestic homicide review refers to an investigation into the circumstances surrounding the death of a 16-year-old or older individual that has or appears to have been caused by violence, abuse, or neglect.

(a) a person to whom he[2] was related or with whom he was or had been in an intimate personal relationship or
(b) a member of the same household as himself,

Where the definition set out in a or b has been met, then a Domestic Homicide Review should be undertaken. Section 2 of the statutory guidance highlights circumstances which indicate a Domestic Homicide Review.

1.1.3 The review was conducted following the Home Office's Multi-Agency Statutory Guidance for Domestic Homicide Reviews (updated in December 2016). [3]

1.1.4 Before Anne's passing in September 2022, she resided in Portsmouth with her husband, Martin. This review examined the agency's responses and support before their deaths.

1.1.5 The DHR panel deliberated on the family's request, and the agency reports on 31 May 2023 before concluding that the review's scope should be expanded to encompass aspects of Martin's mental health care and treatment which might have influenced the domestic homicide.

1.1.6 On 16 January 2024, NHS England informed the family they would commission an independent review of Martin's mental health treatment and care. The panel agreed that the independent mental health review should be considered concurrently with this review to strengthen learning.

1.1.7 In addition to considering agency involvement, the review will evaluate the last year of their lives (August 2021 – September 2022) to determine any relevant background or history of abuse before their deaths, whether community support was obtained and whether there were barriers to seeking community support. Taking an integrated approach, the review aims to find strategies for reducing the risk associated with such scenarios.

[1] https://www.legislation.gov.uk/ukpga/2004/28/section/9
[2] Section 6 of the Interpretation Act 1978 - words importing the masculine gender includes the feminine
[3] https://www.gov.uk/government/publications/revised-statutory-guidance-for-the-conduct-of-domestic-homicide-reviews

1.1.8 The review will focus on the agency's interactions with Anne and Martin from August 2021 to September 2022. Anne's interaction with services before August 2021 was not relevant to the review, as no issues or learning regarding safeguarding, domestic abuse, or relationship challenges were identified during the panel scoping.

1.1.9 The family and panel agreed on the timeframes, focusing on Anne and Martin's initial contacts with agencies.

1.1.10 This review does not replace criminal or coroner's courts or a disciplinary proceeding.

1.1.11 Friends and neighbours of the couple discovered the body of Anne in the bedroom, and Martin was found hanged within the home.

1.2 Case Summary

1.2.1 Since December 2021, Anne and her family have been concerned regarding Martin's deteriorating mental health. In May 2022, at the age of 65, Martin was referred by his son Ethan twice to primary care mental health services provided by Solent NHS Trust. In June 2022, the GP referred Martin to community mental health services (secondary services or people with complex or long-term mental health conditions that are beyond the scope of primary care).

1.2.2 Mental health services determined in June 2022 that Martin was experiencing high levels of stress and anxiety due to the effects of COVID-19 on the business he managed. On 20 June 2022, the Home Treatment Team (HTT provides assessment and treatment at home for adults with acute mental health issues who would otherwise require hospitalisation[4]) Consultant Psychiatrist (Consultant A) reported Martin to have a diagnosis of Psychotic Depression[5].

1.2.3 Anne was Martin's primary carer and, along with their children, Ethan and Taylor, had helped Martin attend his GP appointments and seek assistance for his mental health from the GP and Solent NHS Trust.

1.2.4 Martin's GP, Solent NHS Trust, or Adult Social Care (professionals involved in Martin's care) did not refer Anne for a carer's assessment despite the family expressing concern about Martin's risk to self and Anne requesting guidance from Solent NHS Trust on the care she should provide.

1.2.5 Anne had referred herself to Talking Change[6] (talking therapies – referral to primary care services that support individuals experiencing mild/moderate mental health conditions) on 14 June 2022 due to the stress she was experiencing. She was not fully assessed, as all individuals must complete outcome measures, and Anne's was below the threshold. She disclosed to the

[4] https://www.solent.nhs.uk/our-services/services-listings/crisis-resolution-home-treatment-team-crht/#:~:text=What%20we%20offer,an%20alternative%20to%20hospital%20admission.
[5] https://www.nhs.uk/mental-health/conditions/psychotic-depression/
[6] https://www.talkingchange.nhs.uk/

therapist that she self-referred because of the promise she made to Ethan and that she was seeking support and guidance for caring for her husband. They agreed she would be better directed to alternative services. No documentation regarding the specific services in question was recorded.

1.2.6 Following a GP telephone appointment arranged by Anne, a GP spoke with Ethan, followed by Martin on 15 June 2022. The GP made an urgent referral to Solent NHS Trust adult community mental health services. The adult mental health services responded promptly, and Martin was under their care from this date until his death.

1.2.7 Martin made a significant attempt at suicide on 4 July 2022 at home. Anne called for an ambulance and notified their neighbours and Ethan, who came to support Anne and Martin. Ethan accompanied Martin in the ambulance and was joined by Anne at the hospital.

1.2.8 Martin was formally detained under Section 2 of the Mental Health Act (1983)[7] at the Queen Alexandra Hospital on 4 July 2022 and transferred to Solent NHS Trust on 7 July 2022. Martin was discharged from Section 2 on 25 July 2022 and the ward on 2 August 2022.

1.2.9 The mental health clinical records dated 1 August 2022 show that Martin's mood was low, that he had not engaged with ward staff or activities, that he remained in his room with the curtain closed and that he was ambivalent about taking his medication and was at risk of self-neglect. This is in contrast to the Ward Round's review notes on 1 August 2022, which stated:

"Still flat, but more engaging and spontaneous, no suicidal thoughts. Accepting medication – notices medication is making him feel better".

1.2.10 On 2 August 2022, the clinical notes continued to report Martin was low in mood and did not engage *"much"* with staff and had accepted his medication and no change in risks, reported no suicidal ideation or deliberate self-harm noted. Furthermore, he was being nursed on 15-minute Level 2 observations.

1.2.11 Solent NHS Trust Therapeutic and Observation Policy has adopted the four levels of therapeutic observations described in the NICE guidelines.

1.2.12 Level 2 – intermittent Observation 15-30 minutes is for the following:

- This level is appropriate for patients who are potentially at risk of disturbed/violent behaviour, including those who have previously been at risk but are in the process of recovery.
- The patient's location should be checked every 15-30 minutes. The exact interval of the observation level (e.g. every 15 minutes) should be recorded in the patient's observation sheet.

[7] https://www.legislation.gov.uk/ukpga/1983/20/section/2

- Intrusion should be minimised, and positive engagement with the patient should take place.
- Evaluate the patient's moods and behaviours associated with disturbed/violent behaviour and record these. If concerns are raised regarding the patient, escalate them to the shift leader.
- Observations should be carried out respectfully, ensuring the patient's dignity is maintained.
- A night-time observation risk assessment must be undertaken, and a care plan must be implemented where appropriate.

1.2.13 Level 1 consists of general observations for individuals who pose a minimal risk of self-harm or injury to others. Martin was allocated to level 2 due to the ward's focus on older adults potentially susceptible to falls and not due to the reasons highlighted above. A level 2 observation requirement was imposed as a blanket restriction on the entire patient population of this ward. This practice is no longer taking place and adheres to the guidelines above.

1.2.14 The ward referred Martin to the HTT on 2 August 2022. The clinical notes stated the reason for Martin's admission and that he had fully engaged in the treatment programme, including medication and psychological input from the Occupational Therapist. This contradicts the clinical notes made by the nursing staff, which indicate that Martin was resistant to taking his medication and did not engage with any staff members. HTT admitted Martin to their caseload.

1.2.15 Martin was formally discharged from the hospital on 2 August 2022. The nurse's feedback stated that he had engaged with staff, had no issues with his medication, and was low-risk. According to the family, this nurse did not know Martin and the nurse was not assigned to the same ward as Martin.

1.2.16 On 3, 4, 5, 7 and 8 August 2022, Martin received home visits from the HTT (the visits were not used to monitor medication adherence but to monitor community risks and have occupational therapist support to manage anxiety).

1.2.17 Martin attended the emotional first aid groups online on 7, 8, 9 and 11 August 2022.

1.2.18 Martin received additional home visits on 10, 12 and 15 August 2022, telephone calls on 16, 17, and 19 August 2022, and a home visit on 19 and 22 August 2022 and was seen by Consultant A three weeks before the deaths

1.2.19 Upon Martin's discharge, occupational therapy was not provided, and both the family and the panel agreed that medication adherence should have been a component of the discharge plan.

1.2.20 Ethan reported expressing concern about his father, and Consultant A reviewed Martin 21 days before their deaths. Consultant A suggested an increase in Martin's antidepressant

medication, which Martin declined. It was recognised that the risk to himself would be high if Martin became unwell again.

1.2.21 Following this, Martin received telephone calls from HTT; he had been referred to Early Intervention in Psychosis (EIP)[8] by HTT; however, he was informed he was one year over the service threshold.

1.2.22 Martin called the mental health team two days before their deaths; he had enquired if the HTT would visit him as they had not arrived at the planned time; he had received a call from the Cognitive Behavioural Treatment (CBT) therapist, and thus, the visit had been cancelled; the home visit was rescheduled to a date in September 2022 the day Anne and Martin were found deceased

1.2.23 According to Solent NHS Trust clinical records dated 3 August 2022, Martin 'declined consent to share patient data with a third person: His wife, Anne. Subject to his Mental Capacity, it is within his right to determine which members of his social network and, to an extent, depending on the risks, which agencies can receive information about him.

1.2.24 Anne and his children visited Martin almost daily while he was inpatient with Solent NHS Trust. Throughout his earlier interactions with the Portsmouth Hospitals University NHS Trust and Solent NHS Trust, he had requested that family members be present during reviews; this was not always possible, and the family attributes this to an absence of communication.

1.2.25 The family, for example, was not informed of the revocation of consent to share information or his Section 2. Martin told them of the revocation of his section.

1.2.26 Consequently, it was unclear how consent to share information would affect Anne's ability to care for Martin if he had not granted permission to share information with her. Furthermore, there was no indication in the clinical records whether Martin was queried regarding the rationale behind his decision to modify his consent to share information with Anne (the panel anticipate this will be further explored within the Independent Mental Health Review to be commissioned by NHS England).

1.2.27 Anne's friend, Rose, planned to meet Anne the day she died. Rose contacted Ethan because she could not contact Anne. Ethan then contacted Anne and Martin's neighbour, Gemma, but they had seen neither Anne nor Martin. Ethan then called Mary, Martin's ex-wife, who had a spare key and requested she go to the house. Mary discovered Martin and alerted Gemma and Bart, the neighbours.

1.2.28 Anne and Martin's neighbour called the ambulance to report that Martin was hanged and Anne had a severe head injury. Upon the arrival of the crew, both were deceased. The ambulance service contacted the police.

[8] https://www.england.nhs.uk/south/our-work/mental-health/early-intervention-in-psychosis/#:~:text=Early%20Intervention%20in%20Psychosis%20(EIP,a%20first%20episode%20of%20psychosis.

1.2.29 It is suspected that Martin killed Anne before taking his own life. A note found stated:

> *"Anne planned all this and drugged and drugged me back last year. Sorry everyone. I love Ethan and Taylor so much. So sorry xxx".*

1.2.29 According to Ethan and Taylor, Martin was the author of the note.

1.3 Background Information about Anne and Martin

Anne

1.3.1 Anne and Martin met, working alongside each other throughout the 1980s and 1990s at a small independent business. Anne and Martin married in 1995 and had two children: Ethan and Taylor.

1.3.2 After giving birth to Ethan in 1995, Anne became a stay-at-home mother until her children were settled in school.

1.3.3 Anne then pursued a new career in special-needs education. When her children left education, Anne returned to work with Martin. Anne and Martin had also operated a separate jewellery-making business since 2002.

1.3.4 Anne had three older brothers, who all pre-deceased her between 1993 and 2008. Her mum died in 2007, and her dad in 2008.

1.3.5 Anne had a very close relationship with her two children, who regularly visited and supported her during Martin's mental health decline.

Martin

1.3.6 Martin was survived by one younger brother who has experienced and managed depression over several years. Martin's father died of cancer in 1995, and his mother died of cancer in 2014. She also had experienced depression. Martin had no other family with whom he was in contact with.

1.3.7 Martin had no previous history of mental health illness, and his medical notes received from his GP confirmed this.

1.3.8 Martin had held a firearms license since July 2010 and would visit the club's indoor and outdoor shooting ranges with friends and Ethan. Before 2022, there had been no interactions with the police besides obtaining the licence or reports of mental illness.

1.3.9 Martin had worked for a small independent business since the early 1970s. After managing store branches, Martin managed the whole business in 2000 on behalf of the owner's wife. After the owner died, the wife retained ownership of the business.

1.3.10 Since 1999, Martin had experienced back pain and muscle loss in his left leg. In March 2021, he reported to Solent Musculoskeletal Services that he was feeling exhausted and fatigued daily for the past four months, which was out of character for him as he was typically very active. He was feeling stressed and anxious due to the lockdown and furlough.

1.3.11 Martin managed the business and support staff when COVID-19 significantly impacted it. Martin was responsible for selling the inventory and coordinating redundancies on behalf of the business owners when the business was forced to close in April 2022.

1.3.12 Anne and Martin had several close friends, as evidenced by the author's contact with them and the information in this report. They were sociable and frequently holidayed with friends.

1.3.13 No evidence was found that Martin perpetrated domestic abuse against Anne or vice versa. Martin's mental illness became apparent to his family by March 2022, after they noticed he was significantly more stressed due to pressures from work towards the end of 2021 and to close friends in April 2022.

1.3.14 Martin did not believe himself to be ill and did not seek help. His family sought help from his GP and mental health services in May 2022, once Martin's mental illness developed and deteriorated to the point that they felt unable to manage themselves.

1.4 Timescales

1.4.1 Following the 2016 Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews, Portsmouth Safer Community Partnership commissioned a Domestic Homicide Review (DHR) on 7 October 2022 in response to a decision to proceed with a review.

1.4.2 The Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews specifies the requirements of the review chairs and authors in sections 36 through 39. In this review, the responsibilities of the chair and author were merged.

1.4.3 The independent author for the DHR was commissioned on 6 December 2022.

1.4.4 The first panel meeting was held on 11 January 2023.

1.4.5 In a second panel meeting, agency chronologies were discussed, and the revised terms of reference were updated in light of family input. The Serious Incident Review authored internally by Solent NHS Trust focused on responding to most of the terms of reference. Thus, the panel recommended thematic terms of reference for this review.

1.4.6 The panel concluded that four Individual Management Reviews (IMRs) would be required from Portsmouth Hospitals University NHS Trust, Anne's GP, Martin's GP, and Solent NHS Trust.

1.4.7 The Solent NHS Trust's Family Liaison Manager provided Ethan with the process for making Subject Access Requests to Martin's GP, the Portsmouth Hospitals University NHS Trust, and the Solent NHS Trust.

1.4.8 The family reviewed the Solent NHS Trust's Serious Incident Review and determined that it lacked significant portions of the information that they had obtained through a Subject Access Request and contained some inaccuracies. The family wrote to the Solent NHS Trust's Chief Executive Officer and met with the Solent NHS Trust. They received an email dated 17 May 2023 offering two options: commission a new independent external investigation or have a new member of the Trust Governance team investigate himself.

1.4.9 At the panel meeting on 17 May 2023, the panel agreed to request NHS England's participation in the review due to the need to revise the Solent NHS Trust review and the panel's determination that a substantial portion of the review centred on Martin's engagement with the Solent NHS Trust and his care and treatment.

1.4.10 The panel, which included a representative from NHS England, agreed to extend the scope of the DHR on 31 May 2023 to include aspects of Martin's mental health. Subsequently, the panel revised and approved the Terms of Reference on 8 June 2023, with the family approving these on 6 July 2023. A request was made for additional information from Solent NHS Trust and an IMR from Martin's GP.

1.4.11 The panel discussion on 28 July 2023 allowed panel members to address issues, request clarifications, and discuss the draft overview report, the lessons learned and the review's recommendations.

1.4.12 Ethan represented his sister, as well as wider family and friends. Throughout the review, Ethan and Taylor were kept apprised of the progress. After the panel's approval, the report was sent to Ethan and Taylor for comments and feedback on 16 October 2023. Following a revision in light of the comments/feedback, the revised report was sent to Ethan and Taylor on 5 February 2024, and further comments were received on 7 March 2024.

1.4.13 It was duly recognised that the panel could not address every single statement. In light of this, the author suggested to the family that specific questions would be more appropriately addressed through alternative channels, such as the inquest, or directed to the relevant agencies. In addition, the NHS England Representative agreed to meet with Ethan and Taylor to discuss the queries related to Solent NHS Trust.

1.4.14 NHS England commissioned an Independent Review to consider Martin's care and treatment under Solent NHS Trust.

1.4.15 Concerning the family's comments on Martin's care, the author conveyed that the Independent Mental Health Review would be a more appropriate forum. Furthermore, neither the author nor the panel believed that prospective insights regarding domestic abuse could be gleaned from these incidents concerning this DHR.

1.4.16 The family received a revised version of the report (V8) on 19 April 2024. It detailed particular aspects in which the NHS England review could provide more comprehensive responses to their concerns regarding Martin's mental health care.

1.4.16 The Home Office's guidelines stipulate that reviews, including the overview report, should be concluded within six months of their initiation, whenever possible. Expanding the review to include mental health components caused delays. A further postponement ensued to ensure the family had adequate time to review the report and offer comments and input. The delays were communicated to the Home Office.

1.4.17 Portsmouth Safer Community Partnership approved the finalised report on X.

1.5 Confidentiality

1.5.1 Until the Home Office Quality Assurance Panel approves the overview report's release, each review's results are confidential. Only contributing officers/professionals and line managers have access to confidential information.

1.5.2 The preliminary report was provided to the coroner with the Home Office's approval and the direction that it is not distributed outside the coroner's jurisdiction. The report is subject to revision following the Home Office's quality and assurance procedure.

1.5.3 The review has been appropriately anonymised following the 2016 Home Office Domestic Statutory Guidance. To protect their identities, the family and friends consented to the following pseudonyms being used throughout.

1.5.4 The following terms have been anonymised throughout this report:

- The Victim: Wife – Anne
- The Perpetrator: Husband – Martin
- The Son – Ethan
- The Daughter – Taylor
- Friend – Rose
- Friend – Charlie
- Friend & neighbour – Mary
- Friend & neighbour – Gemma
- Friend & Neighbour – Bart
- Martin's boss – Shanella
- Friend & Colleague – Tom

- Ethan's partner – Sophie
- Sophie's father – Lee
- Sophie's mother – Lucy
- Sophie's sister and Martin's colleague – Alice
- Anne's friend - Sofia

- HTT Consultant – Consultant A
- Ward Consultant – Consultant B
- Consultant Psychiatrist – Consultant C (Although he had no communication with Martin or his family, he reviewed Martin's care from the Solent NHS Trust and is employed by Solent NHS Trust).

1.5.5 Only the independent author and review panel are identified. The date of the deaths has been removed to maintain confidentiality.

1.6 Terms of Reference

1.6.1 Section 3.2 contains the complete terms of reference. On 13 February 2023, the terms of reference were shared with Ethan and Taylor, who added to them to ensure Anne's voice was heard and to identify learning from the services she and Martin accessed and how this may have impacted Martin's ill mental health.

1.6.2 The terms of reference were revised in response to Ethan, Taylor's, and the panel's comments. An agreement was reached on 22 March 2023.

1.6.3 Due to the expansion of the DHR to add a multi-agency review concerning Martin's mental health, the terms of reference (Version 4) were finalised on 8 June 2023 by the panel and on 6 July 2023 by the family.

1.6.4 This review intends to identify the lessons learned from Anne and Martin's tragic deaths and respond to those lessons to prevent such deaths and ensure that individuals and families are supported more effectively.

1.6.5 On 29 April 2021, the Domestic Abuse Act was signed into law. The Act specifies the following legal definition of domestic violence:

Behaviour of a person ("A") towards another person ("B") is "domestic abuse" if:

(a) A and B are each aged 16 or over and are personally connected to each other, and
(b) the behaviour is abusive.
Behaviour is "abusive" if it consists of any of the following—
(a) physical or sexual abuse;
(b) violent or threatening behaviour;
(c) controlling or coercive behaviour;
(d) economic abuse;
(e) psychological, emotional, or other abuse; it does not matter whether the behaviour consists of a single incident or a course of conduct.

"Economic abuse" means any behaviour that has a substantial adverse effect on B's ability to— *(a)acquire, use, or maintain money or other property, or* *(b)obtain goods or services.* *(5) For the purposes of this Act A's behaviour may be behaviour "towards" B even though it consists of conduct directed at another person (for example, B's child).*
Two people are "personally connected" to each other if any of the following applies: *(a) they are, or have been, married to each other;* *(b) they are, or have been, civil partners of each other;* *(c) they have agreed to marry one another (whether or not the agreement has been terminated);* *(d) they have entered into a civil partnership agreement (whether or not the agreement has been completed);* *(e) they are, or have been, in an intimate personal relationship with each other;* *(f) they each have, or there has been a time when they each have had, a parental relationship concerning the same child;* *(g) they are relatives.*

1.6.6 In 2015, NHS England assumed responsibility for commissioning and monitoring independent investigations. The NHS England Serious Incident Framework (NHS England, 2015) and DH Article 2 of the European Convention on Human Rights establish the conditions and criteria under which an independent investigation must be considered.[9]

1.6.7 The NHS England regional investigations team should commission an independent investigation of mental health care-related homicides when a homicide has been committed within the past six months by a person who is or has been subject to a care programme approach or is receiving care from specialist mental health services.[10] The NHS England representative and the family agreed to commission a further report on 16 January 2024.

