HUNTINGDONSHIRE
COMMUNITY SAFETY
PARTNERSHIP

Huntingdonshire Community Safety Partnership

Domestic Homicide Review Overview Report

The death of 'Sally'
August 2015

Report Author:
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Report completed: August 2017

Huntingdonshire Community Safety Partnership
Domestic Homicide Review: Overview Report

Preface

Before formally introducing this Review, the Huntingdonshire Domestic Homicide Review Panel would like to express their deepest sympathy to all of those affected by this awful tragedy.

In particular, the panel notes the contribution of the victim's family and friends; this Review could not have been completed without their challenge and support. No words that can be written within this report can adequately describe their loss. However, we are motivated to undertake a review and compose a report that properly reflects the circumstances leading to the events of August 2015 and ensures that any lessons learnt are identified so that others can benefit from that learning.

The impact upon professionals who were involved with the couple in the years and months prior to the incident and those who attended the incident itself is not lost upon us.

The Independent Chair and author of this Review would also like to thank all those staff from statutory and voluntary agencies and organisations who assisted in compiling and reviewing the information culminating in this report; all have been touched by the circumstances.

Glossary

DHR	Domestic Homicide Review
IMR	Individual Management Review
HCSP	Huntingdonshire Community Safety Partnership. A statutory partnership comprising several public bodies serving the Huntingdonshire district area and responsible for delivering community safety services across the district.
NHFT	Northamptonshire Healthcare NHS Foundation Trust. An organisation commissioned to provide mental health services across Northamptonshire
CPFT	Cambridgeshire and Peterborough NHS Foundation Trust. An organisation commissioned to provide mental health services across Cambridgeshire and Peterborough local authority areas.
CPN	Community Psychiatric Nurse
CMHT	Community Mental Health Team
CRHTT	Crisis Resolution Home Treatment Team

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The format of this report

This Review was commissioned by the Huntingdonshire Community Safety Partnership following notification of the death in this case in circumstances which appeared to fulfil the criteria of Section 9 (3)(a) of the Domestic Violence, Crime and Victims Act 2004.

This Overview Report has been compiled as follows:

Section 1 will begin with a **summary of the circumstances** that led to the commission of this Review. It will then **explain the process** undertaken to complete it. The Review commenced in accordance with the then existing Home Office Multi-Agency Statutory Guidance 2013[1]; however, the Review has evolved to take account of the changes introduced within the 2016 refresh of that Home Office Statutory Guidance[2]; this section will demonstrate its compliance and note and explain any departure therefrom that the Chair and Panel felt necessary in the circumstances of this case.

Section 2 of this report will **set out the facts** in this case **including a chronology** to assist the reader in understanding how events unfolded that led to the death of the victim.

Section 3 will provide an **overview of the information** known to family, friends, employers, statutory and voluntary organisations and others who held relevant information. It will then **analyse** the involvement of those agencies identifying good practice and that where lessons can be learned with recommendations arising therefrom.

Section 4 will provide the **conclusion** debated by the Panel and will consolidate **lessons learned and the recommendations arising therefrom**.

To protect the identity of the victim, their family and friends, the pseudonym of 'Sally' will be used to identify the victim and the pseudonym 'Tom' will be used to identify the perpetrator hereafter and throughout this report.

[1] Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews, 2013
[2] Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews, December 2016

Section 1 - Introduction and the Process of Review

1.1 Summary of circumstances leading to the review

1.1.1 At just before 11pm on a Saturday night in late August 2015 Sally made an emergency telephone call to the Ambulance Service saying that her husband had a knife and was cutting his own neck at the home they shared in Cambridgeshire.

1.1.2 The operator who took the call kept the telephone line 'open' alerted paramedics and requested the police attend to support medical staff as a weapon had been cited during the call. The call was monitored for around 35 minutes during which time communication with the Sally ceased. It was clear during the call that an incident of extreme violence was occurring. As a result of the nature of the call police were granted taser and firearms authority on-route to the premises.

1.1.3 Upon arrival Police made a forced entry to the house and found the deceased body of Sally and the couple's dog in the kitchen.

1.1.4 Tom was taken from the house and was arrested on suspicion of her murder. He initially went to hospital for treatment to his self-inflicted neck injury and received surgery before being later taken into police custody.

1.1.5 Once in custody he was subject to a psychological assessment to determine whether he was capable of understanding what was happening. He was subsequently interviewed and charged with the murder of his wife.

1.1.6 In March 2016 Tom pleaded guilty to manslaughter on the grounds of diminished responsibility. This was not challenged by the prosecution. He was detained indefinitely under Section 37 of the Mental Health Act 1983, together with an order issued under Section 41 of the Mental Health Act 1983; known as a 'Restriction Order'.

1.2 Timescales

1.2.1 The Huntingdonshire Community Safety Partnership was notified of the death by Cambridgeshire Constabulary on 30th August 2015.

1.2.2 The Chair of the Community Safety Partnership made the decision to undertake a Domestic Homicide Review. The Home Office was notified of the decision on 7th September 2015.

1.2.3 An independent Chair was appointed on 20th October 2015; the review commenced immediately thereafter.

1.2.4 A meeting between the Chair and the police senior investigating officer (SIO) was held on 18th November followed by an initial DHR strategy meeting on 30th November 2015. The meeting was informed that the police investigation was still on-going and the likely timescales for criminal proceedings. It learned that there had been no prior reports of domestic abuse or other information to suggest an on-going abusive relationship had been identified at that stage and that whilst there was significant and long-term health service involvement with the couple, there had

been little engagement with other services. It was agreed that the Review would continue in limited scope only until such time that the issues within the impending criminal trial became clearer or until the conclusion of those criminal proceedings. Those proceedings concluded in mid-March 2016 (see 1.2.18 for further information on this point).

1.2.5 Contact with Sally's family was initiated immediately by the Chair through initial introduction to the Review by the police family liaison officers who had an existing relationship with the next of kin. Full engagement with Sally's family and attempts to engage with Tom's family began immediately following the conclusion of the criminal trial. This is further elaborated upon at point 1.4, later within this report.

1.2.6 Thereafter followed three Domestic Homicide Review Panel meetings; 30th March 2016, 27th February 2017 and 2nd November 2017. The CSP were briefed on draft findings at a meeting on 12th October 2017.

1.2.7 At the Panel meeting of 30th March 2016, an update was provided as to the conclusion of the criminal proceedings and an overview of the information learned to that date was given. It was agreed that IMRs would be required from the police, GP's who provided primary care to both Sally and Tom and the NHS Foundation Trusts that provided mental health services to Tom in both Northamptonshire (NHFT) and Cambridgeshire (CPFT). The Chair undertook to seek engagement of the employers of the couple, the family of both Sally and Tom, together with a range of friends and others who could provide information relevant for the purposes of the Review. It was acknowledged that the range of individuals may change as information was received.

1.2.8 A further panel meeting to discuss the gathered information was scheduled for June 2016.

1.2.9 The Chair subsequently wrote to each of the organisations and individuals requesting IMRs and/or their engagement. It was agreed that NHS England would co-ordinate the information from GPs and they also assisted in the approach to both NHS Foundation Trusts.

1.2.10 Personal contact between the Chair and the family of Sally began. Attempts to engage Tom's family were unsuccessful.

1.2.11 Subsequent to the first Panel meeting NHS England determined that an Independent NHS Review, held in accordance with the NHS England Serious Incident Framework, (March 2015), would be undertaken. Following discussions between the Chair of this Review and NHS England it was agreed that the two Reviews would run in parallel where possible to avoid duplication and aid efficiency. Two of the NHS Foundation Trusts who provided care to the perpetrator in this case also undertook their own serious case reviews; these have been pulled together within the overarching NHS Independent Review. The Chair of this DHR and the lead investigator for the NHS Review have worked together on a number of areas of Review including joint interview of some staff and appropriate sharing of information that has helped inform both Reviews.

1.2.12 The GP surgery providing primary care to Tom declined to assist either the DHR or the NHS Independent Review from the outset and thereafter began many months of delay in completing this and the NHS England Review.

1.2.13 The scheduled panel meeting earmarked for June 2016 was cancelled, the Chair opting to provide written updates to the CSP single point of contact and other panel members until such time as the GP issue was resolved. Sally's family were appraised of progress by the Chair.

1.2.14 Significant time, correspondence and effort was in place by both NHS England and the Chair of this Review to unlock the GP issue. Agreement as to their involvement was secured in mid-December 2016.

1.2.15 A second panel meeting was held in February 2017 prior to which information had been gained from police, both NHS Trusts, friends and family of Sally and the employer of both Sally and Tom. The Panel noted the progress to that point, asked for additional clarification regarding any cultural issues that may have affected the couple in the circumstances in this case and work to finalise information from the GPs and consolidate both Reviews was agreed.

1.2.17 The Review was completed in August 2017. The Chair of the Review presented its draft findings to the Community Safety Partnership at its meeting on 12th October 2017.

1.2.18 It was not possible to complete the review within the six-month timescales set out within the statutory guidance for the following two reasons:

i) At the time of the commencement of the Review a live police investigation and pending criminal proceedings were on-going. Following discussions between the Police SIO and Chair it was felt necessary to proceed in limited scope (i.e. to secure records only) until the conclusion of that investigation and the subsequent proceedings. There was a lack of information at that time as to what issues were likely to be contested at any trial and thus it was felt that individuals who may be called to give evidence at the trial should not be further interviewed by the DHR. Given the paucity of engagement by the couple with any service (other than health services) it was felt that the majority of information relevant to this Review would necessarily come from family, friends and work colleagues and many of those were expected to be witnesses at any forthcoming trial. The criminal proceedings subsequently concluded in mid-March 2016 and the first Panel meeting was held within two weeks.

ii) The GP Surgery that provided primary care to both the victim and the perpetrator declined to engage with this Review (and the NHS Independent Review) for many months. This stance was adopted as a result of legal advice that they received. The Chair of this Review felt that the health care of both the victim and perpetrator was so central to the Review that it was not possible to complete it without exhausting all avenues to obtain their engagement.

1.2.19 The stance of the GPs in this case delayed completion of this report by many months. It is clear that there was a lack of understanding within this particular surgery of the statutory and multi-agency nature of a DHR; even when they had agreed to be interviewed, at the interview itself which was conducted jointly by the Lead Investigator for the NHS and the Chair of this Review, one of the GPs present was hesitant to speak because the Chair of the DHR was not an NHS employee. The first recommendation of this Review is that the CCG do all they can to remedy this situation.

Recommendation 1.
That the Cambridgeshire and Peterborough CCG work to ensure that commissioned GP Surgeries are aware of DHRs, their responsibilities to engage with them and the statutory guidance that supports them.

1.3 Confidentiality

1.3.1 The content and findings of this Review are held to be confidential, with information available only to those participating officers and professionals and where necessary their appropriate organisational management. It will remain confidential until the Review has been approved for publication by the Home Office Quality Assurance Panel.

1.4 Family engagement

1.4.1 This DHR sought to engage with the families of both the victim and the perpetrator in order to help shape the Review and answer any questions they may have.

1.4.2 Engagement with the victim's family has been consistent throughout even though they lived overseas. The Chair of the Review has met with the victim's brother who acted as the single point of contact appointed by the family on several occasions at various locations when he has visited the UK. Further contact has been maintained by email and telephone. The Home Office DHR information documents and terms of reference were shared with the family at an early stage. The Chair of the Review has also introduced the parallel Independent NHS Investigation to the victim's family on behalf of NHS England. Due to the logistical difficulties apparent in this case it has not been possible to offer the family a meeting with the panel, rather the panel's views have been shared with the family through meetings with the Chair and vice versa. The family have welcomed the personal engagement by the Chair.

1.4.3 The family of the victim wanted the Review to consider whether neglect had been present in any of the care provided to the perpetrator and victim. This is an area where the specialist Independent NHS Investigation has been helpful. The purpose of a DHR is not to apportion blame.

1.4.4 Various attempts have been made by both this Review and the Independent NHS Investigation to engage with the perpetrator and the perpetrators family. They have been provided with the Home Office DHR information documents. They have declined all attempts at engagement by both reviews.

1.5 Dissemination

1.5.1 The following individuals/organisations will receive copies of this report:

- Chair of the Huntingdonshire Community Safety Panel
- Cambridgeshire Police and Crime Commissioner
- Chief Constable, Cambridgeshire Constabulary
- Chief Executive, Cambridgeshire and Peterborough NHS Foundation Trust
- Chief Executive, Northamptonshire NHS Foundation Trust
- Chair, Cambridgeshire and Peterborough Clinical Commissioning Group
- NHS England, Eastern Region
- Chair, Cambridgeshire Adult Safeguarding Board
- Chief Executive, East of England Ambulance Service
- GP Practices involved in this review
- Family of the Victim
- Family of the Perpetrator

1.6 Terms of Reference

1.6.1 The specific terms of reference for this Review are to be found at Appendix A of this Report.

1.6.2 By way of summary, the purpose of this Review is to:

- Establish the facts that led to the incident. Identify whether there are any lessons to be learned from the case about the way in which local professionals and agencies worked together to safeguard the victim.

- Identify what those lessons are, be clear about how they will be acted upon and what is expected to change as a result.

- Establish whether the agencies or inter agency responses were appropriate leading up to and at the time of the incident: suggesting changes and/or identifying good practice where appropriate.

- Establish whether agencies have appropriate policies and procedures to respond to domestic abuse and to recommend any changes as a result of the review process.

1.6.3 The Panel also considered the wider aspects of a Domestic Homicide Review and worked with the understanding that its overriding purpose is to:

- Prevent domestic violence and homicide and improve service responses for all domestic violence and abuse and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;

- Contribute to a better understanding of the nature of domestic violence and abuse;

- Apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate; and

- Highlight good practice

1.6.4 The Review considered information from the period of 1st January 2004 through to the date of the incident. The rationale for this early date being that the Panel acknowledged all the information suggested that Tom's behaviour changed significantly as a result of a motorcycle crash in 2004 following which he suffered consistent and serious mental ill-health.

1.7 Methodology

1.7.1 This Review was undertaken by way of a combination of organisational Individual Management Reviews (IMRs), personal interview by the Chair/Overview Author (combined with the lead investigator of the NHS Independent Review in the case of primary health care services) and by way of interview followed by written questions and response from the employers of Sally and Tom.

1.7.2 In addition to the receipt of IMRs, reports and personal interviews, the Chair of this Review has reviewed a number of documents to assist in compiling this report including:
Specialist Violence Against Women and Girls Service Mapping across Cambridgeshire and Peterborough 2016;
Cambridgeshire and Peterborough Domestic Abuse and Sexual Violence Needs Assessment 2016;
National Confidential Inquiry into Suicide and Homicide by people with Mental Illness, Annual Report, October 2016;
Domestic Abuse, Homicide and Gender; Monkton-Smith and Williams, 2014
Cambridgeshire and Peterborough Domestic Abuse and Sexual Violence Partnership web-site;
Cambridgeshire and Peterborough Domestic Abuse and Sexual Violence Partnership Annual Report 2016-17.

1.8 Contributors to the Review

1.8.1 Those contributing to this Review do so under Section 2(4) of the statutory guidance for the conduct of DHRs and it is the duty of any person or body participating in the Review to have due regard for the guidance.

1.8.2 All panel meetings included specific reference to the statutory guidance as the overriding source of reference for the Review. Any individual interviewed by the Chair, or other body with whom the Chair sought to consult, were made aware of the aims of the Domestic Homicide Review and referenced the statutory guidance.

1.8.3 The following agencies contributed to the Review:
Cambridgeshire County Council
Cambridgeshire Constabulary
Cambridgeshire and Peterborough Clinical Commissioning Group
Cambridgeshire and Peterborough NHS Foundation Trust (CPFT)
Northamptonshire Healthcare NHS Foundation Trust (NHFT)
NHS England, Eastern Region
GP Surgery; Primary Care for Sally and Tom
Employer of Sally

Employer of Tom
Carer's Support Agency providing support to Sally

1.8.4 The following individuals contributed to the Review.
Family of Sally
Friends of Sally and Tom

1.8.5 The following agencies and individuals declined to assist the Review:
Family of Tom

1.9 The Review Panel

1.9.1 The members of the DHR Panel conducting this Review were:

Name of panel member	Role or job title	Organisation
Gary Goose MBE	Independent Chair and Overview Author	
Claudia Deeth	Huntingdonshire CSP lead officer	Huntingdonshire District Council
Chris Mead/Lorraine Parker (subbed by Neil Sloan)	Head of Public Protection	Cambridgeshire Constabulary
Carol Davies	Safeguarding Lead	Cambridgeshire and Peterborough CCG
Mette Vognesen	Head of Independent Investigation	NHS England, Midlands and East
Paul Collin	Head of Adult Safeguarding	Cambridgeshire and Peterborough NHS Foundation Trust
Vickie Crompton	Domestic Abuse and Sexual Violence Partnership Manager	Cambridgeshire County Council
Simon Kerss	Domestic Abuse and Sexual Violence Partnership Manager	Cambridgeshire County Council
Ben Tolley	Head of Specialist Services	Northamptonshire Healthcare NHS Foundation Trust
James Bambridge (subbed by David York, one meeting)	Review Officer	Cambridgeshire Constabulary

1.10 The Independent Chair and Author of the Overview Report

1.10.1 The Community Safety Partnership took the view that a combined role of Independent Chair and Overview Author was appropriate in this case. They appointed Mr Gary Goose MBE to that joint role.

