BIRMINGHAM COMMUNITY
SAFETY PARTNERSHIP
WORKING TOGETHER FOR A SAFER CITY

Domestic Homicide Review

under section 9 of Domestic Violence Crime and Victims Act 2004

In respect of the death of a woman

DHR2011/12-03

Report produced by Kathy McAteer
Independent Chair and Author
Presented to Birmingham Community Safety Partnership on
9th May 2013

Glossary

A&C: Birmingham City Council Adult Social Care, formerly Adults and Communities Directorate
AMHP: Approved Mental Health Practitioner
BCC: Birmingham City Council
Birmingham East & North Primary Care Trust: The former Primary Care Trust responsible for commissioning mental health services in Birmingham
Birmingham & Solihull Cluster: Primary Care Trusts responsible for commissioning local health services (until April 2013 when statutory responsibilities transferred to the new Clinical Commissioning Group)
BSCP: Birmingham Community Safety Partnership
BSMHFT: Birmingham & Solihull Mental Health Foundation Trust – the organisation providing local mental health services
CARE FIRST 6 (CF6): electronic database and recording system used by Birmingham City Council People Directorate
CMHT: Community Mental Health Team – multi-disciplinary team providing community based assessments and support to people with serious and enduring mental illness
CPA: Care Programme Approach: the process how mental health services assess someone's need, plan ways to meet needs and to review and check that needs are being met
CPN: Community Psychiatric Nurse
DHR: Domestic Homicide Review
IAPT: Improving Access to Psychological Therapies – provision of counselling services
IMR: Individual Management Review – reports submitted to review by agencies
LPU: Local Policing Unit
MHA: Mental Health Act
OASIS: log used by Police
OCU: Operational Command Unit (Police)
PNC: Police National Computer
Primecare: out of hours GP service
RIO: electronic database and recording system used by Birmingham & Solihull Mental Health Foundation Trust
VPO: Vulnerable Person's Officer (Police)
WC392: Information log used by West Midlands Police
WMAS: West Midlands Ambulance Service

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SECTION ONE: INTRODUCTION AND BACKGROUND

1.1 Introduction

This report of the Domestic Homicide Review (DHR) examines the circumstances leading up to the homicide of an elderly woman, by her son. During the evening of the death, the perpetrator called the police from his mother's address and reported that he had strangled her, beaten her about the head, and stated that she was dead. [*redacted – sensitive information*] The perpetrator was known to mental health services and it appeared that he had relapsed and been psychotic for some time prior to the incident. At the time of the incident he was under the influence of alcohol and had not been taking his medication. The perpetrator had been seen at a mental health outpatient's appointment earlier that day and had moved in with his mother as he did not feel safe in his flat. It is clear from both the conclusions of the Serious Incident Review undertaken by the Mental Health Trust and from the criminal proceedings that the homicide was a direct result of the perpetrator being psychotic and responding to psychotic experiences.

1.2 Purpose of a Domestic Homicide Review

Domestic Homicide Reviews were established on a statutory basis under Section 9(3) of the Domestic Violence, Crime and Victims Act (2004). The Act requires a review to be undertaken in circumstances '…*in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by:*

(a) a person to whom he was related or with whom he was or had been in an intimate personal relationship, or
(b) a member of the same household as himself, held with a view to identifying the lessons to be learnt from the death'

Domestic Homicide Reviews are not inquiries into how a victim died or who is to blame. These are matters for Coroners and criminal courts. Neither are they part of any disciplinary process. The purpose of a Domestic Homicide Review is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;
- Apply these lessons to service responses including changes to policies and procedures as appropriate; and
- Identify what needs to change in order to reduce the risk of such tragedies happening in the future to prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

The review serves to meet the requirements of Section 9 of the Domestic Violence, Crime and Victims Act (2004) and was delivered in accordance with the Home Office guidance - 'Multi-Agency

Statutory Guidance for the Conduct of Domestic Homicide Reviews' and followed the key processes that are outlined within the "Governance and Procedural Arrangements for Domestic Homicide Reviews in Birmingham.''

1.3 The Review Process

Birmingham Community Safety Partnership (BCSP) was notified of the death three months after the homicide. The reason for the delay was because the case was not initially identified as meeting the domestic homicide definition. The homicide was perpetrated by the victim's son, who had temporarily moved in with her due to being unwell. During this time, a Serious Incident Root Cause Analysis was being undertaken by the Internal Homicide Review Team of Birmingham & Solihull Mental Health Foundation Trust. BCSP sought advice from the Home Office to see whether this would satisfy the requirements of a DHR. Some months later BCSP received Home Office guidance to undertake a full review. Department of Health statutory guidance[1] sets out *(former)* Strategic Health Authority responsibilities for commissioning independent investigations against a set of criteria, including a homicide committed by a person under the care of specialist mental health services within six months preceding the homicide. The internal Serious Incident Root Cause Analysis was completed as part of this process.

BCSP made the decision to commission a Domestic Homicide Review on the 3rd May 2012 and notified the Home Office on 14th May 2012. An independent chair was appointed and terms of reference drafted within the month. As the Serious Incident Review was being concluded, a decision was taken to defer the first panel meeting to 7th September 2012, when the report became available, to enable the Panel to consider the information within the report and to avoid duplicating requests for information.

A panel was formed with the following panel membership:

Agency	**Position**
Independent Chair & Author	Independent social care consultant
Birmingham & Solihull Mental Health Foundation Trust	Lead for User Engagement
Birmingham Community Safety Partnership	Senior Service Manager, Violence Against Women
Birmingham MIND	Operations Manager
West Midlands Police	Detective Sergeant
Joint Commissioning Team, NHS and Birmingham City Council	Senior Strategic Commissioning Manager
Birmingham City Council People Directorate, formerly Adults & Communities Directorate	Lead Practitioner – Safeguarding Adults
Solihull Clinical Commissioning Group	Designated nurse –Safeguarding Adults and Children, Mental Capacity Act Lead and health advisor to the panel

[1] Independent investigations of adverse events in mental health services, DH, June 2005

The independent chair/author was selected from a pool of chairs/authors who are fully independent of all agencies involved, and selected via a procurement process. The Panel members were selected by the respective agencies on the basis that they had no direct operational responsibility for the case. In addition the Panel included an independent person from a voluntary organisation and a health advisor from an independent NHS body.

