Portsmouth CITY COUNCIL

Anne and Martin

Preface

Only the review panel are identified, as all other names have been changed.

The Independent Chair and Review Panel send their deepest condolences to all those impacted by Anne and Martin's untimely passing and thank them for their involvement and support in this process.

The primary objective of this review is to permit the learning of lessons from the deaths of persons aged 16 or over who have or appear to have resulted from violence, abuse, or neglect by a person to whom they were related or with whom they had been in an intimate personal relationship or a member of the same household. In addition, the review will also address Martin's mental health care and treatment.

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

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

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

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

Ethan & Taylor

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

Tom

"Best couple in the world"

Bart and Gemma

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

Rose and Charlie.

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

Shanella

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

Mary

Contents

Section One: The Review Process

1.1.1 This summary outlines the process undertaken by the Portsmouth City Council domestic homicide review panel in reviewing the deaths of Anne and Martin, who were residents in their area.

1.1.2 The following pseudonyms have been used in this review for the victim and partner to protect their identities:

- The victim: Wife – Anne
- The Son: Ethan
- The Daughter: Taylor
- Husband: Martin
- Friend: Tom
- Neighbour: Gemma
- Friend: Rose
- Friend: Charlie
- Neighbour: Bart
- Friend: Mary
- Martin's Manager: Shanella
- Friend: Lee
- Friend: Lucy
- Friend's daughter: Alice
- Ethan's Partner: Sophie

1.1.2 Anne was 60 and Martin 66 at their deaths. Anne and Martin were found deceased in their home by friends. It is suspected that Martin killed Anne before taking his own life. The note found stated that Anne had "drugged me". According to Ethan, Martin was the author of the note.

1.1.3 The process began with an initial meeting of the Community Safety Partnership on 7 October 2022, when the decision to hold a domestic homicide review was agreed upon. All agencies that potentially had contact with Anne and Martin before the point of death were contacted and asked to confirm whether they had involvement with them.

1.1.4 Five of the fifteen agencies contacted confirmed contact with Anne and/or Martin and were asked to secure their files.

Section Two: Contributors to the Review

2.1.1 The following agencies and their contributions to this review:

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

2.1.2 The chronologies and reports were authored by professionals independent of the case management or service delivery.

Section Three: The Review Panel Members

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

Name	Role	Organisation
Bryan Carter	Serious Case Reviewer	Hampshire and Isle of Wight Constabulary
Catherine Mead (left the panel on 22 Sept 2023)	Adult Safeguarding Lead	Portsmouth Hospitals University NHS Trust
David Joyce (joined the panel on 3 May 2023)	Head of Service Safeguarding, Mental Health, and Learning Disability	Adult Social Care Portsmouth City Council
Dr David Ashby	General Practitioner	GP Practice
Jane Leech	Public Health Protection Development Manager	Public Health – Suicide Strategy
Dr Jennifer Dolman (joined the panel on 28 July 2023)	Independent Consultant Psychiatrist	Southern Health NHS Foundation Trust
Kathryn Barber	Named Professional Adult Safeguarding	Solent NHS/Mental Health
Leeanne Hazelwood (replaced Catherine Mead on 22 Sept 2023)	Named Nurse for Safeguarding Children	Portsmouth Hospitals University NHS Trust
Lucien Champion (Joined the panel on 31 May 2023)	Head of Investigations	NHS England
Jayne Hardy (replaced Tonia Redvers on 22 Sept 2023)	Assistant Director	The YOU Trust
Michelle Ennis	Senior Designate Nurse Safeguarding Adults	Integrated Care Board
Sarah Beattie	Head of Portsmouth & Isle of Wight Probation Service	Probation Service
Sayma Begum	Domestic Abuse Analyst	Portsmouth City Council

Tonia Redvers (left the panel on 22 Sept 2023)	Director of Paragon, Young Lives and Counselling – Expert Witness	The YOU Trust
Parminder Sahota	Independent Chair and Author	PS Safeguarding LTD

3.1.2 The panel met a total of twelve times.

Section Four: Author of the Overview Report

4.1.1 Parminder Sahota is an independent author with ten years of experience in domestic abuse and safeguarding. Advocacy After Fatal Domestic Abuse provided the DHR Chair training in 2021. She has worked as a mental health nurse in the NHS for over twenty years and is a Director of Safeguarding, Prevention, and Domestic Abuse Lead for an NHS Trust.

4.1.2 Parminder Sahota is independent of all agencies involved and had no prior contact with family members or the Portsmouth Community Safety Partnership.