1.10.2 Mr Goose is not employed by, nor otherwise has any conflicting interest with, any of the statutory or voluntary agencies involved in the review. He has significant criminal justice, local government and partnership working experience. Most recently he was involved in local government as Interim Assistant Director, Head of Community and Safety Services, with Peterborough Unitary Authority which included the commission of domestic abuse services. He was formally a detective with Cambridgeshire Constabulary retiring as a Detective Chief Inspector in 2011, four years prior to this incident. He had not worked in the geographical area in which this incident occurred and due to Police restructuring and collaboration he had not worked at any time with the senior management responsible for this area of policing. He was awarded an MBE for Services to Policing in the 2006 New Year's Honours list. He has previous experience of Domestic Homicide and Child Protection Reviews within both his police and local authority roles. He is now self-employed as an Independent Chair providing Domestic Homicide Review services and has worked, or is currently working, across Suffolk, Norfolk, Lincolnshire, Essex and in the Bristol areas.

1.11 Parallel Reviews

1.11.1 At the outset of this Review the Chair liaised with the Chair of the Adults Safeguarding Board and established that no parallel Adults Safeguarding Review was being undertaken.

1.11.2 As aforementioned an Independent Mental Health Homicide Investigation was established under NHS England Serious Incident Framework, (March 2015), has been undertaken in partnership with this Review.

1.11.3 Criminal Proceedings were established prior to the commencement of this Review and are now concluded. Coronial matters are also complete.

1.12 Equality, Diversity and Cultural issues.

1.12.1 Throughout the conduct of this Review the Chair and Panel have been cognisant of all aspects surrounding any equality and diversity issues that may arise. As new material arose those aspects were considered as part of the ongoing Review process. In particular, the Panel was aware that attitudes, policies and processes relating to culture and mental health required particular scrutiny.

The Review finds that all agencies paid attention to the issues that presented themselves and we do not find that there was any direct or indirect discrimination in any of the organisations policies or practices, or indeed displayed by any of the staff working with or for them.

The Chair and Panel considered very carefully the issue of information sharing, in particular the level of mental ill-health being suffered by Tom in so much as knowledge of it may have assisted any agency involved with the couple. There is evidence of good information sharing between criminal justice and health agencies in this case that led to a thorough but appropriately disposed incident six years prior to the incident that resulted in the death of Sally.

The current national debate about parity of esteem and awareness around mental ill health is helpful in this respect. The NHS England paper on parity of esteem can be found at:

(https://www.england.nhs.uk/mentalhealth/parity/)

The Panel also sought assurances about whether Sally's heritage (Hong Kong Chinese) may have been a factor in this case. This is explored and explained later within this report but is not thought to have been a factor.

Section 2 - The Facts

2.1 Introduction

2.1.1 Sally was a white female, born in Yorkshire to parents of Chinese heritage. She moved overseas with her family shortly after her birth before returning to the UK at the age of five; she has remained within the UK since. She was 39 years old at the time of her death.

2.1.2 Tom was a white British male aged 40 at the time of the incident. He had lived in East Midlands for most of his life.

2.1.3 Sally and Tom met at University and had been a couple ever since.

2.1.4 They had lived together since meeting at University, and married in 2010. Their time together had been spent in Northamptonshire before they moved to Cambridgeshire in late 2013. They had no children but the Review has learnt of significant efforts by the couple to explore IVF privately.

2.1.5 Tom suffered from acute mental ill-health. The evidence is clear that this arose immediately following a motorcycle collision in 2004 as a result of which he suffered significant burns, a severe head injury and the subsequent mental ill-health.

2.1.6 **There is little doubt that everything that followed, culminating in this tragedy, resulted from that motorcycle crash.**

2.1.7 As a result of his illness Tom had been under the almost constant care of specialist mental health services for several years in Northamptonshire and more recently in Cambridgeshire where his care appeared shared between primary health care (his GP) and specialist mental services. He was diagnosed with acute psychotic depression together with delusional disorder and subsequently schizophrenia.

2.1.8 Tom's condition was managed with a combination of medication and other psychiatric treatment; it included time in NHS inpatient psychiatric care following a suicide attempt at home in 2011. The attempt appears to have been unsuccessful only because his wife heard him fall to the floor in their bathroom after he had cut his wrists.

2.1.9 It seems very clear that a pattern of Tom's non-concordance with his medication at times of increased social stress had the capacity to, and indeed did, lead to periods of severe illness with resulting catastrophic outcomes (two incidents of significant self-harm and the final incident in this case). Tom was often not open with medical professionals and Sally about the fact that he had stopped taking his medication until such time as his illness worsened considerably and by then he was often in crisis.

2.1.10 Despite the severe bouts of depression for the majority of time he appeared able to lead a 'normal' life, living at home with Sally and being employed full-time.

2.1.11 Both Sally and Tom were in full-time employment. Sally was a scientist working at a company whose UK base was on the Cambridgeshire/Hertfordshire border. Tom was

employed as Practice Liaison Officer by a company based in Cambridge. The company provided a range of services for GP practices; Tom's role necessitated visiting GP surgeries around the country. His job was quite isolating as he travelled alone visiting surgery's often staying away from home.

2.1.12 One of the symptoms of Tom's condition was paranoia. In this case that paranoia surrounded a belief that he was a paedophile. These thoughts began to manifest themselves after his motorcycle crash and there is clear evidence that they increased to the point of obsession at times of increased stress or non-compliance with his medication. This resulted on one occasion, in 2009, of him presenting himself to police asking to be arrested for an offence he believed had committed. Investigation at the time proved that no offence had taken place and that it was a delusion resulting from his condition. This self-presentation and the ensuing investigation appeared to have a positive effect upon his mental health for a while and the couple were married the following year. Unfortunately, his mental health deteriorated again in subsequent years with periods of severe illness and accompanying symptoms such as the self-harm attempts, a lack of self-worth and delusions returning including hearing voices from the television telling his to do things; this is specifically significant given the events of the incident itself.

2.1.13 This Review has learned that there were several periods of separation; in December 2006, he was living at his parents' house during the week lasting until at least June 2007. From around September 2014 they separated again, with Tom moving back in with his parents until around March 2015. In the weeks leading up to the incident their future together had again become less that certain; one of Sally's closest friends saying they believed the relationship would end on the weekend that the incident took place.

2.1.14 Sally's involvement with those providing his care continued during the times of their separations.

2.1.15 Throughout their time together there were no reports to any agency of domestic abuse or violence. In addition, Sally did not confide to any of her close friends any physical or emotional abuse during the relationship and actively rebuked anyone who suggested that risk to her was present. However, this Review has learned that close friends were concerned as to the potential of harm arising from Tom's erratic and, what they felt, was controlling behaviour towards her, that they warned her about it and made a bed ready for her should she ever need to leave.

2.1.16 Life was clearly not easy for Tom, who was enduring significant levels of illness. It was similarly difficult for those around him, including his own family and Sally, who clearly loved and supported him despite the symptoms of his illness making him difficult at times to deal with.

2.1.17 Sally engaged with support groups arising from his treatment and these too continued during their periods of separation.

2.1.18 The separations described previously within this section arose directly from the strain of coping with Tom's mental-health. The very real emotional dilemma faced by Sally will be detailed later within this report as the conversations with friends and

others in whom she confided show how difficult it was for her to cope with his condition from which there seemed to be no light at the end of the tunnel.

2.1.19 The couple moved from Northamptonshire to Cambridgeshire in late 2013 and with that move came the transfer of care for Tom and the transfer of support services for Sally.

2.1.20 In March 2014 Tom presented to his new GP with a decline in his mental ill-health and a referral was made by the GP to specialist services within Cambridgeshire (CPFT).

2.1.21 He was treated by CPFT and in June 2014 a decision was made to discharge him back into primary care for on-going treatment by his GP.

2.1.22 In September of 2014 he presented again with a further deterioration and was engaged again by specialist services. He was discharged again by them in July 2015 back to the care of his GP.

2.1.23 In August 2015 his condition began to worsen again and on 21st August Tom and Sally attended their GP surgery together, Sally telling the GP that Tom was avoiding taking his medication.

2.1.23 On 26th August, Tom attended the on-call GP this time with his parents. He was signed off from work until 2nd September.

2.1.34 On 28th August, he attended the GP with Sally. He reported feeling paranoid and had thoughts of suicide. He was assessed and a plan was put in place for the weekend which meant that Sally would contact the out of hours team if things deteriorated further. An urgent referral to specialist services was made for further assessment and treatment.

2.1.35 The following day the incident occurred resulting in the death of Sally.

A full chronology of events and a summary of information known by family, friends, agencies and others will follow within this report.

2.2 Chronology

The chronology that follows contains a significant amount of detail. The panel discussed the detail necessary at length. All felt that in this case such detail was necessary as it sets the context for Tom's mental health and the level of involvement of Sally in Tom's care. It provides the back-drop for the sections that follow in this report.

Prior to May 2004 there are no issues that are of such note as to appear in a chronology for the purposes of this Review. Tom and Sally had met at university, had been a couple ever since and were living together. They had not married and had no children. In May 2004, both were 28 years of age and in full-time employment.

May 2004: Tom had a motorcycle crash which resulted in serious injuries including a head injury and severe burns to his body and neck. He was treated at a hospital in Oxford for his physical injuries and this included plastic and reconstructive surgery which continued through to 2007.

June 2004: During the treatment for the physical injuries he received he began to show the first signs of psychiatric illness. He succeeded in ripping out the first venous bypass graft in his thigh with the intention of killing himself and developed delusions and hallucinations that the nurses were trying to kill him. He was seen and assessed by the psychiatric consultation service who diagnosed delirium due to infection and pulmonary embolism, with secondary depression and anxiety. The depression and anxiety were considered to be part of an 'acute stress reaction continuing to an adjustment reaction three to four days post injury'. It was noted he had experienced visual hallucinations and intense paranoia

Dec 2005: Tom was referred by those treating his physical injuries to a consultant clinical neuropsychiatrist at Oxford. He was described as having residual psychological issues arising from the motorcycle crash; these included paranoid ideation and significant loss of self-confidence. **This was his first referral to mental health treatment services.**

July 2006: Tom was discharged from Oxford Hospital's mental health services.

July 2006: Tom contacted the mental health service again. He reported feeling paranoid and suspicious about people. He was reassured by email correspondence.

Oct 2006: Tom contacted the service again from abroad where he was at Sally's sister's wedding. He reported feeling paranoid and similar feelings to those he had experienced in hospital. He was reassured and the service agreed to further sessions once back in the UK.

Dec 2006: The Mental health service contacted Tom's GP to agree the sessions but suggested that this may now be a long-term condition with onward referral to local mental health services probably required.

Dec 2006: Tom finished working at his father's company and becomes unemployed.

Dec 2006: Tom and Sally are living apart. He returned to his parent's address.

Feb: 2007: The doctor treating Tom contacted his GP with concern for Tom's state of mind. She had seen him and his condition had worsened, she felt he was at risk of having a 'catastrophic' incident. Tom's GP saw him and the following day made an urgent referral to Northamptonshire mental health services. These services were provided by Northamptonshire Healthcare NHS Foundation Trust (NHFT). Tom had presented as agitated, paranoid and in deep depression.

This was the first referral to NHFT and he remained in their care until the couple moved to Cambridgeshire in September 2013.

An initial screening assessment carried out by a community mental health nurse three days later. Tom was displaying paranoid thoughts of people out to get him. He also spoke of not being able to physically do the things he once could (run etc).

A further two days later he saw the GP again and was described as 'desperate for help'. He mentioned thoughts of having abused a young girl for the first time. That same day he was seen by the Northamptonshire's crisis mental health team. Tom had become convinced he had assaulted a young female relative many years previously and was therefore a paedophile. Over the next few days he was treated further by the crisis team and this was described as a psychotic episode and that his thoughts were delusional and a symptom of his illness.

He was discharged from the crisis service into NHFT's community mental health team pending a further move into the Northamptonshire's NSTEP team. NSTEP was a team for those aged between 14 and 35 who were experiencing their first episodes of psychosis and who had not been in treatment previously.

April 2007: Early April Tom's preoccupation with thoughts of being a paedophile had receded. He was accepted onto NSTEP's caseload. His mood continued to fluctuate greatly however.

June 2007: Tom and Sally were living together again as a couple.

August 2007: Tom commenced individual therapy sessions.

Oct 2007: Tom began a Masters course at University. Within two weeks he had become paranoid that others knew he was a paedophile and called the Samaritans where he had a discussion about suicide. He told them he had no plans to do it and in any event he wouldn't because of the effect upon his family and friends.

Nov 2007: Changes to Tom's medication were made after it became clear he had reduced some of it himself because of the side effects. His worsening condition was felt to be because of the two types of medication he was

taking. This was explained to both Tom and Sally. After the change of medication his condition improved and he returned to his college course.

Also in November, Sally attended a friends and family session run by NSTEP.

Jan 2008: A carer's assessment was offered to Sally and this began in March.

March 2008: Tom disclosed to his nurse that he had stopped taking some of his medication because it affected his concentration.

April 2008: Tom appeared much better. He was no longer having paranoid thoughts and that he had started taking his medication again. He discussed looking forward to being best man at a friend's wedding abroad.

May 2008: Tom had difficulties with his mental state whilst abroad. Drops out of being best man and calls NSTEP saying he was paranoid and anxious. He was advised to ensure that he re-start his medication. This appeared to have a positive effect.

Sept 2008: Tom completes and hands in his masters thesis. He started a temporary job but quickly reports to NSTEP that his paranoid feelings are returning; he makes the decision to try and work through it.

October 2008: Sally called NSTEP, very worried about Tom and wanted him seen urgently. He was seen by the service and reported that he had lost the will to live, paranoid thoughts of molesting a child and conspiracy by his co-workers to kill him had returned. He was talking about suicide, although he had no plans upon which to carry it out. He was risk-assessed as low-risk.

A pattern of Tom calling and wanting help when he was distressed but then distancing himself from treatment when he began to feel better was discussed with him.

Nov 2008: Sally reported to NSTEP that Tom had stopped taking part of his medication again because of what he felt was the side effects. This was discussed with him and he asked for extra sessions to help him prepare for a job interview. Tom told his psychiatrist that that he wanted people to believe that he had molested a young girl, and be appropriately punished, rather than have to accept that this was a facet of his psychosis.

(The psychiatrist has explained that he did not feel it appropriate to activate child protection procedures because he did not believe Tom was a risk to children.)

The following day Tom turned up unexpectedly at the NSTEP team base stating he had suicidal thoughts of stabbing himself in the chest with a knife. He was seen for assessment and he was concerned that there was no move to place him on the sex offenders' register. Social stressors were noted, that is he was due to start a new job on Monday, he was concerned that his relationship with Sally was deteriorating because of his ruminations, and there was recent media coverage of paedophile activity

It was agreed that he would be seen daily by the crisis team with a plan to gradually move him back to NSTEP.

Dec 2008: By mid-December it was determined that he was no longer in crisis and returned to the NSTEP caseload.

It is believed that Tom had returned to live with his parents although the dates cannot be accurately determined. He attended some appointments during this period with his mother and she was offered a carer's assessment.

April 2009: Tom and Sally were seen together by his psychiatrist and Tom said things were improving and that he was spending more time with Sally rather than at his parent's house. Sally spoke of her hopes of having children with Tom and that she was prepared to do anything to prevent him having a relapse.

Tom told his psychiatrist that he had attempted to contact the father of the girl he believed he had molested and was strongly advised not to do this.

May 2009: Tom and Sally were seen again together by services and discussed their relationship and the effect of Tom's illness upon it. Both had concerns about their future and agreed to have some sessions together with the psychiatrist and other staff.

June 2009: Tom and Sally attended a couple's session together. They spoke of always planning to get married (Tom had proposed after the motorcycle crash and Sally had accepted) but had never got around to it. Sally spoke of her desire for children.

July 2009: Tom attended a police station and asked to be arrested for being a paedophile believing he had touched a young female relative back in 1995. He was arrested and an investigation carried out. Police believe no offence occurred and there were no subsequent proceedings. The police took the view, having looked at all of the information and having liaised with his psychiatrist, that his belief arose as a symptom of his mental illness.

August 2009: The couple attended further joint sessions. Tom appeared calm and rational and said that he was pleased had had handed himself in as it meant facing up to what he had done.

The police investigation concluded (as described above) and at future sessions the couple spoke of their intention to move closer to where Sally worked and to continue with their plans for marriage.

Things were going well enough for them both to decide that further joint sessions were unnecessary.

July 2010: Tom and Sally got married.

Feb 2011: Tom's grandmother died.