The process began with an initial scoping exercise prior to the first panel meeting. The scoping exercise was completed by BCSP to identify agencies that had involvement with the victim and perpetrator prior to the homicide. Where there was no involvement or insignificant involvement, agencies advised accordingly. BCSP identified within its domestic homicide review procedures the importance and value of independent specialist voluntary sector representation on its panels. To this end it ensures that in cases of domestic violence that Birmingham and Solihull Women's Aid will be represented on the Panel and in cases of familial violence where no intimate relationship is featured but mental health issues are involved, then Birmingham MIND will be represented on the Panel. Birmingham MIND were represented on the panel for this review.

Though the scope of the review requested information on the deceased and the perpetrator from 2009, agencies were asked to include the date of their first contact with any of the parties, and to highlight any relevant information prior to 2009 that the Panel should consider. This was particularly pertinent in this case given the perpetrator's mental health history, and the general lack of contact between agencies and the victim. Though there was a lot of information available about the perpetrator, there was very little information about the victim. For this reason, the panel sought any additional knowledge that agencies held on the victim and on her relationship with her son. The review therefore considered information relating to the victim and perpetrator dating back to 2002.

25 agencies responded as either having had no recorded contact with the victim and/or her son, or any contact was out of scope and was not of relevance to the review.

- Allens Croft Centre
- Anawim
- Aquarius
- Birmingham City Council Homes and Neighbourhooods Directorate
- Birmingham MIND
- Birmingham and Solihull Women's Aid
- Birmingham Community Health Care Trust
- Birmingham Community Safety Partnership, Safer Communities Team
- Birmingham Crisis Centre
- Birmingham Drug and Alcohol Team
- Birmingham Women's Hospital
- Bournville Village Trust
- Breathe
- Freshwinds
- Gilgal
- Heart of England NHS Foundation Trust
- Jan Foundation
- Rape & Sexual Violence Project

- Royal Orthopaedic Hospital NHS Foundation Trust
- Sandwell and West Birmingham Hospitals NHS Trust
- Shelter
- Staffordshire and West Midlands Probation Service
- University Hospitals Birmingham NHS Foundation Trust
- WAITS

The following agencies had recorded contact with the victim and/or the perpetrator within the review timescale and/or held information that was relevant to the scope of the review:

- Birmingham & Solihull Mental Health Foundation Trust
- The Primary Care Practice where both parties were registered, supported by Birmingham South Central Clinical Commissioning Group
- Birmingham City Council Adult Social Care
- West Midlands Ambulance Service
- West Midlands Police

Each agency and/or service was asked to submit two key documents as follows:

- A chronology of events detailing in date order all contacts with one or both of them
- An individual management review (IMR) detailing key information, based on the key lines of enquiry, including:
    - an analysis of the involvement of all services within the agency including contact and actions taken, outcome of any assessments undertaken, support and services delivered and offered, decision points and reasons for decisions taken
    - the effectiveness or otherwise of inter-agency working, the triggers for information sharing and any missed opportunities to share information
    - learning points and proposed actions for the agency/service
    - learning points and proposed actions for improving inter-agency working

Agencies submitting information were invited to attend an IMR author's briefing where all IMR authors confirmed that they were independent of the management of this case, having had no direct involvement or line management responsibility.

A chronolator tool was used for the chronology and a standard format for the IMRs was used for consistency and ease of analysis.

West Midlands Ambulance Service was asked to provide a chronology only.

In addition, the Panel received a copy of the Serious Incident Root Cause Analysis Report completed by the Internal Homicide Review Team of Birmingham & Solihull Mental Health Foundation Trust.

1.4 Contact with family and friends

Contact was made with the Consultant Psychiatrist responsible for the perpetrator's care to seek an opinion as to whether he should be made aware of the review and invited to contribute. It should be noted that he was interviewed for the internal Serious Incident Review. A telephone interview between a designated panel member and the Consultant Psychiatrist took place on 12th December 2012 in relation to the perpetrator's current mental state and capacity to be interviewed by the DHR team. The psychiatrist recommended that at present and for the foreseeable future the perpetrator should not be interviewed by the DHR panel [redacted – sensitive information].

Contact was made with the victim's only known relative, who did not respond to BCSP invitations to be involved in the DHR. During the internal Serious Incident Review, she had been contacted by the Police and Victim Support, however declined to be engaged.

The panel also contacted six friends and acquaintances that had been identified during the police investigation, of which three responded [redacted – sensitive information].

1.5 Terms of Reference for the Review

- To establish whether it was known, or could have been suspected, that the perpetrator posed a serious risk to his mother, the victim, and whether any action could have been taken to prevent the homicide. To establish whether the domestic homicide was predictable or preventable.

- To identify how effective agencies were in identifying the victim's vulnerability to domestic abuse and whether risks were identified and appropriately managed

- To identify how effective agencies were in identifying the risks that the perpetrator posed to the victim or others, and how effectively such risks were managed

- To establish how well agencies work together and to identify any gaps and/or changes that are required to strengthen inter-agency working, practice, policies or procedures to improve the identification of people subject to domestic abuse within Birmingham

Key Lines of Enquiry

- **History of events and relationships:** What was known about the perpetrator's relationship with his mother? What was the sequence of events leading up to the date of the homicide?

- **Information and assessments:** How was information about the perpetrator and the victim received and addressed by agencies? What assessments were completed and what was the outcome of these? Were there trigger points or missed opportunities for sharing information that would have made a difference? What are the thresholds for decision making?

- **Risk Assessments:** What risk assessments were completed to a) assess the risks to the victim and b) to assess the risks posed by the perpetrator? Did the perpetrator have a history of violence and, if so, how was this managed? What were the outcomes of any risk assessments? Were these completed on a single agency basis or jointly with other agencies? What actions were taken?

- **Contact with and support from agencies:** What contact did each agency have with the victim and the perpetrator? What support did each receive and from whom? What care and treatment did the perpetrator receive? What was the history of engagement and compliance with treatment including medication? What processes were followed and what were the key decision points and why? Was there any additional action that could have been taken and would it have made a difference?

- **Adult Safeguarding:** Were there any safeguarding issues in respect of the victim and if so were these appropriately managed?