1.6.8 The Patient Safety Incident Response Framework will replace the above and be rolled out across Solent NHS Trust from autumn 2023.

1.7 Methodology

1.7.1 The Home Office guidelines outline the procedure for undertaking a DHR.[11]

1.7.2 Anne and Martin resided in Portsmouth at their deaths, so the review panel comprised Portsmouth agencies.

1.7.3 At the first review panel meeting, panellists shared their agency engagements for Anne and Martin. As a result, the panel determined the review period from August 2021 to September 2022. This resulted from Anne's first engagement with health care after fracturing her wrist following a fall from an electric scooter whilst with Ethan.

1.7.4 The review's approach was to request that agencies provide a chronology to determine which agency would be required to conduct an Independent Management Review (IMR) or summary.

[9] https://www.england.nhs.uk/south-east/wp-content/uploads/sites/45/2019/10/independent-investigations-for-mental-health-homicides-in-england-exec-summary.pdf
[10] https://www.england.nhs.uk/wp-content/uploads/2020/08/serious-incidnt-framwrk.pdf
[11] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575273/DHR-Statutory-Guidance-161206.pdf

1.7.5 Fifteen agencies were asked about their contact with Anne and Martin. Five agencies provided chronologies and four provided IMRs. Furthermore, the author was provided with the Solent NHS Trust Serious Incident Report and the transcripts from the Serious Incident Report interviews, which were utilised to compile the report.

1.7.6 Independence and quality of the IMRs and summaries: They were written by professionals not involved in case management or service delivery. The reports allowed the panel to analyse its interactions with Anne and Martin and compile the lessons learned for this review. The IMRs indicated eleven recommendations. The reports, chronologies, and engagement with family and friends influenced the recommendations in this review.

1.7.7 The following supplementary documents were provided by the agencies and the family who submitted a Subject Access Request (SAR) to the agencies seeking information to substantiate this review:

Documents	**Provided by**
1. Ethan's Coronial statement	Ethan
2. Email conversation between the Lead Nurse and the Consultant Psychiatrist regarding Martin's inpatient mental health care on July 6 and 7, 2022.	SAR
3. Subject Access Request made by Ethan about Martin's GP.	SAR
4. Ethan made the client MSK Service, Subject Access Request.	SAR
5. Ethan made the Solent East Mental Health Services Subject Access Request.	SAR
6. Ethan made the QA Subject Access Request.	SAR
7. Clinic letter from Solent dated 20 June 2022 to Martin's GP.	SAR
8. 'My Crisis Care Plan' dated 27 June 2022	SAR
9. Clinic letter from Solent dated 29 June 2022 to Martin's GP.	SAR
10. 'My Crisis Care Plan' dated 17 July 2022.	SAR
11. Community Care Plan (Solent) 19 July 2022.	SAR
12. 'My Crisis Care Plan' dated 3 August 2022	SAR
13. Crisis Care Plan (Solent) 3 August 2022.	SAR
14. Risk summary concerning Martin	SAR
15. Solent hospital Discharge Re: Martin (Admission July 2022 - August 2022).	SAR
16. Talking Change referral dated 6 May 2022	SAR
17. Talking Change referral dated 26 May 2022	SAR
18. Mental Health Act documents (Martin)	SAR
19. Statement from Adult Social Care	ASC
20. Portsmouth Hospital's Enhanced Care Observation Policy.	Portsmouth Hospital
21. Portsmouth Restriction and Restraint in Adult Care Policy	Portsmouth Hospital
22. Solent NHS Trust Care records for Martin	SAR
23. Solent NHS Trust's interview transcripts: 1. Consultant A	Solent NHS Trust

2. Consultant B 3. Consultant C 4. HTT Clinical Manager	

1.7.8 The family shared the SAR with the author, so it was unnecessary to request this information from the agencies.

1.7.9 The additional information and panel discussion on 17 May 2023 determined the necessity of extending the DHR to include aspects of Martin's mental health care and treatment at the Solent NHS Trust. Consequently, additional information was requested.

1.7.10 The panel met a total of twelve times.

1.8 Involvement of Family, Friends, Neighbours and Wider Community

1.8.1 The review's author and the review panel acknowledged the vital role Anne and Martin's family and friends could have in the review.

1.8.2 Victim support informed the family of the DHR on 11 January 2023.

1.8.3 Due to a referral by the police investigation team, a homicide case worker was appointed to Ethan and Taylor. In addition, the family liaison manager from Solent NHS Trust was allocated to support Ethan and Taylor following the Trust Incident Review meeting. The police approached Ethan and Taylor, who consented to provide the author with their contact information. The family liaison manager from Solent continues to support the family.

1.8.4 The author contacted Ethan and Taylor and agreed on a face-to-face meeting. Ethan represented his sister, Taylor, as she was unable to meet with the author then. Ethan represented her voice throughout.

1.8.5 The face-to-face meeting was arranged with Ethan on 15 February 2023.

1.8.6 The author met with Ethan and a family friend for support. Discussions centred on the terms of reference and the difficulties Ethan and his family encountered with Martin's mental health care.

1.8.7 Ethan described how he and Anne had attempted to obtain help multiple times from the GP and Solent NHS Trust for Martin before his hospitalisation on 4 July 2022 following a suicide attempt. On discharge from the hospital, Martin's family requested additional support and advice from Solent NHS Trust on how to care effectively for Martin at home. Ethan reported that this was not received. They feared he would not take his prescribed medication, attempt suicide again and be successful.

1.8.8 Together, the author, Ethan and Taylor, amended the terms of reference to ensure that they prioritised the issues and addressed and identified lessons to reduce the likelihood of a similar incident.

1.8.9 Ethan and Taylor stated they did not believe Martin was ever abusive to Anne and confirmed that Martin was never mean to them.

1.8.10 Ethan and Taylor shared with the author a copy of the note Martin left on the day he died. Ethan and Taylor believe the homicide was unconnected with domestic abuse. They believe Martin killed Anne due to his mental illness, unrelated to domestic abuse.

1.8.11 Ethan and two family friends met with the panel; they discussed the terms of reference and were concerned that the review should not delay the Coroner's inquest. The inquest was later adjourned.

1.8.12 Ethan and Taylor were informed of the review's progress and provided feedback on the final report.

1.8.13 Ethan and Taylor provided contact details for friends and neighbours. They also offered statements they had prepared for the inquest and permitted the author to use the information in these statements for the review.

1.8.14 **The author made contact and arranged a telephone call with Tom on 22 March 2023**

1.8.15 Tom, who had known Anne and Martin for 35 years, was shocked to learn that Martin had killed Anne. He believed Martin was a caring individual, and the business's closure was stressful for him. Anne worked part-time at the business, and Tom frequently contacted them. He knew Anne was concerned about Martin's unwell condition, and she maintained regular communication with others.

1.8.16 **The author made contact and spoke with Gemma on 23 March 2023.**

1.8.17 Anne and Martin's neighbour for thirty years was Gemma. They were close, had no fence between their gardens, and considered one another family.

1.8.18 Gemma knew Martin had grown withdrawn and unwilling to engage in activities. She believed Anne kept her reservations over Martin to herself. She thought Anne would not have been concerned with her safety since she would have been focused on Martin's care.

1.8.19 **The author contacted Rose and Charlie and arranged a virtual meeting on 29 March 2023.**

1.8.20 Charlie had known Martin since school and was his best man at Martin's wedding with Anne.

1.8.21 Charlie and Rose, friends of Martin and Anne, were in daily contact with them and recently holidayed with them. They noticed Martin being paranoid and worried about someone

following him. They felt Anne had lost her wife's role, became Martin's carer, and was responsible for finances. They believed Anne needed help from services to support Martin. However, they found relief when Martin was under the care of mental health professionals.

1.8.22 Martin expressed feelings of guilt and believed he was an awful father. He suspected people on the streets and in cars were spying on him. Martin disliked taking medication and stopped taking anti-depressants due to hypertension. They assumed Martin did not take his prescribed medication before the fatalities.

1.8.23 Charlie and Rose had no reason to believe Martin would harm Anne, and they had stayed with them the weekend before their deaths. They felt Anne could not speak with mental health professionals privately or voice her concerns. Martin did not believe he had a mental illness and thought things were being done without his consent.

1.8.24 Rose and Charlie believed Martin needed to stay in the hospital longer and that the staff had to establish rapport with him.

1.8.25 Rose and Charlie emailed the author a statement, which they agreed to share with the panel and include in this review. The police shared the statement with the coroner.

1.8.26 The statement included a chronology embedded in the combined chronology. In addition, the information in the statement supported Anne and Martin's background and the analysis of the terms of reference.

1.8.27 **The author arranged a call with Bart and Gemma on 3 April 2023.**

1.8.28 The couple lived next door to Anne and Martin for thirty years. Their children were raised alongside Anne and Martin’s children. Their daughter would introduce and describe Martin as her second dad.

1.8.29 The couple and Mary discovered Anne and Martin deceased in their home. They assumed Martin had taken his own life and had not thought to find Anne deceased.

1.8.30 Gemma and Bart have chosen to move due to their inability to continue living next door.

1.8.31 They holidayed with Anne and Martin around seven to eight times yearly and booked a trip for June 2022. However, Martin's poor mental health prevented them from going.

1.8.32 Bart and Martin used to shoot together with Tom and Ethan; due to Martin's illness, Bart removed Martin’s firearms from the home to a trusted dealer at the start of 2022, but he could not recall the exact date. The police were informed that the firearms were sent to the dealer on 2 June 2022.

1.8.33 They observed Martin's deteriorating health as he discussed his fear of being watched and described him as a *"grey"* colour before his admission to the mental health unit.

1.8.34 The couple described Anne and Martin as loving and Martin as caring. They believed Martin would never harm Anne. Anne was concerned about Martin's mental health and contacted mental health services, thinking he was not taking his medication.

1.8.35 They believe Martin told services what they wanted to hear and was possibly not taking his medication.

1.8.36 **The author emailed Mary on 17 March 2023**.

1.8.37 Mary sent a statement to the author beforehand before the scheduled phone call. Mary asked that her statement not be shared and consented to its use as review support. Before adding the statement's contents to the review, the author confirmed with Mary what could be used.

1.8.38 Mary and Martin had known each other since 1975; they were married in 1981, separated in 1988 and divorced in 1991. Mary is the godmother to Taylor. Mary lived near Anne and Martin and had their spare house key. Mary was the first to find Martin and Anne's bodies, followed by Bart, Gemma, and Rose.

1.8.39 Mary described Martin as a *"caring, helpful, and calm person. He was well regarded and respected by so many".*

1.8.40 Martin managed a retail business that had been operating for a century. He had worked there for approximately fifty years, starting as a Saturday job before going full-time. Martin was committed to his position and did his best for the company.

1.8.41 Mary observed that he had become stressed over recent years about his job, the weekly figures, and the general shift away from the high street. Additionally, the pandemic significantly impacted the business, and Martin was required to carry out all the administrative duties and support the staff during the lockdown.

1.8.42 Mary feels certain Martin, with the passing of years, would have been considering his retirement options combined with the future of the business. The pandemic would have hastened and forced Martin to close the company and retire.

1.8.43 Due to the pandemic and Mary's illnesses, Mary's contact with Anne and Martin was limited as she was clinically extremely vulnerable. Therefore, Anne and Martin would sometimes bring her groceries and meals and would drop by for a doorstep chat when passing as they went for a walk.

1.8.44 In the months leading up to the business closure, Mary didn't see much of Martin or Anne, with Martin working long hours, and she was still isolating. When she did see them, she observed Martin had become unusually withdrawn and more inclined to be stressed and preoccupied. She noticed how grey Martin looked. Mary attributed this to the intense work that had to be done to close such a long-standing business.

1.8.45 By possibly later April or early May 2022, Mary learned that Martin was seriously ill; he had lost weight and was easily fatigued, and she described him as a *"shadow of himself."* However, she thought that having had COVID-19 in April may have contributed to that, although she did realise by then that he was far from well.

1.8.46 Mary was not concerned about Anne's safety at any time; instead, she was concerned about Anne in her capacity as a carer for Martin, who had attempted suicide, and felt this was a significant source of stress for Anne and the children. Mary says she was greatly concerned about Martin. He hadn't shown great insecurities and anxieties in the years she had known him. He had always been the one to support others.

1.8.47 Mary believed that Martin was discharged from the mental health unit too soon and without achieving the necessary skills or support to manage his mental health problems. Neither Anne, Ethan, nor Taylor was offered guidance on how they, or any of the close circle of friends, could aid Martin's recovery or what they could do to support him.

1.8.48 Mary was aware that Anne and Ethan had requested a meeting with the mental health team before Martin's discharge, but she was uncertain whether or not this occurred. In addition, she was aware that, during his admission, he spent most of his time alone in his room and declined to participate in the occupational therapist's suggested activities. Mary does not know how often they were offered or how he was encouraged. As a skilled craftsman, simple arts and crafts would not have interested him

1.8.49 Mary recalls that one of Martin's virtual course sessions with the mental health team in August 2022 was unsuccessful because they could not hear him, and he was required to type his responses or questions.

1.8.50 Mary believed Martin was devoted to Anne, which could often be seen in social settings, with further examples such as he would frequently buy her special surprise gifts for Christmas and birthdays and take her on short trips away. Mary had no reason to believe he would harm Anne or anyone else.

1.8.51 Mary believes that Martin would not have pre-planned or intended any harm to Anne, nor would he have wanted his actions to have such a devastating impact on Ethan and Taylor (or his close friends).

1.8.52 **The author arranged an online meeting with Taylor and Ethan on 26 April 2023**.

1.8.53 Taylor was distressed and requested another meeting, to which Ethan responded that he would keep her updated on the review. The author informed Taylor of the AAFDA advocacy services she could access if she required additional assistance with the review.

1.8.54 **The author wrote to Shanella, Martin's employer, informing her of a DHR and providing her with Home Office-produced information. Contact was established on 20 July 2023.**

1.8.55 Shanella, who had known Martin for fifty years, described him as compassionate and well-respected by all. Anne told her he was stressed due to the government's obligations during the COVID-19 pandemic. She indicated that an assistant manager was available to assist him.

1.8.56 She stated that Martin would never harm anyone and was shocked to learn he had attempted suicide. She was shocked to know of the deaths.

1.8.57 Shanella was aware that Martin was not one to take medications or discuss himself with others.

1.8.58 Shanella reported that her last encounter with Martin occurred after he was discharged from the hospital, and she saw that he was not his usual self.

1.8.59 **The author arranged a virtual discussion with Lee, Lucy, and Alice on 21 July 2023.**

1.8.60 Lee and Lucy, the parents of Sophie, Ethan's girlfriend, had known Martin and Anne for twelve years.

1.8.61 Martin was characterised as a *"nice guy"* who was always considerate of others. They were shocked by the news of the deaths and believed Martin was ill at the time because his actions were out of character.

1.8.62 They discussed what they deemed vital before Martin's discharge, believing he needed to remain in the hospital longer. Since everything had stayed the same since his admission, it was unclear why he was discharged at that time.

1.8.63 While working with Martin and Anne, Alice (Lee and Lucy's daughter) never observed any red flags that would have led her to suspect domestic abuse. She reminisced about Martin, who constantly worked to make the business's employees feel valued and listened to them attentively. She described him walking out in the heat to buy ice cream for everyone and purchasing coffee and snacks on other occasions. She felt he was a gentleman who always placed others before himself.

1.8.64 **The author arranged a virtual meeting with Sophie on 24 July 2023.**

1.8.65 Sophie had known Martin and Anne for fifteen years, and their relationship had become closer recently. She felt like a family member, describing Anne and Martin as friendly and loving, and always felt welcome at their house for supper.

1.8.66 Sophie worked with Martin and Anne at the business and noted that, in retrospect, Martin was not his typical self; nonetheless, she knew that the business's closure was the most likely source of his worry.

1.8.67 Sophie described her initial realisation that Martin was ill. She had gone on holiday with Ethan, and upon their return in April 2022, Anne informed Ethan that Martin was experiencing paranoid thoughts. Ethan spent much time at his parents' house supporting them. She stated that Martin's family did not know what support he needed and sought professional assistance.

1.8.68 Sophie described people asking Martin whether he was okay, but Anne was not usually asked the same question.

1.8.69 **The author contacted Sofia by phone and email on 22 September 2023**

1.8.70 Anne and Sofia had been friends since they were 11 years old. She described Anne as a hardworking, incredibly kind, and remarkable individual.

1.8.71 Sofia was aware that Anne had to manage Martin's ill mental health and that Anne was also afraid that others would think badly of Martin and wished that he would recover and life would return to normal.

1.8.72 Anne was in regular phone contact with Sofia, and when Sofia inquired about Anne's well-being, Anne revealed that she had considered the possibility of Martin harming her. Sofia encouraged Anne to discuss this with professionals. However, she felt Anne would not do this because she was private and was concerned that people would judge Martin.

1.8.73 Anne had informed Sofia upon Martin's discharge that he was not well despite his progress. Sofia believes Anne might have wanted more involvement with mental health professionals and was left alone to manage Martin.

1.8.74 A few days before the deaths, Sofia remembered a telephone call with Anne. Anne told Sofia she did not feel the same way about Martin and hoped he would not hear her, as she believed he was in the garage then. She discovered that he was present and may have heard Anne. There were no further talks over this.

1.8.75 Sofia noted Anne had never reported any abuse she had endured at the hands of Martin, and Sofia assumed that Anne would not have come forward if the abuse had occurred.

1.8.76 Martin's family and friends believed he required a lengthier hospital stay since they did not believe the grounds for his admittance were investigated. Because he had not engaged with the ward staff, they were unaware of how he was genuinely feeling and what thoughts he was experiencing. An extended hospital stay was proposed to ensure he took the prescribed medication, which may have facilitated his engagement with staff and allowed for developing trusting relationships.

1.8.77 No information or concerns regarding domestic abuse between Anne and Martin were held by family and friends.

1.9 Contributors to the Review

1.9.1 The following agencies were contacted, and no involvement with Anne and Martin was recorded.

1. Stop Domestic Abuse
2. HM prison and probation service (Hampshire & Isle of Wight)
3. Victim Support
4. Society of St James
5. Portsmouth City Council Local Authority Housing
6. Portsmouth City Council Adult Social Care
7. Hampshire Fire and Rescue Service

1.9.2 The following agencies and their contributions to this review:

Agency	Involvement	Contribution- Chronology/IMR/Letter/Other
Adult Social Care	Concern received by the South Ambulance Service	Statement
Ambulance	Conveyance to Hospital July 2022	Chronology
GP for Anne	GP	Chronology and IMR
GP for Martin	GP	Chronology and IMR
Hampshire and Isle of Wight Constabulary	Police	Chronology
Portsmouth Hospitals University Trust	Acute Hospital	Chronology and IMR
Solent NHS Trust	Mental health and acute care	Chronology and IMR
Solent MSK Service	Musculoskeletal services for Anne	Chronology

1.10. The Review Panel Members

1.10.1The independent panel members for this review were the following:

Name	Role	Organisation
Bryan Carter	Serious Case Reviewer	Hampshire and Isle of Wight Constabulary
Catherine Mead (left the panel on 22 Sept 2023)	Adult Safeguarding Lead	Portsmouth Hospitals University NHS Trust
David Joyce (joined the panel on 3 May 2023)	Head of Service Safeguarding, Mental Health, and Learning Disability	Adult Social Care Portsmouth City Council
Dr David Ashby	General Practitioner	GP Practice
Jane Leech	Public Health Protection Development Manager	Public Health – Suicide Strategy
Dr Jennifer Dolman (joined the panel on 28 July 2023)	Independent Consultant Psychiatrist	Southern Health NHS Foundation Trust
Kathryn Barber	Named Professional Adult Safeguarding	Solent NHS/Mental Health

Leeanne Hazelwood (replaced Catherine Mead on 22 Sept 2023)	Named Nurse for Safeguarding Children	Portsmouth Hospitals University NHS Trust
Lucien Champion (Joined the panel on 31 May 2023)	Head of Investigations	NHS England
Jayne Hardy (replaced Tonia Redvers on 22 Sept 2023)	Assistant Director	The YOU Trust
Michelle Ennis	Senior Designate Nurse Safeguarding Adults	Integrated Care Board
Sarah Beattie	Head of Portsmouth & Isle of Wight Probation Service	Probation Service
Sayma Begum	Domestic Abuse Analyst	Portsmouth City Council
Tonia Redvers (left the panel on 22 Sept 2023)	Director of Paragon, Young Lives and Counselling – Expert Witness	The YOU Trust

1.11 Chair and Author of the Overview Report

1.11.1 Parminder Sahota is an independent author who has worked in Safeguarding and Domestic Abuse for eleven years and obtained DHR Chair training in 2021 from Advocacy After Fatal Abuse. She has also worked in the NHS for over twenty years as a Mental Health Nurse, with a particular focus on crisis work and collaborating with people diagnosed with personality disorders. She is the Director of Safeguarding, Prevention, and Domestic Abuse Lead for an NHS Trust.