Tom had been seen monthly by NSTEP during the months following the joint sessions that they had attended and it appears a period of stability. (Tom's family had called NSTEP in March 2010 with concerns about what would happen if he were discharged from the service because they felt he still isolated himself, he was retained in service in any event)

May 2011: Tom and Sally were referred for three courses of IVF treatment. This was not immediately commenced for two reasons: firstly, Sally had a latex allergy that needed managing and secondly, Tom disclosed his arrest and psychiatric condition to them and they wanted comment from his psychiatrist as to any risk he posed to children.

In relation to the risk he may pose to children the clinic wrote to NHFT saying that he had told the clinic he had had medication and had 'delusions that he had abused a child in the past, reported himself to the police, that this was fully investigated and found to be false'. The service responded by confirming he had received treatment for psychosis but was not taking any medication currently, and stating that there are 'no known current factors in [Tom's] mental health that would deem him at risk to the welfare of children, born or unborn.

June 2011: Tom attempted suicide at home. He severely cut both wrists severing the tendon's in one after receiving messages from the television telling him to do it. The attempt was only discovered because Sally heard him collapse on the bathroom floor. He received emergency treatment at a hospital in Leicester.

Following treatment at Leicester he was admitted to a psychiatric ward, informally, in Northamptonshire. He continued to be very depressed and a week later it is noted that he was still saying he would kill himself if he had the chance. It was determined that he had not been taking any medication at the time of the attempt.

July 2011: NHFT wrote to Tom's GP outlining several triggers for his suicide attempt. His was diagnosed with schizophrenia which it was reported that he and his family found upsetting.

Tom commenced taking medication by way of depot injection.

August 2011: Discharged from psychiatric ward.

Sept 2011: Sally began bi-monthly meetings with a carer support worker.

Tom began working as a Practice Liaison Officer for the company by whom he was employed until the incident resulting in the death of Sally.

October 2011: Tom contacted NSTEP with concerns about paranoia returning. Medication reviewed and a plan put in place in case of further deterioration.

Nov 2011: Tom concerned about side effects of depot and it was agreed to lower the dose.

May 2012: Both Tom and Sally asked if he could come off the depot injection as a result of side effects. This was agreed and oral medication re-started.

June 2012: Three course of IVF treatment embarked upon. All negative (concluded in February 2013)

Sept 2012: Sally and Tom were both seen by NSTEP. Tom was noted to be very well, was enjoying his new job, and coping well with medication. It was noted they were trying for IVF treatment. Both Tom and Sally agreed it was appropriate to transfer him to the Community Mental Health Team (CMHT), and their plans to move to Cambridge were no further forward.

Jan 2013: Both Tom and Sally attend his first appointment with the CMHT. There was discussion about medication as both were concerned about the effect it may have upon their on-going IVF treatment. Tom requested that his medication be reduced, and a lengthy discussion about the risks of this was described. Sally in particular raised concerns that Tom tended to deteriorate very quickly and has harmed himself when experiencing auditory hallucinations

Sept 2013: (Between January and September there had been almost bi-monthly meetings with the CMHT that both Sally and Tom attended – no reported issues).

At the appointment in early September 2013 Tom described feeling less well, with a recurrence of some of his delusional beliefs in relation to believing that he may have done something to a child in the past. He was preoccupied with these beliefs. Tom was noted to say he had never experienced any hallucinations but had experienced delusions of reference where he believed the TV may be referring to him. Despite this, he was working full time. His psychiatrist felt he was suffering from a delusional disorder rather than paranoid schizophrenia because he had not shown any disintegration of personality.

It was noted that they were about to register with a new GP surgery in Cambridgeshire and to avoid his care becoming lost in transition his psychiatrist agreed to see him again in November 2013. The intention was that the new surgery would be requested to refer Tom to the local community mental health team.

The couple move from their home in Northamptonshire to Cambridgeshire.

Nov 2013 Both Tom and Sally registered with a new GP in Cambridgeshire.

A week later both met with NHFT and Tom described an improvement in the way he was feeling since the increased aripiprazole. It was agreed by he could be discharged to the care of his new GP, with a view to a referral being made to the local CMHT if needed. No risks were elicited and he did not describe any thoughts of self-harm or suicide, and he was noted to be compliant with medication with no reported side effects. A letter was sent to his new GP with this information.

Jan 2014: Tom had a health check at the surgery

Feb 2014: Tom and Sally both attend GP. Tom reports that he had stopped taking medication. The notes suggest the plan was to refer to local mental health services.

March 2014: Tom attended GP with another family member (not Sally). Reports that he was not taking his medication. Referred to Cambridgeshire mental health services (Cambridgeshire and Peterborough NHS Foundation Trust – CPFT) local Assessment and Referral Centre (ARC). This was the first referral to CPFT. He was subsequently moved to the Adult Crisis Resolution Home Treatment team (CRHTT).

Following these assessments, a referral was made to the Adult Locality Team (HALT).

Tom was seen for an extended assessment by the CRHTT junior doctor and placed within crisis support and anxiety management on a daily basis. Sally and Tom's family were involved in various meetings with him and medical staff discussing his care.

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April 2014: Tom discharged from crisis care and moved to the care of HALT. During this period various contacts were made by Sally to say things were not too bad, and requesting the appointment be moved, then when rearranged for May, she cancelled again as they were going on holiday.

The appointment was again rescheduled by Sally to late May, and Sally said he 'wasn't too bad' and was working at present. Tom did not attend the rescheduled home visit in May, and when called he said things were a lot better, and asked for an appointment out of hours because he was working now. It was explained that HALT was a 9-5 service. Tom said he did not think he needed support from the HALT team now and said he would contact next week, Tom is noted to have said he has a good GP and his wife was supportive. Tom's nurse noted a plan to discuss this with the HALT psychiatrist and the plan after this discussion was to discuss with his GP practice with a view to transfer back to primary care as his mental state had improved.

June 2014: Discharged from CPFT to primary care.

Sept 2014: Tom and Sally separate.

Incident in Norwich. Second CPFT referral.

Tom's mother called CRHTT, with concerns about him. She stated he had been doing really well, but had a call from him today. He was in Norwich with work, sounded vague and said he couldn't think. It was advised he would need to see his GP to be re-referred to the CRHTT or that Tom could go to A&E to be assessed. Sally also called CRHTT, and said she had been called by Tom, who sounded very anxious. The route for referral was

explained, and Sally was noted to be not very happy as she thought he could be seen again by CRHTT without seeing his GP.

Tom was seen by a GP with Sally, he said he had stopped medication himself three months ago, and had failed to go for psychiatric follow up. He reported feeling low, for the past three months he had been hearing auditory hallucinations on the radio, he was not threatening, and not suicidal. Referred back to CPFT.

Feb 2015: Sally called the GP, very concerned about Tom's mental health. Tom had cut his wrists, she felt unable to keep him safe. Injuries treated at surgery.

A five-day referral was initially sent by the GP to ARC, but it was picked up as an open case with HALT.

March 2015: Tom and Sally appear to be living together again.

July 2015: Tom discharged back to primary care.

Tom and Sally seen together at GP surgery, both talk about plans to continue to try for children. A routine 'mental health review' was carried out by a GP on 23 July 2015.

August 2015: On the morning of 21 August 2015 Tom attended the GP surgery with Sally. He reported ongoing problems with his mental health, and was "trying to avoid taking medication". He said he had stopped it eight weeks ago; Sally was unaware.

On 26 August 2015 Tom attended an on-call GP with family members (not Sally). He was noted to have a long supportive chat, said he was unable to think and concentrate, couldn't work, was very anxious but didn't know why. He was regarded as not fit for work and was signed off with a medical certificate until 2 September 2015. The diagnosis noted was 'stress related problems'.

On 28 August Tom attended the GP surgery again with Sally, saying he was paranoid and wanted medication. The impression noted was that this was work related stress; he discussed work, saying he has to travel and work away for weeks at a time, staying in guest houses so it was very isolating. He also said he hasn't been taking his medication whilst away. He said he had fleeting ideas of suicide but no plans. On examination he was slow to answer questions but also restless. Medication plan agreed. If things escalated at the weekend Sally agreed to contact the out of hours service. It was also planned to send a fax to the Tom's CPN to ask for review/support. The fax was sent addressed to CPN at HALT with the title 'for urgent attention please' and made reference to Tom having relapsed due to not taking his medication, and requesting that his CPN review him urgently

29th August. Tom killed Sally at their home in Cambridgeshire after firstly injuring himself.

Section 3 - Overview of information known to family, friends and agencies

3.1 Introduction

3.1.1 This Review sought to involve the families of both Sally and Tom in its direction and scope. Sally's family contributed primarily through her brother who acted as a single point of contact. Tom's family declined involvement. The Review also engaged with a number of friends and work colleagues of the couple, the majority of whom knew both Sally and Tom before the motorcycle crash that clearly changed life for both of them.

3.1.2 Those spoken to have provided a rich picture as to how the victim was feeling about the relationship, her own internal dilemma as to what was best for the future, together with insight into deterioration of the relationship in the days and weeks immediately preceding the tragedy.

3.1.3 The Review has also spoken with the employers of both. Following the tragedy both employers were thrown into circumstances that neither had encountered before and from which both organisations have shown a willingness to learn and develop.

3.1.4 This information both complements and supplements that known by agencies who were providing support to Sally and Tom prior to the tragedy.

3.2 Friends, work colleagues and family

3.2.1 Sally had worked as a scientist at a UK branch of an international life science company since 2003. Whilst to most people she was a very private person she had developed some close friends at the company in whom she confided much about her marriage and the difficulties she faced in looking after her husband whom they felt she clearly loved, was loyal to, and felt responsible for.

3.2.2 She tended to start work a little later than most due to the fact that she wanted to make sure that her husband was ok and off to work before she left. This seems to be entirely down to his illness, one of the symptoms of which, at times, was lethargy and lack of motivation. This also meant that she finished slightly later, around 6 to 6:30 and as a result began a close friendship with a colleague who also worked similar hours. This friend will hereinafter be known as Friend A.

3.2.3 They confided in each other about their feelings for their loved ones, their marriages and other personal issues. Friend A described how they would spend hours after work talking when others had left. He got to know both Sally and Tom as he met him at various social functions as well as at the victim's home. As the friendship developed Friend A thought that Sally was avoiding going home. This is an aspect also mentioned by another friend further within this summary.

3.2.4 Friend A described how he personally experienced Tom's change after the crash; he became very self-aware and paranoid, particularly with the burns he suffered and always felt people were staring at him. This got worse as time went on. Friend A saw Sally working hard to make him more sociable.

3.2.5 Sally was concerned about money issues when they went down to one salary following the crash. This was a source of regular worry on the victim's part as Tom seemed to be unconcerned and just kept on spending money whenever he felt like it without reference to her.

3.2.6 Whilst Friend A had never seen Tom be violent towards Sally they witness had encountered one occasion when in his words, Tom 'flipped'. Sally was with several friends from work who intended to go out into the town for a leaving drink, the group were intending to leave from her home. He became very aggressive and shouted at her friends for no apparent reason. He witnessed Sally taking him to one side and she was able to talk him down from a state of agitation.

3.2.7 Friend A was aware of previous separations. Sally had said when they separated that she had needed a break, was tired out and needed space. He went back to live with his parents. She felt his parents were not really very helpful and took the view that it was her responsibility to look after him. When he moved back in she didn't really want him to come back. He came back on odd days to begin with, staying in the spare room to start with. They then resumed what had become their normal relationship although it wasn't a really romantic get together, she was still unsure but felt she had to look after him because she was his wife. They were not really living a life together as they rarely did anything together.

3.2.8 Friend A describes that in the weeks before the incident Sally had got really frustrated with how things were going again, she was having to make all the decisions, do all the work, and take responsibility for everything. She had found out that he had stopped taking the medication again. Had bought a dog without telling her. She was worried that his downward spiral could lead to another suicide attempt.

3.2.9 Friend A thought that Tom was manipulative enough to know that he was on a 'short leash' with his wife. That he too knew things were getting bad but that he also needed her. He was manipulative enough to stop taking the medication so that she would not leave him. He knew what buttons to press with her, he wanted to live his life in a certain way, but she was also very loyal.

3.2.10 Friend A was worried enough to ask her outright whether her husband would ever hurt her. He asked this because he had experience himself of a person taking what he described as the small step from hurting themselves to hurting a loved one. She looked genuinely hurt that he would even think that.

3.2.11 Immediately prior to the weekend of the incident, Friend A was aware that she had said things had got so bad again that he fully expected her to come into work on the Tuesday and say that they had separated again. She was really struggling to cope with his behaviour. She spoke a lot about his depression and paranoia. She said, "It's been 10 years and it's not got any better".

3.2.12 Friend B had known Sally and Tom since 2004. She and Sally had developed a very close friendship, describing them as almost like sisters with a very high level of trust who confided in each other. Sally discussed lots of aspects of her marriage and although she talked about their problems she remained very loyal to him. She loved him although the relationship was draining her and making her feel unwell.

3.2.13 Sally visited her friend regularly after work as she lived in the same town that Sally worked. This would sometimes be a few times a week, others a few times a month. She got the impression that she was doing it to avoid going home.

3.2.14 Friend B had met Tom on few occasions. She describes being wary of him and in fact scared of him; she could not say why other than he just made her feel nervous.

3.2.15 Friend B was aware of motorcycle crash through Sally and was aware of physical and psychological effects that it had had. She also knew that he should have been taking medication but that he regularly stopped. In her view, Tom used the threat of not taking the medication as a way of controlling her. She recalled an occasion when he phoned the victim to say that was intending to hurt himself again. He was in Norwich at the time with work and she had to go and get him.

3.2.16 Friend B felt that he knew what buttons to press to control her. He controlled her not by threats or violence but by knowing how to make her feel responsible for him. He often called when she was visiting, in the friend's view, as a way of controlling her. Sally told her of the previous suicide attempt and that she was really scared of a repeat because she didn't think she would be able to cope with another. She always described it as his 'accident'.

3.2.17 When they had separated she described Sally as a different person with more life and more energy. She took him back reluctantly but felt responsible. The separation was simply because of the difficulties they had in maintaining a relationship given the symptoms of his illness that resulted in some very difficult behaviour.

3.2.18 She describes Sally as very loyal and felt it her responsibility to look after him. It was becoming more and more draining upon her. He would buy things when they had no money. She was tired, exhausted and drained from the stress and anxieties that the relationship caused her.

3.2.19 Friend B was very worried about Sally's safety and had discussed it with her and offered her a place to stay. She was aware of that he was on medication and his regular non-compliance with it, of his suicide attempts and what she felt was other general controlling behaviour, for instance he bought a dog without any prior warning. In friend B's view, this was bought with the intention of tying Sally to him by making her jointly responsible for it. He was very unreliable when they had social plans, often changing his mind at the last minute thus disrupting plans.

3.2.20 In the months leading up to the incident she was talking about divorcing him and had talked through the financial options. These conversations reflected the dilemma that she felt she faced because she was also felt very aware of her age and was concerned that if she left Tom the chances of her meeting someone and building a relationship strong enough to have children was getting more and more remote. She had talked about having children together but was really worried that she would be left to do everything with them too and so was questioning whether she had the energy to stay with him. However, this was a dilemma for her as she still felt a strong loyalty towards him.

3.2.21 These conversations were also repeated the last time they met. This was a couple of weeks before the incident when they went shopping together and had lunch.

When Friend B had picked her up in the morning Sally told her that they had just had a week away in Cornwall which had actually been really nice. She then turned to Friend B and said, out of context, "(Tom) would never hurt me". It was said out of the blue and wasn't part of the conversation. Friend B had that in her mind the rest of the day and when they were talking during the day she told her she was really worried about her; Sally again replied that he wouldn't hurt her.

3.2.22 Another friend spoken to by the Review had known Tom for around 20 years and had got to know Sally through him. He will be known as Friend C for the purposes of this report.

3.2.23 Friend C lost touch with Tom for a couple of years around the time of the crash. When he met him afterwards he was clearly different person. He had then got to know Sally over the years and she would often instigate contact. By then Tom was different, he was not the same person physically or mentally and he was struggling to get work.

3.2.24 Friend C described him as 'a bit lost' and for a while Tom did some work for Friend C. It is a testament to the care taken by Friend C that he constantly checked with both Sally and Tom that the work was not putting too much stress on him as he clearly cared deeply for him as a friend. After some time contact went quiet and he found out that Tom had tried to commit suicide. He told him he had heard voices from the TV telling him what to do. Friend C understood that he was 'sectioned' for 6-7 weeks. It was clear though that Sally valued the continued friendship and she was really good at keeping in touch. Friend C got the impression it was tough living with someone with such mental illness. Friend C remembers a conversation with Sally when she described, 'Isolation for (Tom) was a part of his life'.

3.2.25 Friend C formed a view that there was a sadness with Sally; she was trying hard to make things happen and have a life. He did feel that the relationship was perhaps breaking down as there was more of a detachment between them over the last few visits.

3.3 Sally's Counsellor

3.3.1 The information provided by Sally to her Counsellor is included at this point within the report as it contains information about her personal feelings disclosed in a confidential environment in many ways similar to the nature of discussing issues with close friends.

3.3.2 The Counsellor worked with an organisation commissioned by the local authority to provide support to family, friends and carers of those suffering from mental illness. The only stipulation being that the cared for person must be between the ages of 18 - 65. It does not provide support to mental health service users.