- **Awareness of domestic abuse indicators:** To what extent were staff and agencies aware of the indicators of domestic abuse? Were these appropriately identified and what action was taken? Does the agency have policies and procedures in place for dealing with concerns about domestic abuse?

1.6 The Facts

Summary of events

During the evening of the homicide, the perpetrator called the police from his mother's address and reported that he had strangled her, beaten her about the head, and stated that she was dead. Prior to the homicide the perpetrator had moved in with his mother whilst he was unwell, and had been showing signs of a relapse of his mental health condition for some time. He and his mother had attended a mental health out-patients appointment earlier on the day of the homicide. The perpetrator had not been taking his medication for several weeks, though he had told health professionals that he had restarted it. He was also under the influence of alcohol, having been to the pub earlier in the evening. The Serious Incident Review Report completed by the Internal Homicide Review Team of Birmingham & Solihull Mental Health Foundation Trust concluded that the homicide was directly due to the perpetrator's psychotic illness and had been a response to his psychotic experiences: he stated after his arrest that he had killed the "she devil". He said that his mother had "shape changed" into a demon, and that his rage had come from the voices telling him to hurry and kill the devil. Forensic and post mortem evidence showed that the victim had been strangled and that the perpetrator had stamped repeatedly on her head with his bare feet.

Subjects of the Review

The victim:

The victim was elderly [redacted – sensitive information]. Very little was known about her by the agencies who had contact with her son, and people who knew her described her as a private person with few close friends. It appears she was fit and healthy for her age, having not had any face to face contact with her GP for the three years prior to her death, and having declined offers of health screening and flu vaccinations. She had been widowed ten years prior to her death, when the perpetrator's father died following a stroke. She appears to have had no close family other than her son, who was her only child, and she had regular contact with him. The victim had a sister with whom she had little contact for several decades. Her sister did not want to be involved in either the

mental health homicide review or the domestic homicide review. The victim did however have regular telephone contact with a distant family relative of her husband's in recent years.

Though it was recorded that the victim actively supported her son, she had infrequent contact with mental health professionals, limited to when he was unwell. It is known that the perpetrator had been living with his mother between 2000 and 2002. Following a mental health episode in 2002, the victim stated that she was finding it very hard to look after him and didn't feel able to cope with him living with her permanently. She stated that she wanted someone else to take over the day to day caring role and he moved into his own accommodation (initially via supported hostel accommodation), though he appeared to move back in with her when he was unwell. Following the homicide, the perpetrator indicated that his mother had felt unsupported "*let down"* by mental health services. This view was reiterated by friends who described her anger at an incident some years ago when she had met with a health professional who subsequently shared information with the perpetrator. Friends described the victim as someone who did not like people in authority and would not therefore easily engage with them. There was no evidence that the victim was frightened of her son but it is alleged that he had taken money from her and she had changed her locks to stop him coming into the house unannounced.

The perpetrator:

The perpetrator was middle aged and lived alone at the time of the homicide. His marriage of twelve years broke down more than ten years prior to the homicide, allegedly due to his wife not being able to cope with his illness and he was divorced two years later. He lived with his mother from around 2000 to 2002 due to finding it difficult living independently after his marital breakdown. He had no children. The perpetrator's father died following a stroke and the perpetrator had previously reported that he did not get on well with his father shortly before his death. The perpetrator's paternal grandfather and his uncle had both committed suicide. Though the perpetrator usually reported that he had a good relationship with his mother and that she was supportive, it was at times recorded that their relationship was problematic and he disclosed in 2009 that she had physically and emotionally abused him as a child. At the time of the homicide, the perpetrator was living in a flat close to his mother's address. He had moved in with his mother shortly prior to the homicide due to being unwell and feeling unsafe in his own flat.

The perpetrator had been known to mental health services since 1999, having been diagnosed initially with a moderate depressive illness, then in 2002 with Schizophrenia with persecutory delusions. In 2003 it is recorded that he had severe depression and in 2005 that he had severe enduring mental illness of bipolar affective disorder. His mother described him in 2002 as being plausible in masking his illness, even when he was ill. When unwell he had periods of anxiety and low mood as well as periods when he was paranoid and suspicious – usually marked by hearing voices telling him to harm himself, experiencing visual hallucinations of people changing shape and size, and believing in magic. At these times he was often described by mental health professionals as hostile and angry towards staff.

The perpetrator's compliance with medication was generally poor and increased alcohol consumption was often associated with relapse. He was acutely and floridly psychotic at the time of the homicide and his violence towards his mother was driven by his psychotic symptoms. His previous history indicated that he was unable to identify early warning signs of relapse. However, during previous relapses, the perpetrator had been a danger to himself rather than others, with

risks of self-harm or suicide. He had no history of violence towards others, though his behaviour when unwell created anxiety for members of the public. He had last been unwell and admitted to hospital in March 2009, 2 years and 4 months prior to this relapse.

The Relationship between the Victim and the Perpetrator:

Little was known about the true relationship between the victim and her son and there are conflicting accounts recorded by agencies. It was known in 2002 that the victim found it difficult coping with her son's behaviour and wanted someone else to take day to day responsibility for his care. At that time it was recorded that they appeared to have a close and supportive relationship. It was also recorded that he had spent a lot of her money. Two years later, in 2004, it was recorded that he had *some* contact with his mother and that the relationship was problematic, though there is no further information as to what the issues were. In September 2005, it was recorded that he had limited contact with his mother but three months later, in December 2005, it was recorded that he had a good relationship with her. In March 2006, it is stated that he saw her regularly (weekly) and they spoke on the phone daily. He did not however want his mother to attend his review.

In March 2009, it was recorded that the perpetrator would go to stay with his mother when he was unwell. However, it was subsequently recorded in November 2009, that he had disclosed physical and emotional abuse by his mother during his childhood, and that he was seeing a psychologist with regard to his early life and his "*poor relationship with mother when he is ill"*. The records contradict previous reports that he would go to his mother when unwell because he felt safe. At this time the perpetrator reported that when he hears voices, they are derogatory and are negative responses to over critical parent figures in his life.