1.11.2 Before this review, Parminder had no contact with Anne and Martin's family, friends or the Portsmouth Safer Community Partnership and is independent of participating agencies.

1.12 Parallel Reviews

1.12.1 A police homicide investigation determined that no other party was responsible for the homicide. The police provided the coroner with the investigation's conclusion. The coronial Inquest was initially scheduled for Summer 2023 and moved to Spring 2024.

1.12.2 The family wrote to the Coroner requesting a delay until the conclusion of this review. The author also asked the coroner about this. The Coroner agreed to postpone the hearing, which was scheduled for Spring 2024.

1.12.3 Solent NHS Trust had commenced a Serious Incident Review for Martin's care and treatment. The NHS England Serious Incident Framework governed the process.[12]

1.12.4 Anne and Martin's family requested a Safeguarding Adult Review under Section 44 of the Care Act 2014[13]. The Safeguarding Adults Board examined the request and determined that the criteria for a Safeguarding Adult Review were not met. The family disputed the decision. The author asked that Adult Social Care be a panel member to support the process and ensure

[12] https://www.england.nhs.uk/wp-content/uploads/2020/08/serious-incidnt-framwrk.pdf
[13] https://www.local.gov.uk/topics/social-care-health-and-integration/adult-social-care/resources-safeguarding-adults-boards/Authors-and-business-managers#:~:text=The%20Care%20Act%202014%2C%20sections,is%20concern%20that%20agencies%20could

safeguarding was considered throughout. The panel agreed to notify the Safeguarding Adults Board if they received information requiring escalation.

1.12.5 The Solent NHS Trust agreed to request an Independent Mental Health Representation of a Consultant Psychiatrist who had not worked for Solent NHS Trust at the time or was involved in Martin's care on the review panel. The panel invited an NHS England representative to support the review.

1.12.6 On 16 January 2024, NHS England agreed to commission an Independent Mental Health Review.

1.13 Equality and Diversity

1.13.1 During the review process, the review author and panel reviewed all protected characteristics under the 2010 Equality Act.

1.13.2 Anne and Martin were of white British heritage. At their deaths, Anne was 60, and Martin was 66.

1.13.3 The characteristics relevant to this review are age, disability (as related to Martin), and sex.

Age and Sex

1.13.4 According to Age UK[14], one out of every four victims of domestic homicide is over the age of 60.

1.13.5 The Office of National Statistics[15] produced data on the characteristics of domestic abuse victims. As of March 2021, 43.3% of females were domestic abuse victims, with 11.1% of South West England residents reporting a domestic abuse-related offence.

1.13.6 In November 2020, the Local Government Association and the Association of Directors of Adult Social Services in England published a report[16] with the following:

- "There were failures to consider the possibility of domestic abuse, [and] to recognise the impact of the abuse on all family members" (page 99)
- "Notably overlooked was domestic abuse in later life" (page 99)
- "Coercive and controlling behaviour in domestic abuse and sometimes in other relationships did not. Several reports noted a lack of understanding of coercive control and its role in the exploitation of people who have particular vulnerabilities" (page 100)

[14] https://www.ageuk.org.uk/latest-press/articles/2019/october/at-least-200000-older-people-experienced-domestic-abuse-last-year--but-the-experiences-of-over-75s-are-being-entirely-overlooked/

[15] https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/domesticabusevictimcharacteristicsenglandandwales/yearendingmarch2021#age

[16] https://www.local.gov.uk/publications/analysis-safeguarding-adult-reviews-april-2017-march-2019

- "In a case of serious domestic abuse, the response to the risks the family faced was described as superficial and over-optimistic" (page 113)
- "A major failing noted in many reviews was the absence of information-sharing. (page 140 – 142)

1.13.7 The above underscores the necessity for services to be aware of domestic abuse throughout the lifespan, emphasising the importance of information sharing and the identification of coercion and control.

1.13.8 The DHR revealed that the information disclosed to the family was inaccurate and that information sharing between internal and external services required strengthening.

1.13.9 According to Safe Lives[17], victims older than 61 are more likely than those younger than 60 to experience abuse from an adult family member or current intimate partner. Age UK[18] noted that one in every four domestic killings involved a victim over 60.

1.13.10 According to research conducted by Women's Aid[19], 94.3% of domestic abuse perpetrators are men. Refuge highlighted that the police receive a call about domestic abuse every 30 seconds, but only around a quarter of them are reported to the police.

1.13.11 The data shows domestic abuse is a gendered crime; although men are abused, women are more likely to face recurrent and severe abuse.[20] However, it should be noted that the review did not uncover any instances of domestic abuse in Anne and Martin's relationship.

Disability

1.13.12 Martin received support from mental health services from Solent NHS Trust in June 2022. The Trust had received a referral from Martin's GP on 15 June 2022 that he was depressed and paranoid, fearing that his mobile phone and computer equipment were being monitored. Anne was his primary carer and was entitled to a carer's assessment, but this was not officially acknowledged by any professionals with whom either had contact. In addition, Ethan had referred Martin twice (May & June 2022) to Talking Change; no support was in place following the referrals, and he was under Community Mental Health Services from June 2022.

1.13.13 Martin received mental health care from Solent NHS Trust in June 2022 at 65. According to their reports, he was experiencing suicidal ideation, guilt, regret, depression, and paranoia, believing his mobile phone and IT equipment were being monitored.

[17] Spotlight #1: Older people and domestic abuse | Safelives
[18] At least 200,000 older people experienced domestic abuse last year – but the experiences of over-75s are being entirely overlooked | Age UK | Media
[19] https://www.womensaid.org.uk/wp-content/uploads/2021/12/Domestic-Abuse-Report-2022-Early-Release.pdf
[20] https://www.womensaid.org.uk/information-support/what-is-domestic-abuse/domestic-abuse-is-a-gendered-crime/

1.13.14 Paranoia is a delusion of self-reference, not necessarily persecutory in nature. However, as Martin believed his mobile phone and IT equipment were being monitored, his paranoia was persecutory in nature.

1.13.15 A delusion occurs when an individual has an unwavering belief in something false. For example, people experiencing persecutory delusions may believe an individual or organisation plots to harm or kill them. People experiencing psychotic episodes are generally unaware that their delusions are not genuine, which can cause them to feel fearful or anxious.[21] Martin's paranoid thoughts fulfil the criteria for delusions.

1.13.16 Martin was diagnosed with Psychotic Depression by the Solent NHS Trust. Psychotic depression is sometimes referred to as severe depression with psychotic symptoms. It is characterised by psychotic symptoms, such as delusions and hallucinations, in addition to many common symptoms of depression.[22] Dr Dolman (Independent Consultant Psychiatrist on the panel) agreed that Martin met the criteria based on the information in this report.

1.13.17 In the public's perception, mental illness and violence remain inextricably linked, and much of the stigma associated with mental illness may be attributable to the tendency to conflate mental illness with the concept of danger. The media reinforces this perception, sensationalising crimes committed by people with mental illness. In such reports, the focus is on mental illness, ignoring that most violence in society is caused by individuals without mental illness.[23] According to the material in this report, there was no evidence that Martin had previously engaged in aggressive behaviour towards others.

1.13.18 A study by Oxford University[24] found that 3.7% of men and 0.5% of women who were clinically depressed committed violent crimes. This is in comparison to 1.2% of men and 0.2% of women in the general population. However, they also emphasised that most depressed individuals had not been convicted of violent crimes and that the reported rates are lower than those for schizophrenia and bipolar disorder and significantly lower than those for alcohol or drug abuse. In depression, there is considerable concern regarding self-harm and suicide.

1.13.19 Although most people with psychotic illnesses such as schizophrenia or schizoaffective disorder are not aggressive, there is a correlation between psychotic disorders and violence, particularly homicide.[25]

1.13.20 A note left by Martin revealed at that time, he believed Anne had been drugging him. A patient may act violently with the intent to kill because they feel an individual (e.g. their significant other) will suffer intolerably if they do not act ('care-harm'); they may be angry over perceived persecution at the hands of an external agency (e.g. the police) and decide to take justice into their own hands ('fairness-injustice'); or they may act violently while experiencing anger or grief, believing they have been betrayed by someone close to them (loyalty-'betrayal).[26]

[21] https://www.nhs.uk/mental-health/conditions/psychosis/symptoms/
[22] https://www.priorygroup.com/mental-health/depression-treatment/types-of-depression/psychotic-depression
[23] https://jech.bmj.com/content/70/3/223
[24] https://www.psych.ox.ac.uk/news/depression-linked-to-violent-crime-study-finds
[25] https://bmcpsychiatry.biomedcentral.com/articles/10.1186/s12888-019-2372-4
[26] https://bmcpsychiatry.biomedcentral.com/articles/10.1186/s12888-019-2372-4

1.13.21 Martin did not express paranoid, persecuting thoughts about Anne during his interactions with the Solent NHS Trust. Nevertheless, Martin's decision to withdraw approval for Solent NHS Trust to disclose his information to Anne was not discussed.

1.13.22 According to the findings of a study examining the relationship between understanding the experiences of spouse mental health carers, caring for a spouse with severe mental illness is unique compared to other caring roles. First and foremost, spouse carers prioritise maintaining a relationship with their partner by accommodating mental illness. Due to this, people frequently lead artificial lives characterised by intense emotional pressure and solitude. This may affect how mental health service providers work with and support spouse carers.[27]

1.13.23 Mental Health First Aid England[28] emphasised the repercussions of mental illness:

- 1 in 4 people experience mental health issues each year.
- 792 million people are affected by mental health issues worldwide.
- At any given time, 1 in 6 working-age adults have symptoms associated with mental ill health.
- Mental illness is the second-largest source of burden of disease in England. Mental illnesses are more common, long-lasting, and impactful than other health conditions.
- Mental ill health is responsible for 72 million working days lost and costs £34.9 billion annually.
- The total cost of mental ill health in England is estimated at £105 billion per year.
- People with long-term mental health conditions lose their jobs yearly at around double the rate of those without a mental health condition. This equates to 300,000 people – the equivalent of the population of Newcastle or Belfast.
- Men aged 40-49 have the highest suicide rates in the UK.
- 70-75% of people with diagnosable mental illness receive no treatment.

1.13.24 A report commissioned by the Violence Reductions Unit of the Mayor of London and published by SCIE[29]; the following was reported:

- In six cases reviewed, there was a caring relationship between the victim and perpetrator.
- Five of the homicides were committed with knives or a bladed object;
- Nearly all the perpetrators in the cases of adult family violence we reviewed had serious mental health problems;
- A worsening of perpetrators' mental health problems; disengaging, or being discharged, from mental health services, or ceasing to take prescribed medication was a common feature;

[27] https://doi.org/10.1177/1049732313520078
[28] https://mhfaengland.org/mhfa-centre/research-and-evaluation/mental-health-statistics/
[29] https://www.scie.org.uk/safeguarding/evidence/reviews-of-homicides-and-violent-incidents/

- The cases of adult family violence often featured behaviours meeting the definition of domestic abuse. However, these were rarely recognised by practitioners as such.

1.13.19 Anne was vulnerable to harm due to her age, gender, and the additional risk factor due to her caring responsibilities for her husband, who had been diagnosed with psychotic depression.

1.13.20 Martin was diagnosed with psychotic depression in 2022, and his family and friends believed he might not have been taking his prescribed medication, which would have increased the likelihood that he would continue to experience psychotic and depressive symptoms.

1.14 Dissemination

1.14.1 After the Home Office grants permission to publish, this report will be widely disseminated, including, but not limited to:

- Family
- Members of the Portsmouth Safer Community Partnership
- Agencies represented.
- The report will also be published on the Portsmouth Safer Community Partnership Website
- NHS England
- Domestic Abuse Commissioner

2.1 The Facts

2.1.1 On 6 May 2022, Ethan referred Martin online to Talking Change. Talking Change emailed Martin to request confirmation of the referral, which was unknown to Ethan. Ethan contacted Talking Change on 25 May 2022 to enquire about the referral's status. He was informed that the referral was closed after five working days as they had not received any communication from Martin. Ethan was required to provide a second referral and monitored Martin's email in anticipation of a response.

2.1.2 On 12 May 2022, Martin had a GP duty triage telephone consultation. He reported a loss of weight in the last two months, 7-8Kgs, tired all the time and discussed his bowel – no constipation or blood and nocturia.[30] He also reported lifestyle and personality changes. A blood test and a face-to-face consultation were booked for the doctor's next available routine appointment (26.05.2022).

2.1.3 On 26 May 2022, Anne and Martin presented at his GP surgery. Anne provided the background of her concerns about Martin. She stated that Martin had not been himself since Christmas 2021, citing his work as the cause. Anne had hoped he would be better since leaving his job (April 2022), but this was not so. She stated that he had become obsessed with specific activities, such as checking the door lock multiple times and staring into space.

[30] A patients need to get up at night regularly to urinate.

2.1.4 The GP observed Martin's apathetic demeanour. He avoided eye contact and said he did not see the problem. Anne was tearful and noted that Martin had changed entirely. At this appointment, the GP was informed that the family had accessed Talking Change and was still waiting for contact. According to Ethan and Taylor, Martin and Anne thought the GP would refer Martin to the mental health service, per the recorded entry in the GP notes. The referral did not occur until Martin's next presentation in June 2022.

2.1.5 Martin was under the Solent NHS Trust's Community Mental Health Services following a referral by his GP on 15 June 2022. His GP highlighted concerns regarding Martin's mental health: paranoia, anxiety, significant weight loss, and the family's struggle to cope with Martin's mental health.

2.1.6 On 4 July 2022, Martin attempted suicide; he was conveyed by ambulance to Queen Alexandra Hospital (Portsmouth Hospitals University NHS Trust) and detained under Section 2 of the Mental Health Act (1983) from 5 July 2022 to 25 July 2022. This formal detention can last for 28 days for assessment and potential treatment.

2.1.7 On 7 July 2022, Martin was admitted to the mental health unit (Solent NHS Trust). On 2 August 2022, he was discharged from the hospital under the care of HTT.

2.1.8 Martin was discharged under the Care Programme Approach (CPA, a package of mental health care services. However, the CPA was replaced in April 2021 by the Community Framework. [31](Solent NHS Trust launched the new strategy on 5 June 2023). The new strategy is founded on five principles, including the designation of a key worker. Upon discharge, Martin was not assigned a named key worker.

2.1.9 The family requested a medical review by Consultant A in late August 2022, as Martin exhibited a flattened affect. Anne and Ethan reported that he was not smiling or laughing and lacked motivation and energy, which was out of character for Martin. Solent NHS Trust referred Martin in late August 2022 to the EIP service and a referral for Cognitive Behavioural Therapy in Psychosis (CBTp). Unfortunately, Martin was ineligible for EIP due to his age, and HTT stated Martin would be informed of the CBTp waiting time.

2.1.10 The panel discovered after their deaths that the waiting period was one year and nine weeks; Martin and Anne had not been told of the waiting period, as HTT planned to do so on their next appointment with Martin.

2.1.11 Martin spoke with a Solent NHS Trust psychologist over the telephone five days before his and Anne's death; CBTp was discussed, he and Anne were informed that they would be advised of the waiting list for this, and a Nurse-Led clinic was offered in the interim.

2.1.11 Two days before their deaths, Martin called Solent NHS Trust to enquire whether he would receive his planned visit from HTT. He was informed that a visit would occur in two days.

[31] https://www.england.nhs.uk/wp-content/uploads/2021/07/B0526-care-programme-approach-position-statement-v2.pdf

Martin had been accepted for CBTp, and family intervention was to be offered in addition to a referral to the Nurse-Led Clinic. A letter confirming his acceptance to CBTp was received on the day Martin was found deceased.

2.1.12 The review and contributors noted that Martin did not consistently engage with mental health services or take medication; the author recognised Martin's communication with HTT as atypical.

2.1.13 Anne was scheduled to meet Rose the morning Anne and Martin died. Rose contacted Ethan to state that Anne had not shown up. Ethan attempted to call Anne and Martin, but neither answered. He contacted Gemma to ask if Anne and Martin's vehicles were at home and if she had heard from them. She confirmed that the cars were present and had not heard from them.

2.1.14 Gemma knocked on the door but received no response. Mary, who had a spare key to Anne and Martin's home, received a text message from Ethan requesting her to update Rose, who was on her way to the house.

2.1.15 Mary, Gemma, and Bart were shocked and saddened to discover the bodies of Anne and Martin. They were pronounced dead at the scene after the ambulance and police were called.

2.2 Key Events from August 2021 to September 2022

Date	Anne/Martin	Contact	Agency
06.08.21	Anne	**E-Scooter injury** Anne dialled 111 after falling off an E-scooter and suffering an arm injury. She was reviewed at the emergency department and sent home with pain medication.	GP Practice
Nov 2021	Martin	**Rose and Charlie noted that Martin's mental health was deteriorating**. They described Martin as appearing grey and losing weight. The stress of closing the business was believed to have caused this.	Rose and Charlie
April 2022	Martin	**Martin was becoming increasingly suspicious of technology and unwilling to use it.**	Rose and Charlie
13.04.22	Anne and Martin	**Anne sent a message to Rose stating:** *"He'll be on tablets at this rate."* Martin was wary of IT and mobile phone communications. He believed he was being monitored or hacked. Anne considered these symptoms to be a result of the stress of the past few months.	Rose and Charlie
	Martin	**Martin messaged Ethan**: *"I'm sending you some money for safekeeping for a short while. I will want it back."*	Ethan's statement
	Martin	**Martin tested positive for COVID-19**	Ethan's statement
15.04.22	Anne and Martin	**Ethan called Anne** Anne was in tears when Ethan called her and informed her that Martin was not himself and was experiencing paranoia around	Ethan's statement

		money, security, and technology. Martin visited Ethan at his home. Martin told Ethan he was convinced he had been hacked and thought all their savings were at risk.	
18.04.22	Anne	**Anne reached out for support from her son** *"I'm not really coping" and "I feel helpless."* Martin had said, *"My head is not in a good place—driving Anne mad."*	Rose and Charlie
21.04.22	Martin	**A message was sent to Martin's boss, supported by Ethan:** *"I need to call a final handover meeting for next week… The last six months have been intense and exhausting for me, and now COVID has taken its toll, and I need to concentrate on my health…"*	Ethan's statement
30.04.22	Martin	**A new router was installed** at the home out of concern for the security of the previous one.	Ethan's statement
May 2022	Martin	**Retired from work**	
05.05.22	Martin	**Ethan contacted Talking Change to make a referral for Martin.** Martin was reportedly paranoid and anxious about technology.	Ethan
12.05.22	Martin	**Ethan convinced Martin to arrange a face-to-face appointment with his GP.**	Ethan's statement
	Martin	**Martin had a GP duty triage telephone consultation.** He reported a loss of weight in the last two months, 7-8Kgs, tired all the time and discussed his bowel – no constipation or blood and nocturia. He also reported lifestyle and personality changes. A blood test and a face-to-face consultation were booked for the next available routine appointment (26.05.2022).	GP Practice
25.05.22	Martin	**Ethan contacted Talking Change** to inquire about the referral's status. He was informed that the case had been closed due to Martin's lack of communication.	Ethan's statement
26.05.22	Martin and Anne	**Anne accompanied Martin to his GP**. Martin stayed silent for most of the appointment. Therefore, Anne provided the history: Anne said Martin had been a different person since Christmas 2021. She anticipated him returning to normal after he retired from a stressful career two to three months ago, but he hadn't. Martin was preoccupied, leaving Anne extremely upset and unsure of what to do. Martin told the GP he could not determine the source of the problem. Martin appeared flat to the GP. He denied any changes in his behaviour, but Anne sat alongside him in tears since she thought he had changed considerably.	GP
	Martin	**Martin was referred to Talking Change due to his high-stress levels**. When approached to arrange therapy by Talking Change, Martin stated that he was already seeing a psychiatrist and that it would be too overwhelming for him to have two groups of people assisting him. The risk was highlighted as modest, and they advised that he could re-refer.	Solent
28.05.22	Anne and Martin	**Anne told Ethan she was struggling and that Martin had changed all the passwords**.	Ethan's Statement