3.3.3 Sally was referred into the service at the end of August 2013 by Northants specialist services (she had been receiving support through Northants Community Mental Health Team). They wanted to make sure that her support continued as the couple moved from Northamptonshire. She remained in contact with service for about a

year to begin with before disengaging initially in August 2014. She re-referred in April 2015 and was still active at the time of the incident, although she had cancelled the last couple of appointments and not been spoken with since July 2015. During that first year of engagement she was seen typically at intervals of between 4 and 6 weeks. The meetings were held at her home and were usually first thing in the morning to accommodate her working arrangements. They were not 'hidden' from her husband as he was often leaving for work as the support worker arrived at the house and was fully aware that she was receiving support.

3.3.4 The main issue that Sally raised was the impact of her husband's illness upon their relationship. His lack of motivation to do what she felt was a fair share of work around the house and his lack of general decision making around normal everyday issues was a source of frustration. She was trying to understand whether this was a result of the illness and his medication, or whether he was just lazy. She was conscious that she didn't want to 'nag' but equally just wanted him to share the load as she worked long hours and was having to make all the decisions. She wanted him to share the effort so that, for example, they could do normal things that couples do at weekends.

3.3.5 She spoke about wanting a baby but was unsure about how her husband could or would cope and whether she would be left to do everything. She felt that time was moving on and that her age was becoming an issue in relation to having children.

3.3.6 Sally was constantly concerned about her husband making another suicide attempt and was unsure whether she would be able to cope with it again. She had previously helped him after a suicide attempt, and had managed, but was worried whether she could cope with another. She was concerned about whether the relationship that they had was right and discussed on a number of occasions separating from him. Their social life was suffering as a result of her husband's lack of sociability. She struggled to get him to do anything or go anywhere with her. The discussions included the possibility of not necessarily a permanent break-up but perhaps a temporary one to see how things went. Although she was a very private person she had said she had spoken with a friend about the possibility of separating but did not say that she had made decisions about it. She was concerned about her age and feeling that it was too late to start again with someone new and have a family.

3.3.7 She disengaged from services after a year or so because she had finally made the decision to have a temporary separation from her husband and at that time felt she was in a better place to cope. Her husband had moved back in with his parents and they were going to see how things went.

3.3.8 In April 2015 she re-referred to services and dialogue began again. Her husband had moved back in and she was once again taking on the full carers role. She was seen on two further occasions and things were very much as before with the same concerns and issues. She had also spoken about thinking of changing her job. She said she was having to make all of the life decisions for the both of them and what she really wanted was to be in a partnership and not just a carer. She was very surprised when her husband got the dog and it was initially a source of tension between them but he seemed to genuinely care for it, as did she, and in some way's it had the potential for bringing them closer together. She cancelled the last two

pre-arranged appointments by text (as was her normal way of cancelling if it was necessary) saying it was down to work arrangements.

3.3.9 During the entirety of the service's involvement with her she never once seemed to have any concern for her own safety and never mentioned or intimated at any violence on her husband's part. All her concerns were for his state of mind and his own safety with the potential for further suicide attempts being very real. The incident, when it occurred, came as a complete shock for those from the service involved with her as it was so different to the image that Sally had painted to those working with her.

3.4 Sally's family

3.4.1 Not unusually, Sally tended to confide more in the close friends she had made than she did with her family. Therefore conversations with Sally's family elicited little additional information in terms of the day to day dynamic of the relationship that existed between the couple. Distance was an inhibitor in the family knowing much about how their relationship was functioning. The family were aware of difficulties in the relationship because during the separation that took place over the winter of 2014 Sally spent time with them abroad. They didn't delve into the reasons for the separation and she didn't talk about them. They said, as did everyone else who the Review has spoken to about that time, that she appeared to have more life, more energy and that she was enjoying life again. They knew that she loved her husband and was incredibly loyal to him but that she was simply exhausted by managing the symptoms of her husband's illness for so long.

3.4.2 The Panel considered whether any cultural issues affected Sally's behaviour in this case. As a result, they asked for this aspect to be explored further with the victim's family. The family were very clear that she was brought up in Britain, with British schooling and beliefs and that the family have a 'strong sense of family', meaning that they would stick together through thick and thin. The family do not believe this to be anything peculiar to their culture and do not believe culture had anything to do with her sense of love, loyalty and responsibility. The family quoted the vows taken by Sally on her wedding day, in that she tried her best to be with her husband 'in sickness and in health'.

3.5 Summary of friend's information unknown to agencies

3.5.1 All of those spoken to, without exception, make it clear that Sally loved and was loyal to Tom. She was fully involved in the care of his illness and worked to manage the symptoms when they arose. She was though exhausted and drained by impact of the illness upon their relationship and it was making her unwell. As one friend described it, she put loyalty before her own wellbeing and happiness.

3.5.2 Several friends were aware that things had reached a critical point. It had become clear to Sally that whilst she still hoped that her husband's illness would improve and that they could have a future together his continuous lapses in being concordant with his medication meant that things were in reality not improving at all. Any improvements in their relationship following a separation that lasted a few months, some 12 months previously, had evaporated and his latest lapse in medication had taken things to another low. She appears to have given up hope of a

having a family with Tom and was having a real dilemma as to whether to stay with him.

3.5.3 Two of her closest friends were concerned enough to raise the issue of her safety directly with her. Neither had any evidence that Tom had directed any violence towards her in the past but both felt uneasy at what they felt was his manipulative behaviour towards her, were aware of his illness together with some of its symptoms and aware of his previous suicide attempt. One friend had a bed ready for Sally should she ever feel the need to leave him at any time of day or night; another had made it clear that she could call them at any time if she needed to get away.

3.5.4 All of the information before this Review suggests that Sally genuinely had no fear for her own safety at the hands of her husband and in fact became upset with her friends for thinking something could happen.

3.5.5 Whilst the health element of this Report will be dealt with separately it is clear that Sally had never voiced any concerns with those services treating her husband about her own safety, none of the professionals involved felt such a threat existed.

3.5.6 Perhaps the biggest indicator of how difficult things had become in the days and weeks leading up to the incident is information from a work colleague and close friend of Sally who said that they firmly believed when Sally returned to work following the Bank Holiday weekend that she would have separated finally from her husband.

3.5.7 Whilst there is no information available to this Review, either through its own information gathering exercise or that which was gathered by the police or indeed placed before the Courts, that this was a conversation that actually materialised leading to the tragic events of the night, it is an insight into how difficult Sally was finding things at the time.

3.5.8 Whilst both Tom and Sally were well known to a range of health service providers, little was known about them to other organisations. There had been one interaction with the police, no relevant interactions with local authorities and none with the probation service. There was no engagement at any level with domestic abuse services.

3.5.9 As stated earlier employers for both Sally and Tom fully engaged with this Review following initial hesitation by both. In some respect the unfortunate delay in completing the Review caused by the GPs lack of engagement helped in getting the employers involved. Both felt the initial approach to have been made too close to the death of their colleagues and thus did not want to become involved. The time delay assisted in that respect and a further request to them by the Chair was met with full and positive engagement.

3.6 Sally's employer.

3.6.1 Sally had been employed by a life science company with a UK and US base since 2003. She was employed as a scientist.

3.6.2 The US-based element of the company employs approximately 70 staff, including most of the administrative functions for our organisation (HR, finance, IT). The UK-based research services business employs approximately 30 staff, predominantly scientists experienced in the delivery of human tissue based data to research clients. In essence, the UK business operates as a specialist Contract Research Organisation (CRO).

3.6.3 The company were asked what knowledge, as an organisation, they had of Sally's home circumstances. In response, they told the Review that whilst Sally was quite private about her home situation following her husband's accident. Her line manager and senior manager had a top-level awareness, allowing her the time, as needed, to deal with the subsequent care and rehabilitation support she provided for her husband. They were, thus, aware of the motorcycle accident. They were aware that he had developed depression as a result of the accident and the prolonged recovery/rehabilitation. The victim also told them about his suicide attempts and his on-going mental ill health issues. They were not aware of any danger to the victim at all.

3.6.4 The company provided details of the Sally's sickness record and it is clear that they were extremely flexible in giving her additional time off to help with her husband's initial recovery post-accident, time off following the suicide attempt, and also regular time off for counselling that she was receiving to support her caring for him. Her level of sickness did not suggest any other concerns, there were no unexplained injuries or unexplained absence that could or should have prompted concerns about domestic abuse in any form if it existed.

3.6.5 The company assisted this Review further by looking at its post incident management. They clearly acted with sensitivity and professionalism in the face of a situation that thankfully no-one had previously experienced. This Review acknowledges the way the situation was managed and is grateful to the company and its employees for their engagement with this Review.

3.7 Tom's employer.

3.7.1 Tom's had been employed by his current employer since September 2011. The company were based just outside Cambridge and are a social enterprise working in the UK healthcare system. The company provides a range of services to GP surgeries.

3.7.2 At the time of the incident the company employed around 20 people. 14 of which were based at the office with the others working remotely.

3.7.3 He was employed as a Practice Liaison Officer, his role involved managing the company's relationship with practices; visiting GP practices across the country to discuss the services they provide and recruiting practices for studies, sending out patient questionnaires, sending out letters for studies from practices via phone or manually, sorting and scanning questionnaires and updating company spreadsheets with practice information.

3.7.4 He did not attend the company office on a daily basis as his role largely required him to be travelling around the country to the various GP Practices where his attention

was required. He was based at offices in Cambridge and would attend GP practices as and when services demanded. Colleagues did not have any difficulties working with him. He had good working relationships with all team members. However, there were occasions when he was less sociable. These occasions were normally recognized by himself and he would seek leave at these times (sick leave or time off in lieu), management would support these requests with appropriate follow up support meetings.

3.7.5 There were no health screening questions used as part of the recruitment process leading to his employment. Thus, the company had no knowledge of his levels of acute mental ill-health and did not know of his previous suicide attempts.

3.7.6 It appears that some of his colleagues got to know about his motorcycle crash as a result of conversations with him in the office but those conversations do not appear to have gone any further in terms of the long-lasting psychological effects upon him. Again, by normal work based conversation there was some knowledge that the perpetrator lived at home with his wife and their dog. Little else appears to have disclosed by the perpetrator and this seems to concord with the private nature of his demeanor. In addition, the amount of time that he spent away from the office meant that he had less of an opportunity to forge close friendship ties at work than perhaps would be the case were he to have been office based.

3.7.7 The company assisted the Review with a review of his sickness records and there had been none recorded at all during 2014 and 2015 until the week before the incident. However, the company have made the point that because he managed his own diary and accrued his own time off that he may have used this at times of illness and not disclosed this to the company's management.

3.7.8 There were no disciplinary issues at all whilst the perpetrator worked at the company, there were no occasions where he seemed to lose his temper or other behavior that gave rise to cause for concern.

3.7.9 In the week leading up to the incident itself he notified the company that he was not attending work as he was ill on the afternoon of Monday 24th August 2015 and Tuesday 25th August 2015. He briefly attended the offices on Wednesday 26th August 2015 but was suffering with a migraine, management granted leave from work and he continued to be off work for the remainder of that week. Monday 31st August 2015 was a bank holiday. As such a return to work support meeting was arranged for him on the following working day, 1st September 2015.

3.7.10 The company assisted this Review further by looking at its post incident management. Since this incident they have introduced a health screening questionnaire as part of the recruitment process and have tightened their absence management programme. This is welcomed but should in no way be taken as indication of failing at the time, they have learned from this awful experience and have amended policies that will better protect their employees and the company in the future.

3.8 Police involvement.

3.8.1 Sally had no convictions, no police record and had not come to the notice of the police in any way prior to the tragic events of the 29th August 2015.

3.8.2 Tom had no convictions prior to the homicide and had not come to the notice of the police other than an historical reference to an arrest of him occurring in 2009 (the self-presentation for his belief that he was a paedophile). The details of this occurrence are examined within the later narrative.

3.8.3 There were no prior reports of domestic abuse between the couple. Cambridgeshire Constabulary has no record of attending at the home address of the couple since they took up as the occupiers in 2013, or any otherwise reported occurrences.

3.8.4 Police involvement thus is confined to dealing with the incident on the night in question and what was then revealed as a result of their subsequent murder investigation.

3.8.5 Sally called the ambulance service at just before 11pm on the night of the incident. She reported that her husband had a knife and was cutting his neck. She was very distressed, the receiving operator kept the 'phone line open in order to support and re-assure the caller and the matter was also almost immediately referred to the police. As a consequence, the unfolding events were listened to in live time by the emergency services and the incident was voice-recorded as it continued. The line remained open until later intervention by the police and other emergency services.

3.8.6 On attendance police forced entry to the address and it was apparent that within a relatively short period of time that the Tom had attacked Sally possibly initially using the same knife that he had used to self-inflict his injuries. He attacked her stabbing her repeatedly around the neck area and although the victim made efforts to defend herself she became overwhelmed with the ferocity of the attack.

3.8.7 Officers were confronted by the dead body of the victim lying in the kitchen and also the body of their pet dog which was lying close to her.

3.8.8 A post mortem revealed that Sally was attacked and suffered extensive injuries inflicted by what could be described only as a ferocious attack by more than one weapon. Multiple sites of stab or incision wounds were identified. The forensic pathology showed that it is likely that she would have been incapacitated very quickly, rendering the victim unconscious and therefore incapable of further defending herself following which the final fatal injuries were probably caused.

3.8.9 Tom was charged with the Sally's murder following advice from the Crown Prosecution Service but it was apparent that the perpetrators mental health was in question and that this would be the focus of future proceedings.

3.8.10 **The trial process**

The prosecution case indicated that the medical evidence was plain and could not be rebutted. It was clear that at the time of the killing that Tom was suffering from a mental illness which caused an abnormality of the mind substantially affecting his

ability to behave rationally and keep his self-control. Had it not been for that, he would not have killed the wife who loved and cared for him and to whom, on the available evidence, he had never previously threatened any violence.

He admitted in interviews that during the temporary estrangement from his wife he had stopped taking the medication which had been prescribed for his mental health problems and that appears to have remained the position according to his admissions up until the time of the killing. Following his arrest, a blood sample taken from him was analysed by a forensic toxicologist and evidence of a prescribed anti-depressant drug was found but at a concentration level that fell below that which would be expected had he been taking the drug correctly and as he had been prescribed.

3.8.11 **Other historical issues**

In June 2009, Tom voluntarily attended a police station in Northamptonshire stating that he wished to report that he had sexually assaulted a 5 year old female. He was arrested and interviewed during which time he stated that he considered that he had inappropriately touched a family friend in 1995 (when he was 19 years old) when he had touched her bottom over her clothing. He stated that he had been worried about the incident for years and although neither his partner nor his parents believed that this had occurred, it appears that he had convinced himself that it had occurred and that he wanted to admit what he knew that he had done wrong and be punished for his actions.

3.8.12 It was apparent from the interview conducted of him at that time, that he had psychological issues and when officers visited his wife in connection with the investigation, she confirmed that he had a fixation for being punished for what he claimed to have done, which was part of his behavioural pattern, for which he was receiving professional medical support. The victim was co-operative and supportive of the police action taken and he was released from police custody with no further action being taken.

3.8.13 The record created of this occurrence on the Police National Computer (PNC) identified warning markers of a *'vulnerable [risky] adult'* and of Tom having a *'suspected mental disorder'*. These warnings are discretionary and are created by the investigating and reporting officers in order to notify others of potential concerns for the individual, but were clearly made as in the professional view of officers, the issues raised were significant enough for them to consider that the individual may (or was likely) come to notice of the police again.

3.8.14 Tom did not come to notice of the police again, although it is possible that he may have been encountered by officers but where no other record of the contact was deemed necessary.

3.8.15 **Recommendations**

There are two minor issues in respect of data quality that will be brought to the attention of the respective areas of business within the Constabulary.

In addition: The police author identifies and will bring to the attention of the head of the Major Crime Unit (MCU) the potential opportunities that may be presented to Senior Investigating Officers of homicide investigations, where there is domestic violence involved, for the dedicated engagement with the family or a representative of the perpetrator's family during the course and conduct of the homicide investigation. This arises out of a perception that Tom's family may have become somewhat isolated during the process of investigation.

Recommendation 2.
That in cases where a homicide occurs and the perpetrator and victim are in an intimate relationship that an officer be considered as a dedicated point of contact for the perpetrators family as well as the victims.

3.9 Health Service involvement.

3.9.1 This Review draws its health service information from the NHS Independent Investigation carried out on behalf of NHS England.

3.9.2 This Review is grateful to NHS England and their appointed investigator for the stance taking in compiling their investigation and the sharing of information and the collaborative approach adopted. Joint working between the two Reviews has helped provide a richer picture for the benefit of both.

3.9.3 This Review has adopted a position that whilst there is information to suggest that Tom was at times somewhat withdrawn and lacked confidence as a child and young man, there is nothing to suggest any level of mental ill-health prior to the motor cycle crash in 2004. At the time of the crash he had just turned 30 years of age and already in a relationship with Sally.

3.9.4 Whilst the physical injuries arising from the crash were significant, in particular the burns to his right arm and face, it was the enduring psychological effects that were most damaging.