Evidence from friends was that the victim wasn't frightened of her son but that she was reluctant to let him in as he had previously taken money from her – she had changed the locks some years previously and also had a "special knock" when a family friend visited. Though she didn't often talk about her son or how she coped with his behaviour, friends described her being reluctant to take phone calls or accept visitors when he was in her home. A friend who spoke to the victim on the phone the day before the homicide stated that it was the first time the victim had sounded in any way concerned about his presence in the home, this being the same day that the victim rang the clinic and expressed concern about her son's mental state.

Following his arrest the perpetrator said that he had regular contact with his mother – that she rang him twice a day and he used to see her once a fortnight, describing her as supportive. There were no known previous episodes of violence by the perpetrator towards his mother.

Domestic Abuse History:

The perpetrator has no known history of domestic abuse.

Convictions:

Prior to the homicide, mental health records report that at the age of 17, the perpetrator smashed a window and that he had two convictions for drunk driving and making obscene gestures in a public place. No sentences appear to have been passed.

The perpetrator was found guilty of manslaughter due to diminished responsibility. He was unfit to plea and has been detained at a secure mental health facility under section 37/41 of the Mental Health Act.

1.7 Equality and Diversity

Due consideration was given to each of the protected characteristics under the Equality Act and the following were found to be relevant:

- The victim was an elderly woman [redacted – sensitive information]
- The perpetrator had a known diagnosis of serious and enduring mental illness

The review took into account the victim's age and potential vulnerability, as an elderly woman who was next of kin and sole carer of her son. This included exploring whether there was any evidence of adult safeguarding issues in relation to the victim. The review also took into account the perpetrator's vulnerability due to his mental health issues. In relation to the vulnerability of both victim and perpetrator, the Panel considered the level of support provided by agencies to both parties.

1.8 Summary of key events

A full chronology was provided to the review panel and is summarised below:

Date	Event
March 2002	First recorded contact with police was following an incident when the perpetrator had cut his wrists and was taken to hospital; described as recently divorced and with alcohol issues.
September to December 2002	The victim rang police in September 2002 due to concerns about her son's mental state. He had been acting aggressively, growling and had stopped taking medication. The perpetrator was detained under Mental Health Act and transferred to hospital. A Mental Health Assessment and carer's assessment was offered in October 2002 but the victim said she could not continue caring for him at home. A Mental Health Act Assessment Section 3 found that the perpetrator had spent a lot of mother's money and was vulnerable to self-neglect and self-harm. The victim said that he could be plausible in masking his illness.
January 2003	Mental health services report the perpetrator having severe depression with pessimistic thoughts and suicidal ideation.

November 2003	The perpetrator was admitted to hospital under Section 3 of Mental Health Act
September 2005	The perpetrator received a diagnosis of bipolar affective disorder. He was described by mental health services as opposed to medication and hostile and angry at times, when unwell. He was reported missing from the hostel where he was living and was found throwing bottles at traffic whilst very drunk
March 2009	The perpetrator, living alone, contacted police as local children were causing him nuisance. On a subsequent date, he was found by police lying naked in the middle of the road and admitted to hospital under Section 2 of Mental Health Act. The perpetrator had not been taking medication and had not disclosed this. He had caused damage to his flat prior to admission The perpetrator made an allegation of rape to police and to mental health services which was not followed up
April 2009	The perpetrator was discharged to his own home under the care of Home Treatment Team
October – November 2009	The perpetrator self-referred to mental health services as being unwell and hearing voices, describing these as derogatory and linked to over critical parent figures. His notes refer to abuse during childhood; it is recorded that he had visual hallucinations of people changing shape and size in front of him; he was referred to the 'Mood on Track' course.
March 2010	The perpetrator completed the 'Mood on Track' course – notes were kept in separate file and not with the Care Plan
May 2010 – January 2011	The perpetrator was regularly reported by mental health services as doing well (though hearing voices was a constant theme)
Four months to one month prior to the homicide	The perpetrator missed clinic appointments but self-reported to mental health services that he was hearing negative voices. His blood tests showed sub-therapeutic drug levels but he self-reported that he was taking medication
Month before the homicide	Change of CPN1/Care Co-ordinator due to retirement
Day before the homicide	The victim rang the clinic to say that her son was unwell; not called back; CPN2 rang the perpetrator instead who said that he was hearing voices; he admitted that he hadn't been taking medication, but said that he had taken it that day
Day of the homicide	The victim accompanied the perpetrator to the clinic where he denied having hallucinations. The perpetrator was not keen on Home Treatment – a decision was made for the Community Mental Health Team to monitor him instead, which

	was not in line with the Care Plan. He was given his psychiatrist's mobile number. It is recorded that the victim didn't want him admitted to hospital and was keen he stay with her.

SECTION TWO: ANALYSIS OF AGENCY INTERVENTIONS

2.1 Birmingham & Solihull Mental Health Foundation Trust

Birmingham and Solihull Mental Health NHS Trust was established on 1st April 2003 as a result of the merger of Northern Birmingham Mental Health Trust and South Birmingham Mental Health Trust. The organisation was granted Foundation status in July of 2008 and became Birmingham and Solihull Mental Health NHS Foundation Trust. Its main focus is on the provision of secondary mental health care to the population of Birmingham and Solihull through its home treatment, in-patient, assertive outreach, early intervention and older people's services. It also provides some drug and alcohol services, a youth service and a range of specialist services including medium and low secure forensic mental health services, eating disorder, deaf, prison health care and perinatal mental health services.

The organisation employs approximately 4000 staff and has contact with approximately 40,000 people each year. At any one time, there are between 25,000 and 30,000 people receiving a service from the Trust.

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Summary of Involvement:

In addition to the IMR, the Panel took into account the findings of the Serious Incident Review which identified key recommendations in relation to management of medication, clinical monitoring and appropriate treatment responses integrated within CPA arrangements, care planning and implementation of the care plan, crisis response by the clinical team and communication between professionals.

The victim had never had contact with mental health services as a patient. Her contact was as the mother of a patient only. This contact was minimal.

The perpetrator had been known to mental health services since 1999. He had not been accepting of his illness initially and therefore did not engage in treatment and intervention which appears to have resulted in a number of admissions to hospital. By 2009 however, he was well engaged with the Team and although his illness and symptoms presented with many complexities he had a good relationship with his Community Psychiatric Nurse (CPN). CPN1 and the Consultant Psychiatrist had both been involved with the perpetrator for eight to ten years so would have developed much insight into him and how his illness impacted on him and his life.