02.06.22	Martin	**Martin had held a firearms licence since 21.07.10**. He reported to the police that his firearms were stored at a local firearms storage facility.	Police
06.06.22	Martin	**After retirement, Martin's condition deteriorated and did not improve as they had initially anticipated.** Anne had taken on the role of Martin's carer with support from Ethan and Taylor. **Anne and Martin went on holiday with Rose and Charlie**.	Rose and Charlie
	Anne and Martin	**Text conversation with Ethan and Anne:** Martin was experiencing difficulty during the holiday and was becoming increasingly distressed. He stated he was an awful husband and father, felt guilty for everything, and suspected he was being followed.	Ethan's Statement
15.06.22	Martin and Anne	**Anne was distressed and deeply concerned for Martin.** Martin was anxious and had lost a significant amount of weight. He was paranoid that technology was listening to him, and he did not use WIFI phones, as he believed that something had gotten into the system. He was worried that everyone was in physical and financial danger and had obsessive thoughts – for instance, that leaving a cup on the table could cause damage.	GP
	Martin	**Referral by the GP to the HTT for deteriorating mental health**. Martin was not previously known to community mental health services.	Solent
	Martin	**GP made a referral for assessment due to deterioration of mental health.**	Police
	Anne	**HTT urgently contacted Anne to see Martin since he had expressed suicidal thoughts to Ethan.**	Solent
	Martin	**HTT home visit.** Martin was concerned about all his internal problems and identified triggers such as technology, low mood, and the end of his career. The risk was seen as deteriorating mental health and suicidal ideation. **He was admitted to HTT.** Martin requested the same staff member visit. The goal of the visits was to check Martin's mental state, routine and mood management, medical review for medication and identify any cognitive /memory impairments.	Solent
	Anne	**Anne expressed relief that they were now in the system and receiving HTT visits**. However, Anne was troubled by the change in Martin's mental health as he showed signs of paranoia.	Rose and Charlie
	Martin	**Martin described experiencing anxiety while managing a business during the pandemic, which ultimately closed and ended his career.** He believed organising the furlough scheme and adapting to COVID-19 restrictions were challenging.	Solent SAR

		He reported a one-stone weight loss and changes in sleep and routine and described the triggers as technology, the end of his career, and an overall low mood.	
16.06.22	Martin	**Anne was present for the HTT's home visit.** Martin stated that he felt overwhelmed and did not desire daily visits. However, he consented to a phone call. He felt paranoid, but no immediate risks were discovered, and he consented to a medical review.	Solent
17.06.22	Anne	**Anne informed HTT via phone that Martin's presentation had worsened.** Martin declined a medical review.	Solent
	Anne	**Anne stated in the initial call that she did not want Martin to know she called.**	Solent SAR
	Anne	**Anne sent a message:** *"*He is really agitated today. Would not sit down but would watch through blinds to see if anyone is watching".	Rose and Charlie
	Martin	**Risk assessment to enquire about domestic abuse in the home**, to which he replied, *"Never".* Anne reported that Martin is not the same person he once was.	Solent SAR
	Anne and Martin	**Anne stated Martin was:** *"Not very good today and had become anti-everything … a caged lion".*	Ethan's Statement
19.06.22	Martin	**Martin disclosed to Taylor some of his ruminating thoughts and all he had allegedly done in connection with financial theft**. He was convinced he would be imprisoned forever.	Ethan's statement
20.06.22	Martin	**Anne and Ethan were present for the medical review**. Martin reported having fleeting suicidal thoughts without intent, but the doctor suspected he was downplaying this in front of his family. Impression - Severe depressive episodes with significant anxiety, guilty ruminations, and psychotic symptoms may not currently present a high suicide risk, but there may be more hopelessness than the individual confesses. Plan—Medication: HTT will conduct a home visit, follow up in one week, transfer to Older People's Mental Health, and discuss an EIP referral.	Solent
	Martin	**Agreed to take anti-depressant medication.** However, Anne became increasingly concerned that he would not accept the prescribed medications, and a battle of wills ensued between them. He was diagnosed with psychotic depression.	Rose and Charlie
21.06.22	Anne	**Message sent*:*** *"I can't get Martin out at the moment. I will try again in a bit. He won't even sit in the garden."*	Rose and Charlie
	Anne	**Anne, who answered the phone when HTT called Martin**, reported that he remained confused and requested to speak with a specific staff member because he does not open up to others. The staff member was absent for one week.	Solent SAR
22.06.22	Family	**Martin's family believed he was depreciating after seeing Consultant A, and he described having thoughts of harm without any intent or plan**.	Solent

	Martin	**HTT arranged to discuss Martin's care with the Consultant for Older People.**	Solent SAR
	Anne	**Anne told HTT that Martin:** "H*as depreciated in his ability to comprehend things since the last time he saw the Doctor''.*	Solent Care records
	Anne and Martin	**Anne told Ethan she wondered whether Martin was flushing the medication down the toilet.**	Ethan's Statement
23.06.22	Anne	**Anne contacted HTT** because Martin's medicine decreased his blood pressure, and he did not want to take the medication. The doctor attempted three phone calls to Martin and left a voicemail. Taylor then requested a return call via telephone—a recommendation to continue medicine.	Solent
25.06.22	Martin	**The home visit disclosed that Martin was not taking the medication as prescribed.** The HTT worker observed that Martin desired confirmation that the worker was not an imposter. The worker recorded that Martin lacked self-confidence, self-esteem, and self-worth. They reviewed the business structure he had worked and managed for 50 years.	Solent Care Records
26.06.22	Martin	**Bart informed Ethan that Martin told him he would not take medication.**	Ethan's Statement
27.06.22	Martin	**According to Anne and Martin, his mood had improved.**	Solent
28.06.22	Anne	**Anne reported:** *"Nothing made sense to Martin on TV, so they played Rummikub instead."*	Rose and Charlie
29.06.22	Martin	**The local Firearms facility expressed concern about Martin**, and he would not be authorised to shoot at the club. The neighbour had taken the gun, and Anne had contacted the GP.	Police
	Martin	**The older people's service informed Consultant A that their minimum age remains 65.** Anne and Ethan were present during Consultant A's call to Martin. According to his family, since starting Mirtazapine, he was less anxious, slept better, and was objectively brighter in mood. However, he continued to report difficulties with technology usage. He requested a discussion of EIP at the next appointment. His medication was increased.	Solent SAR
30.06.22	Anne	**Anne informed the GP** that Martin stopped taking his blood pressure medicine ten days ago. The GP texted Martin to request that he arrange a discussion concerning the medication.	GP
	Anne	**Message:** *"It was not a good evening. Martin was given new meds. The same medication was increased from 15 to 30mg."*	Rose and Charlie
01.07.22	Anne	**Anne informed Martin's GP of anxiety and stress.** Martin was under the care of the HTT and had been prescribed Mirtazapine and Diazepam but had not yet begun taking them. Martin had a panic attack the previous evening and was on the waiting list for surgery for bilateral hernias.	GP
	Anne and Martin	**Anne notified Ethan via text message.** Martin was agitated and concerned about his blood pressure because the Mirtazapine packet stated that the prescription	Ethan's Statement

		would lower it; hence, he had intermittently neglected to take his blood pressure medication.	
04.07.22	Anne	**After discovering Martin self-harming in the bathroom, Anne dialled 999.** Anne reported that Martin's mental health deteriorated after closing the business during COVID-19. He had self-harmed, resulting in a moderate amount of blood loss. As a result, a Safeguarding Adult Concern was submitted to the Local Authority.	Ambulance
	Anne and Martin	**Rose joined Anne at her home following Martin's serious attempt to take his own life**. When she arrived, Anne told her what had happened that morning when she had encountered Martin in the middle bathroom holding three knives. It was only when Rose and Anne discussed her conversation with the emergency services that she mentioned the first thing they advised her to do was open the front door and, if possible, the back door so that she had an escape route if required. Only then did it dawn on Anne that she might be in danger from Martin, something Rose and Charlie would have never believed of Martin. This was not mentioned or discussed again.	Rose and Charlie
	Martin	**Ethan went to the home to support Anne and attended to Martin's injuries.** He had to restrain his father at home and in the ambulance.	Ethan's Statement
	Martin	**The South Central Ambulance Service notified Adult Social Care of the attempted suicide.**	Statement from ASC
	Martin	**Request for an assessment of mental health at the QA hospital**. Martin attempted to take his own life. A Mental Health Act Assessment was arranged.	Solent
	Martin	**They reported that Martin went three days without medication at the QA hospital.**	Rose and Charlie
05.07.22	Martin	**Martin was detained under the Mental Health Act: Section 2.**	Solent
06.07 & 07.07.22	Martin	**An email conversation between the Solent lead nurse (older adults ward) and Consultant B's ward team.** The lead nurse requested that any information be forwarded to their ward. Consultant B disagreed and stated that Martin should be admitted to their ward, as he was not experiencing delusions or psychosis. Consultant B noted that Martin was very depressed but that his mood could fluctuate and questioned the psychosis.	Email
07.07.22	Martin	**Martin was admitted to the mental health ward.**	Solent
	Martin	**Diagnosed with Psychotic Depression,** a brain scan was planned to rule out any organic causes for psychotic symptoms. Martin reported feeling anxious and fearful while in the hospital.	Solent SAR
08.07.22	Martin	**Martin contacted 999** to report that he had stolen jewellery from a jeweller. However, he could not recall what he had stolen, and there was no evidence that the jewellery had been stolen.	Police
11.07.22	Martin	**Martin was relocated to a quieter ward**, but his medical care remained with the ward where he was initially admitted.	Solent SAR

		(According to Solent NHS Trust reports, the family requested the move, while it also states it was due to ward refurbishment.)	
12.07.22	Martin and Anne	**Medication was missed because Martin was asleep.** Concerns were recorded about self-neglect due to his poor food and fluid intake. Solent NHS Trust determined Martin to have a stable weight and a healthy body mass index. Anne called the ward to express concern that Martin spent all of his time in bed sleeping and was depressed.	Solent SAR
13.07.22	Martin	**Food and fluid intake were reported as very good,** with Martin having a healthy BMI and stable weight.	Solent
19.07.22	Martin	**Consultant A reported that Martin's mental state had not significantly improved.**	Solent SAR
21.07.22	Martin	**Martin initially refused his medication and requested to see the doctor because he believed he could return home.** Eventually, he was encouraged to take the medicine.	Solent SAR
	Martin	**The ward doctor reviewed the records.** Martin was accepting medication despite noting he had initially declined the medication the previous night. He was described as stable on the ward; his wife, children, and friends visited him frequently, and he felt ready for discharge. His food and fluid intake had improved.	Solent SAR
22.07.22	Martin	**A social worker on the ward saw Martin**. The visit's objective was to discuss his care and support needs. Martin was respectful and appeared anxious and withdrawn. He replied that he did not require support at home and lived with his wife. He was eager to schedule a visit with his family, so the meeting was cut short. The plan was to continue attempting to engage Martin.	Adult Social Care
23.07.22	Martin	**The record stated that Martin was compliant with interventions but could sometimes be reluctant to take medications.**	Solent SAR
25.07.22	Martin	**Martin reported no longer believing he required medication because he felt clearer and less confused**. Discussion regarding the possibility that medication was the cause. It was observed that he did not appear preoccupied or paranoid, and his responses were somewhat more spontaneous. The plan was to consult with the family, rescind Section 2, and discharge Martin within two days if the family did not suggest a continued role for inpatient care. He was to receive HTT upon discharge. **The family was not consulted.**	Solent SAR
	Anne and Martin	**Martin spoke to Anne and told her he was holding a letter stating that the Section had been removed**. Anne called Consultant B and arranged to meet them the following day.	Ethan's statement
	Anne and Martin	**Martin informed Anne that his section had been lifted, and he could return home.** This development, which had not been communicated to Anne, caused her great anxiety. She feared that Martin had not yet demonstrated genuine signs of recovery, as the medication had insufficient time to affect him	Rose and Charlie

		fully. This was carried out despite assurances that the family would be consulted before any changes were made. Back at home, she would be responsible for ensuring that Martin continued to take his medication, a task that had previously been fraught with difficulty and deceit. Anne explained to Rose that Martin's news prompted a discussion/negotiation with the Doctor, who, with Martin present, established Anne as the one working to keep Martin away from his home for an extended period. She was concerned Martin would interpret this negatively.	
26.07.22	Martin	**Revocation of Section 2, no suicidal behaviour. However, family members are worried about suicide.**	Solent
	Martin	**Martin received information about the Men's shed**[32] and agreed to look at this.	Solent SAR
	Martin and family	**Consultant B met with Anne and Ethan and explained that the section was rescinded because Martin had demonstrated the capacity to consent**. In addition, Consultant B believed Martin's depression was improving. However, he would require long-term medication, and he noted there had been minimal staff interaction. **Consultant B reported that Martin's suicidal risk had been reduced and that there were no risks on the ward, and this would need to be tested at home**. Martin was granted six hours of leave with his family.	Solent SAR
27.07.22	Family	**The family worried about suicide risk, Martin not taking medication and upcoming discharge.**	Solent /Family
	Family	**Martin's family was concerned about his potential discharge because he had not engaged with inpatient services.** Instead, according to the records, he spent his time in his bed space with the curtains drawn.	Solent SAR
28.07.22	Martin	**According to the documentation, Martin was in a low mood, sitting in the armchair in the dark with little response when spoken to.**	Solent SAR
01.08.22	Martin	**MRI Scan:** Martin requested his family to escort him for this. (This appears to be a recording error, given that the request and scan both involved a CT scan.) According to the documentation, Martin was depressed, isolated himself from the world and himself (closed curtains, keeping the room dark), and had minimal interaction with staff despite numerous attempts.	Solent SAR
02.08.22	Martin	**Discharge CPA from the ward** so that Martin could receive HTT. Recorded he would receive OT and SW follow-up. The latter did not occur.	Solent
	Martin	**The risk record** indicated that due to the risk of retaliation, there is a potential risk to others; however, this risk is low because Martin has family support and denied having thoughts of harming others.	Solent SAR
03.08.22	Anne	**According to Anne, Martin was concerned about who knew he had been a patient at the mental health unit.**	Rose and Charlie

[32] https://www.amh.org.uk/services/mens-shed/

	Anne and Martin	**Anne reported to HTT that Martin's mental state was improving due to his medication.** Anne stated there had been a substantial improvement, but there was still room for progress.	Solent SAR
04.08.22	Martin	**Firearms renewal application on hold.**	GP
05.08.22	Martin and Anne	**Email documentation stated that Martin no longer consented to share information with his wife.**	Email
16.08.22	Martin	**Mental health review.**	GP
	Anne	**Anne informed HTT that she and Martin had visited the GP because Martin had been constipated for two weeks**, and they were frustrated at being prescribed additional medication. She believed this issue should have been addressed while Martin was hospitalised.	Solent SAR
17.08.22	Martin	**The clinic records state:** "*I suggested to Martin that the notes suggest he is subjectively struggling to see improvement, but objectively, his wife is seeing improvement. Martin said he did feel he was improving…"*	Solent SAR
24.08.22	Martin	**Martin was objectively better than when the doctor last reviewed him.** However, Anne and Ethan saw that he still needed continued support despite Martin's improvement, as he was not back to his usual self. The possibility of increasing antidepressants was discussed. The clinical notes were documented to advise the family to be aware of the signs of a relapse. However, the family does not recall being told this, and no documentation has been recorded to state this.	Solent
25.08.22	Anne	**Rose and Charlie felt Anne had lost her voice with HTT**, as all communications from that date had been over the telephone with Martin.	Rose and Charlie
31.08.22	Martin	**HTT informed Martin that he was above the age threshold for EIP and would be referred to other groups**. Martin did not report any medication side effects and had been engaging with HTT. However, he had reported side effects of constipation to his GP and was taking medication for constipation. **Martin was referred for CBTp.**	Solent SAR
Sept 2022	Anne	**Anne told her hairdresser and a family friend***:* *"That we would never get the old Martin back, but don't tell the others".*	Rose and Charlie
07.09.22	Martin	**Accepted by Psychology service concerning CBTp.**	Solent
09.09.22	Martin	**Martin felt much better and had a more tranquil mind.** However, Anne observed that Martin enjoyed fewer things.	Solent
14.09.22	Martin	**He was accepted for CBTp**. Unfortunately, the wait was one year and nine weeks, and he would be offered family work in the interim.	Solent
Sept 2022	Anne and Martin	**Found deceased by neighbours**	

3.1 Analysis of Agency Involvement

3.1.1 This section explores the agencies' involvement with Anne and Martin.

3.1.2 Anne and Martin communicated with the following agencies:

- Adult Social Care - Martin
- GP Practice – Anne
- GP Practice - Martin
- Solent Mental Health and Community Services – Martin and Anne
- Queen Alexandra Hospital – Anne and Martin

Adult Social Care – Martin

3.1.3 ASC received a concern from South Central Ambulance Service dated 04 July 2022. They reported that Martin had self-harmed and was conveyed to the hospital. ASC determined that Martin did not meet the Section 42 Safeguarding Enquiry: Care Act 2014 threshold[33].

The criteria for an enquiry:
Where a local authority has reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there):

a) has needs for care and support (whether or not the authority is meeting any of those needs),
b) is experiencing, or is at risk of, abuse or neglect, and
c) Due to those needs, they cannot protect themselves against abuse, neglect, or risk.

3.1.4 ASC stated that Martin was not a victim of abuse or neglect. Hence, he did not satisfy the criteria, and mental health services would better assist his support needs.

3.1.5 According to the Local Government Association[34], there should be instances where the risk of suicide is recognised as a safeguarding issue. Responses should be person-centred, dealing with the individual's situation and addressing the causes of suicidal ideation and the risks involved.

3.1.6 The author agreed with the ASC's conclusion that mental health services would better support Martin, and there would be no indication of ASC input at the time.

3.1.7 A social worker from ASC visited Martin in the ward on 22 July 2022. They agreed to return to attempt to engage Martin but did not. No explanation was provided regarding this.

GP Practice - Anne

[33] https://www.legislation.gov.uk/ukpga/2014/23/section/42/enacted
[34] https://www.local.gov.uk/understanding-what-constitutes-safeguarding-concern-faqs

3.1.8 Anne was registered with a different GP practice than Martin. Anne's interactions with her GP revealed no issues related to domestic violence or abuse. According to their records, they were unaware of Martin's mental illness and its effect on Anne.

3.1.9 In August 2021, the contact was primarily due to a scooter fall, resulting in a closed fracture. Anne was discharged from Physiotherapy for rehabilitation in February 2022.

3.1.10 The GP had no concerns regarding domestic abuse, and her injury was consistent with a fall from a scooter.

GP Practice - Martin

3.1.11 On 12 May 2022, Martin had a GP duty triage telephone consultation.

3.1.12 On 26 May 2022, Anne attended a face-to-face appointment with Martin. This information is included in the key events. There were no concerns regarding domestic abuse or Anne's safety during this encounter. Martin was the focal point of the appointment and to facilitate his receiving assistance following a presentation on work-related anxiety and stress. At this appointment, neither paranoia nor psychosis symptoms were reported.

3.1.13 The GP practice acknowledged that they should have considered support for the family during this appointment, such as advising Anne to seek support via her GP or Talking Change

3.1.14 Primary care is uniquely positioned to provide mental health care as the first point of contact for most individuals when they have a health care need or the onset of symptoms.[35] The Royal College of General Practitioners acknowledges the significance of early recognition and diagnosis of mental health problems, particularly first-episode psychosis, and recommends education and training. This will ensure that people with "mental states at risk" receive effective early treatment, referral to community services, and early intervention.[36]

3.1.15 The GP reported they considered a referral to Mental Health Services according to NICE recommendations for the initial presentation of a mental health diagnosis.

3.1.16 The guidance related to common mental health problems: identification and pathways to care (CG123: 2011[37]) suggests the following recommendations:

1. **Improving access to services**: To increase access and utilisation. The GP was informed of Ethan's referral to Talking Change. However, the GP noted that Martin did not believe a problem existed. Consequently, the recommendation stipulates that a designated professional (typically the GP in a primary care setting) must supervise the entire period. The GP documented an unsuccessful attempt to contact Martin; no further contact had been arranged. The panel could not establish why further contact had not been arranged.

[35] https://www.rcgp.org.uk/representing-you/policy-areas/mental-health-in-primary-care
[36] https://www.rcgp.org.uk/representing-you/policy-areas/mental-health-in-primary-care
[37] https://www.nice.org.uk/guidance/cg123/chapter/Recommendations#step-1-identification-and-assessment

2. **Stepped Care** – The model is intended to assist individuals with common mental health disorders and their families and carers. The GP accepted that support should have been offered to Anne.
3. **Identification and Assessment** – The recommendation is to utilise a Generalised Anxiety Disorder Scale,[38] a screening instrument for determining the severity of generalised anxiety disorder. The Generalised Anxiety Disorder scale was completed on 14 June 2022, scoring seven. Five, ten, and fifteen scores correspond to mild, moderate, and severe anxiety. Simultaneously, a Patient Health Questionnaire[39] was completed with a score of 19. The Depression Severity scale is 0-4 none, 5-9 mild, 10-14 moderate, 15-19 moderately severe, and 20-27 severe. They indicated moderately severe depression. The conclusion made at this time (15 June 2022) was that Martin had been referred urgently to the community mental health services (HTT).
4. **Risk Assessment and Monitoring** – The GP noted no concerns regarding safety to self or others.