3.9.5 Just over a week after the crash and whilst still in intensive care in Oxford, Tom became agitated with paranoid delusions that the nurses were plotting to kill him and his family. He succeeded in ripping out the first venous bypass graft in his thigh with the intention of killing himself. At this early stage, post-crash, he was noted as having experienced visual hallucinations and intense paranoia as a result of an acute stress reaction to his injuries. He subsequently received care for scarring to his face and body from the department of plastic and reconstructive surgery and it was they that made the first referral to mental health services in December 2005.

3.9.6 He suffered mental health problems from the crash to the time of the tragedy. The level of illness varied according to stressors in his life as did his concordance with his medication regime. At times, he would be stable and able to lead a relatively normal life, at other times he would be prone to episodes of serious mental ill-health resulting in attempts at self-harm, suicide with resultant in-patient stays within psychiatric units.

3.9.7 This Review has adopted the same scope as the NHS Independent Investigation, that is to say that it has not revisited his care immediately after the crash but has chosen

to look at the couple's care during their engagement with specialist care services in Northamptonshire and subsequent move to primary and specialist care services within Cambridgeshire. This is a timescale of in excess of 10 years and provides sufficient understanding of how health issues and health care affected the lives of the couple.

3.9.8 It was clear from a very early stage that the transition from Northamptonshire to Cambridgeshire would need special focus, as would the clear difference between the approach to care between Northamptonshire and Cambridgeshire.

3.9.9 Tom received mental health services from Northamptonshire Healthcare NHS Foundation Trust (NHFT) from 2007 to 2013 followed by Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) during 2014 and 2015. He was transferred to a Cambridgeshire GP from Northamptonshire upon the couple's house move in the autumn of 2103.

3.9.10 Sally was fully engaged in the care of Tom, attending numerous appointments with him and was afforded access to a carer's support group as well as them attending couples' work together.

3.9.11 Sally was registered with GP's in Northamptonshire and transferred to the same surgery as Tom in Cambridgeshire upon the house move in 2013.

3.9.12 Whilst the NHS Independent Investigation was concerned with the care of Tom there are numerous references to support for the victim within the notes examined by the investigation. In addition, this Review has been afforded access to Sally's full medical records and a joint meeting involving the Chair of this Review, the independent investigator and the couples GP has helped with understanding any issues surrounding Sally's care.

3.10 GP care of Sally

3.10.1 The Independent NHS Investigation did not include the care of Sally within its terms of reference, however it has helpfully referenced a number of interactions between her and services providing support for Tom such as her own carer's assessments and referrals to carer's support networks as well as couples' groups for both. These issues will be dealt with later.

3.10.2 This Chair of this Review has, however had the opportunity to review the primary care offered to her since birth and has undertaken a full review of her medical notes when released by her GP.

3.10.3 From childhood to the time of her death there are no indications that Sally presented with any unexplained injuries, any injuries for which the explanation was, with the value of hindsight, questionable, she did not routinely fail to attend appointments or visit the GP at a frequency which could prompt questions, nor indeed did she present with any levels of stress or anxiety which could have prompted deeper exploration. She suffered a variety of what could be considered 'normal' issues for a girl growing into womanhood; they are not for mention here.

3.10.4 There is good evidence with her notes of a range of lifestyle questions being asked by her GP and that she engaged and answered these questions fully. These include questions such as smoking and alcohol intake. Whilst there is nothing specifically asked about home circumstances during this screening process there is evidence that when they moved surgeries to from Northamptonshire to Cambridgeshire they registered together and there are good notes relating to the couples' desire to be considered for IVF treatment. Given that there was no evidence or indeed indication of a domestically abusive relationship between them it is not inappropriate for no questions to have been asked by the GP in this case.

3.10.5 The records scrutinised include copies of letters relating to the couples attempts at IVF treatment in 2011 and 2012. There is strong evidence of good cooperation between the clinic working with the couple on their desire to have children and the mental health services treating Tom. Letters addressed to Sally detail all these issues and thus nothing is hidden from either during what turned out to be an unsuccessful regime of treatment.

3.11 Mental health care of Tom and their service involvement with Sally.

3.11.1 Tom's initial mental health care was provided by services in Oxford where he was seen from 2005 through to 2007.

3.11.2 His initial assessment in late 2005 diagnosed generalised anxiety with panic attacks and low mood. There was, at that time, no clear evidence of post-traumatic stress disorder (arising from the crash). He received six sessions of cognitive behavioural therapy and was discharged from the service in July 2006 with the service noting some significant reduction in his overall level of anxiety but some residual difficulties relating to self-confidence arising from long-standing issues not connected to his trauma. It was felt he had sufficient insight and skills to address these himself in his own time.

3.11.3 He contacted the service again in late July after experiencing paranoid feelings but was reassured by email. He contacted them again by email, this time from abroad, where Sally's sister was getting married. He was experiencing paranoia, having panic attacks and was agitated and suspicious of people. This appears to have worsened because he felt he was the only person who could not speak Chinese.

3.11.4 Tom was seen on his return to England and his condition had worsened significantly. He now had a social phobia and his concerns about work had led to what are described as catastrophic thoughts (suicidal). Because the Hospital service remit was to support acute neurosciences and because this was now thought to be a long-term condition it was recommended that he be referred to local mental health services. After a course of agreed treatment at the hospital he was then referred, urgently, by his GP to NHFT community mental health services in early 2007.

3.11.5 His initial assessment included his own concerns about how was unable to do the sports he used to do following the crash and how he had paranoid thoughts about people talking about him and wanting to harm him. A risk assessment took place as a result of which he was initially offered an outpatients appointment. A couple of days later he had deteriorated further and visited his GP again, this time with a

family member. Both are described as being 'desperate' about his mental health and the first mention is made of him becoming convinced that he had abused a young girl. He was seen the same day by a consultant psychiatrist. Had had given up his job in the family firm, was unmotivated and lacked energy and in the last two weeks had become convinced that he had sexually assaulted a young girl and had told his family so. By now he had embarked upon a medication regime which was increased as a result of this visit. The medication included some to help him sleep and in a risk assessment a couple of days later this appears to have had some success. The risk assessment notes that at that time he had no suicidal ideal or behaviour and no history of violent or impulsive behaviour. He was however, continuing to be obsessed with his ideas about harming a child in the past, was preoccupied that people were out to get him and had little motivation. He was living with his parents at the time.

3.11.6 At Tom's next appointment, the issue of his concerns of abusing a child were revisited. He said he felt unsafe in his own home, hence he was living with his parents. This was because he felt his neighbours thought he was a paedophile and therefore a threat. His feelings towards children were discussed further in detail. His diagnosis at this time was 'psychotic episode'. In effect, his concerns a delusion arising from his illness. No immediate risks to himself or others were noted and in particular the Doctor wrote "in particular I do not believe that (he) poses a risk to children".

3.11.7 For the next couple of months (March and April 2007) he was seen twice a week by mental health workers. By early April it was noted that his concerns about being a paedophile were receding and he was feeling more confident. He spoke about the possibility of moving with his girlfriend nearer to Cambridge where she worked.

3.11.8 Later in April 2007 he made an urgent request to be re-seen as he had heard a passer-by in the street use the word 'lunatic'. He had immediately thought it referred to him and thus his mood had dropped and his feelings of being a paedophile had returned. This consultation improved things and again a risk assessment noted no immediate risk to himself or others. He was then accepted onto the case load of a specialist service providing support for those entering the mental health care system for the first time and provided with a key worker and a consultant psychiatrist. He was seen once a week and by July 2007 it is noted that he is living with Sally again.

3.11.9 Individual psychology sessions began in August 2007 with work to help him deal with comments in social situations which trigger concerns about groups of people being out to get him. These feelings are linked back to his hospital stay following the motorcycle crash. A care coordinator was appointed in September 2007 who then worked with him until his discharge from the aforementioned specialist service in September 2012.

3.11.10 In October 2007 he started a masters degree but became so concerned that those at university thought he was a child abuser that he rang the Samaritans and had an urgent appointment the following day with his support team.

3.11.11 In November 2007 it became known for the first time that he had begun to reduce his medication himself. He complained of the side effects and changes were made to

his medication. He also talked about the individual psychology sessions providing an explanation for his beliefs about abusing a child but he struggled to accept it. In late 2007 and early 2008 it is known that Sally and Tom were attending 'Friends and family' sessions together and that the Sally was offered and accepted a carer's assessment.

3.11.12 By March 2008 he had again stopped taking some of his medication because he said it interfered with his sleep. He said he would start it again if his paranoia returned. In May he was due to be the best man at a friend's wedding. Work had been done with him to help him cope with stressors whilst out there. However, he called the service saying that was feeling paranoid and had dropped out of being the best man. He was advised to start taking his medication again.

3.11.13 Tom started a new job in late September 2008 but again his health plummeted. Sally called the service asking for him to be seen urgently. He was seen and was saying he had lost the will to live, was paranoid with his co-workers being out to kill him and had become obsessed with molesting a child again. He was seen and treated by the service during October and November, disclosed he had stopped taking some of his medication but maintained his low mood and his obsession with molestation and the need to be punished.

3.11.14 The consultant treating him explained very clearly that he did not activate the child protection procedures because he did not believe that Tom was a risk to children.

3.11.15 He was seen again whilst in this mood and now said he had suicidal thoughts of stabbing himself in the chest with a knife. He was concerned that there were no moves to put him on the sex offenders register. It was noted that there were social stressors present again as he was due to start a new job the following week.

3.11.16 It was at this meeting (November 2008) that he disclosed being concerned that his relationship with Sally was deteriorating because of his behaviour.

3.11.19 The November meeting led to him being seen by the Crisis Resolution Home Treatment Team because his circumstances had deteriorated. He was with them until December when he had recovered somewhat and reverted to his original support team. The service kept in contact with both Tom and Sally over the course of the next few months into 2009. The couple were spending more and more time together again as his condition improved and they talked about having children together.

3.11.20 In May 2009, the couple were seen together and offered 'couple's work'. It appears that both had concerns about the future of their relationship and agreed to some initial sessions.

3.11.21 At the first of these sessions Sally said that he had proposed to her after the motor cycle crash and that she had accepted; they had just never got round to it. She was more concerned with having children than actually getting married though.

3.11.22 In July 2009, the service became aware through a family member that Tom had attended a police station and asked to be arrested for molesting the child he had spoken about in his sessions previously. He was interviewed and subsequently

placed upon police bail until August of that year. The service engaged with the police; the police saying that he had disclosed he had not been taking his medication during the previous week. At the next session Tom appeared calm saying he was pleased that he had gone to the police as it meant he was facing up to what he had done.

(We are able to say that the police investigation did not result in any charges and a view that the incident did not occur).

3.11.23 Later in 2009 things appear to have been improving. By September the couple talked to services about moving forward with their marriage plans and potentially moving house closer to where the victim worked. There were monthly visits by the service during 2010 and things were generally much better.

3.11.24 Sally and Tom were married in July 2010.

3.11.25 In May 2011, a private fertility clinic wrote to Tom's community psychiatric nurse asking for details of any psychiatric treatment with regards to risks to any unborn child. The letter informed the trust that he had disclosed that he had told the clinic that he had medication and previously held delusions that he had abused a child in the past. This had been fully investigated by the police and found to be false. The Trust responded confirming his treatment for psychosis but stating there were no known factors that would deem him as a risk to the welfare of children, born or unborn.

3.11.26 On 11th June 2011, Sally contacted the Trust's Crisis Team to inform them that he had cut his wrists at home and had been taken to Leicester Royal Infirmary for treatment. This was a deliberate act of self-harm. He had made cuts that had severed tendons to his left arm, requiring surgery to repair. He had also cut his right wrists but to a less severe degree. Following the emergency treatment, he was admitted informally a psychiatric ward in Kettering. He was assessed and the triggers for the incident were noted as:

- seeing the fertility clinic four weeks earlier,
- grandmother's death, and,
- unemployment.

He said he was used to hearing voices but says he has learnt to ignore them. Sally had been working in Germany the previous week, returning on the Thursday. They had stayed up late on the Saturday night and he had snapped at her, then went upstairs about 23.30. He said this was triggered by messages from the television saying 'you might as well end it all', 'you are walking around with your head in the clouds'. He had locked the bathroom door but fell and hit his head after cutting himself, Sally heard and came to find out, then she applied first aid.

3.11.27 During his stay, he told staff he would kill himself if he had the chance. He was not taking any antidepressant or antipsychotic medication at the time. Tom's mood and mental state gradually settled and he agreed to medication by depot injection. At this stage he expressed regret for what he had put his family through and was no longer suicidal, and spoke of undertaking a PhD in the future.

3.11.28 On 24 June 2011 an initial summary was sent to Tom's GP. Some of the identifiable triggers were:

- they had been trying for a baby for the last five years, and during the last visit to the fertility clinic Tom had to complete a form asking him to declare any mental health or child protection issues.
- between 2007 and 2009 he was jobless, and was not in receipt of any benefits. His DLA and jobseekers allowances expired, and he didn't bother to renew them because he was planning to work.
- his grandmother died in February 2011, she was described as a great source of strength and inspiration. Tom said his grandfather had mental health issues, so he thinks the odds are against him and he will only get worse.
- his wife has a demanding job and works far from home. She is able to keep up the mortgage payments. No relationship problems were disclosed but there were enough problems to put a strain on things.

A diagnosis of schizophrenia was made, which Tom and his family found upsetting, and information on the diagnosis and treatment options was shared. After many leave periods Tom was discharged from the inpatient ward in August 2011. His hand had healed well and he was accepting depot medication, and felt much better. He did however complain of sexual dysfunction since the start of the depot. He was still on oral medication at this time, and this was being gradually reduced. At this time Sally was being seen monthly by the carer's support organisation, which she reported she found very helpful.

3.11.29 In early October 2011 Tom phoned services to say he had heard someone whistling at work and felt really uneasy. He was seen by his consultant psychiatrist and his CPN. He showed no signs of psychosis but had catastrophic thinking, which was thought may be early warning signs of relapse. Tom stated he could keep himself safe and had no intent and no plans to harm himself. It was noted that NSTEP were confident his family would be in touch if there were any difficulties, and the crisis plan was to contact key worker, or another member of NSTEP team. If unavailable, out of hours or in an emergency contact primary care services in the usual way or the Crisis and Telephone Support Service (CATSS) which is a 24 hour service.

3.11.30 In October and November 2011 Tom presented as mentally well and was seen monthly by NSTEP and to administer his depot. In mid-November, he complained of sexual dysfunction, with low mood and motivation. He did not express any suicidal ideas. A review meeting with Tom, Sally and his psychiatrist took place. It was agreed that he would have a lower dose of depot injection. He was seen fortnightly and by the end of January 2012 Tom reported that he felt less sedated, had no 'breakthrough' symptoms, felt well and was working near Cambridge.

3.11.31 In March 2012 Tom complained of a fine tremor after his depot injection and in May Sally and Tom asked if he could come off the depot injection. This was agreed at a meeting with them in June.

3.11.32 In July 2012 Sally called to say she was concerned that Tom was over-sedated, and he was tired and irritable, although not showing any signs of psychosis. Medication was discussed and changed slightly and he remained well and talked of moving to the Cambridge area with Sally and renting out their house, and that they were trying for IVF treatment.

At this time a possible referral to CMHT was discussed, and both Tom and Sally were noted to be in support of this.

3.11.33 Sally had started regular meetings with a carer support worker in September 2011 and was seeing her bi-monthly. At the time the carer support workers were allocated to individual CMHTs. In July 2012, the carer notes recorded that Sally said she was undergoing fertility treatment. There are monthly entries by the carer support worker, documenting her meetings with Sally, between September 2012 and November 2013.

3.11.34 By the end of September it was agreed with both Tom and Sally that his care would be moved to a local team.

3.11.35 An appointment was offered in November 2012, which was changed to 29 October 2012, and he was eventually seen for the first time in late January 2013. It is not clear what caused this delay. There are no notes of any handover meeting between the clinical teams, and it was clarified that there was no handover meeting. It was noted that he had a diagnosis of paranoid schizophrenia. Tom was seen with Sally, and they were concerned about side effects of medication because they had been trying to conceive and were about to undergo IVF treatment. Tom request that his medication be reduced, and a lengthy discussion about the risks of this was described. Sally in particular raised concerns that Tom tended to deteriorate very quickly and has harmed himself when experiencing auditory hallucinations. Tom did not describe any psychotic symptoms or any thoughts of self-harm or suicide. It was decided that he would be reviewed again in the April.

In late March 2013 it was noted by the service that Tom and Sally reported that they had gone through IVF treatment but it was not successful.

3.11.35 Tom and Sally were seen again in May 2013, and Tom reported that he had become more preoccupied with his thoughts and had been sleeping less, although he had no breakthrough psychotic symptoms.