Records indicate that the perpetrator suffered with anxiety in social situations, low mood as well as periods when he was paranoid and suspicious, believed in magic and heard the voice of God. There is some documentation that he heard four voices and some that says up to twenty voices,

sometimes telling him to 'do things'. The perpetrator had made attempts to harm himself when low in mood in the past. The documentation states he had a diagnosis of bipolar affective disorder and it appears he was low in mood for much of the time. It also indicates that the voices he experienced were there in the background most of the time even when 'well'. Use of alcohol was a feature that increased when he was becoming unwell and it appears that he had been drinking the night that his mother was killed.

The perpetrator had ten hospital admissions between 2002 and 2009 as well as previous involvement with the Home Treatment Team. From 2009 onwards he remained in regular contact with his team and appeared to engage in treatment and interventions offered. The perpetrator was described as an articulate and intelligent man.

The perpetrator had input from a number of health professionals from the Community Mental Health Team including a Consultant Psychiatrist and a CPN, as well as receiving treatment/support from a Psychologist and a Dietician. He was also referred to psychological therapies and attended a 'Mood on Track' course to assist him to understand his illness, monitor his symptoms and to track his own relapse signature. His CPN and/or staff from the clinic saw him regularly at his home, at the clinic or in a community venue as arranged. He liked to have control of his treatment and there were agreed negotiations about his medication and the dose. He controlled this himself – reducing and increasing the dose based on how he felt. Though the service offers 'Hearing Voices' work, the perpetrator was not referred for this group.

The last contact prior to the homicide was initiated by the victim. She had made a concerned telephone call to the Community Mental Health Team the day before the homicide. Although this was responded to speedily, contact was made with the perpetrator rather than ringing the victim to explore her concerns further. The victim attended the clinic with her son to see the Consultant Psychiatrist the following day as arranged. Although the perpetrator was unwell and had stopped his medication for a few weeks (it was not clear for how long), he had said that he was back on his medication now and that he would be staying with his mother. This was accepted and he was to be seen two days later by his Consultant Psychiatrist. It was later on the day of that consultation that the perpetrator made a 999 call to say that he had killed his mother.

Analysis

BSMHFT found no evidence that services had engaged with the victim other than when she rang staff at the clinic, which was rarely. There was no documented evidence to say that she was spoken to as part of the assessment. The documentation seems to suggest that the victim tended to be involved when the perpetrator was unwell; however, there were contradictory accounts about the amount of contact they had and about their relationship including a disclosure by the perpetrator that his mother had physically and emotionally abused him in his childhood. There was no evidence to suggest that this disclosure was taken into account from a risk perspective although it appears this may have been explored in work that the Psychologist had been doing for a number of years. There was no evidence that the Psychologist was in attendance at care reviews or this information was included in any on-going assessment or risk assessment. The account that suggests that the Psychologist was addressing issues of his childhood could have indicated some risk to his mother and there were implications in that account that the voices were connected to his childhood parenting issues. During his hospital stay between 25th March and 30th April 2009, he disclosed that he did not like being touched by male staff because he had been raped. There is no

evidence in the records of this disclosure being explored to establish a clearer picture and no further mention of this disclosure anywhere in the documentation

Following the death of his mother, the perpetrator said that he saw his mother once a fortnight and she rang him every day, twice a day and he stated that she was not happy with services and felt let down. This indicates a lack of positive engagement that was not being addressed or potentially known about. It was not documented that the perpetrator did *not* want his care team to have contact with his mother.

There was no evidence however, that the perpetrator had any significant history of risk of violence to his mother or to anyone else. The risk assessment identified potential risk to self, based on the history of suicidal attempts and self-harm. This had not been an issue for the perpetrator for a number of years. There was no evidence that domestic abuse was present in this relationship. Neither were any issues of safeguarding identified for the victim.

The final contact with the Consultant Psychiatrist prior to the victim's death seems to suggest that the victim did not believe there was any risk to herself and did want the perpetrator to come home with her. The case record states that "*she didn't want him admitted"*, that "*she didn't feel he was very unwell"* and that she stated that "*he will do as I ask, he's a good man*". The psychiatrist did however identify that the perpetrator's mental state could deteriorate quickly so had planned to see him again in two days' time. This was in fact noted to be the first time that the psychiatrist had met the victim as the perpetrator usually came to his appointments on his own.

It may be that a more positive engagement and involvement with the victim over the many years that the perpetrator was known, as well as further exploration of the perpetrator's disclosed abuse from his mother towards him as a child, would have given a more comprehensive picture of the relationship between them and identify any potential risks. However, without this knowledge it is not possible to say that this would have prevented her death.

There was no joining up of the various professionals who were also seeing the perpetrator for specific purposes, such as the 'Mood on Track' course and psychologist involvement. The health professionals involved did not attend any care reviews and the notes from these services were kept separately. There is no evidence in the Care Plan that information from these interventions were included or that they were having any positive impact for the perpetrator.

There appears to be evidence on reviewing this case that the perpetrator may not have been as compliant with his medication as the Care Plan suggested. There were a couple of episodes revealed afterwards that when he had become ill, he had stopped his medication and not told anyone, even when being seen regularly. He was never symptom free which questions whether he was regularly taking the prescribed medication or the correct dose. This did not seem to be considered and further questioning or monitoring may have been necessary.

On interview by the Internal Homicide Review Team following the death of his mother, the perpetrator identified that he had gradually reduced and stopped his medication although he was unclear why. He said that he had not told anyone and that no one had asked him. It is always a challenge to know if someone is actually complying with the medication, however this did not appear to be considered as an issue and his word alone was accepted.

The evidence also indicated that there was also a lack of exploration about his symptoms on an on-going basis – when unwell he became paranoid and suspicious, which would suggest that he may be reluctant to disclose everything or disclose who he was suspicious of.

BSMHFT medication management policy has guidance for practitioners working with those who are not compliant with medication treatment. However as non-compliance had not been identified as an issue, this policy was not utilised.