Section Five: Terms of Reference for the Review

5.1.1 The statutory guidance sets out the purpose of domestic homicide reviews to:

- Establish the facts that led to the deaths in September 2022 and whether any lessons can be learned from the case about how local professionals and agencies worked together to safeguard Anne and Martin.
- Determine the lessons drawn from the deaths regarding how local professionals and organisations will work individually and collaboratively to protect victims and those with care and support needs.
- Identify these lessons, both within and between agencies, how they will be implemented, within what timeframes, and what is anticipated to change.
- Apply these lessons to service responses, including modifying national and local policies and procedures.
- Develop a coordinated, multi-agency strategy for identifying and responding to domestic homicide and suicide and improving service responses.
- Improve the understanding of the nature of domestic violence.
- Highlight effective methods.
- Ensure Anne's and Martin's voices are heard regarding their experiences, allowing their journey to be narrated and identifying the lessons that can be learned.

5.1.2 The review's time frame was set to cover August 2021 to September 2022. The selected chronology resulted from Anne's first engagement with health care after fracturing her wrist following a fall from an electric scooter with Ethan.

5.1.3 The panel agreed on themed terms of reference that focus on Mental Health, Risk, Engagement, resources, and Others.

Section Six: Summary Chronology

6.1.1 Anne and Martin had known one another since the 1980s. They married in 1995 and had two children, Ethan and Taylor.

6.1.2 In May 2022, Anne accompanied Martin to his GP appointment, where he remained mute for most of the visit. As a result, Anne supplied context and revealed that Martin had not been himself since Christmas. Anne expected him to return to normal around two to three months after retiring from a highly stressful job, but this had not occurred. She reported Martin was preoccupied with other matters, such as double-checking that the door was locked. Anne was consequently emotional and unsure about what to do. Martin told the GP that he could not identify the cause of the problem. The GP found Martin to be relatively flat. Anne sat by him in tears because she believed he had radically changed, but he was oblivious to any behavioural changes and stated that there was no problem.

6.1.3 Martin's GP made an urgent referral to the Solent NHS Trust Mental Health Service in June 2022 because he was exhibiting symptoms of stress and anxiety due to the impact of COVID-19 on the business he managed. According to the Consultant Psychiatrist, Martin was experiencing a depressive episode with suicidal ideation.

6.1.4 Martin's first contact with a mental health service was in June 2022; he presented with symptoms of depression and was reported by family and friends to be paranoid about technology and to have undergone a complete personality transformation.

6.1.5 Martin attempted a significant suicide attempt in July 2022, and Anne discovered him at home. She called the ambulance service, her neighbours, and Ethan. Martin was detained for twenty days under the Mental Health Act, a voluntary patient for another eight days, and diagnosed with Psychotic depression.

6.1.6 Martin did not interact with the staff during his hospitalisation and had no rapport with healthcare professionals; he was also hesitant to engage with HTT. Anne visited the unit frequently and voiced concern to Martin's consultant psychiatrist with Ethan that they believed Martin required a more extended stay; as a result, Martin remained in the ward as a voluntary patient following his formal detention being rescinded and had day leave with his family.

6.1.7 Martin was referred to the early intervention service following discharge from the hospital. However, due to his age, he was ineligible. He was also referred for Cognitive Behaviour Therapy for psychosis, which he was awaiting acceptance for.

6.1.8 Martin was discharged to the Home Treatment Team (HTT - this service provides assessment and treatment at home for adults with acute mental health issues who would otherwise require hospitalisation).

6.1.9 Martin was reluctant to take the medication the mental health service prescribed and required encouragement during his hospitalisation. The service did not observe medication compliance at home, and family members and HTT think he did not take his medication after discharge.

6.1.10 Towards the end of August 2022, a referral was made to a nurse-led clinic for family intervention; a letter explaining this was received on the day the bodies of Anne and Martin were discovered.

6.1.11 Martin's last call to the team was two days before the fatalities.

6.1.12 The review panel found no evidence of domestic abuse; there had been no interaction with services regarding abuse, and neither family nor friends were aware of any domestic abuse.

Section Seven: Key Issues arising from the Review/Lessons Learned

7.1.1 **Recognising the significance of the carer's role in treating psychosis and paranoia.**

7.1.2 Anne was not provided with a carer's assessment or consulted separately from Martin about his discharge, her concerns, or offered any formal support.

7.1.3 Anne found that Martin's section had been revoked. Anne and Ethan were told they would be included in this discussion. They expressed concern about Martin's self-harm; he had a day's leave to "test" his mental health. The “test” did not involve medication at home.

7.1.4 Anne was unaware of the potential risks of her role as a carer and supporting Martin's medication compliance, as Martin lacked insight into his mental health and need to take medication.