3.11.36 Tom and Sally met again with services in June 2013. It was noted that Tom and Sally said they were in the process of moving to St Neots and they were requested to let the service know so that his care could be transferred to the local CMHT. At an appointment in September 2013 Tom described feeling less well, with a recurrence of some of his delusional beliefs in relation to believing that he may have done something to a child in the past. He was preoccupied with these beliefs. Tom was noted to say he had never experienced any hallucinations but had experienced delusions of reference where he believed the TV may be referring to him. Despite this, he was working full time. His medication was changed to help with the hallucinations. It was noted that they were about to register with a new GP surgery in St Neots, and to avoid his care becoming lost in transition, his psychiatrist agreed to see him again in November 2013. The stated intention was that the new surgery would be requested to refer Tom to the local community mental health team.

3.11.37 Tom and Sally both attended the appointment in November Tom and Sally and Tom described an improvement in the way he was feeling since the increased some of his medication. It was agreed that he could be discharged to the care of his new GP, with a view to a referral being made to the local CMHT if needed. No risks were elicited and he did not describe any thoughts of self-harm or suicide, and he was

noted to be compliant with medication with no reported side effects. A letter was sent to his new GP with this information.

3.11.38 On request from CPFT his psychiatrist wrote to CPFT's CRHTT psychiatrist in April 2014, to summarise the medication, and noted that Tom's mental health appeared stable at the last appointment in November 2013, and he had not described any thoughts of self-harm, nor did he describe any psychotic symptoms or any mood disorders.

3.12 Cambridgeshire and Peterborough NHS Foundation Trust 2013 - 2015

3.12.1 First CPFT contact.
A referral was made to CPFT Advice and Referral Centre (ARC) in March 2014, after Tom was seen at the GP's surgery with a family member. He had told the referring GP he had not taken medication for two or three months. He said he had been feeling more anxious, had auditory hallucinations, feeling that songs on the radio were directed at him, and was not sleeping well. He said he had no suicidal ideas. An urgent assessment was requested from ARC. This request was acknowledged within two hours, and allocated to the Crisis Resolution Home Treatment team (CRHTT). A CRHTT social worker called Tom. Tom said he's feeling much better this afternoon, mornings are worst. He agreed to go to the local service centre a few days later and was going home to his wife that afternoon and would be able to keep himself safe. A 'notification of assessment outcome' form was faxed to the GP surgery with a summary of the assessment conducted by a Community Psychiatric Nurse. Tom was noted to believe songs on the radio relate to him, his motivation and energy levels had decreased to the extent he was finding it difficult to get himself to work. He was not sleeping well and had gained weight. His mood was rated as 4 or 5 out of 10. He did not feel at risk to himself but was worried it might become an issue. It was noted that this may be more of a chronic condition rather than a crisis, and an extended review with the team doctor was planned late in March 2014, and the current plan was to see Tom on alternate days until then. Tom accepted CRHTT engagement. A referral to the Adult Locality Team (HALT) was made.

3.12.2 Subsequently, Tom was seen for an extended assessment by the CRHTT with Sally and another family member. He spoke about difficulties with his medication which in turn had led to some relationship difficulties and at one point Sally was considering leaving him. It was noted by the GP that Tom had made the decision to come off medication to try to tackle all these things, and had not told Sally this. The GP advised the lesson to be learned was to try and involve his medical team in decisions. Ongoing psychological issues were noted that needed addressing, with loss of self-confidence and self-worth. Tom said he had never had any psychological work, which was not actually true. No risks were expressed, and Sally challenged him about this but Tom was clear he had no intent to act on his fleeting suicidal thoughts. Tom was taken on for crisis support for anxiety management and daily planning. He was referred to HALT for ongoing support. His old notes were requested from Northants.

3.12.3 Tom was seen daily, and reported an increase in his ability to structure his day and motivate himself. Sally had been referred to a carers support group and was seeing a counsellor. By April 2014 Tom agreed he was no longer in crisis but would benefit from 'a more permanent support structure'. A referral to HALT had been made and

he was discharged from CRHTT care. Various contacts were made by Sally to say things were not too bad, and requesting the appointment be moved, then when rearranged for May, she cancelled again as they were going on holiday. The appointment was again rescheduled by Sally for May, and Sally said he 'wasn't too bad' and was working at present. Tom did not attend the rescheduled home visit in May, and when called he said things were a lot better, and asked for an appointment out of hours because he was working now. It was explained that HALT was a 9-5 service. Tom said he did not think he needed support from the HALT team now and said he would contact next week, Tom is noted to have said he has a good GP and his wife was supportive. His CPN noted a plan to discuss this with the HALT psychiatrist, and the plan after this discussion was to discuss with his GP with a view to transfer back to primary care as his mental state had improved.

3.12.4 The CPN called his surgery in June and it was agreed that Tom would be transferred back to primary care, with the understanding that he could be referred back to HALT via the CPFT Advice and Referral centre (ARC) if needed.

3.12.5 Second CPFT contact

A member of Tom's family called CRHTT in mid-September 2014, with concerns about him. She stated he had been doing really well, but had a call from him today. He was in Norwich with work, sounded vague and said he can't think. It was advised he would need to see his GP to be re-referred to the CRHTT, or Tom could go to A&E to be assessed. Sally also called CRHTT, and said she had been called by Tom, who sounded very anxious. The route for referral was explained, and Sally was noted to be not very happy as she thought he could be seen again by CRHTT without seeing his GP. A 5-day referral was subsequently received from his GP through ARC and was passed to his CPN, as it was noted that he still appeared 'open' to the HALT service.

3.12.6 An appointment was scheduled for September 2014. Sally called to ask if the appointment could be rescheduled as they were hoping to take some holiday, so it was rescheduled for October. Sally said he was very unwell again and she thought he had stopped taking his medication. Sally and Tom were seen together at the rearranged appointment in October, Tom reported a recent deterioration in his mental health having discontinued his medication. He said he had now restarted. He described recent low mood, anxiety and panic attacks. He believed songs on the radio referred to him, and feels low in mood and motivation. Sally said they were currently on a trial separation however said she still wanted to be supportive of Tom.

3.12.7 The next appointment was arranged for the beginning of November. Tom denied experiencing disturbing or paranoid thoughts, and said his mood tends to fluctuate, on bad days he finds no enjoyment in life and has no interest. His sleep was variable, he and Sally had been separated for a while and Tom was living with his parents. Sally was noted to be receiving counselling. There was no thought disorder elicited but Tom was noted to appear depressed and anxious. The impression noted was of a delusional disorder with depressive symptoms. There were no risks to himself expressed. He had stopped taking some of his medication. The plan was for Tom to be prescribed antidepressant medication, but Tom did not agree due to his reluctance to take medication. It was suggested they see a relate counsellor

together. He was reminded that if he had increased thoughts of self-harm or suicide he should contact HALT, or out of hours GP or A&E.

3.12.8 Tom was seen several times in December at his parents' house. Tom reported he had been feeling paranoid, and things were not good. He said he had started taking aripiprazole as well as risperidone to try to manage his mental health. Sally was going abroad to visit family over Christmas and he was unsure of the future of their relationship. He denied any thoughts of self-harm.

3.12.9 He was contacted by telephone towards the end of January 2015, he said he was 'fine' but was unable to talk as he was at work but would call back the following day. He did not call back. The service wrote to Tom in early February 2015, noting that it was a while since their last meeting, and offering him an appointment to review how he was doing. An appointment was offered for later that month.

3.12.10 A week later, the ARC had a call from a GP at Tom's surgery; it was reported that Tom had cut his wrist deeply, and this was dressed at the surgery. Apparently, Sally had persuaded him to attend the GP surgery and expressed concern that she could not keep him safe. The referral was made to ARC but it was noted he was 'open' to HALT. The ARC called Tom, who said he had not been sleeping properly, was anxious, feeling that history might be repeating itself and increasingly paranoid. He said he stopped aripiprazole because of weight gain & lowered motivation. Has a gym at home but was not using it. Tom's CPN spoke to Sally who reported a deterioration in Tom's mental state, and she said he had cut superficially which needed A&E attention over the weekend Tom also spoke to the CPN and said he was feeling very paranoid, ruminating on things from the past and his accident; he was unsure he could keep himself safe. He was moved to the 'red zone' and CRHTT were contacted to see him that day, with a follow up visit from the CPN by the Wednesday. CPFT have explained that the 'red zone' was an informal system within HALT (e.g. not trust wide) – which denoted the level of patient need/risk and input needed.

3.12.11 Tom was seen by the CRHTT in February 2015. Tom was difficult to engage and slow to communicate. He stated this was a suicide attempt, but something stopped him going through with it, and he was unable to get over the initial pain. He had a feeling that he had let someone down, had said too much about something that led him to the conclusion that he needed to end his life. He was not clear about how long he had felt this way, and unclear about whether he had resolved this issue, but was 'able to admit that he may have been beating himself up over something that was not based in reality.' Tom expressed regret for what he had done, mainly because of what it put his parents and Sally through. Tom said he did not believe he was depressed or low in mood, despite describing some of the classical symptoms of anhedonia: low energy, poor motivation, guilt, lack of future, feeling helpless and hopeless, having attempted suicide, anxiety and paranoia. He agreed after much discussion that there might be something that could help with this, he had some medication that was previously prescribed and he agreed to try this. Tom remained very concerned about possible side effects he had experienced before; weight gain, sedation and sexual dysfunction. He would not consider any change to his antipsychotic medication. The doctor's opinion was that there was an element of mourning the loss of his premorbid life and personality, and he was also experiencing the stress of his relationship not being stable, and guilt that he had let

his family down also. Tom said he had had some psychological input on the past but doesn't feel it would be helpful now. He did not feel this would be beneficial now, and needs to work so it would be hard to access. He spoke of work not being very sympathetic to mental illness. The doctor noted that he made sure Sally had an opportunity to speak up about her view points and concerns.

3.12.12 Tom was seen by a CRHTT nurse later in February, he declined to complete a safety plan and felt the crisis/contingency plan in his CPA care plan was sufficient. This plan was to distract himself from his thoughts by working on his computer or reading, as these are things he enjoys. He stated he will talk to his wife or go for a walk with her if he feels things deteriorating. Relapse indicators/warning signs were listed as: increase in anxiety, lack of sleep, lack of appetite, restlessness, and fidgeting, increased consumption of alcohol. The crisis numbers were all available. The contingency plan was to attend A&E, and/or call the emergency contact numbers. Tom was noted to be aware of the plan to transfer him back to HALT at the end of the week. Tom was seen also in February 2015 by a CRHTT staff nurse, he appeared flat but said he had no current thoughts to harm himself. He had not started the medication because he said he couldn't find the tablets, so a new prescription was provided. Tom had been back to work and been more active at his parents' house. Short term planning was discussed, along with the worry tree and information on unhelpful thinking. Tom was keen to meet a peer support worker to work on self-esteem. Sally's view as carer was ascertained, she said she had seen a small improvement, but agreed he seemed flat and low in mood. Sally's view was again sought at the next meeting with them and she said she felt he was still low but had improved slightly. Sally said they have been supporting each other and the focus is on supporting Tom, recognising that they will ultimately need to make a decision about the future of their relationship.

3.12.13 A number of further meetings took place during February and it was noted he was not expressing any risk to himself but has declined to look at this in greater detail in the framework of a safety plan. His risk was thought to be dependent on his mood, he has accepted antidepressant medication to tackle this for the first time, but the impact will need monitoring by his community team. Tom had agreed to alert the team if things felt different for him, and this would be followed up and the safety plan revisited. When next seen he said he gets up and goes to work which is a good thing, and he enjoys the work, which work takes him across the country. He said he feels down in the mornings, but was trying to do the best he can. Tom said the medication helps a bit, he was still having some paranoid thoughts but does challenge these thoughts to bring himself back to reality. How to manage his risks was discussed, Tom said he will call people to talk his worries through, and his family was a protective factor. He was encouraged to try to make a safety plan that could help when he is feeling impulsive and he said he would. Tom said he was taking the medication as prescribed. Carer support was discussed with Tom, in terms of how he thought Sally was coping. He was spending weekdays at his parents and weekends with Sally, they have been discussing whether they would split permanently but no decisions had been made. He said he doesn't think it is fair for her to cope with his illness, but things are easier for now as he is staying at his parents.

3.12.14 At a home visit in March 2015 Tom spoke of enjoying his job, reflecting that it was important to him to have a sense of purpose. He reflected on the effects of the motorbike accident in 2004, recognising it had had a huge effect on his mental

health. He reported that his mood had much improved, taking interest in things around him and being more active.

3.12.15 In early April Tom appears to have become more difficult to contact, a number of texts and telephone calls from CPFT seem to have been unanswered and when he did speak he seemed to want to change appointments because of an impending holiday. The couple met with CPFT for an appointment in early May. Tom reported his mental state had much improved, he said he feels almost back to his normal self, only occasionally struggling to motivate himself or leave the house, and has only missed a few days off work. He had no concerns about sleep or appetite and had a good level of energy, and said his mood had improved since starting on the medication. He was exercising regularly, and walking the dog. He had moved back to live with Sally and said he enjoys a good supportive relationship with her.

3.12.16 In early June further attempts to contact Tom by CPFT were unsuccessful but when he was eventually spoken to he reported that things were going well, and it was agreed that he would be discharged back to his GP.

3.12.17 An 'outpatient review' (discharge) letter was sent to Tom's GP in July, which appears to be the discharge letter. The letter summarised the last meeting in May 2015 and reiterated that Tom said he would talk to his wife if he feels that things are getting worse for him. It was stated they are both aware of the out of hours services available and that he can be 're-referred to our services via yourself'. This letter does not specify whether Tom and Sally were consulted and agreed with this plan.

3.13 Tom's GP contacts 2013 - 2015

3.13.1 Tom made initial contact with his new GP in November 2013, having registered in November. His history of self-harm and psychosis was noted, and the telephone contact was requested by the GP to clarify what psychiatric medication he was receiving. Tom phoned to clarify his medication. The GP noted these did not require any specific monitoring and issued the prescription.

3.13.2 As part of their surgery health checks Tom was seen in early January 2014 to discuss his BMI and blood pressure. Diet and exercise were discussed and it was noted he was discharged from his previous mental health team in Northants. Tom reported no side effects and was doing well, and it was noted he was aware of warning signs and symptoms, and to contact the GP if there was any recurrence.

3.13.3 Tom saw his GP with Sally in late February 2014 and said he had stopped taking some of his medication for the past two or three months as he felt it wasn't helping. He said he was not sleeping well. The GP noted he had last seen a psychiatrist in November 2013. It was noted that it was planned to go through the notes and refer him to a local psychiatrist, but there were no notes to record that this was done.

3.13.4 On 28 March 2014 Tom was seen with another family member, the history taken was that he had been under the care of a psychiatrist in Northants and had been discharged on medication, as his mood was stable. Tom said he had stopped some of the medication 2 weeks previously as it made him tired, and was also not taking another element regularly. Recently he had become more anxious, had auditory hallucinations, feels songs are directed to him, not sleeping well, but no active

suicide thoughts. It was planned to refer him through ARC, as the GP felt he needed urgent assessment. A referral to ARC was faxed that day, and in discussion with ARC it was agreed they would call that day. Subsequently the ARC staff asked if Tom's medication could be restarted but the 'GP did not feel confident to do this' and was concerned about potential risk, referring to previous suicide attempts. It was agreed he would be referred through ARC and assessed by CRHTT. The GP surgery continued to supply prescriptions with advice from CPFT services.

3.13.5 In June 2014 Tom's CPN called the surgery to inform them that Tom was unable to keep follow up appointments, that he felt well and that he and his wife agreed with the discharge. This was not followed by a discharge letter.

3.13.6 In September 2014 Tom was seen by a GP with Sally, he said he had stopped medication himself three months ago, and had failed to go for psychiatric follow up. He reported feeling low, for the past three months he had been hearing auditory hallucinations on the radio, he was not threatening, and not suicidal. The plan was for referral to ARC.

3.13.7 On 9 February 2015 Sally called the GP, very concerned about Tom's mental health. GP explained that she did not have permission to talk to Sally, but made an appointment for him later that day. Tom attended with Sally, and gave written permission for the GP to talk to her. He said some of his medications had been discontinued, and he never started taking one element that was suggested by the psychiatrist. He had become increasingly paranoid and depressed, and cut his wrist on Saturday night quite deeply. He bandaged it himself, didn't ask for help or let Sally know. Sally said he has never taken an overdose, he has always cut himself when suicidal. He didn't attend A&E, but had the wound dressed at the surgery. The GP examined the wound which was described as 'slightly deep over ulnar aspect, not bleeding but not cleaned, dried crusted blood, no signs of infection'. Tom appeared withdrawn and monosyllabic. The plan was to discuss with mental health services, for urgent evaluation tonight or in the morning. The GP suggested a specific course of medication that would be helpful, and gave them 12 tablets for Sally to supervise. Sally was advised to call 999 tonight if she felt Tom was unsafe. A five-day referral was initially sent by the GP to ARC, but it was picked up as an open case with HALT.

3.13.8 A routine 'mental health review' was carried out by a GP in July 2015. The notes record that Tom was seen with Sally and their continued plans to conceive were discussed, noting they had been trying for five years. A plan was put in place to help them with their desire for children.