Following the death of his mother, the perpetrator disclosed that he had believed she was part of the 'black magic' and that her 'shape had shifted' so he believed she was the devil. Records identified previous experience of hallucinations and were on his relapse signature. The perpetrator did not disclose on the final appointment with the Psychiatrist that he believed his mother to be involved in black magic. There is no evidence that this was monitored, either on an on-going basis or at that final appointment.

Evidence suggests that the CPA process did not appear to have been followed and the Health and Social Care Assessment was out of date. Information relating to his mother and the disclosed childhood abuse was not utilised effectively within the risk management or in his Care Plan. Although the perpetrator disclosed being raped at another time this also was not picked up, explored or reflected in his Care Plan. Experiences of violence and abuse are often a key factor in people's pathway into mental health services and should always be taken account of due to their potential profound impact.

There was an up to date Risk Assessment but it was not fully completed and had not considered any risks outside of risk to self. There was no history of risk of harm to others and so no safeguarding issues were considered in relation to his mother.

There was no documented evidence that any 'voice work' was offered or available for the perpetrator, and the voices appeared to be an on-going issue even when well. There is a 'Hearing Voices Group' meeting weekly at the clinic which all service users can have access to – either by self-referral or via their practitioners. This has been in operation for over three years. There was no evidence in any documentation that any discussion or consideration was given to this group and the perpetrator was never referred to the group.

There is no evidence documented that any transition work was carried out with the perpetrator about the change in Care Co-ordinator. The impact of building a relationship with a specific worker over so many years and then to lose that without preparation may have been under estimated. Although the perpetrator had had some contact over the years with staff at the clinic and had met CPN2 who was to be his new Care Co-ordinator, there was no contact with her from the three weeks prior to the homicide.

It was the victim who highlighted that her son had become unwell and stopped taking his medication; it was this that initiated the final contact with the Consultant Psychiatrist on the day of the homicide.This contact did not follow the Care Plan of utilising Home Treatment intervention. Although it was the victim that alerted the clinic and left a message, the duty nurse did not call her back but called her son. At this appointment it was accepted that the perpetrator had re-started his medication because he had said so, although no robust monitoring was put in place for this. When

interviewed following the death, his previous CPN did say that a call from his mother would have raised her concern and she would have made immediate contact.

Lessons Learnt

(a) Good Practice

- There was a good relationship between the Consultant Psychiatrist and patient and the Care Co-ordinator and patient. The perpetrator was given considerable autonomy in managing his own illness including the management of medication. It is often difficult to ascertain what the right balance between autonomy and close supervision should be when managing medications for people with a serious mental illness.

- The perpetrator had access to the 'Mood on Track' course run by the Manic Depression Service to help identify his early warning signs.

- The perpetrator was given every opportunity to access services in case of need. This included having the Consultant Psychiatrist's mobile telephone number as well as the CMHT duty nurse number.

- When contacted by the victim with information that her son was showing signs of relapse, the medical secretary who took the call made appropriate and timely arrangements for the perpetrator to be reviewed by the Consultant and Care Coordinator.

- There was a good immediate response from both the CMHT and clinic and excellent management of the case following the incident.

- There was good support for the Team post incident including follow up several months after the event.

(b) Areas for Improvement

BSMHFT identified a need for their organisation to:

- Engage with those relatives/friends/significant others in a more positive and meaningful way. Even if not identified as the 'carer' this does not mean they are not having significant input and impact on and in the service users' life and vice versus. There is a gap in the assessment unless information is gathered from around service users – the perspective of significant others can give a broader picture. There is a clear process for a carer's assessment and this needs implementing - without this, the context of the individual's life and the nature of their relationships is not clear and no account taken of the impacts. Understanding the context of a person's life and their relationships would assist in identifying broader risks. The risk assessment training needs to promote thinking about the broader risks as there is a tendency to see risk in a blinkered way and not to see the potential risks.

- Consider the impact of change in practitioner and ensure where possible that transitional work is carried out. This will particularly impact when the service user/patient has had the same worker for many years. There is also the need to consider how clinical and management supervision challenges practice - there may be issues when a CPN has worked so long with one person that there is a 'maintenance' effect. There is some indication that the interventions on the care plan were just repeated on the review process – not evaluated and re-looked at with reflection.

- Have some professional curiosity when monitoring medication compliance within the community. It can be a real challenge but there is a policy that advocates consideration of non-compliance needing to be reviewed and questioned to ensure robust monitoring at all contacts. Where someone has some history of non-compliance, where there is on-going symptomology and where the person is self-altering the medication would point to a need to consider whether there is total compliance.

- Robustly audit the CPA process including feedback taken and changes implemented where issues are raised. There is currently an audit process that considers quality of the use of CPA including an annual audit and self-audits and these are signed off by managers and lead nurses.

Agency Recommendations

- To include in the assessment all significant others living with and involved in the life of the service user. It should be clearly stated in the records that this discussion has taken place and if the service user does not want someone specifically involved in their care this needs to be documented and include the reasons why. This should be part of a multi-disciplinary discussion and reviewed especially if the specific person does have an active role in the service user's life when they are ill.

- A carer's assessment should always be considered and offered where a significant other is offering a caring role, even if this is at specific times only. They do not have to live with the service user. This should be included in the care plan and any relapse plan.

- To formalise the procedure for transfer of care from one practitioner to another. There is a clear process if the transfer is to another team and this needs to be extended to within teams to enable all aspects of attachment to be considered and addressed.

- A proactive approach should be taken when patients with severe mental illness are showing signs of relapse and there is indication that compliance with medication may be poor. It is recommended that there is a clear protocol for monitoring medication compliance for people who are considered to require sustained (long-term) treatment with antipsychotic medication. There should be a systematic method for evaluating medication compliance in such instances as part of the CPA. Whilst accepting that it is appropriate and commendable that patient choice and autonomy are recognised in the context of long term treatment with medication and patients are given responsibility to manage their own medication, we advise that such arrangements should be subject to regular and formal reviews, especially if there is evidence that the patient may be becoming non-compliant and / or showing signs of relapse.

- The formal audit process of CPA is continued and built upon to continue to improve the quality of documentation and that this reflects actual practice.

2.2 West Midlands Police

Summary of Involvement

West Midlands Police had little direct contact with the victim or her son. There were no reported incidents within the time scales set for the Domestic Homicide Review aside from attendance at the scene following the fatal incident.