3.1.17 The Royal College of General Practitioners is aware of the growing demand in the NHS and the need for innovative appointment and service delivery methods. Introduced measures include digital and telephone communication, which may impede access for various individuals, such as those who are deaf, have a degree of cognitive impairment, do not own the necessary technology, or are confused or mentally ill. It must be ensured that these individuals are not excluded from services.[40] As a result, the author considers that a further appointment should have been scheduled based on the recommendation above to improve access to services or that additional contact with the family should have been made to confirm that the referral to Talking Change had been accepted and that the outcome was appropriate.

3.1.18 Appropriately, the appointment (15 June 2022) with the GP resulted in an immediate referral to HTT. At this appointment, there were additional psychosis-related concerns. These were associated with Martin's suspicion that technology was listening in on him. Martin's gun licence was known to the doctor, who was assured the firearms had been removed. The referral to mental health services did not mention Martin's possession of firearms.

3.1.19 Depression is listed on firearm and shotgun certificate application forms as a relevant health condition. If nothing is disclosed, police firearms enquiry officers write to the GP to confirm that there are no medical issues and request that the GP place an encoded reminder on the patient record indicating certification. Certifications must be evaluated every five years.[41] The GP did not inform the police about Martin's mental illness, which would have resulted in the police ensuring he did not have firearms.

3.1.20 Access to lethal means is a significant factor in suicide rates. The author expects the GP to have notified the mental health services and police despite being informed that Martin no longer possessed the guns. This would ensure a robust risk assessment.

[38] https://patient.info/doctor/generalised-anxiety-disorder-assessment-gad-7
[39] https://patient.info/doctor/patient-health-questionnaire-phq-9
[40] https://www.rcgp.org.uk/representing-you/policy-areas/mental-health-in-primary-care
[41] https://www.cambridge.org/core/journals/bjpsych-advances/article/guns-and-psychiatry-what-psychiatrists-need-to-know/50A3E5A071F9276969BECA67E5280D38

3.1.21 The next day, the GP documented that Martin had declined HTT's assistance and was discharged. However, Martin was not discharged and remained under HTT from 15 June 2022 to 4 July 2022. The GP notification stated that HTT had completed the Generalized Anxiety Disorder scale and determined that Martin was experiencing mild to moderate anxiety. Additionally, they had completed the Patient Health Questionnaire (PHQ-9[42]), a tool used to assess the severity of depression. According to the questionnaire, Martin was depressed to a moderate to severe degree. However, the clinical records stated that Talking Change completed these tools on 15 June 2022 during the telephone consultation.

3.1.22 On 30 June 2022, Anne contacted the GP practice to advise Martin had stopped taking his medication for his blood pressure; he was under HTT and had been prescribed Mirtazapine 30mgs[43] (anti-depressant) and Diazepam[44] (for the treatment of anxiety). However, he had not started the Diazepam and was taking the Mirtazapine inconsistently. The GP contacted Anne on 1 July 2022, and she reported anxiety and stress due to Martin's mental illness. Unfortunately, no support was offered to Anne, and the practice acknowledges that she should have been directed and supported to contact HTT.

3.1.23 Martin's GP was informed of Martin's attendance at the Emergency Department and subsequent admission on 4 July 2022.

3.1.24 The GP received an application from the police for the automatic renewal of Martin's firearms, which was placed on hold pending a response from Martin. The practice reported that they would have contacted the police had Martin actively pursued the application. However, the author believes the police should have been informed of Martin's significant suicide attempt and mental illness.

3.1.25 The police confirmed that this was not a new firearm application. Martin's mental health had been directly brought to the police's attention, and the police were responding. The police had to verify that Martin did not possess the firearms and revoke his licence. The GP did not notify or respond to the police's three separate requests. (This has been followed up outside of the review.)

3.1.26 Martin was concerned about constipation following his hospitalisation and medication for mental health. Martin had taken laxatives, but they were ineffective. He reported eating well and maintaining a healthy diet. The GP suggested this could be a potential adverse effect of the psychotropic medication and discussed with Martin and Anne, titrating laxatives. Due to side effects, Martin had previously stopped taking medication for his physical health condition, and alternative medicines were discussed.

3.1.27 Concerns regarding the constipation report were communicated to the GP over ten days; therefore, it would be appropriate for the GP to discuss the psychotropic medication with the

[42] https://patient.info/doctor/patient-health-questionnaire-phq-9
[43] https://www.nhs.uk/medicines/mirtazapine/
[44] https://www.nhs.uk/medicines/diazepam/

mental health service to determine if there was an alternative and what other intervention would be necessary.

3.1.28 According to a study, the most common reasons for discontinuing psychiatric treatment were patient choice, lack of efficacy, and intolerable side effects.[45] The study suggests four strategies for enhancing concordance: Communication, Strategy-Specific Interventions, such as adjusting medications to reduce adverse effects, reminders, which Anne performed, and medication valuation. Upon discharge, Martin did not receive a face-to-face review of his medication by the community mental health team.

3.1.29 The GP received a letter dated 24 August 2022 from the mental health service stating that Martin was objectively much better and almost back to normal. Anne and Ethan observed that he was still recovering and did not laugh, smile, or have the same motivation or energy as before his illness. Martin reported not experiencing any persecutory or guilt-based delusions. He reported no suicidal or self-harming thoughts and was reluctant to change medications.

3.1.30 The letter stated that if he stopped taking his medicine, his risk to himself would increase. In addition, his dosage of antidepressants should be increased. The letter suggested the family were briefed on signs of relapse, and Martin and the family do not feel he required ongoing HTT support; they thought he would benefit from psychology input instead. The family do not recall being provided with information on signs of relapse.

3.1.31 The Royal College of General Practitioners established a five-year clinical priority with a Mental Health and Whole-Person Care Lead and Clinical Fellow for Mental Health to assist general practitioners.

1. Mental health is a core part of the primary care business.
2. The GP's role in managing mental health problems should be that of the expert generalist rather than developing specialist or extended interest roles.
3. GPs should champion the development of mental health care for under-represented, potentially vulnerable groups of patients, including, for example, children and young people, people with dementia, asylum seekers and refugees, travellers, offenders, people with intellectual disabilities and/or autism, people experiencing homelessness, and be aware that there are higher rates of problems in a socially excluded and vulnerable group.
4. The College officially endorses the delivery model for Collaborative Care and Support Planning (CCSP) as key to delivering person-centred care in the growing prevalence of multi-morbidity long-term conditions and mental health problems. CCSP should be part of the core work of General Practices.

Queen Alexandra Hospital, Portsmouth Hospitals University

[45] https://www.cambridge.org/core/journals/advances-in-psychiatric-treatment/article/why-dont-patients-take-their-medicine-reasons-and-solutions-in-psychiatry/7BAF0EC10C89CE9AA7224495837CA576

3.1.32 Anne's contact with the hospital within the period under review was related to a fracture sustained following a fall from an electric scooter. There were no indications of domestic abuse, and her injury was consistent with the fall she reported.

3.1.33 Martin was taken to the hospital on 4 July 2022 after attempting suicide. Anne and Ethan accompanied him. The hospital noted that he had been experiencing stress with the closure of his business due to the COVID-19 pandemic.

3.1.34 Due to the risks Martin posed to himself, the hospital mandated continuous security presence and a mental health nurse. He was referred to the mental health service; the hospital recorded that he had been assessed by mental health services twice on 4 July 2022, and a Mental Health Act Assessment had been arranged.

3.1.35 Martin was detained under Section 2 and admitted to the QA hospital, pending a bed becoming available at the mental health unit. According to the hospital notes, the next of kin was informed and agreed to the transfer.

3.1.36 The hospital assessed that a secure transport consisting of one driver and three support staff was necessary. This was due to Martin's significant attempt to end his life; there were concerns he might abscond, and he possessed a firearms licence. The family reported they were unaware of the requirement for four staff members.

3.1.37 The transfer was delayed because the crew (driver and support staff) raised concerns about the legal paperwork, which needed to be revised. Martin was transferred at approximately 0039hrs on 7 July 2023.

3.1.38 A CQC national thematic review[46] found generally inadequate coordination and collaboration between acute and mental health services and delays in assessments and bed availability. The shortage of mental health beds exacerbated these delays. Ethan reported that he had contacted the mental health unit while Martin was in the QA hospital, but they were unaware of Martin's impending admission to the ward. The family believe Martin's admission was expedited due to their persistence with the hospital doctor for a bed. However, the hospital reported delays due to bed availability, the required transport and incomplete paperwork.

3.1.39 Ethan reported he had to restrain his dad in the ambulance as he was trying to get out of the moving vehicle and in the QA hospital emergency department as Martin attempted to open the sutures. The hospital had mandated security presence. The family stated that Martin was not constantly supervised. Although the hospital indicated that a mental health nurse was not required when the family was present, the author believes this is inappropriate because the family is not trained to support Martin during his crisis.

[46] https://www.cqc.org.uk/sites/default/files/20201016b_AMSAT_report.pdf

3.1.40 Furthermore, it would put pressure on them to keep him safe. Martin was discovered to be alone on the ward when Ethan visited. Martin informed him that the 1:1 had to leave early in the morning, and another individual was scheduled to take his place, which did not occur.

3.1.41 Ethan reported that Anne had brought Martin's medication to the ward; they were told they could not administer this and the hospital could only provide medication for anxiety. The family informed the staff that they had discovered a pill under Martin's bed, but they were uncertain whether it was Martin's medication or someone else's. No further discussions were had concerning this.

3.1.42 The QA hospital reviewed the medication records, which are held digitally and confirmed the following:

- Amlodipine 5mg daily—prescribed on July 5th and given as prescribed on July 5th and 6th.
- Olanzapine 2.5mg od – prescribed on 6/7/22 but not given.
- Chloramphenicol 1% eye ointment is to be applied to wounds thrice a day. It is prescribed on the evening of the 4th of July and given as prescribed. On the 6th of July, two doses were given, but the lunchtime dose was missed because the patient was unavailable.
- Mirtazapine 30mg daily—prescribed on July 5th and given as prescribed. The dose was not given on July 6th.
- The Bedview patient record indicates medication was given on 06.07.2023 @ 17.09.

3.1.43 The QA hospital was unable to confirm why medications had been missed. On transfer, the hospital provided the following:

- Amlodipine 5mg daily– one box of 28
- Chloramphenicol 1% eye ointment for wounds three times a day – one tube
- Mirtazapine 30mg daily – one box of 28

3.1.44 The family highlighted their concerns about the ward Martin was admitted to at the QA hospital whilst waiting for a mental health bed as unsupportive to his needs. A CQC report found instances in acute wards where ligature risks had not been eliminated, putting patients with mental health needs at risk. A CQC report stated that one-on-one security guard supervision is inappropriate.

3.1.45 According to a CQC report, clinical staff lacked the competence and confidence to provide mental health care due to a lack of training. Consequently, they relied heavily on psychiatry teams for mental capacity assessments, ethical issues, and patient care. In some instances, this was appropriate, but in some medical teams, the mental health needs of patients were viewed as "outside their remit."

3.1.46 Ethan remarked that Martin and his family received excellent care in the emergency department, which was significantly different when he was transferred to the medical ward.

Solent Mental Health and Community Services

3.1.47 Ethan initially referred Martin to Mental Health Services: Talking Change on 6 May 2022 and 26 May 2022.

3.1.48 The referral dated 6 May 2022 that the author viewed lacked a reason for referral and did not identify the risks. It was a checkbox form, and the “Self-Referral Check-In Crisis” section contains the word "no." Ethan was clear that he had completed the referral describing the concerns. However, as a primary mental health service, they would only support mild to moderate mental health conditions.

3.1.49 Due to the second referral to Talking Change, received on 26 May 2022, a telephone consultation occurred on 15 June 2022. The diagnosis of a "depressive episode" was recorded on the "Patient Boarding Card," which indicated "risk not assessed." The PHQ9 score on the patient boarding card was 19, and the GAD score was 15.

3.1.50 Additionally, the assessor described Martin as appearing disinterested and averse to accepting assistance. When queried about contemplating the notion of "being better off dead", he replied, "No, not within the past two weeks". He described how his levels of stress and anxiety had steadily risen over the past few months, during which he had been preoccupied with worries about everything and found it challenging to stop these thoughts. He also reported experiencing difficulty falling asleep. He wished to control his anxiety and stress.

3.1.51 The plan recorded was ‘stress management’. It further stated Martin called back to state he was working with a psychiatrist and another mental health team and felt it would be too “overwhelming” to have two services supporting him. Martin was advised to refer to Talking Change at any time. HTT had arranged an assessment for 15 June 2022. The Solent NHS Trust policy states that patients cannot simultaneously be open to two services.

3.1.52 Ethan recalled advising Martin to end the call with Talking Change on 15 June 2022 as Martin was becoming distressed and confused.

3.1.53 Following Martin's GP appointment on 15 June 2022, he was urgently referred to HTT, who met him and Anne on the same day and initiated the assessment.

3.1.54 The mental health team telephoned Anne on 15 June 2022; they documented her concerns as the following:

- *Up and down*
- *Currently calm in the presence of his son*
- *He is worried about everything and feels a sense of something bad happening to him being followed.*
- *Lack of motivation or wanting to do anything, such as going for a walk.*
- *Has expressed some suicidal ideation to their son last night.*

- *Is sleeping.*

3.1.55 Martin was seen face-to-face by HTT on the same day and informed them that he was concerned about worries in his head. He believed his mobile phone had been bugged or monitored but could not identify who or why. He had also observed that his computer was malfunctioning. Martin felt he was not the same person he once was, and his and his wife's lives had changed.

3.1.56 He discussed the difficulty of running an independent business throughout the pandemic. Martin stated it was difficult to organise the furlough programme and adjust the business to COVID-19 constraints such as PPE and other equipment. The business closed in April 2022, ending his entire career. Martin reported that he had lost weight and had poor sleep.

3.1.57 Martin requested that the same HTT representative visit him, which would make him feel more at ease. In addition, he thought that daily visits would be too much, so they agreed to a phone call that could be changed to a home visit if deemed necessary by either Anne or Martin. Martin said HTT's assessments were overwhelming, and he wanted to avoid being seen on the weekend. Anne informed HTT that Martin's personality and behaviour had changed and that he was not the person he used to be.

3.1.58 The risk assessment dated 17 June 2022 recorded Anne's views as a change in Martin's personality and behaviour. The family was instructed to contact HTT if necessary. No relapse indicators were reported.

3.1.59 Anne called HTT on 17 June 2022 to report that Martin's presentation had deteriorated. When HTT spoke with him, he settled down and said nothing had changed. He declined a medical review and asked not to be contacted over the weekend. The author believes this would have been an opportunity to ensure Anne was receiving support, and if Martin did not wish for a visit, it should have been considered visiting Anne to offer support.

3.1.60 Consultant A reviewed Martin in the presence of Anne and Ethan on 20 June 2022. In the Consultant's opinion, Martin was experiencing a severe depressive episode with prominent anxiety, guilt ruminations, and psychotic symptoms. Suicide risk was not present at that time, but it was acknowledged that he might feel more hopeless and suicidal than he disclosed.

3.1.61 HTT indicated that an assessment under the Mental Health Act should be considered if his mental health deteriorated. He was instructed to take Mirtazapine daily and Diazepam as needed.

3.1.62 Consultant A noted that they talked with Martin about the medication. However, the records relating to this contact did not mention a discussion with Anne or Ethan regarding medication or the support they may require.

3.1.63 Martin completed a crisis plan on 27 June 2022 with HTT; the below was extracted from the clinical records. The plan is in place to prevent the likelihood of an individual's mental health

deteriorating; a crisis plan should identify the social network and be centred on the service user. Additionally, the contingency plan should specify the interventions, actions, and responses that will follow. Identifying indicators of relapse is a critical piece of information that is missing.

- *What am I like when I am feeling well?: Generally happy and enjoy seeing family and friends.*
- *What keeps me well (Protective Factors)?: My family and friends.*
- *What can make me unwell (Triggers)? Sometimes feel stressed about work things.*
- *How do I feel when I am becoming unwell?: worried and a bit anxious*
- *What can I do that is helpful when I am in crisis?: talk to family and friends.*
- *What can services do when I become unwell?: There's a lot of support available when needed.*

3.1.64 In addition to completing crisis and contingency planning with Martin on 27 June 2022, he was also given a satisfaction questionnaire regarding his mental health. The panel was not provided with the completed questionnaire, and its completion status remained unknown.

3.1.65 Ethan concurred with Consultant A that the care offered to Martin was of a good standard. The author confirmed that Ethan had no reservations about HTT care at the time of their input.

3.1.66 Due to Martin's age, Consultant A had requested that the Older Person's Consultant review the care. Although Martin did not fulfil the criterion for fragility, the Older Person's Consultant remarked on the care HTT provided Martin as 'exemplary'. The Older Person's Consultant did not recommend an alternative to the treatment provided by HTT. Additionally, Consultant A stated that HTT did not routinely work with older individuals, which is why the Older Person's Consultant requested oversight.

3.1.67 Information about the patient's history, a mental state examination, and medical workups are necessary to support the management of the presentation.[47] The author would like to emphasise Consultant A's request that the older person's Consultant review the care as an example of good practice.

3.1.68 The clinical record dated 27 June 2022 highlighted the risk as: 'Denied any thoughts to self-harm and willing to engage with services. However, the risk assessment did not consider Martin's possession of firearms and membership in a gun club, which the neighbour had removed before HTT's involvement. Limiting access to the most common means, such as pesticides, firearms, and certain medications, is an effective strategy for preventing suicide and suicide attempts.[48]

[47] https://www.racgp.org.au/getattachment/6306eede-8a77-4609-a98a-ca7ee2e118da/attachment.aspx#:~:text=Psychotic%20symptoms%20arise%20in%20the,complex%20combinations%20of%20disorders%20(eg.
[48] https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/college-reports/college-report-cr229-self-harm-and-suicide.pdf?sfvrsn=b6fdf395_10

3.1.69 There is an argument for refocusing on therapeutic risk assessment, collaborative formulation, and risk reduction rather than risk prediction. Frequently, risk prediction is not translated into risk management plans based on collaboratively developed formulations that explain the precipitants and influences of an individual's risk.[49] For example, a significant factor regarding Martin's risk to himself was the end of his career.[50] HTT had discussed loss with Martin, and he denied suicidal ideation. Martin's reaction to the loss was partly unclear because he was not fully engaged with services. The conclusion of his career was not explored further.

3.1.70 Suicide is a behaviour, not a condition. Any given individual cannot be accurately predicted at a single point in time to end their life by suicide. Suicide is typically the result of a multifactorial process, during which vulnerability to suicide may develop over several weeks, months, or years.[51]

3.1.71 Consultant A spoke about risk assessments, and while they use the categories "low, moderate, and high," they indicated that these terms are not helpful on their own. They advised that there should be an open dialogue with the person to assist and direct management rather than a risk assessment. Consequently, Consultant A extended the risk rating to include conditions that may increase the risk.

3.1.72 On 29 June 2022, the family reported that Martin slept better and was less anxious since beginning Mirtazapine. However, Martin remained cautious about technology, and his Mirtazapine was increased. Referral to EIP was discussed, and it was decided to continue the conversation on the next visit. However, it was not mentioned until August 2022.

3.1.73 Martin was visited at home two days before his suicide attempt, and he rated his anxiety as a five out of ten, with ten being panic. However, Solent NHS Trust's internal report did not specify whether this was an improvement or what was required to improve the rating; it would be expected that this would be part of his care plan to support recovery. The rating had decreased from seven when assessed on 16 June 2023.

3.1.74 The Solent NHS Trust implemented the Health of the Nation Outcome Scales (HoNOS), which assesses behaviour, impairment, symptoms, and social functioning. Nonetheless, this was not used for therapeutic objectives at the time but was incorporated into the Mental Health Minimum Dataset. HoNOS has been substituted with DIALOG+, a patient-administered instrument used to gauge satisfaction with both treatment and life. It facilitates the formulation of treatment plans and emphasises the patient's subjective priorities.

3.1.75 Likert scales[52] offer a practical means of assessing unobservable constructs. However, they are subjective and a snapshot in time and should be viewed in the context of how ratings are determined. The author suggests that the same scale should have been applied to Martin's family members' observations to improve the assessment.

[49] https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(22)00313-3/fulltext
[50] Risk and Protective Factors | Suicide | CDC
[51] Suicide risk mitigation - Symptoms, diagnosis, and treatment | BMJ Best Practice
[52] https://www.britAnneica.com/topic/Likert-Scale

3.1.76 Martin attempted suicide on 4 July 2022 and was admitted to a mental health unit on 7 July 2022 under the Mental Health Act. Individuals detained under the Mental Health Act require immediate treatment for a mental health disorder and pose a risk to themselves or others. Martin was admitted because he posed a risk to himself.

3.1.77 During Martin's admission to the mental health unit, his low mood was frequently observed, and he spent most of his time in his room with the curtains drawn, refusing to leave his room to eat, preferring to eat at his bedside, and engaging minimally with staff. His family frequently visited him, and he would leave his room and the ward only with them. The family noted that they were not informed of this and told that Martin was progressing well and interacting with staff. On 22 July 2022, a social worker visited Martin to assess his care and support needs. Martin informed the worker on this day that he lived with his wife and did not require assistance. The Social Worker was due to return to complete the assessment; however, they did not.