3.13.9 On the morning of 21 August 2015 Tom attended the GP surgery with Sally. He reported ongoing problems with his mental health, and was "trying to avoid taking medication". He asked for a repeat prescription of a particular element. He said he had stopped taking one element eight weeks ago, of which Sally was unaware. Tom said he was not taking any medication, and felt paranoid and was very anxious. His past self-harm was noted, and that suicidal thoughts had been slow to build up in the past. Compliance was discussed with Sally; she said he had CBT and mindfulness in the past. Tom didn't think it was helpful but Sally was noted to think it would be a good investment. He asked for a repeat of lorazepam prescription but then said he had plenty for the weekend. The GP emphasised the need to take medication safely and sensibly. He agreed to take a new antidepressant.

3.13.10 On 26 August 2015 Tom attended an on-call GP with other family members. He was noted to have a long supportive chat, said he was unable to think and concentrate, couldn't work, was very anxious but didn't know why. He was regarded as not fit for work and was signed off with a medical certificate until 2 September 2015. The diagnosis noted was 'stress related problems'.

3.13.11 On 28 August Tom attended the GP surgery again with Sally, saying he was paranoid and wanted medication. The impression noted was that this was work related stress; he discussed work, saying he has to travel and work away for weeks at a time, staying in guest houses so very isolating. He also said he hasn't been taking his medication whilst away. He said he had fleeting ideas of suicide but no plans. On examination he was slow to answer questions but also restless.

3.13.12 The agreed plan was that he would take renewed medication, and a prescription was issued. If things escalated at the weekend Sally agreed to contact the out of hours service. It was also planned to send a fax to Tom's CPN to ask for review/support. The fax was sent addressed to CPN at HALT with the title 'for urgent attention please' and made reference to Tom having relapsed due to not taking his medication, and requesting that CPN review him urgently.

Section 4 - Analysis of agency involvement; their responses and the responses of others.

Friends, family, non-statutory agencies

4.1 The chronology set out at Section 2 details how the information known to agencies evolved. Section 3.1 summaries the totality of the information known by those agencies and others with influence during the years leading up to the deaths. The detailed chronology will not be repeated here; rather this section will provide an analysis of agency involvement.

4.2 The information within Section 2 of this report (that which was known to family and friends) demonstrates clearly that Sally had no fear for her own safety at the hands of Tom. When concerns were pointed out to her by those to whom she was very close, she rebuked them. Given everything that has been learned about what she disclosed to her closest confidants, one comes to the conclusion that she genuinely did not feel at risk.

4.3 There is no evidence or information to suggest that any prior threats, intimidation or violence existed within the couple's relationship.

4.4 Some of her closest friends feel that Tom's behaviour was controlling, and one friend feels it was intentionally controlling. These are views that are honestly held arising out of personal interaction, personal experience and an interpretation of Tom's behaviour as told to them by Sally.

4.5 This Review has considered those views in light of the totality of the information known to a variety of individuals and across a range of agencies. It has considered whether Tom's behaviour fell into a pattern of coercive and controlling behaviour as defined within Section 76, Serious Crime Act 2015. On balance, it feels that whilst some elements of behaviour could be interpreted in that way, the Review does not have sufficient information to say that Tom coerced and controlled Sally in a way which would place their relationship into one that could be deemed as domestically abusive.

4.6 None of the above should be taken in any way as to diminish the difficulties they faced together and the turmoil and desperation that Sally felt in balancing her love for Tom and the effect upon her arising from managing his illness.

4.7 Certainly, none of their friends or family should reproach themselves for not having done more, or having done things differently. Those who had concerns raised them with Sally and made it clear they were there to help in any way at any time if needed. Others tried to help the couple with work, time and effort.

Health Services

4.8 The independent NHS investigation has looked in great detail at very health specific aspects of Tom's care. The entirety of their deliberations and recommendations and conclusions are not repeated here however this Review is concerned with some aspects of health care; that which can assist the Review in understanding any contributory factors leading to this horrendous incident. There are some areas of

care though that demand commentary; in particular those where risks could reasonably have been expected to exist. Those include:

- **the transfer arrangements of Tom's care from Northamptonshire to Cambridgeshire services,**
- **the difference in treatment approaches clearly identified between Cambridgeshire and Peterborough services,**
- **the care and support offered to the couple as a couple,**
- **the identification and understanding of risk that might exist to Tom and/or Sally**

4.9 What can be apparent even from the list above is that the couple's decision to move from Northamptonshire to Cambridgeshire had the capacity to destabilise Tom's care and that potentially increased the risk of relapse. Certainly, this was something that was not lost on Northamptonshire services and there are a number of references within their documents to show that they wanted to make efforts to ensure appropriate continuity of care.

4.10 The term 'destabilise' is, of course, relative. It is not the case that Tom was completely stable whilst under the care of Northamptonshire and that changed under the different regime of Cambridgeshire. He was prone to episodes of severe illness whilst in Northamptonshire and made what appears a serious attempt at suicide whilst under their care. However, the change of GP, change of service provider with different key workers, changes in medication and treatment and changes to a way of working with services that the couple had become accustomed to all increased the risk of serious relapse.

4.11 Reviews such as this need to ensure that services are fully aware of the increased risk when circumstances change from what individuals had come to consider as the norm.

4.12 Before moving on to the specific points of consideration outlined above this Review will firstly consider the general care provided to Tom and Sally and some specific issues contained therein.

4.13 The first referral for mental health care was instigated by the Hospital that treated him following the motorcycle crash, he was referred to a consultant clinical neuropsychologist at that hospital.

4.14 It seems to this Review that the care and treatment provided by mental health services at that time was appropriate to the circumstances that presented at the then. A view was formed that Tom's immediate psychological reaction to his injuries was best treated by a serious of cognitive behavioural therapy sessions. These were completed, and he was discharged on the basis that it was felt he had the capacity to deal with some residual issues of self-confidence that were longer standing. There is good evidence that the service kept its 'door open' for Tom and that Tom knew where to turn for help in the months immediately after his discharge as he called from abroad and returned for further sessions when acutely stressed. The service came to a conclusion that he had by then developed longer term issues that needed specialist local care.

4.15 The NHS Review states that there was good continuity of care in contacting the GP in Northamptonshire and handing over thoroughly.

4.16 The initial referral to the Community Mental Health Team (CMHT) by the GP was acted on quickly. Tom was seen for assessment and then referred to the Crisis Home Treatment Team (CRHTT). This assessment was escalated when it became apparent that there was a need to prescribe medication. Tom's care was held by the CMHT until the NSTEP assessment was completed, and he was seen regularly.

4.17 The expected period of care with NSTEP is three years and Tom was treated for five years from April 2007 to 2012. While this may well have been clinically appropriate, there is no evidence of a documented considered reason for this. At interview with the psychologist who worked with him in 2011, it was acknowledged that there were some internal challenges about discharge, particularly related to Tom's serious self-harm incident in 2011. The usual length of care period at that time was said to be three to four years.

4.18 The detailed information contained both within this Review and the NHS Independent Investigation shows how Tom's illness progressed, how his symptoms changed and the efforts made to manage it by all involved. Northamptonshire services actively involved Sally and other members of Tom's family in his care and the evidence of their efforts adequately reflects the very challenging nature of managing such illness.

4.19 The issue of Tom's delusional belief that he had molested a young female child and the Trust's management of it requires special mention. Tom first mentioned his belief that he was a paedophile in February 2007 and his belief continued and became what can only be described as an obsession until he presented himself for arrest in June 2009. As Tom's obsession grew so did the amount of very specific information he gave about the specific incident that was troubling him. The doctor treating Tom made the decision not to invoke child protection procedures taking the view that Tom was not a risk to children and that his beliefs were a symptom of his illness. This was a huge call to make. There is no evidence that the doctor liaised with other professionals over this decision.

4.20 In time, the doctor has been shown to have held the correct view but he/she took a huge responsibility upon their own shoulders by making that decision. One accepts that the events began over 10 years ago and one would hope that all Trusts would now ensure that clinical staff record meticulously the thought processes that lead them to decisions in any cases where there may be safeguarding issues. This Review does not criticise that clinician for making that decision at the time, however where such specific information exists about such potentially serious issues one would now expect a multi-disciplinary professionals' discussion to triangulate information ensuring as near as possible the absence of risk to the vulnerable.

4.21 In this case, the most stable period of Tom and Sally's relationship appears to have come after Tom had asked to be arrested and after that police investigation cleared him of any wrong-doing. When one looks at the progression of those beliefs it appears that nothing was going to dissuade him until that eventuality happened.

4.22 There is good evidence throughout the Review of the involvement of Sally and other members of Tom's family in his care and treatment. This Review has considered whether there was an over-reliance upon them and Tom to recognise the symptoms of his downwards spirals and make the necessary calls to services. Put at its most simplistic, Tom was not someone who was open about his condition until the symptoms of a further period of downturn were apparent. By then it was often the case that he had stopped taking some parts, or indeed all, of his medication and had this hidden this from all of those caring for him, professionals and loved ones alike.

4.23 His attempted suicide in 2011 and his further self-harm in February 2015 appeared to happen in just such circumstances. The issue central to this is who is responsible for ensuring that a person is concordant with their prescribed medication? It is clear that Tom had capacity to make his own decisions in relation to his medication. It appears that he was prone to avoiding some or all of his medication. Some of this was because of the side effects he felt he was experiencing that was affecting his relationship with Sally in a variety of ways; some of it may have been because of a malaise he felt simply because of his illness. In any event, being non-concordant with his medication resulted in episodes of crisis and almost all those episodes of crisis ended up being referred by his loved ones. It does seem optimistic therefore in this case to have expected Tom to be the one who would act upon concerns when he felt things were going bad, sometimes he did but was unreliable in this respect.

4.24 There is good evidence that services maintained contact with Tom, especially during times of crisis, that contact moved to a more routine level once he was risk-assessed as being out of crisis. There is no evidence that services did not maintain contact, both Northamptonshire and Cambridgeshire kept up visits and telephone contact but they were of course reliant upon what they were told by Tom. Perhaps the severity of his suicide attempt in 2011 became slightly diluted with the passage of time but there had been a period of relative stability during 2010 and 2011 and again thereafter.

4.25 When Sally contacted the GP surgery in Cambridgeshire in February 2015 with concerns about Tom she was told they could not discuss his treatment with her. She may have been frustrated at this response having been involved so substantially in all his previous care over the previous 10 years and having attended appointments with him at that very surgery. She was however told that Tom needed to make contact with them direct, which he did later that day and the issue was resolved.

4.26 As set out earlier within this section; this Review has considered the elements set out below for special scrutiny as they had the capacity to be areas where risk was increased:

4.27 The transfer arrangements of Tom's care from Northamptonshire to Cambridgeshire services.

4.28 Earlier within this section we about the how the couples move from Northamptonshire to Cambridgeshire had the capacity to destabilise Tom and thus increase the risk of serious incident involving Tom (however, one has to say at that point it is reasonable to suggest 'serious incident' would be self-harm or suicide by Tom and not harm to Sally).

4.29 Northamptonshire services (NHFT) clearly recognised this and there are several references to the psychiatrist responsible for Tom's care being alert to it and a desire for a specialist service to specialist service discussion. In the event this discussion did not take place. However, the psychiatrist took care not to discharge Tom until such a time as the new GP in Cambridgeshire had been identified. This is in fact what happened. The psychiatrists view was that he expected the new GP to refer Tom to secondary specialist mental health service upon receipt of his discharge letter. The NHS Independent Review has examined the letter and it does not specifically mention such a referral.

4.30 In their IMR for this Review NHFT recognise this point and identify it as a lesson learnt in that

- "(Tom) was discharged from CMHT to the care of his GP at the point at which he moved to Cambridgeshire. The author found that it would have been best practice to refer TA to secondary mental health services in Cambridgeshire, to support (Tom) in the transition when moving from one county to another."

They further make a recommendation as follows:

- To support best practice, a patient should always be referred on to secondary mental health services when they move to another county.

4.31 Whilst this Review acknowledges and supports their stance it has to be remembered that in this case Tom was thought as suitable for discharge to primary care services and had he not moved areas the discharge to a local GP would have been carried out by way of discharge letter. The complication here was that he was moving areas and because he was suitable for discharge dialogue between services was unnecessary because he was not going to be referred immediately into secondary mental health services upon transfer as he was deemed suitable for primary care. If the doctor in Northamptonshire had not thought he was suitable for discharge then it would be right that service to service contact took place; he did not.

4.32 It seems to this Review that there was an element of Northamptonshire staff being slightly nervous or unsure about his discharge, otherwise why would they have retained him in services for as long as they did. Perhaps if they were anything less than sure then the lesson is to retain in treatment, accepting that services are finite and thresholds have to be used to ensure effective and efficient service provision for all.

4.33 Northamptonshire's recognition that increased risk to Tom existed because of the couples move between counties was right. We support the services recommendation to refer to secondary mental health services when a patient moves to another county; the issue for services to determine is cases such as this is when a 'patient' ceases to become a patient.

4.34 It must be noted at this point that none of the information available to Northamptonshire services throughout their involvement with Tom and Sally led them to identify that any risk of harm was posed to Sally. The relationship work they did with them both and the carers services they provided for Sally were entirely appropriate and show a good understanding of the wider issues affecting the couple.

4.35 The difference in treatment approaches clearly identified between Cambridgeshire and Peterborough services.

4.36 The move to Cambridgeshire with a new GP and subsequently new mental health service providers was always likely to be difficult for the couple. When what appears to be a very different way of working is added in to that equation then those difficulties, and therefore the risk, is amplified.

4.37 In general terms, Northamptonshire (NHFT) kept Tom within their service for several years, Cambridgeshire (CPFT) felt it appropriate for short periods of treatment when in crisis and recovery followed by discharge back to primary care.

4.38 The NHS independent review has looked at this element in depth and takes a view that Northamptonshire perhaps kept him in treatment for longer than would normally be expected and that Cambridgeshire services dealt well with Tom's crisis episodes but did not perhaps take a longer-term view of his treatment.

4.39 The NHS review states:

"Tom's mental health care in NHFT began in 2007 and was his first diagnosed episode of psychosis. He was diagnosed initially with delusional disorder in 2007, schizophrenia in 2011 and this was changed to delusional disorder in 2013. The change to delusional disorder was explained at interview with the East Northants CMHT psychiatrist; that is based on the absence of a disintegration of personality such as would normally be seen in patients with a diagnosis of schizophrenia. He had an inpatient admission in 2011, and was subsequently treated as an outpatient only, not on CPA, from September 2012.

Tom's consultant psychiatrist at East Northants CMHT said at interview that he tried to ensure that the GP registration was established, and requested that Tom's notes were transferred, so that the new GP had the records before Tom's discharge from NHFT. The new GP practice has no record of when the information arrived from the previous GP.

The implication (although it is not explicitly stated) from the discharge letter in November 2013 was that he would have expected the GP to make a referral to secondary mental health services. Although there was a routine double appointment made by the GP after his registration in January 2014, a referral to secondary mental health services did not happen until the crisis presentation in March 2014.

There is a marked contrast between the treatment Tom received in NHFT and in CPFT. CPFT assessed Tom in crisis on three separate occasions, March 2014, September 2014 and February 2015. The GP saw him in crisis again in August 2015 just before the homicide, and intended to make a referral to secondary mental health services. Tom was discharged on three separate occasions by CPFT services (albeit for one discharge the administration was not completed).

I consider that Tom's pattern of being non-compliant with medication, and lack of engagement with ongoing care should have triggered a more detailed discussion by CPFT mental health services, where this could have been discussed and treatment options considered.

He had a clear history of a serious and enduring mental illness, which had previously been relatively well maintained by outpatient supervision by a community psychiatrist, He did not engage well with CPFT services, and did not comply with treatment offered, which suggests that CPFT should have taken a proactive longer-term view, rather than focussing on short term management.

There was however no history of violence to others, and no suggestion of any violence towards his wife prior to the homicide. "

4.40 In summary, two different NHS Trusts dealt with Tom in the two different ways. There was nothing wrong with either approach and clinicians in both services clearly dealt with Tom in a way they felt was suitable to his presentation at the time. However, those differences in themselves were enough to increase the risk of relapse and thus harm (self-harm) because it was a way of working which was alien to both Tom and Sally. This would be more concerning had there been no service to service contact at all and they each dealt with him in isolation. That is not the case as in April 2014, after Tom's first referral in Cambridgeshire, there was contact and thus a more rounded view of his condition must have been formed.

4.41 The issue of the three GP appointments in the days leading up to the incident are scrutinised in detail within the NHS Review. It looks in particular at the appointment on the day before the incident and says that here is a detailed discussion of the actions of the GP after the consultation on 28 August in faxing a referral to HALT after seeing Tom and Sally. The GP appears to have assumed that as Tom had been seen by HALT before, a rereferral could be done by fax, instead of the accepted practice; which is to make all secondary mental health care referrals through ARC. The GP had said in interview for the CPFT internal report that a discharge letter stated he could be re-referred if needed. The relevant discharge letter written by CPN dated 14 July 2015 includes the line 'can be re-referred to our services via yourself'.

4.42 The degree of 'urgency' of the fax and hence the referral is noted as a possible missed opportunity. The weekend of the incident was a bank holiday and in all the circumstances the offer of an appointment was likely to come after the bank holiday, however it is felt that there was a missed opportunity for a phone call at least to have been made to Tom and Sally. One cannot say whether that would have made any difference to the outcome at all.