7.1.5 Anne was not involved in the discharge planning process, and her family confirmed she would have sought private psychological therapy if she and her family had been informed of the expected lengthy wait for treatment.

7.1.6 Solent NHS Trust acknowledged the need for family interventions to support Anne.

7.1.7 **Recognising the impact of a shortage of available psychotherapies.**

7.1.8 Martin was assessed and treated under Section 2 of the 1983 Mental Health Act. His treatment team anticipates coordinating his continued care after discharge.

7.1.9 Age-based exclusion regulations rendered Martin's referral to the early intervention team ineffective.

7.1.10 Martin and his primary carer, Anne, should have been notified of the community referrals after discharge. If they had known the psychological therapy wait time, they may have sought them privately.

7.1.11 **Continuity of Care**

7.1.12 Martin was discharged without a care coordinator, which is atypical for those under the Care Programme Approach. Martin was discharged to HTT, which does not coordinate care for its service users, and several staff members will be involved in his care.

7.1.13 In the weeks preceding the deaths, no home visits were made by HTT; as a result, Anne had no one to express her concerns to or identify her needs.

7.1.14 **Risk Assessments**

7.1.15 Mental health professionals emphasise risk assessments in care plans. However, these risk predictors are not always correct. All relevant parties must be involved in planning effective care, including the individual's social system.

Section Eight: Conclusion

8.1.1 Since June 2022, Anne, age 60, had cared for her husband, Martin, who experienced paranoia and suicidal ideation.

8.1.2 Anne and Martin lived alone and had two adult children, Ethan and Taylor, and a solid social support system around them.

8.1.3 Anne initiated GP help for Martin in June 2022, as she could no longer support him independently. Martin was referred to HTT, but he could not establish rapport and did not believe he needed mental health care.

8.1.4 In July 2022, Martin was diagnosed with psychotic depression and attempted suicide, culminating in a four-week admission under the Mental Health Act 1983.

8.1.5 It was difficult for staff to determine what had changed during Martin's admission because he did not interact with them and remained in his room with the curtains closed.

8.1.6 After his August hospitalisation, Martin was believed to have discontinued his medication. He was granted a day's leave to 'test' his mental health, but it did not require administering medication; therefore, the ward team would be unaware of whether this would be an issue on discharge.

8.1.7 Anne continued to encourage Martin to take his medication after his discharge from the hospital. Martin rescinded his agreement to share information with Anne, and his suicide note read, "Anne drugged him," indicating that he was paranoid about her

8.1.8 The chair agreed with the HTT consultant that Martin should not have been discharged from the mental health unit when he continued to exhibit depressive symptoms (remaining in his room with the curtains closed). However, it must be acknowledged that this may not have prevented the tragedies.

8.1.9 Anne and their friends noted some improvement in Martin's mental health, and friends commented that his "colour" had returned.

8.1.10 The reports were shared with Ethan and Taylor, and the lessons learned will be shared with the agencies engaged in the review.

Section Nine: Recommendations from the Review

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

Health and Social Care

1.1a To identify carers and ensure they can participate in a carers assessment.
1.1b All clients are to be seen within 48 hours; social care screening will include carers' needs and ensuring carers are offered a carers assessment.

Mental Health

1.1c To offer carers and families literature and resources to help them become more aware of and understand how to support a family member or friend experiencing poor mental health.
1.1d Ensure that carers/family/friends are included in risk assessment and management with the service user's consent.
1.1e To ensure that, in cases where consent has been revoked, the adult's ability is assessed to confirm that they have the mental capacity to withdraw consent. In addition, the individual(s) who previously were involved are told of the request to revoke consent.

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

Mental Health Commissioners

2.1a To review the NHS England publication for implementing the early intervention in psychosis access and waiting time standard[1] and confirm that Solent NHS Trust complies and age is not a barrier to receiving support or advice from the early intervention service.

Integrated Care Board

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

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

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

Integrated Care Board/Mental Health Provider

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

Mental Health

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

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

2.1h Discharge Planning must be explicitly established upon admission or, when practicable, with the service user and family (depending on the service user's consent). The plan

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

must specify what is required for discharge and what might be expected once discharged. The discharge process must include a detailed risk assessment and management plan developed in partnership with the service user and their family and friends with consent.

Queen Alexandra Hospital – Portsmouth University Hospital

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

9.1.3 Recommendation Three: Routine Enquiry

Health and Social Care

3.1a Services must ensure their practitioners know their responsibility to investigate domestic abuse.

9.1.4 Recommendation Four: Gun license process

Integrated Care Board

4.1.a Processes for firearms management has been reviewed.

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