3.1.78 Section 2 of the Mental Health Act 1983 was rescinded on 25 July 2022 as he consented to admission and treatment. Martin was deemed to have the capacity to remain a voluntary patient. In addition, the treatment plan was for discharge as he no longer required inpatient admission.

3.1.79 Consultant B stated that Martin complied with medication and leave with his family; there were no incidents. Consequently, Martin was discharged from Section 2 as the least restrictive procedure because there were no grounds to maintain his confinement under Section.

3.1.80 Consultant B stated he spoke with Martin's family at their request to explain that Martin was a voluntary patient on the ward. They spoke with Anne and suggested trial leave for the next few days, and Martin was adamant that the inpatient stay was not helping him. Anne expressed her concern, which Consultant B documented:

> "My biggest worry is that he might go home and do something like this again. ' *I said to her that is a worry for anybody who's had a suicide attempt with any family, and so the only... Unfortunately, I cannot predict and tell you it won't happen again, but I can tell you that he's not made any attempts so far. The things that are different now are that he's feeling better, we're not seeing any evidence of psychosis, he is taking the medication as prescribed, and we're not concerned he's not complying with treatment plans. He's not articulated any suicidal thoughts. What we have to do is, therefore, maybe test things out, see what he's like at home and then, if we are worried about it or any concerns that come up, we then bring him back into the hospital because it will just be a period of short leave at home to build his confidence with being at home, because also he found it very difficult going home for two reasons; one he told us that there would be people popping round and he didn't want to talk to people about his mental health and the second thing, which was a big issue, going back into the downstairs bathroom where he …* self-harmed *the first time. So he was anxious about how he was going to be at that point, and his wife said she was anxious about that as well, and I said, 'OK, let's*

do this for a few hours on Thursday only, test it out come back, and we will review', and they did."

3.1.81 Consultant B reported that the family stated that the leave went well and that they will continue with further leave and arrange the discharge. Consultant B recalled Anne stating*: 'I can see he is looking for a little bit better compared to the few weeks he's been in hospital'.*

3.1.82 The author suggests that Martin's isolation in his room, lack of interaction with others and/or professionals while on the ward, reluctance to take medication, and reports of his low mood suggested Martin had not recovered on discharge and continued to experience depressive symptoms.

3.1.83 The report from the mental health team suggested that discharge should be considered with the family's consent, and Martin went on six hours of leave on 28 July and 1 August 2022. He was discharged on 2 August 2022 under the CPA. The family did not feel they were actively involved in the discharge.

3.1.84 The NHS stipulates what must be included in a care plan for those under the CPA.

3.1.85 The CPA mandates that Martin be assigned a key worker; however, this was not the case at discharge or before his death. At the point of discharge, Martin had not been referred to the community recovery team, and his care was managed by HTT, which does not individually case hold due to its nature as a 24-hour crisis service.

3.1.86 The plan for EIP would have included the Named Worker (Care Coordinator). However, due to his age, he was ineligible for this service. Moreover, throughout Martin's contact with mental health professionals, it was evident by Solent NHS Trust, family, and friends that Martin had not established a rapport with them.

3.1.87 It has been demonstrated that an effective rapport improves patient adherence to treatment, clinical outcomes, and patient satisfaction.

3.1.88 Anne and Ethan attended the discharge meeting with Martin but felt unable to express their concerns in his presence. They had also been told Martin was engaging with staff and progressing well.

3.1.89 Families play a crucial role in mental illness treatment. Families may be expected to provide care for patients with mental illness. Family involvement in patients with mental illness may result in better patient outcomes, including fewer relapses, longer intervals between relapses, fewer hospital admissions, shorter inpatient stays, and increased medication and treatment plan compliance.[53]

[53] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8801858/

3.1.90 A report by the Royal College of Psychiatrists emphasised the importance of involving families in risk assessment and eliciting their perspectives on risk. In addition, the risk to others must be assessed, and the family must be allowed to discuss and comprehend the potential risks posed by their loved one's illness.

3.1.91 According to Consultant A, Martin's suicide attempt in July was unexpected. Consultant A could not access the Talking Change referral forms (which are on a different electronic system to that used by HTT), the second of which highlighted depression and anxiety.

3.1.92 Consultant A added that Martin had no history of mental illness, came from a stable, safe, loving, and supporting family, and had no history of harm to himself or others. According to Consultant A, Martin was one of the patients with the lowest risk. Therefore, Consultant A was surprised to discover what had transpired, as their interactions with him did not predict the fatalities.

3.1.93 The HTT clinical manager stated they knew of Martin's psychotic depression. The suicide attempt was unexpected, and the team had not identified any warning signs. As previously mentioned, the Talking Change referral was not accessed.

3.1.94 Following Martin's suicide attempt on 4 July 2022, Solent NHS Trust submitted an incident report. The Trust Quality Lead reviewed the incident and communicated with Consultant A on 23 August 2022:

> … *'The IRM (Incident Review Meeting) outcome found no gaps in care or service delivery problems requiring an investigation. However,* Consultant A *discussed that they are not an older adult consultant, and the patient concerned was a 66-year-old male who fits the more traditional OPMH (Older Person's Mental Health) profile.* Consultant A *felt that the care* they *gave the patient was appropriate; however, due to his presentation, they thought it reasonable for the older person's consultant to undertake a case review.* The older person's consultant stated: *'Can I state that clinical assessment and rigour demonstrated, including continuity of care as well as follow-up after discharge from the inpatient unit has been exemplary. I particularly commend access to psychological assessment both in the QAH liaison service and within HTT.'*

3.1.95 Consultant B confirmed Martin was admitted and treated on the ward due to the significant attempt made to end his life. Martin was admitted to an acute adult ward, which was being refurbished; consequently, he was nursed in the older person's ward.

3.1.96 Consultant B noted that the older person's ward did not engage with Martin. It was stated that the transfer from the adult ward to the older person's ward was to ensure the suicide pathway was followed. However, Solent NHS Trust noted that the change was due to bed availability and was not linked to the suicide pathway, which does not exist in the inpatient service.

3.1.97 During Martin's hospitalisation, his multidisciplinary team was from the adult ward, and his nursing care was transferred to the older person's ward. Consultant B thought this arrangement unusual as Martin, over 65, was recommended for an older person's ward; nevertheless, according to his presentation, he should have remained in the adult ward. Consultant B reviewed Martin on the older person's ward but did not receive the nurse handover they were accustomed to receiving on the adult ward.

3.1.98 Martin spent his hospital stay in his room and did not interact with the ward staff, as confirmed by Consultant B. Consultant B recalled a conversation with Martin, Anne, and Ethan. Consultant B presented two options: to remain on the ward and continue disengaging with the ward team, including the occupational therapist, or to observe his progress at home before deciding on discharge. Since Martin was discharged from his Section and thus had the option to remain on the ward or not, his family believed they had no voice.

3.1.99 Consultant B characterised Martin's demeanour as being more positive and engaging after his home leave (six hours); thus, he was granted additional day leave (six hours), and discharge was scheduled for the following week. Martin's family said he wished to be home and Martin wanted Consultant B to believe he had significantly improved.

3.1.100 Due to Martin's mental functioning, Consultant B believed that psychology intervention would be ineffective, and the primary purpose of services was to engage him with mental health services to improve his functioning. In addition, he struggled to acknowledge that he was depressed; therefore, enhancing his ability to function would be the initial step before psychological intervention.

3.1.101 Consultant B suggested that the psychology intervention may not have changed Martin's minimum interactions. However, Consultant B acknowledged that a gap existed and that, as this was his first presentation, a ward psychologist should have assessed him. The panel learnt the psychologist post was vacant at the time of Martin's admission.

3.1.102 Consultant B reported that Martin struggled to talk about how he felt with them and when his family were present. Consultant B stated it was challenging to explore how Martin was, and he did not present in the way he did when he initially came to the service. Therefore, it was suggested that the psychosis had settled and EIP would be a good service to explore this further. Consultant B indicated that EIP had more significant resources to engage patients and is a mental health speciality service. However, Consultant B observed that the issue of Martin's age prevented him from receiving EIP services, and another service gap was identified.

3.1.103 Consultant C stated that EIP should be funded for all patients presenting with the first episode of psychosis, regardless of age.

3.1.104 Consultant A disagreed with the risk assessment on discharge from the mental health unit; the main reason is the knowledge that patients are at an increased risk of harm on discharge.

3.1.105 The hospital could not enforce his admission because Martin was no longer under formal detention. In addition, Martin expressed his wish to be discharged and not remain a voluntary patient. Furthermore, the right to respect family, private life, home, and correspondence is enshrined in Article 8 of the Human Rights Act. Therefore, there is a need to respect his wishes.

3.1.106 NHS England publication titled 'Discharge Challenge for Mental Health and Community Services Providers'.[54] The objective was to ensure solid discharge procedures, ensuring that patients who no longer require inpatient care are discharged and cared for in more suitable locations.

3.1.107 The publication highlighted the Mental Health Initiatives, which included:

- Ensure partnership working and early engagement with the person, family/carers and teams involved in the person's post-discharge support; agree on a joint action plan with critical responsibilities, such as social care, housing, primary care, CMHT, CRHTT, etc.
- Communicate discharge notice at least 48 hours before discharge to the person, their family/carers, and any ongoing support services.
- The CMHT or CRHTT will follow up with the person as soon as possible and within a maximum of 72 hours of discharge to ensure the right discharge support is in place.

3.1.108 The College of Psychiatrists[55] emphasised that the risk of suicide is highest on the second and third days following discharge from a mental health hospital; hence, the aim of following up with at least 80% of patients within three days of discharge was established.

3.1.109 Involving families in health care has clear benefits for the patient. It can alleviate the burden often felt by families and carers and address families' social and emotional needs.[56]

3.1.110 Consultant A provided cover for Consultant B and noted from the records that there were no suicide attempts or psychotic symptoms on the ward. However, Martin was guarded on the ward, did not engage with staff, and did not develop rapport throughout his stay.

3.1.111 Consultant B commented that no 1:1 time was spent with Martin to explore his difficulty accepting that he has a mental health disorder. Consultant B recalled a conversation with Martin:

"I feel better. I don't need medication. Therefore, I said, "Well, actually, you probably feel better because you are on medication".

3.1.112 Consultant B stated that they believed Martin realised that he needed medication, and that Martin was aware of how his suicide attempt affected his family and had indicated that he did

[54] https://www.england.nhs.uk/long-read/discharge-challenge-for-mental-health-and-community-services-providers/#:~:text=Follow%20up%20to%20be%20carried,discharge%20support%20is%20in%20place.
[55] https://www.rcpsych.ac.uk/news-and-features/latest-news/detail/2022/08/22/72-hr-discharge-follow-up-target-for-mental-health-patients-missed-38-000-times#:~:text=The%20risk%20of%20suicide%20is%20highest%20on%20the%20second%20and,days%20after%20discharge%20was%20introduced.
[56] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8502279/

not want to do this because of what he put them through. The family disputes this; they recall sitting with Martin at this time, and Martin had told Consultant B that he did not believe he required medication.

3.1.113 Consultant C indicated that disengagement is a symptom of depression and that this and Martin's history of business loss should have been considered. Consultant C suggested Martin was not in the hospital for long and reported:

"In a first episode of depression, it takes at least nine months to come up with the right medication as you only have a 33% chance of picking the right antidepressant the first time. You are more likely to be wrong, so if it doesn't work, you switch to something else."

3.1.114 Consultant A noted that some suicidal individuals do not necessarily attempt suicide on the ward and that there should be nothing on the ward that may be used to hurt oneself. Therefore, it is vital to consider the family's opinions to ensure the completion of a comprehensive risk assessment.

3.1.115 After Martin's death, Consultant A knew his family was unhappy with his inpatient treatment. Consultant A noted that there had been no noticeable improvement whilst Martin was an inpatient.

3.1.116 Martin was discharged from the hospital to HTT. Consultant A last saw him at the end of August 2022. Martin rated his mood as an eight out of ten. However, Consultant A saw that his mood did not match the numerical value he provided. Eight out of 10 would be very good, but he could have been better. However, his family indicated that the situation had improved from his significant suicidal attempt, and they reported Martin to have increased motivation and enjoyment.

3.1.117 Consultant A acknowledged Martin's reluctance to take medication. Under the Mental Health Act or in the community, the patient cannot be compelled to take oral medication. This is a tricky issue. Therefore, the work focuses on assisting the patient in weighing the pros and drawbacks and enhancing their understanding so they can consent and take the prescribed medications. This supports the panel and the family's recommendation that medication should have been incorporated into the care plan during HTT involvement.

3.1.118 According to Consultant A, Martin was reluctant to take medication because he did not believe he had a mental disorder. He had taken the medication while in the hospital because he felt it was necessary. Consultant A was aware of the possibility that he was not taking the prescribed medication.

3.1.119 Consultant A's discussion with Martin to support medication compliance was unsuccessful. When they last saw Martin, he was not detainable under the Mental Health Act. Thus, medicine could not be forcibly administered (via injections).

3.1.120 The 2 August 2022 care plan identified interventions with labels such as "distress tolerance" and "anxiety and depression management skills." It did not specify their nature or implementation. It also recommended medication monitoring, but this was not performed after discharge.

3.1.121 Martin's request to decline to share information with his wife on 3 August 2022 was not investigated in any records accessed by the author. Mental health cited Martin's family as supportive. They knew Anne was involved in his care, visiting him almost daily on the wards and being responsible for supporting Martin at home. The author would expect this change to have been discussed with Martin to identify why he no longer wished Anne to be involved.

3.1.122 On 9 August 2022, Martin was offered an emotional first aid course (four hours over two days). The course is a psycho-educational course that teaches fundamental crisis recognition and response skills. It was presented using Zoom. Unfortunately, Martin could not access the course because, according to his friends, the facilitator could not hear him, and he was forced to use the chat function; consequently, the course was ineffective.

3.1.123 Online groups differ from in-person meetings and present unique obstacles and challenges that should be compensated for or recognised as losses.[57] As this was a key symptom of Martin's psychosis, the online format may not have been supportive, given that he had reported technological suspicions.

3.1.124 This course may have benefited Martin's family, who reportedly struggled to cope with and comprehend his illness. As a result, the involvement of carers has been designated as a recommendation. However, the course is only for patients, and it is recommended that a similar course be available for families/carers.

3.1.125 On 23 August 2022, EIP declined the referral for Martin, citing his age as the reason. Psychosis is a severe mental illness that affects up to 3% of the population and is associated with impaired social functioning and a shorter life expectancy. It is one of the leading causes of disability and one of the costliest diseases in the world due to the costs associated with hospitalisations, physical health co-morbidities, and unemployment. It has been demonstrated that timely access to EIP significantly impacts the lives and livelihoods of people with psychosis and their families.[58]

3.1.126 Martin was 65 years old when the EIP referral was discussed. NHS England aims to treat at least 56% of 14-to-65-year-olds experiencing their first psychotic episode within two weeks. Martin was referred when he turned 66 years old.

3.1.127 Martin was informed of the outcome of EIP at the end of August 2022; according to the mental health report, he was calm, and they suggested he could be referred to other groups.

[57] https://psychotherapy.psychiatryonline.org/doi/10.1176/appi.psychotherapy.20200034
[58] https://www.england.nhs.uk/south/our-work/mental-health/early-intervention-in-psychosis/

3.1.128 CBTp was approved, but the approval date was the date Anne and Martin were discovered deceased. The longest wait time was one year and nine weeks. As a result, Solent NHS Trust agreed to provide family intervention services and refer him to the Nurse-Led Clinic.

3.1.129 Martin called HTT two days before he and Anne died to enquire whether they would visit him. Consultant A believed a home visit should have occurred on that day; no reason was recorded for why the visit did not happen.

3.1.130 Martin was admitted to the Mental Health Unit under Section in July 2022; he was subject to a CPA; consequently, his discharge planning should have considered what community-based treatment he should receive. Per Solent's admission, discharge, and transfer policy[59] the reason for admission, anticipated outcomes, and expected length of stay will be discussed with the patient and their carer. They will also be informed of the admission's rationale. Before admission, the patient and carer will receive an explanation of the proposed care pathway, including an estimated length of stay. Included in this is discharge planning. Martin should have been offered the nurse-led clinic and family consultations upon discharge.

3.1.131 The Solent internal review stated: "Based on Martin's clinical presentation in his recovery pathway, delay in being seen by the Psychology service may not have had an impact at such an early stage".

3.1.132 The panel and the author anticipate that the NHS England independent review will investigate Martin's care and treatment under the Solent NHS Trust in greater detail and consider the family's additional questions.

3.2 Analysis of Terms of Reference

3.2.1 This report section analyses the Terms of Reference (ToR) to confirm that they have been addressed and met. The consensus among the panel and the author is that conducting a comprehensive analysis of Martin's mental health will enhance learning beyond the confines of a DHR. As a result, the NHS England-commissioned review is expected to examine the care and treatment Martin received thoroughly.

Mental Health

3.2.2 ToR 1a: Anne's husband was experiencing ill mental health. Was Anne acknowledged as a carer, and what support and assessment did she receive following the Care Act (2014)? How were her concerns addressed, and were identified needs accounted for?

Analysis

3.2.3 No agency working with Martin officially acknowledged Anne as a carer, and she was not offered a carer assessment.

[59] https://www.solent.nhs.uk/media/2782/mh03-admission-transfer-and-discharge-policy-v1.pdf

3.2.4 The GP practice acknowledged that they should have offered Anne information on support services. However, following the 15 June 2022 visit, Martin was immediately referred to HTT, thus satisfying Anne's belief that Martin required mental health care, which was her main concern when attending the practice.

3.2.5 Ethan stated that when Martin was admitted to the ward, the family were told they would be included in all decision-making. Still, they did not always feel this happened, and Martin himself informed them regarding his discharge from the Section, which shocked them. Ethan said they could not contribute at the CPA discharge meeting, which was very stressful. The family did not feel their concerns were fully addressed while Martin was an inpatient.

3.2.6 The family attended the CPA meeting, and although they contributed, it would be challenging for them, including Anne, to express their concerns about Martin's leave in his presence. In addition, the family was told that Martin was improving and engaging with staff. According to research[60], a mentally ill person's dependence may be on the carer; therefore, the carer may have the authority to determine whether the patient can return home.

3.2.7 Consistently, research findings indicate that female family carers experience more significant psychological distress, shame, and carer burden.[61] Consequently, the CPA meeting should have considered Anne's required support and offered a Carer's Assessment.[62] Under Section 10 of the Care Act of 2014[63], anyone over 18 caring for a disabled, ill, or elderly adult has the right to a carer's assessment. These assessments should assess the carers' mental and physical health, capacity, willingness to provide care and interpersonal relationships.

3.2.8 The Solent CPA policy advocates the carer's involvement in the process and holistic care planning. Moreover, the principles of the NICE Guidelines, Transition between Inpatient Mental Health Settings and Community or Care Home Settings 2016, include supporting the patient in maintaining relationships with family and friends to identify the person's support networks and working with the person to explore ways in which the people who support them can be involved throughout their admission and discharge.

3.2.9 Anne visited Martin in the hospital and wished to participate in his care. She and Ethan actively sought advice and assistance from mental health services to comprehend better how they could assist Martin in the community.

3.2.10 However, the review found no formal support was provided to Anne as the primary carer in how best to support Martin. She was not offered a carer assessment of her needs or time away from Martin to discuss her concerns.

[60] https://www.bjmp.org/files/2010-3-3/bjmp-2010-3-3-a327.pdf
[61] https://pubmed.ncbi.nlm.nih.gov/27014594/
[62] https://www.carersuk.org/media/obypgdbx/assessments-england_april-2023-24.pdf
[63] https://www.legislation.gov.uk/ukpga/2014/23/section/10/notes#:~:text=Section%2010%20%E2%80%93%20Assessment%20of%20a%20carer's%20needs%20for%20support&text=This%20section%20creates%20a%20single,time%2C%20or%20in%20the%20future.

3.2.11 The carer's role and relationship with the care recipient affect an individual's well-being. Research indicates that close ties, such as being a spouse or cohabiting with a mentally ill person, determine the burden of care experienced by the carer.[64]

3.2.12 Anne had expressed concern that Martin might not return to his former self.

3.2.13 Solent's internal review references the NICE Suicide Prevention Quality Standard 2019, Standard 4, which advocates discussing with the patient whether they want their family to be involved in their care. The first episode of care showed that Martin was willing for his family to be involved in his care. In addition, there was evidence in the records that the family's views were asked for and listened to during the risk assessment and that explanations were given to the family regarding care planning. The clinical notes contradict the information by stating that Martin was progressing well and was engaging while simultaneously implying that he was low in mood and not engaging.

3.2.14 Ethan, Taylor, and friends have contested this; for example, they stated that Anne questioned whether, upon Martin's discharge, she should conceal knives from Martin. She was advised to make her own decision. The author believes this should have been a part of the collaborative risk management plan, so Anne was not solely responsible for the risk.