4.43 This is the third review undertaken by this Chair where the issue of the terminology used by GPs when requesting mental health services by fax has caused confusion. Absolute clarity is needed by all for the use of common terms such as 'urgent', 'immediate', 'routine' and 'priority'. Such continuing confusion means that those in need of urgent care may be missing out because of a simple difference of opinion over language.

Recommendation 3
That CPFT and the CCG work together to ensure that all GP surgeries have absolute clarity over referral routes and the terminology to be used when prioritising cases.

4.44 The NHS Review also identified the fact that there is no standard way in which GP surgeries review notes of those transferred into their care from secondary mental health services and we agree with their recommendation that Cambridgeshire and Peterborough Clinical Commissioning Group should implement a set of standards for reviewing the notes when a new patient with a secondary mental health history is accepted at a GP surgery.

4.45 The care and support offered to the couple as a couple

4.46 There is strong evidence that services understood the key role played by families and loved ones in relation to their mental health. The NHS England review makes the following observation:
"Both saw Sally as key to Tom's care and she was included in decision making and both undertook carers assessment. She was provided carer support counselling and there was good handover between the two services".

4.47 They received five joint psychology sessions by two psychologists in Northamptonshire where it states they were a private couple with low conflict who didn't argue. There was no evidence of any domestic violence or coercion and Sally was happy to challenge Tom. Five sessions is shorter than the recommended number of ten, however these were finished at Tom and Sally's request as they were feeling better and had wedding plans in place.

4.48 The NHS Independent Review states: "Sally received consistent regular carer support during Tom's treatment by both NHFT and CPFT". This Review agrees with that view. The continuity of care, through the carer's support service provided to Sally was something that she was clearly thankful of and she talked openly to them about the problems that they were facing. Both spoke of their concerns about the effect of Tom's illness upon their relationship but at no time was there any suggestion of abuse within the relationship that services could reasonably have been expected to identify; perhaps because there was none.

4.49 Whether Tom failed to take his medication at times in order to influence Sally into staying with him is something that we have considered and something that certainly some of her friends feel was the case; she, however, did not. This Review cannot and will not come to a conclusion about that but it was not something that was voiced with services.

4.50 The identification and understanding of risk that might exist to Tom and/or Sally.

4.51 Central, of course, to this Review is whether the risk of what happened in this tragic event could reasonably have been prevented. There is ample evidence throughout of the difficulties presented to professional's dealing with the type of illness suffered by Tom. It was a chronic illness, at times acute and in need of crisis care, but also for some lengthy periods his condition was stable and he was living what appeared to be a 'normal' life.

4.52 This Review has considered the work contained within the most recent publication by the **National Confidential Inquiry into Suicide and Homicide by people with mental illness (Suicide data 2004 -14).** It has considered this in terms of the death of Sally but also the potential for suicide by Tom.

4.53 It has also considered the work contained with **Domestic Abuse, Homicide and Gender**[3] in particular relating to the protective factors which place victims most at risk of violence.

[3] Domestic Abuse, Homicide and Gender; Monkton-Smith and Williams, 2014

4.54 Whether Sally's death could have been foreseen is not something that is easily transparent in this case. These Reviews, by their very nature, are held with the benefit of hindsight and with all the facts laid out before it. It is right that we should look at whether the totality of that information, if known, could have prevented the tragedy.

4.55 This review has discussed previously an emerging 'pattern' of Tom's non-concordance with medication at times of social stress and it seems reasonable to consider whether his condition may have been better managed by way of 'depot' injection, thus removing the need for Tom to self-medicate. There is ample evidence that this was tried by services in Northamptonshire but was stopped because consent was withdrawn by Tom with Sally's knowledge. It seems there were a number of joint discussions, over a number of years, about the nature and type of medication used and that both Tom and Sally were aware of the dangers of changing medication regimes and the effect of non-concordance.

4.56 It must be said that Tom has to take the larger part of the responsibility for not taking his medication. He had ample experience of the effect it had but chose not to tell those even closest to him to that he was struggling, often until it was too late and he was in crisis. This is said in the knowledge that he was ill and that the illness would have had some effect upon his decision making.

4.57 There is substantial evidence that services treating Tom assessed the risk of self-harm in the light of his condition as presented at the time and the support network he had around him. His attempted suicide and other self-harm injuries occurred at time of crisis; there were many more times of crisis where he did not injure himself and was supported through by a combination of services and loved ones.

4.58 In the days immediately preceding the final incident he was not considered so acutely ill that he needed immediate 'section' under the mental health act and the presence of Sally, a constant in his life for many years and who understood his condition and symptoms better than anyone else, was a considered rightly as a mitigating factor.

4.59 The review of suicides by patients with mental health (2004 -14) indicates four factors that have emerged as the most prevalent pre-cursers to suicide:

- Isolation
- Economic disadvantage
- Alcohol and drug dependency
- Recent self-harm

4.60 In this case, **none** appear immediately to be in place at the time of the incident **unless** a conversation did take place that night (the possibility of which is alluded to earlier within this report) about Sally leaving Tom. If it did, then all of the factors, save for alcohol and drug dependency, had the capacity to be present. We will never know.

4.61 Perhaps rather surprisingly in only 13% of patient suicides was the non-adherence with medication in the month before death an issue. To put this into

numerical context, there is an average of 1266 patient suicides per-year with an average of 152 of those being by people who were non-adherent with their medication.

4.62 Given all of the assessments, medication and support, it would still perhaps have not been a complete surprise had Tom made another attempt at his own life at some stage. Had he done so those supporting him, professionals and loved ones, would undoubtedly have looked at whether they could have done more or done things differently however it is difficult to see what more could have been done.

4.63 If this Review adopts the position above in relation to a possible suicide by Tom, it does not find that there were any indicators, subject to the caveats set out below, where Sally's death at the hands of Tom could reasonably have been predicted or prevented.

4.64 As has been stated throughout this report there were no prior issues of violence between the couple that had been brought to the attention of anyone, friends, family or professionals. Sally's attitude to all, even with her closest confidants, is that Tom would never hurt her; she seemed to genuinely believe this.

4.65 Statistically, there are on average 60 homicides a year by patients with mental ill health in England. Just over half of those patients had a history of prior self-harm and the largest contributory diagnosis was schizophrenia coupled with delusional disorder. However, the persons spouse or partner was the victim in only around 19% of those homicides.

4.66 It would seem therefore, from all the evidence that was laid before professionals in this case; from an analysis of over 10 years of homicides involving people with mental illness and that which was learned during the police investigation from Tom (and the severity of the incident itself), that nothing suggested Sally was at risk from Tom and therefore this incident was a simply unexpected tragedy.

4.67 The only caveat to this however, would be if Sally had made the decision to leave Tom and had voiced that to him that night; it is an established fact that victims are at the most risk at the point of having made that decision to leave.

Police involvement

4.69 There was little police involvement prior to the incident resulting in Sally's death. The incident where Tom had presented himself for arrest in 2009 seems to have been dealt with thoroughly and sympathetically and shows good liaison between police health staff. The use of the 'marker' system on the police national computer is helpful and was appropriately used in this case.

4.70 Police recognise within their IMR that work in cases where domestic abuse may have been a contributing factor in a death may benefit from a dedicated officer supporting the perpetrators family. This Review agrees with that stance and feel it is helpful.

4.71 Subsequent to their IMR Cambridgeshire Police helpfully submitted to the Review a summary of the work they are doing to ensure those suffering mental ill health are appropriately dealt with by criminal justice agencies.

4.72 The scheme is set out as an appendix to this report. It is described as follows:

4.73 In March 2016 an Integrated Mental Health Team Joint Procudure (IMHT) was implemented by the Cambridgeshire Constabulary for the delivery of a mental health triage service in partnership with Cambridgeshire and Peterborough NHS Foundation Trust (CPFT).

4.74 Funded largely by the Cambridgeshire Office of the Police and Crime Commissioner, with additional funding from Peterborough City Council, the practise commenced on 21st March 2016 and is funded for a period of 12 months.

4.73 Its objectives are as follows:

4.74 To ensure someone in crisis receives the right care at the right time and from the right service, at the first point of asking.

4.75 One in four people will experience a mental health problem. For the police, this will mean that of the victims, suspects and witnesses they deal with on a daily basis, a number are likely to be experiencing mental health difficulties. The police may be the first professionals to respond the scene of a person experiencing a mental health crisis and therefore assisting police officers to be able to identify this occurring from that first point of contact - and getting the person the right care - can play a critical role in improving the outcome and diverting care away from the police to the appropriate professional support.

4.76 The objective is to provide an improved response to persons in crisis and reduce the time spent dealing with incidents by supplying a better informed initial assessment. It also offers both police officers and mental health service staff the opportunity to benefit from cross over training, spotting early warning signs and to develop an understanding of the challenges faced by each agency.

4.77 The most appropriate response will be arrived upon through a screening assessment to determine future support in order to resolve the crisis, preferably in the person's own home or community. Any alternative framework of treatment and care should come within the scope of an assessment of need (s47 NHS and Community Care Act 1990). The option of safe and effective short-term care, support and treatment will be at the heart of all decisions made regarding any follow up care that may be required. Clear information will be provided to inform access to alternative solutions to meeting the mental health crisis.

4.78 This scheme, demonstrates good joint working between police, police and crime commissioner, local authority and NHS services and should be welcomed.

Section 5 – Conclusions and recommendations

5.1 This was a truly tragic case which has resulted in the death of a young women, Sally, killed by the person she loved and had cared for over many years, Tom.

5.2 Incidents such as these damage so many lives; those who are left understandably want answers as to why it happened and if it could have been prevented.

5.3 This Review and the associated NHS Independent Review have looked in detail at the totality of the information that was known across agencies and by family, friends and work colleagues in the years, months and weeks leading up to the incident.

5.4 Even with the cumulation of all that information, and whilst an incident resulting in Tom seriously injuring himself or taking his own life may not have come as a surprise, the attack by Tom on Sally remains sudden and unexpected tragic event.

5.5 Some of Sally's friends may feel that this was an incident waiting to happen but that is not what the totality of the information suggests. Certainly, Sally appeared to genuinely not fear for herself at all.

5.6 Incidents such as this have to aid the national understanding of the risk posed by those who are mentally ill to both themselves and others.

5.7 Lessons learned and our consolidated recommendations:

5.8 This Review must add to the local and national learning that exists to demonstrate the difficulties encountered in managing mental illness. Those difficulties exist for the person suffering the illness, those who love and look after them, and those professionals who are charged with their care. That learning has to include the fact that at times of stress and anxiety people will do hitherto unexpected and at times unimaginable things that can end in tragedy.

5.9 Statistically, those with a history of self-harm are not prone to turn that upon their loved ones, however, this case will add to the statistics of those that have. There is an old saying that people often hurt those they love the most; that may well have been the case here and all those involved in care should remember that.

5.10 As with all Reviews there are issues where things could have been done differently. The lack of understanding and perhaps the status of DHRs amongst the GPs in this case delayed its completion; this needs rectifying. The families of those responsible for such incidents can often feel excluded from the process from an early stage through no fault of their own and the police could consider this during the early stages of their investigations. Finally, referral routes to specialist mental health services really do need to be clear an unambiguous for the benefit of all involved.

5.11 This Review has identified the following three recommendations arising from the lessons learned in this case to improve services and protect the vulnerable within Cambridgeshire. These recommendations should be progressed by the CSP through Cambridgeshire's multi-agency Domestic Abuse and Sexual Violence Delivery Board. The NHS Independent investigation will suggest a number of clinical recommendations for the health professionals arising from their scrutiny. We have

chosen not to duplicate them within the body of this report as the routes for publication are very different and we believe the recommendations arising from the DHR are those set out below.

Recommendation 1
That the Cambridgeshire and Peterborough CCG ensure that commissioned GP Surgeries are aware of DHRs, their responsibilities to engage with them and the statutory guidance that governs their conduct.

Recommendation 2
That in cases where a homicide occurs and the perpetrator and victim are in an intimate relationship that police consider a dedicated point of contact for the perpetrators family as well as the victims.

Recommendation 3
That CPFT and the CCG work together to ensure that all GP surgeries have absolute clarity over referral routes and the terminology to be used when prioritising cases.

Multi-agency Action Plan

RECOMMENDATION	Scope of Recommendation	Action to be taken	Lead Agency	Key milestones to enact recommendation	Target date	Progress indicator	Date of completion and outcome
What is the over-arching recommendation?	Local, regional or national level?	How relevant agency will make this recommendation happen? What actions need to occur?			From date of report.	Red Amber Green	
Recommendation 1 **That the Cambridgeshire and Peterborough CCG ensure that commissioned GP Surgeries are aware of DHRs,their responsibilities to engage with them and the statutory guidance that governs their conduct.**	Local	Communication to all commissioned GP surgeries and inclusion in all contracts	Cambridgeshire and Peterborough CCG		3 months		
Recommendation 2 **That in cases where a homicide occurs and the perpetrator and victim are in an intimate relationship that police consider a dedicated point of contact for the perpetrators family as well as the**	Local	Agreement through Major Incident Command	Police		3 months		

victims.							
Recommendation 3. That CPFT and the CCG work together to ensure that all GP surgeries have absolute clarity over referral routes and the terminology to be used when prioritising cases.	Local	Review existing current protocols for GP referral to mental health services Develop and agree language used for level of immediacy of referral and assessment Ensure clear and effective processes are in place for communicating referrals, level of concern and outcomes	MH Trust CCG				

Appendix A

Terms of Reference for the Domestic Homicide Review into the death of 'Sally'.

1. Introduction

1.1 This Domestic Homicide Review (DHR) is commissioned by the Huntingdonshire District Community Safety Partnership (HCSP) in response to the death of Sally in August 2015.

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

1.3 The Chair of the HSCP has appointed Mr Gary Goose to undertake the role of Independent Chair and Overview Author for the purposes of this review. Mr Goose is not employed by, or otherwise has any conflicting interest with, any of the statutory or voluntary agencies involved in the review.

2. Purpose of the review

The purpose of the review is to:

2.1 Establish the facts that led to the incident in August 2015 and whether there are any lessons to be learned from the case about the way in which local professionals and agencies worked together to safeguard the family.

2.2 Identify what those lessons are, how they will be acted upon and what is expected to change as a result.

2.3 Establish whether the agencies or inter agency responses were appropriate leading up to and at the time of the incident in August 2015: suggesting changes and/or identifying good practice where appropriate.

2.4 Establish whether agencies have appropriate policies and procedures to respond to domestic abuse and to recommend any changes as a result of the review process.

3. The review process

3.1 The review will follow the Statutory Guidance for Domestic Homicide Reviews under the Domestic Violence, Crime and Victims Act 2004 (revised 2013).

3.2 This review will be cognisant of, and consult with, any on-going criminal justice investigation and the process of inquest held by HM Coroner.

3.3 The review will liaise with other parallel processes that are on-going or imminent in relation to this incident in order that there is appropriate sharing of learning.

3.4 Domestic Homicide Reviews are not inquiries into how the victim died or who is culpable. That is a matter for coroners and criminal courts.

4. Scope of the review

The review will:

4.1 Seek to establish whether the events in August 2015 could have been reasonably predicted or prevented.

4.2 Consider the period from 1st January 2004 to the time of the incident resulting in the death. This period commences the start of the calendar year prior to 'Toms' motorcycle accident. It is subject to any information emerging that prompts a review of any earlier incidents or events that are relevant.

4.3 Request Individual Management Reviews by each of the agencies defined in Section 9 of The Act and invite responses from any other relevant agencies, groups or individuals identified through the process of the review.

4.4 Seek the involvement of family, employers, neighbours & friends to provide a robust analysis of the events.

4.5 Produce a report which summarises the chronology of the events, including the actions of involved agencies, analyses and comments on the actions taken, the way they worked together and makes any required recommendations regarding safeguarding of families where domestic abuse is a feature.

4.6 Aim to produce the report within the timescales suggested by the Statutory Guidance subject to:

- Guidance from the police as to any sub-judice issues,
- Sensitivity in relation to the concerns of the family, particularly in relation to parallel enquiries, the inquest process, and any other emerging issues.

5. Family involvement

5.1 The review will seek to involve the family in the review process, taking account of who the family may wish to have involved as lead members and to identify other people they think relevant to the review process.

5.2 We will seek to agree a communication strategy that keeps the families informed, if they so wish, throughout the process. We will be sensitive to their wishes, their need for support and any existing arrangements that are in place to do this.

5.3 We will work with the police and coroner to ensure that the family are able to respond effectively to the various parallel enquiries and reviews avoiding duplication of effort and without increasing levels of anxiety and stress.

6. Legal advice and costs

6.1 Each statutory agency will be expected and reminded to inform their legal departments that the review is taking place. The costs of their legal advice and involvement of their legal teams is at their discretion.

6.2 Should the Independent Chair, Chair of the CSP or the Review Panel require legal advice then HCSP will be the first point of contact.

7. Media and communication

7.1 The management of all media and communication matters will be through the Review Panel.

Gary Goose
Independent Chair
Huntingdonshire CSP Domestic Homicide Review