The perpetrator first came to police notice in March 2002, when he called police stating that he was suicidal and had self-harmed. In September 2002, the victim reported concerns about her son's mental health and he was detained under section 136 of the Mental Health Act 1983. A month later, the perpetrator reported being 'mugged and raped' however this was not investigated as a complaint since he refused to discuss the allegation with officers. The circumstances of the report led the officers to believe that the perpetrator was trying to get a lift from Coventry to Birmingham as a 'victim of crime'.

Police had no further recorded engagement with the perpetrator until September 2005. He was apparently living in hostel accommodation provided for males with mental health issues. He was reported missing and two days later was again removed to a place of safety under the Mental Health Act after being found behaving in an 'aggressive and disorderly' way in a public place.

By 2009, the perpetrator was living independently close to his mother's address. Apart from a report of nuisance by local children in March 2009 he did not come to police notice until the early hours of 23rd March 2009 when a passer-by reported him lying 'naked in front of traffic'. He was detained under the Mental Health Act and subsequently taken to a specialist mental health unit, the 'preferred place of safety'. Police had no further dealings with the perpetrator until the tragic homicide of his mother.

Police dealings with the perpetrator were occasional and seemed to coincide with mental health deterioration. On two occasions some years apart, in 2005 and 2009, the perpetrator was detained for being 'aggressive' in a public place. There was nothing to suggest from police reports that he was violent to officers detaining him; more that his behaviour caused alarm and distress to passers-by. All of the recorded incidents relate to the perpetrator and although the victim was seen by officers it was because of her concerns for the welfare of her son rather than because of any identified concerns that related directly to her. Nothing in police records identified the perpetrator as a risk to others or particularly to his mother. The perpetrator had lived in a hostel in 2005 and was now living at his own address. The perpetrator had no convictions or cautions that would have indicated a risk of violence.

Analysis

It is of note that the engagement police had with the perpetrator were outside of the terms of reference set for the Domestic Homicide Review. On three occasions, in 2002, 2005 and 2009, the perpetrator was found in a public place exhibiting signs of mental illness and in need of immediate care and control and was taken to a 'place of safety' under the Mental Health Act Section 136 powers. Although the facts described in the 2005 incident suggested possible Public Order offences, the absence of any actual harm to a member of the public meant that the perpetrator was treated as a mentally vulnerable individual requiring care, rather than as a mentally vulnerable offender. On each occasion he was removed to a mental health hospital after spending varying periods of time in police custody.

Apart from the custody records and OASIS logs which record skeleton details of the incidents, there were no other formal records made describing the perpetrator's mental health issues, the impact they had upon him and any assessment of the risk he posed to himself or others. These are the kind of issues which would be addressed where a police officer met with a mentally vulnerable person whose mental health problems were not sufficiently grave to require the use of police powers to remove to a place of safety. These details would be included on a WC392 vulnerable person log (intelligence log) after the policy change in 2006, although the level of detail would depend upon the professional judgement of the reporting officer and the amount of detail that could be obtained from other professionals, from the subject themselves, or their family or friends. Paradoxically, where a mentally vulnerable individual's needs are such that officers invoke Mental Health powers under Section 136, there has been less likelihood that an intelligence log would be completed.

Although best practice during this period was that officers who had occasion to deal with a mentally vulnerable person would make an internal referral, in reality officers did not routinely follow this course of action; and the absence of an explicit vulnerable adult policy before 2006 meant that any referrals that were made, were often informal. As a consequence the few engagements police had with the perpetrator, if recorded as referrals, have not been transferred to searchable systems. The involvement of mental health professionals undertaking assessments in the custody area and subsequent admissions to hospital or other mental health provision tended to lead officers to believe that their responsibilities had been fulfilled. It is arguably not unreasonable for officers to assume that mental health professionals would assume responsibility for considering the needs of the mentally vulnerable person and their family if and when that person returned to live within the community with or without mental health support. However the absence of an intelligence log also removes an officer's ability to make their own observations concerning the risk that a mentally vulnerable individual might pose to their family or the wider community; information which could be significant in future safeguarding decisions.

More recent guidance on 'Safeguarding Vulnerable Adults' in 2011 was issued for officers and has repeated and clarified previous policies. Where officers make use of Section 136, because of mental health concerns of sufficient gravity in relation to a vulnerable adult that they pose a risk of harm to themselves or others, then this should be recorded on an intelligence log. The policy now allows officers to signpost a vulnerable person who may be experiencing a temporary low risk mental health crisis to health care without completing one.

The police had little or no contact with the victim and consequently there was no active consideration of the victim who was herself elderly and vulnerable.

Major changes in custody procedures in West Midlands Police were adopted in 2011 with the 'Safer Detention' Policy. The emphasis was upon a detailed recording on the electronic detention log details of the mental health assessments and of identified risk factors and protective factors. The statutory duty of care requires custody staff to take all necessary steps to mitigate risk where a risk is identified to the individual in custody or others upon their release. Sharing information with mental health professionals is a cornerstone of this policy. Under the NHS Health Care Commissioning currently being undertaken by West Midlands Police and Staffordshire, the health care needs (including mental health needs) of all persons in custody will be transferred to the NHS. This will mean that a professional health worker will be able to access the medical records of the person in custody and that joint agency assessment of risk based on known history will be possible for the first time. These changes will assist greatly where a mentally vulnerable offender is in custody.

The challenge therefore remains to ensure that officers who use Section 136 powers complete an intelligence log to ensure that key risk assessments and background information from health professionals and family is available should that mentally vulnerable individual come to notice of police in future. It could be argued that officers need to be reminded of the broader picture in relation to mentally vulnerable persons. Although placed in the care of mental health services following a crisis, at some point they will return home to live within the community. New officers may come into contact with the individual or their family and need to interpret behaviours and symptoms. It would be helpful if previous officers had identified in WC392s or intelligence logs, the key carers or supporters and included any professional guidance on what risk the specific mental illness might pose to the carer or the individual. Police need to know not only protective factors - supportive family, friends, neighbours - but also risk factors such as failing to follow a medication regime. During each of the mental health police crises of which police were aware, the perpetrator put himself at risk and posed a degree of risk of harm to others. Several officers were needed to control him and in detention he had to be closely observed.