3.2.15 Martin did not want to be seen by the consultant alone and was most comfortable with his family, which is essential in building rapport with patients. However, Consultant A had advised that Anne and Ethan were seen alone occasionally, and it was felt that there were opportunities for them to express their concerns without Martin being present. According to the documents reviewed for this report, the family could communicate with HTT without Martin's presence. However, this decreased post-discharge due to HTT not visiting Martin at home.

3.2.16 The family did raise concerns, notably regarding the discharge; Consultant B noted that the two possibilities outlined in the preceding analysis were presented. Consultant B stated that they spoke with Anne and urged her to seek assistance from her GP if necessary. Consultant B was unaware that the Solent NHS Trust employed any carer support workers, so no referral was made for carer's support. The panel learned there were no carer support workers then; such support is now in place.

3.2.17 The fact that Martin was cared for in a different ward where his Consultant (B) and nursing team were based may have impeded daily communication with the family, as Consultant B and the nursing team would not have known when the family was on the ward. The ward Manager of the older person's ward has noted this as a challenge in terms of patient care.

3.2.18 Three days of six hours of leave were provided to Martin before discharge. However, it could be argued that additional leave is necessary to determine whether Martin is well enough to return home and to ensure medication adherence will not be an issue; medication adherence

[64] https://academic.oup.com/heapro/advance-article/doi/10.1093/heapro/daac049/6574394

was identified as a problem on the ward, primarily because he had not engaged with the ward staff, and they had observed his unwillingness to take prescribed medication. In addition, Anne would have been able to report on how she was coping and if she believed the leave was going well had he been granted extended overnight leave.

3.2.19 There are no specific guidelines regarding the length of leave before discharge. The patient, their family, and mental health professionals make the decision. Considering the family's opinions, leave was granted. However, because Martin had yet to engage with the staff on the ward, it would be difficult for professionals to comprehend how and what had changed from admission to discharge. In addition, Martin did not want to be hospitalised, so it is possible that he may not have disclosed how he felt, as friends and professionals had previously suggested.

3.2.20 Consultants A and C thought Martin should have spent more time in the ward.

3.2.21 Martin was discharged from the hospital on 2 August 2022; the leave was not overnight, so medication administration at home was not 'tested' during the six hours of leave granted.

3.2.22 Numerous psychiatric medications and their active metabolites have half-lives of at least two days. The half-life of a drug is the time taken for the blood level of the medicine to fall by half, provided that no more doses of the medication are administered in the intervening period.[65]

3.2.23 During the last episode of care, where there was a degree of de-escalation, there were fewer opportunities for discussion and for Anne to make her voice heard. However, HTT viewed her as one of the key stakeholders and a protective factor for her husband. There were no opportunities to speak with Anne alone during the later part of care, when contact with Martin was via telephone, with Anne sometimes joining the call mid-way through. This would have made collaborative care planning more of a challenge.

3.2.24 Care Plans can be considered an agreement or contract with patients, engaging with them and communicating what the service can and will do and what responsibilities they, their family and carers, and the person concerned will have (HTT Guide to Care Planning).

3.2.25 Friends also noted that Anne's voice was lost upon discharge when calls were made to Martin and that she would have been unable to express her observations or concerns in their entirety.

3.2.26 When Anne expressed her concerns via Martin regarding onward care planning, an opportunity was missed to explore these further with Anne to offer her explanation and reassurance and how she and Ethan could have contributed to care in the meantime. In addition, the family contacted HTT three times during this period to enquire about a medical review, psychology referral, and a missed visit and asked about the CT scan results. The Solent NHS Trust report stated they did not raise any concerns regarding medication compliance. The

[65] https://www.psychiatrist.com/jcp/psychopharmacology/importance-of-half-life-in-psychopharmacology/

family disagree with this. Again, sharing care plans with patients and their families would have helped the discussion surrounding care.

3.2.27 Although CPA was commenced on admission to the hospital, a lack of care coordinator meant that the family could not approach one person who would have the specific knowledge and oversight to answer their questions and concerns, especially at times when there seemed to be time lags for them in decision-making and care planning or when Martin was finding contacts intrusive.

3.2.28 Ethan advised that the family had been considering pursuing private psychology care for Martin on discharge but that the family were actively dissuaded from this at the meeting, which made them feel confident that they were on the right path for Martin staying within NHS mental health services.

3.2.29 Consultant B advised the Solent NHS Trust Investigating Officer that there were several reasons given to the family for not pursuing psychological interventions privately:

a) Martin was only starting to respond to the current treatment and needed to engage more effectively with Nursing or OT staff. It would be challenging to engage a patient in that mental state at that point in his treatment. It was evident that Martin could not effectively engage with psychology at discharge from the hospital. The plan was to support him to improve his mental state and then offer psychological interventions depending on the indication.
b) The consultant made it very clear to both Martin's son and his wife at the meeting that the mental health teams were formulating around the problems Martin presents and, when he was ready and able to engage the service, would be able to recommend appropriate psychological interventions. At the point of discharge from the hospital, Martin would only benefit from supportive work, and the effectiveness with which that would be provided would be determined by the private practitioner they would seek out. Furthermore, it wasn't clear what psychological intervention would be therapeutic. The HTT would undertake the supportive work, and Martin was referred for psychological assessment and formulation under their remit with a psychologist within that team. The HTT would not have any control or input into the quality and recommendations for interventions the private psychologist would provide. The consultant advised that Ethan and Anne agreed to wait and did not object to this explanation. The consultant could not recall how Martin reacted to this, but he was either very silent on the matter, or it may have been discussed before Martin joined the meeting.

3.2.30 The panel learned that the wait for CBTp could be twelve months and nine weeks. The family is upset that they were discouraged from pursuing private therapy. Consultant B, however, stated the primary goal was to improve Martin's functioning, and they felt Martin may not have engaged with psychology intervention.

3.2.31 Martin and his family had mentioned the need for the same person to facilitate forming a relationship. With the number of HTT members contacting the family and delays in decision-making, a clear plan of action may have yet to be evident to the family, even if it was perceived to be by HTT

3.2.32 The social worker met Martin on the ward to determine his care and support needs; he stated that he lived with Anne and did not require assistance. Nonetheless, this would have been an opportunity to ensure Anne received a carer assessment.

3.2.33 ToR 1b: How much regard was given to Anne's concerns when the referral was first made to Martin's GP seeking support about his deteriorating mental health?

Analysis

3.2.34 Please see the analysis section under Martin's GP.

3.2.35 ToR 1c: Would different decisions have been made had Anne not taken the role of Martin's carer? How would this have impacted any risk assessment undertaken?

Analysis

3.2.36 Solent NHS Trust offered care based on the individual's needs and on an individualised basis and, therefore, could not state what different decisions would be made.

3.2.37 According to the 2021 census[66] England has approximately 4.7 million unpaid carers. The census also reveals that the proportion of women providing care was higher than that of men.

3.2.38 In many Western nations, the deinstitutionalisation of services has shifted the focus of support from hospitals to the community, where family members and carers play an essential role in assisting those with mental health issues.[67]

3.2.39 Therefore, it is essential to collaborate with carers to alleviate the caregiving burden. However, Martin had revoked permission to share information with Anne. This should have affected his risk assessment and care planning, with Anne as the primary carer ultimately providing and ensuring Martin complied with medication and Solent NHS Trust noting Martin's supportive family. Therefore, they no longer had permission to give Anne information about Martin. However, this would not prevent them from listening to Anne's concerns or updates. Anne had communicated with HTT during home visits, but since the visits had ended, Anne had not been asked for her opinion, and calls were made directly to Martin.

3.2.40 The NHS Community Mental Health Framework[68] emphasises that essential functions should be located in communities and delivered through the Framework's place-based and integrated model to effectively address the needs of individuals with a wide range of mental health needs.

[66] https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/socialcare/articles/unpaidcarebyagesexanddeprivationenglandandwales/census2021#:~:text=On%20Census%20Day%202021%20(21,over%2C%20in%20each%20country%20respectively.
[67] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8502279/
[68] https://www.england.nhs.uk/wp-content/uploads/2019/09/community-mental-health-framework-for-adults-and-older-adults.pdf

3.2.41 Martin was referred for CBTp, but there was a one-year-and-nine-week wait. Unfortunately, on the day Martin and Anne's bodies were discovered, mental health agreed as an interim to refer them for family intervention work and the Nurse Led Clinic. As stated in the CPA, the author expects this to have been planned during admission and that referrals should be made before discharge.

3.2.42 ToR 1d: How did Solent NHS Trust assess Martin, how was a diagnosis made, and did the treating team understand the diagnosis? Was the presentation's consideration of organic causes adequately investigated?

Analysis

3.2.43 HTT requested that a psychiatrist specialising in older people examine the care they provided since they recognised they do not typically work with older adults and believed the additional scrutiny would support and highlight any necessary interventions. The Older Person's Consultant confirmed that HTT required no further measures to support Martin.

3.2.44 Consultant A was not aware that Martin had had a CT scan as an inpatient and had advised that it would have been thought that the patient would go to the GP for results. However, the CT results had yet to be reported at the QA Hospital on enquiry by staff on 18 August 2022. Results were sought further by a junior doctor, reported on 22 2022 and accessed two days before the deaths; the same day, Older People's Mental Health was asked for an opinion of the CT Scan as this was not Consultant A speciality. The results would be given to the family by phone or at the next visit if the tragic events in September 2022 had not happened.

3.2.45 The opinion from the Older People Mental Health Consultant was that the scan should be repeated in six to twelve months, and the current treatment of symptoms/ signs of his psychiatric disorder should be based on the current working diagnosis.

3.2.46 ToR 1e: How did Solent NHS Trust support Martin's mental health in the community and as an inpatient?

3.2.47 The independent review to be carried out by NHS England will place additional emphasis on this ToR.

Analysis

3.2.48 Please refer to the Solent NHS Trust analysis section.

3.2.49 The opinions of Consultant B and C differed, with Consultant B, who was the treating consultant, stating Martin's disengagement was not conducive to his recovery and Consultant C, who reviewed the notes, reported disengagement was a symptom of depression requiring a prolonged inpatient stay.

3.2.50 The HTT attempted to work with Martin and, at his request, reduced visits. However, Consultants A and B felt Martin was not forthcoming about his emotions. When he reported feeling better, they had no reason to disbelieve him, given that his family had observed an improvement since his admittance to the mental health unit.

3.2.51 ToR 1f: Did Martin receive care following best practices? What measures were in place to support his and his family's engagement?

3.2.52 NHS England is anticipated to allocate additional attention to this aspect during the independent review.

Analysis

3.2.53 Consultant B acknowledged they should have offered Martin a psychology assessment. However, Consultant B also expressed their opinion that Martin would not benefit from the services of a psychologist due to his poor functioning following his discharge.

3.2.54 In addition, his age served as a barrier to him accessing EIP and being admitted to the adult ward.

3.2.55 Martin was provided and prescribed medications for his mental illness, but it was clear that he had not developed a rapport with mental health professionals.

3.2.56 The family had engaged with services but felt they needed to be fully informed of the plans when Martin was in the hospital. Anne lost the ability to communicate with services when HTT switched to telephone contact.

3.2.57 ToR 1g: Was Martin's discharge following the guidelines of the Solent NHS Trust?

3.2.58 It is expected that NHS England will devote further consideration to this area throughout the independent review process.

Analysis

3.2.59 Martin was discharged to the HTT, providing him with community support to aid in his recovery. There were arrangements to refer Martin to the nurse-led clinic and CBTp.

3.2.60 Despite this, the discharge procedure was not thoroughly followed, as evidenced by the brief documentation that did not capture the intricacies of the meeting discussion, so the GP was deprived of an accurate account of the meeting. Moreover, the lack of alignment between the family's, the inpatient services, and HTT's expectations resulted in each party being inadequately informed about the discharge expectations. Furthermore, the substandard documentation further rendered the information ineffective.

Risk

3.2.61 ToR 2a: What knowledge/information did your agency have that indicated Anne may have been a victim of domestic abuse, and how did your agency respond to this information?

Analysis

3.2.62 Solent reported in their review:

> *The risk assessment on admission and discharge to the inpatient ward acknowledged that there could be a risk of retaliation to others due to the paranoia Martin had expressed of being watched and bugged, which was thought to be low due to having family support. However, it was also acknowledged at his medical review in August 2022 that the risk to himself should he become unwell again would be high. A Crisis Care Plan was developed in the first two episodes of care but only partially completed in the last episode of care.*
>
> *Consideration of risk of harm appears to be more focused on the patient as the care period progressed, as opposed to risk to others and the family was very much seen as a protective factor in the mitigation of risk; the possible identified risk to others does not appear to have been considered from a family perspective in the risk analysis. Therefore, during the final episode of care, where there were fewer visits to the home, there was no opportunity to view and assess the dynamics in the house and to speak with Anne alone to ask her if she felt safe in the home or if there was any indication to signpost Anne to Domestic Abuse services in the city. This may have provided an opportunity to explore Anne's concerns noted during the telephone contact on 25 August 2022 regarding the onward Planning of care and the impact of Martin's mental illness on her as a carer.*

3.2.63 The author found no evidence that Martin committed domestic abuse against Anne before the homicide.

Risk

3.2.64 ToR 2b How did services assess Martin's risk, including if they knew he possessed a gun license and how this information was communicated? Did agencies determine whether he posed a threat to others, including Anne and the family?

Analysis

3.2.65 Martin received three episodes of care from Solent; a review of the risk assessment and management plan for these episodes has been included in their report.

3.2.66 The risk of his first episode was rated as low to self.

3.2.67 Solent review states:

The Lead Consultant in Inpatient Adult Mental Health has advised that the risk assessments would not have changed the outcome of the tragic events for Martin and Anne according to current evidence from the Royal College of Psychiatrists Report, Self-harm, and suicide in adults 2020, as the understanding of which factors differentiate those who will have thoughts of suicide and those who will act upon those thoughts and attempt suicide is still elementary. This document advises that demographic risk factors increase the suicide risk of a whole population across a lifetime but do not predict suicide in an individual at a single time. Furthermore, suicide risk assessment is a complex, unpredictable intervention influenced by the practitioner, patient, and organisational factors. Therefore, a person may still be at high risk of suicide even though they might not be assessed as a member of a high-risk group.

Conversely, not all members of high-risk groups are equally at risk of suicide. Moreover, suicidal thoughts (and risk) can vary relatively quickly. The presence of risk factors indicates that someone may be particularly at risk of suicide but should not be used to predict or rule out an individual suicide attempt. This document advises that using terms such as low or high risk is unreliable, open to misinterpretation and potentially unsafe; for various reasons (stigma, embarrassment, shame, fear), people may conceal or minimise their suicidal thoughts.

3.2.68 The risk assessment before the incident revealed a low threat to others. It is hypothesised that Anne would have agreed that Martin did not pose a threat to her. Ethan, Taylor, and their friends concur. However, they were unaware of Martin's mental illness and its implications. Martin expressed paranoia towards technology, believing he was being followed and experiencing emotions and thoughts such as shame, guilt, and regret.

3.2.69 Martin's admission to the mental health unit was the subject of the second episode. Solent NHS Trust deemed Martin a high risk for self-harm. However, regarding the risk he posed to others, he was considered low risk.

3.2.70 Martin was detained under the Mental Health Act because he posed a risk of self-harm and suicide and declined treatment.

3.2.71 The Mental Health Act 1983: Section 26[69] defines the nearest relative; Anne was Martin's nearest relative. The nearest relative can request a Mental Health Act Assessment and a discharge from the Mental Health Act. Anne agreed that Martin should be hospitalised, and when his section was rescinded, she and Ethan voiced concerns about Martin's risk to self, which supported a later discharge than the date the section was rescinded.

3.2.72 This could have been interpreted as Anne having authority over Martin and desiring his hospitalisation. This may have strained and imbalanced the relationship, with Anne being asked whether she wished for Martin to be detained in the hospital.

[69] https://www.mentalhealthlaw.co.uk/Identification_of_nearest_relative#Does_the_patient_have_a_.E2.80.98relative.E2.80.99_.28as_defined.29.3F

3.2.73 The Nearest Relative function attracts powers and rights that can influence the decision-making process for mental health services, such as whether to place a patient in detention or seek community alternatives.[70]

3.2.74 Providing care for people with mental illness requires a substantial investment of personal resources, harming family carers' quality of life.[71] In light of this, the indirect risk to Anne should have been highlighted in the risk assessment, prompting services to consider what assistance Anne would need to maintain her well-being. The only time this was highlighted was by the emergency service call handler at the first suicide attempt, suggesting this is a widely known risk.

3.2.75 The transition from hospital to community care is a high-risk period, particularly during the first two weeks after discharge. Deaths were associated with admissions lasting less than seven days, the absence of a discharge care plan, and adverse life events, suggesting that some patients return to the stresses that necessitate hospitalisation.[72]

3.2.76 Martin did not interact with staff on the ward and remained in his room for most of his admission; therefore, it would be difficult for professionals to fully comprehend what had changed since his admission and how the admission might have affected his relationship with Anne and vice versa.

3.2.77 The third episode following Martin's discharge from the hospital. Solent NHS Trust reported:

> *The planning lacks details on how risk should be monitored, and there are apparent delays in onward referral to services. In addition, the investigation has been unable to identify reasons for the number of phone contacts during this period instead of home visits, which may have significantly impacted risk assessment and monitoring.*

3.2.78 Martin had revoked consent to share information with Anne; the mental health service did not explore this, and Anne and their family were unaware of this change. The risk assessment shared with the author did not document the change in consent, and there was no indication that this had been discussed in the MDT or with Martin or that his family would be notified of the change.

3.2.79 Please refer to the Solent analysis for information on risk assessments and the accuracy of risk prediction.

3.2.80 ToR 2c: What options did Martin have to address his poor mental health and ensure his and others' safety? If they were not considered, what barriers impeded their implementation?

3.2.81 An additional aspect that warrants more comprehensive examination in the NHS England review

[70] https://uwe-repository.worktribe.com/output/1946353/experiences-of-relatives-acting-as-the-nearest-relative-under-the-mental-health-act-england-wales-uk
[71] https://onlinelibrary.wiley.com/doi/full/10.1111/hsc.12968
[72] https://documents.manchester.ac.uk/display.aspx?DocID=37580

Analysis

3.2.82 Ethan referred Martin to Talking Change, and Martin received an opt-in letter. Since he did not respond, no contact was made with him, and no contact was made with the referrer, Ethan, to notify him of the opt-in.

3.2.83 Opt-in systems reduce non-attendance; however, they may unintentionally deny access to clients with the most prevalent mental health issues, such as anxiety disorders and depression.[73]

3.2.84 Martin told his GP he had no concerns, so unsurprisingly, he did not respond. However, understanding a mental illness diagnosis is essential for successful coping and recovery.[74] Therefore, the focus would be on assisting Martin in recognising and understanding his mental illness.

3.2.85 Martin was admitted for assessment and treatment at the mental health unit. On discharge, he remained hesitant about medication, and according to the records from Solent NHS Trust, family, and friends, he could not establish a rapport with professionals who could support his awareness of and need for treatment for his illness.

3.2.86 Martin was referred for CBTp, but the wait was lengthy, and he was not referred for services such as the Nurse-Led Clinic and family interventions until much later. Solent could not determine why the delay occurred and why a care coordinator was not provided.

3.2.87 Martin received care in the community from HTT.

3.2.88 ToR 2d: How did your agency respond to the information that Anne may have been a victim of domestic abuse or at risk of harm owing to Martin's mental illness? Was Anne allowed to be seen alone to enquire about potential risks, including domestic abuse?

Analysis

3.2.89 Please refer to ToR four; Anne was not identified as a victim of domestic abuse.

3.2.90 ToR 2e: Was information regarding Martin's poor mental health and risk communicated promptly and with all necessary partners and family members throughout the period covered by this review? For example, did any discussion occur with family members about the risk of a diagnosis of psychotic depression?

3.2.91 The NHS England review should further delve into this area for greater detail.

[73] https://www.cambridge.org/core/journals/the-psychiatrist/article/effects-of-optin-letters-in-a-national-health-service-psychotherapy-service/ED4A36AF22253CE707B7F80258950D68
[74] https://www.sciencedirect.com/science/article/pii/S0883941719303917

Analysis

3.2.92 ToR five explores the risk assessment. Ethan, Anne, and Martin's friends believe that the risk Martin's diagnosis poses to others was not discussed, and the Solent NHS Trust stated that the risk to others was low. Solent's primary interventions aimed to reduce the risk of self-harm and suicide.

3.2.93 ToR 2f: Were assessments performed to evaluate mental illness and other risk factors, including a care plan outlining treatment goals following NICE guidelines? How did the family participate in the assessment process?

3.2.94 A further domain that warrants more comprehensive examination in the NHS England review.

Analysis

3.2.95 Martin received formal mental health assessments by HTT and a Mental Health Act Assessment while in the QA hospital. Martin was deemed a risk to himself, which led to his detention in a mental health unit. However, the most significant difficulty was engaging Martin, which was difficult and ultimately unsuccessful.

3.2.96 Anne and Ethan participated in the initial mental health assessment. Neither the discharge from the hospital nor the third episode of care engaged the family to the extent they felt necessary. Solent NHS Trust accepted the third episode, in which Anne's voice could not be heard due to telephone communication with Martin.

3.2.97 ToR 2g: Did the Solent NHS Trust, in collaboration with Martin and his family, create a Crisis plan and relapse indicators?

Analysis

3.2.98 Martin completed crisis plans on 27 June 2022, 17 July 2022, and 3 August 2022; however, the information was limited and did not explore the triggers and/or how and what would support Martin or those around him. Anne and Martin's family received no formal support or advice on assisting Martin, for instance, referral for a carer's assessment and receiving support and information as a carer.

3.2.99 ToR 2h: Were there any issues with Martin's medication noncompliance? Was that handled properly by Solent NHS Trust?

3.2.100 The NHS England review should incorporate a more thorough analysis.

Analysis

3.2.101 Martin was reluctant to take medication in the community and when on the ward. Consultant B reported conversing with Martin about his medication and believed he was complying. The

family recalled Martin stating he did not wish to take medication, and Consultant B believed he required it.

3.2.102 Consultant A expressed reservations about Martin's compliance and was aware Anne was observing compliance. However, this did not prompt the HTT to monitor medication compliance on discharge.

3.2.103 No formal monitoring was in place when Martin was in the community.

3.2.104 ToR 2i: Regarding Martin's medication, discharge, etc., did the Solent NHS Trust effectively communicate with the GP?

Analysis

3.2.105 According to the panel, the following areas were identified:

- There was a lack of evidence of clear assessment of the person's mental health and their risk to themselves or others.
- There was a lack of evidence of planning, including the family's views, the carer's assessment, good crisis planning, risk assessment, and inconsistent reports of Martin's presenting in his clinical notes.
- Even if the person could remain in the hospital informally, there is no evidence of multiple leaves, including overnight and consistent medication taking at home.
- There was no evidence of consistent medication taking in the hospital.

3.2.106 ToR 2j: Did Martin give informed consent to sharing information with his family, and was a Capacity Assessment conducted concerning this and his admission to the hospital?

Analysis

3.2.107 Martin had revoked consent to share information with Anne. This should have been explored.

3.2.108 Consultant B determined that Martin could consent to his admission to the ward. Dr Dolman emphasised this factor when examining the least restrictive option/alternative to the Mental Health Act. Still, it is not the deciding factor for repealing the section.

3.2.109 Dr Dolman described the following areas used to assess if somebody can be admitted or remain in a mental health hospital informally. The person needs to understand and agree to:

- Be in a hospital to receive care and treatment for a mental disorder.
- That care and treatment will include varying levels of supervision (including supervision in the community), physical restraint use, and medication prescription and administration.
- Hospital staff will be entitled to carry out property and personal searches.

- The person must seek permission to leave the hospital and, until decided otherwise, will be unable to leave without supervision.
- If the person left the hospital without permission, the steps would be taken, including contacting the police.
- The rules of the hospital and to abide by them.

Engagement and Resources

3.2.110 ToR 3a: Were there capacity or resource constraints that hindered your ability to provide services to Anne, Martin, or the family? Did these concerns hamper the agency's ability to collaborate with other organisations?

Analysis

3.2.111 The delays to CBTp are lengthy, but the referral was not accepted until the day he died.

3.2.112 Martin was a patient under the older people's service, but on admission, he was placed in an adult ward whilst his medical and nursing team was in another ward. Solent NHS Trust remarked that keeping his treating team and doctors informed of his progress was difficult. Nevertheless, the service utilises a solitary electronic recording system that allows teams operating within the service access to records.

3.2.113 The expertise of old age psychiatry services lies in treating individuals with complex psychological, cognitive, functional, behavioural, physical, and social issues typically associated with ageing. Current evidence indicates that specialised services for older adults are best equipped to diagnose and treat mental illness among our ageing population. However, restricting access to a service based solely on age is illogical and likely illegal in the United Kingdom.[75] HTT obtained support and guidance from the older people's Consultant to ensure they treated Martin appropriately.

3.2.114 The Faculty of Psychiatry of Old Age of the Royal College of Psychiatrists has established need-based criteria.

a. People of any age with primary dementia.
b. People with mental disorders and physical illness or frailty that contribute to, or complicate, the management of their mental illness. This may include people under 65 years of age.
c. People with psychological or social difficulties related to the ageing process, end-of-life issues, or who feel their needs may be best met by a service for older people. This would typically include people over 70 years of age.

3.2.115 Martin did not fall into the categories above, so transferring him to old age psychiatry was unnecessary.

[75] 2022.06.21 Criteria for Old Age Services sent to Dr Lucas from OPMH Consultant

3.2.116 EIP did not accept Martin due to his age, which has been identified as a service gap.

3.2.117 A psychology vacancy existed on the ward at the time of Martin's admission.

3.2.118 ToR 3b: Did the COVID-19 pandemic alter Anne and Martin's service responses?

Analysis

3.2.119 COVID-19 did not influence service responses to Anne or Martin.

3.2.120 Ethan and Taylor report COVID-19 restrictions were implemented within the mental health unit, which dictated the permissible hours for visitors. They remember when the ward was closed to visitors due to COVID-19.

3.2.121 Family and friends have speculated that COVID-19 was a factor in Martin's declining mental health and his managing the new administrative tasks required, such as closing the business during COVID-19, protecting staff salaries, and the end of his career.

3.2.122 **ToR 3c:** What holistic approach was in place to safeguard the family?

Analysis

3.2.123 The family participated in the admissions process and was invited to the Discharge CPA. Nevertheless, the clinical records indicate they were given inaccurate information that painted a favourable picture of Martin. Before and on the day of discharge, the records documented Martin as having a low mood and not engaging with staff.

Other

3.2.124 ToR 4a: Identify good practices where responses may have surpassed requirements.

Analysis

3.2.125 It was observed that Consultant A was available to Martin's family despite the team having over 50 cases and just one Consultant Psychiatrist. Consultant C and the author agree that this practice surpassed the requirements.

3.2.126 Consultant A communicated with the older person's consultant to request a review of the care and to ensure that it adhered to best practices and was receptive to recommendations and alternatives.

3.2.127 The author viewed Consultant A's interview with the Solent NHS Trust Investigating Officer and wanted to emphasise that they appeared to be compassionate, caring, and skilled

practitioners who had endeavoured to help Martin's recovery and engaged with him and his family.

3.2.128 ToR 4b: Are there lessons to be learnt from this case on how your agency safeguards and promotes the welfare of victims or how it identifies, assesses, and manages risks? Where could the method be improved? When interacting with other agencies and resources, are there repercussions for working practices, training, management, and supervision?

Analysis

3.2.129 The learning surrounding risk has been emphasised, mainly how this is accomplished and acknowledging that this cannot forecast all future risks.

3.2.130 Solent NHS Trust acknowledged that they could not determine Martin's mental state and that he was uncommunicative about his feelings. Consultant C stated that this should have been viewed as a symptom of Martin's depression.

3.2.131 Martin's age prevented him from receiving EIP, and Consultant C emphasised that this should be available to all age groups.

3.2.132 Section six will discuss the learning in detail.

3.2.133 TOR 4c: Does your agency have policies and procedures for identifying and addressing safeguarding adult concerns and domestic abuse, including the domestic homicide timeline? Were these assessment tools, procedures and policies considered effective?

Analysis

3.2.134 All participating agencies have policies and procedures in place. No agency had concerns regarding domestic abuse.

3.2.135 ToR 4d Are there areas where agencies can identify national or local improvements to the existing legal and policy framework?

Analysis

3.2.136 One gap observed was the age barrier to EIP, which aligns with the local and national criteria for EIP.

3.2.137 According to an NHS England publication[76], people with psychosis have a very high risk of suicide, and most suicides occur early in the illness. Therefore, all age groups should receive the appropriate treatment at the appropriate time from an EIP service.

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

3.2.138 ToR 4eThe reports should consider any equality and diversity issues that appear to be relevant to the victim and alleged perpetrators, such as age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex, and sexual orientation.

Analysis

3.2.139 Please refer to section 1.13

4.1 Conclusion

4.1.1 The purpose of the review is to determine the circumstances behind the deaths of Anne and Martin in September 2022 and 'articulate life through the eyes of the victims.'[77]

4.1.2 Anne was 60 years old, retired, and had become the primary carer for her husband, Martin, from Christmas 2021, who was experiencing a mental illness, specifically paranoia and suicidal ideation.

4.1.3 Anne and Martin lived alone; they had two adult children, Ethan and Taylor, and many close friends who considered them family.

4.1.4 Anne had no prior contact or experience caring for someone with a mental illness but wished to support her husband during his illness.

4.1.5 Anne initiated service support from Martin's GP in May 2022, as she could no longer support him independently. At this time, he was offered HTT, which did not have the desired impact because he could not establish rapport with an individual. HTT does not hold individual caseloads, and Martin did not believe he required mental health services.

4.1.6 Martin was diagnosed with psychotic depression in June 2022 and attempted suicide in July 2022, resulting in a four-week admission to a mental health unit under the Mental Health Act (1983).

4.1.7 Following Martin's detention in a mental health unit, he did not engage with the staff and remained in his room throughout; consequently, professionals were not fully aware of his progress. He was prescribed antidepressant and antipsychotic medication while hospitalised.

4.1.8 Antipsychotic medications can help to calm and clear confusion in a person with acute psychosis within hours or days, but their full effect can take up to four to six weeks. These medications can aid in symptom management but do not treat the underlying condition.[78]

[77] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575273/DHR-Statutory-Guidance-161206.pdf
[78] https://www.camh.ca/en/health-info/mental-illness-and-addiction-index/antipsychotic-medication#:~:text=Antipsychotic%20medications%20can%20help%20to,not%20cure%20the%20underlying%20condition.

4.1.9 There is overwhelming evidence that nothing else is as effective as antipsychotic drugs in treating the positive symptoms (hallucinations and paranoia) of schizophrenia and other serious illnesses. However, antipsychotic medication alone cannot restore many individuals to whole and active life.[79]

4.1.10 Typically, antidepressants must be taken for one to two weeks (without missing a dose) before their benefits become apparent. It is essential to continue taking them even despite experiencing mild side effects early on, as these effects typically subside rapidly. A course of treatment typically lasts at least six months after the onset of improvement. Some individuals with recurrent depression may be advised to take antidepressants permanently.[80]

4.1.11 Martin opposed taking prescribed medication, and family, friends and Consultant A believed that he did not accept it after his hospital discharge in August 2022. He was granted 6 hours of leave to 'test' how he was. It is essential to note the leave did not include medication administration, so it could not 'test' how he would take his medications at home.

4.1.12 At discharge, Anne assumed the role of the primary carer and encouraged Martin to take his medication. In an email dated 5 August 2022 by an administrator within Solent NHS Trust, Martin withdrew consent to share information with Anne. The date on which Martin withdrew his consent is unconfirmed

4.1.13 Family and friends were shocked by the tragic circumstances surrounding Anne's death. However, they sadly were not as surprised by Martin's death as they all felt he was discharged too early from the hospital and continued to be a suicide risk.

4.1.14 Martin was not provided with a care coordinator or formal psychological interventions upon discharge and was referred to HTT.

4.1.15 The family interventions were agreed upon on the day of their deaths.

4.1.16 Anne could no longer express her concerns after Martin was discharged from the mental health unit, as they only spoke with Martin via telephone. In addition, she did not want Martin to feel like she was taking control of his treatment, so she only communicated with the service when he was present and at his request. The service should have offered Anne a Carer's Assessment, as she was the primary carer.

4.1.17 Anne was Martin's primary carer, and her efforts to obtain assistance for him were evident from her engagement with services. Martin's GP, the mental health service, and the social worker did not acknowledge Anne as a carer. Therefore, Anne could not discuss the support she could receive as a carer upon discharge Martin's discharge.

4.1.18 The review examined Martin's admittance to the mental health unit, and the author concurs with Consultants A and C that he should not have been discharged at the time. Martin

[79] https://www.rcpsych.ac.uk/mental-health/treatments-and-wellbeing/antipsychotics
[80] https://www.nhs.uk/mental-health/talking-therapies-medicine-treatments/medicines-and-psychiatry/antidepressants/overview/

continued exhibiting depressive symptoms, such as withdrawing to his room with the curtains drawn. The staff had been unable to communicate with him to conduct a risk assessment. However, there was evidence of his reluctance to take medication and an awareness that non-adherence to drugs would result in symptoms resurfacing. Nevertheless, it is essential to recognise that a more extended admission may not have averted the deaths.

4.1.19 Martin requested discharge, and upon the revocation of the section, he was no longer formally detained and was an informal (voluntary) patient. The ward staff had no authority to request that he remain on the ward unless they believed other Mental Health Act provisions could be employed (Doctor's or Nursing holding powers).

4.1.20 Anne had noted that Martin's mental health had improved at the time of his discharge, and his friends had observed that his "colour" had returned.

4.1.21 The review revealed no previous instances of domestic abuse, and Anne and Martin were described as a loving couple by family and friends.

4.1.22 Ethan, Taylor, and the friends with whom the author conversed believe that Anne's killing was the result of Martin's mental illness. The author, who has been employed in mental health for over two decades, concurs with this assertion.

5.1 Lessons to be Learnt

5.1.1 The review, in collaboration with the pane, family and friends, identified the following themes:

Recognising the significance of the carer's role in treating psychosis and paranoia:

5.1.2 Anne was not provided with a carer's assessment, nor was she consulted separately from Martin regarding his discharge. Subsequently, her concerns and how she could be supported were not adequately addressed or comprehended.

5.1.3 Anne learnt from Martin that Section 2 (Mental Health Act 1983) had been revoked. Solent NHS Trust informed Anne and Ethan that they would be included in this discussion before adjustments to Martins's inpatient status were made. This requirement was not met.

5.1.4 Martins's family subsequently conveyed their immediate concerns regarding his potential risk for suicide. Martin was promptly permitted six hours of leave to "test" his mental state. This "test" did not entail overnight leave or medication adherence at home.

5.1.5 The potential risks associated with Anne's role as a carer and supporter for Martin, who remained unaware of his mental illness and medication, were not known to her. Anne was given the responsibility to encourage Martin to take his prescribed medication.

5.1.6 Anne was not actively engaged in the discharge planning process. If she and her family had been aware of the possibility of a protracted delay in psychological treatment, they would have pursued it privately.

5.1.7 Solent NHS Trust recognised the necessity of family interventions to provide Anne with the necessary support. On the day of their deaths, the family was admitted for family-specific therapy.

Recognising the impact of a shortage of available psychotherapies.

5.1.8 Martin was admitted for assessment and treatment under Section 2 of the Mental Health Act (1983). Based on this admission, his treating team is anticipated to plan the ongoing support he will need for a safe discharge and his continued recovery in the community.

5.1.9 The referral to the EIP was an exercise in futility due to the EIP's age-based exclusion criteria.

5.1.10 The family felt private therapy was discouraged. Solent NHS Trust emphasised specific difficulties associated with private pharmacological treatment. For example, the NHS service would not have oversight of private prescriptions, which could lead to overprescribing or contraindications.

5.1.11 Martin and his primary carer, Anne, should have been informed of the support they would receive in the community at discharge.

Continuity of Care

5.1.12 Martin was not assigned a care coordinator upon discharge, as is customary for CPA patients. Martin was discharged to HTT, a service that does not assign a care coordinator for its service users. Therefore, he was under the supervision of multiple staff members.

5.1.13 Martin and Anne lacked a single point of contact with whom they could establish rapport, express their concerns, and/or identify their individual needs.

Risk Assessments

5.1.14 Mental health providers have prioritised risk assessments as essential for formulating management strategies and care plans. Yet, as previously mentioned, these are not exact predictors of future risks. Engaging all relevant stakeholders, including identifying the individual's social system with their consent, is essential to facilitate effective care planning and risk management.

5.2 Recommendations

Individual Agency Recommendations

5.2.1 Queen Alexandra Hospital – Portsmouth University Hospital

Recommendation One

To raise awareness of the lessons learned from the DHR to implement best practices around domestic abuse and mental health support for patients and their families

Recommendation Two

To roll out a DASH/ Domestic Violence and Abuse training programme across PHU NHST Trust and commence this training delivery within the identified departments and wards within the DHR, i.e., the ED Department, Fracture Clinic, Rheumatology Department, and AMU ward D3.

5.2.2 Solent Mental Health NHS Trust

Recommendation One

The significance of the complexity of mental illness with psychosis and disguised compliance should be considered as part of the decision-making to de-escalate home treatment.

Recommendation Two

To raise the importance of clear, accurate care planning with details of how this will be monitored. Electronic records should be made transparent and accessible to all staff in SystmOne. Clear scrutiny pathways should be developed with a formal escalation pathway for staff.

Recommendation Three

The Outlier must be audited and adapted accordingly to mitigate risk and the challenge of risk assessment when patients are nursed in a ward different from where the clinical and risk management team are based.

Recommendation Four

Ensuring that the well-being of carers is included in the patient's care planning and monitoring and that their voices are heard is in line with Trust Policy.

Recommendation Five

To update and develop staff expertise in risk assessment, mandatory risk training, which reflects current evidence and includes the consideration of the safety of others for all staff in AMH, should be increased in frequency to yearly and domestic abuse questions embedded into risk assessment according to Trust policy and procedure.

Recommendation Six

Patients cared for under CPA need an allocated care coordinator with a Trust Policy reflecting this coordinator's crucial role in aiding communication, collaboration, and care oversight.

Recommendation Seven

To emphasise the significance of the clear, accurate documentation of comprehensive, holistic information to enable robust risk assessment and care Planning.

Recommendations to the Panel

5.2.3 Recommendation One: Recognising the significance of the role of the carer in the treatment of psychosis and paranoia:

Health and Social Care

1.1a To identify carers and ensure they are participating in a carers assessment.

1.1b All clients are to be seen within 48 hours; social care screening will include carers' needs and ensuring carers are offered a carers assessment.

Mental Health

1.1c To offer carers and families literature and resources to help them become more aware of and understand how to support a family member or friend experiencing poor mental health.

1.1d Ensure that carers/family/friends are included in risk assessment and management with the service user's consent.

1.1e To ensure that, in cases where consent has been revoked, the adult's ability is assessed to confirm that they have the mental capacity to withdraw consent. In addition, the individual(s) who previously were involved are told of the request to revoke consent.

5.2.4 Recommendation Two: Referral to Mental Health / Early Intervention Service/Psychological Therapies

Mental Health Commissioners

2.1a To review the NHS England publication for implementing the early intervention in psychosis access and waiting time standard[81] and confirm that Solent NHS Trust complies, and that age is not a barrier to receiving support and/or advice from the early intervention service.

Integrated Care Board/Mental Health Providers

2.1b The long-term plan specifies all areas that should be commissioning early intervention and psychosis services in line with NICE guidance from the age of 14 to 65 years.

2.1c ICB will seek assurance that protocols are in place for patients between 60 and 65 years to encourage MDT discussions to identify the most clinically appropriate pathway.

2.1d Learning from the DHR will be shared with the Mental Health Partnership Board, ICB safeguarding designated education forum and the health sub-group of the Hampshire Domestic Abuse Partnership Board, ICB Portsmouth Place Health and Care Quality Group.

Integrated Care Board/Mental Health

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

2.1e Audit of notes for those aged between 60 and 65 years to seek assurance that MDT discussions have taken place in line with an agreed protocol.

Mental Health

2.1f To ensure that mitigation measures, including concerns regarding medication compliance, are in place to assist service users on waiting lists for psychological therapy. This must be considered concurrently with the recommendation for therapy and included within the community care plans.

2.1g Admission: Care plans must be developed with the service user and their family/friends (with their consent) to identify treatment options, risks, and risk management during admission. These care plans must be reviewed per local policies, highlighting where changes have occurred and what support is required.

2.1h Discharge Planning must be explicitly established upon admission or, when practicable, with the service user and family (depending on the service user's consent). The plan must specify what is required for discharge and what might be expected once discharged. The discharge process must include a detailed risk assessment and management plan developed in partnership with the service user and their family and friends with consent.

Queen Alexandra Hospital – Portsmouth University Hospital

2.1i Portsmouth University Hospital NHS Trust will review pathways for detained patients to identify any barriers to swift transfer.

5.2.5 Recommendation Three: Routine enquiry: Domestic Abuse

Health and Social Care

3.1a Services must ensure that their practitioners know their responsibility to enquire about domestic abuse.

The Portsmouth Community Safety Partnership will assess the action plan and ensure that its partners receive the lessons learned from this review.

5.2.6 Recommendation Four: Gun license process

Integrated Care Board

4.1a Processes for firearms management has been reviewed

The ICB named GP for Safeguarding Adults for Portsmouth Primary Care is taking forward a one-minute guide for primary care regarding their responsibilities within the firearms legislation when a person's mental health has declined and they are owners of firearms. This information will be shared across the ICB footprint (Hampshire, IOW, Southampton and Portsmouth).

Acronyms

Care Programme Approach	CPA
Cognitive Behavioural Therapy in Psychosis	CBTp
Community Safety Partnership	CSP
Domestic Homicide Review	DHR
Early Intervention in Psychosis	EIP
Health of the Nation Outcome Scales	HoNOS
Home Treatment Team	HTT
Subject Access Request	SAR