West Midlands Police introduced detailed 'Mental Health Protocols' from 1st August 2006. These covered 'Uniform Operations' and provided officers with detailed guidance on mental vulnerability in a public place and the use of Section 136. It provided assistance on recognising indicators of mental vulnerability and a range of tactical options before the use of Section 136. It also acknowledged that a mentally vulnerable offender may need to be arrested where an apparent offence is of sufficient gravity.

It does seem that the decision to exercise powers under Section 136 of the Mental Health Act in the perpetrator's case were appropriate. The perpetrator spent time in custody which was generally related to the length of time it took to identify a suitable bed in mental health provision. The Act allows police to detain a mentally vulnerable individual in a place of safety for up to 72 hours to allow assessments to take place. The longest time the perpetrator spent in custody whilst these issues were clarified was 12 hours, which whilst not ideal, was well within legal limits on detention under Section 136.

The use of a place of safety designated by the health services as a 'preferred place of safety', a specialist mental health unit, is now fully implemented across the West Midlands Police area. It is

now very unlikely that a mentally vulnerable individual needing care and control under section 136 would be removed to a police station in the first instance, unless the preferred place of safety had no capacity. However the issues raised in the IMR concerning safeguarding considerations are likely to be just as pronounced when it is more likely that officers would use Section 136 powers to simply remove the apparently mentally ill individual to a hospital. The opportunity for agencies to share relevant information has probably lessened as procedures are more streamlined.

What seemed clear to the police IMR author is that the violent attack upon the victim by her son could not have been foreseen or prevented by police. Police had no engagement with the perpetrator for two years prior to the incident. After a period in mental health care in March 2009, the perpetrator had gone home. There is nothing on police systems to suggest that he placed himself or others at risk during this period.

Lessons Learnt

Although the IMR described a West Midlands Police mental health policy which is detailed and effective, it has highlighted weaknesses in information exchange between police and mental health services. The role of the two agencies is perhaps too focused upon the immediate care and control of a mentally ill individual during a mental health episode. There is currently little expectation from police that mental health services will share with them the current risk assessment of a patient no longer in mental health care who has returned to the community. Mentally vulnerable individuals may experience periods of crisis and mental health services may be of the view that they can be managed as a single agency. However if mental health services are aware of a current patient in crisis, there should be a discussion of any safeguarding considerations with both Local Policing Units but also Public Protection The police IMR author found it impossible to tell whether better information exchange could have had a positive impact in relation to the safeguarding of the victim.

It is the view of West Midlands Police that it is appropriate to remind officers of the need for searchable records to be completed for every use of section 136 Mental Health Act powers; this would be an effective enhancement to safeguarding. The completing officer would need to establish certain key information; identifying the family background and key carers, the history of involvement with mental health and their risk assessment. Officers should be able to identify the presence of high risk behaviours which may be controlled by medication or hospitalisation but which could easily be present in later police engagements.

Agency Recommendations

West Midlands Police identified the need to ensure that on each occasion a mentally vulnerable individual is moved by police to a place of safety under section 136 Mental Health Act, officers complete an intelligence log in line with Force Policy

2.3 Primary Care

The GP practice was formed in October 2008 as a partnership of three existing local GP Practices covering [*redacted – sensitive information*] areas of Birmingham. There are fifteen GPs working at the practice serving a population of 24,671.

Summary of Involvement

Both the victim and her son were registered with the same GP surgery to receive general medical services.

During the period covered by the terms of reference the surgery had no direct contact with the victim, other than to send routine letters each year offering her the opportunity of a flu vaccination. The victim did not take up this offer, nor did she visit the surgery at all during this period. She was not seen in person by anyone at the practice in the three years leading up to the homicide.

During the period covered by this review, the perpetrator visited the practice five times: three visits were unrelated to his mental health, one visit was for a blood test, and one was to discuss Olanzapine levels. He saw four different members of staff in the course of these visits. During this period the practice also received regular updates on the perpetrator's mental health from specialist mental health services, most frequently via correspondence from his Consultant Psychiatrist.

The perpetrator's medication was being prescribed by the Mental Health Trust rather than the practice. There was cause to invite the perpetrator into the surgery on one occasion to discuss his Olanzapine level on [two months before the homicide] [*redacted – sensitive information*]. This was found to be low following a blood test. This test was requested by the mental health clinic responsible for his care and the bloods were taken at a local hospital. On receipt of the test results the practice rang the perpetrator and arranged an appointment for him to attend surgery. The perpetrator responded quickly to this request. The GP was happy that he was in fact very well with no signs or symptoms of mental illness at that time. The records state*: "he is doing exceedingly well and the dose is reducing with agreement of his psychiatrist. He had successful mood balance counselling and is now able to recognise his mania triggers. This has allowed him to deal with his highs much better. He was previously worried re: being sectioned. Due to see his psychiatrist end of May".*

Analysis

There was no indication in the practice's patient record that the perpetrator presented a risk to his mother. Nowhere in this record or in the correspondence received from the mental health trust was his mother mentioned. The perpetrator did not present as violent, aggressive or as posing a risk to others on the few occasions when he attended the practice. There was no note or indicator (red flag) on his file to this effect - no record of any threats or intimidation being directed toward staff at the practice, nor toward his mother. The GP stated when interviewed that in the course of her consultations with the perpetrator [one and two months before the homicide] [*redacted – sensitive information*], she had no reason to suspect that the perpetrator's mental health had deteriorated or to believe that he represented any risk of violence to anyone.

Correspondence from the Mental Health Trust to the GP surgery was usually prefaced with a brief summary table which included diagnosis, treatment, risk indicators and crisis plan. There was no indication in the correspondence from the Mental Health Trust that the perpetrator's mental health was deteriorating. The last time the perpetrator was seen in person at the practice, none of the risk indicators in the correspondence were identified as being present.

The victim had no contact with the practice during the period of reference, and therefore the practice had no opportunity to either identify or respond to potential indicators of domestic abuse, or to identify her potential vulnerability, had such indicators in fact been present. There is nothing in the patient record to indicate that the victim either felt at risk of domestic abuse or was in fact experiencing domestic abuse. There is no mention of her son or of the nature of her relationship with her son in the patient record, and the victim and perpetrator were registered as living at different addresses.

The victim was elderly but there is nothing in the patient record to suggest that she either saw herself, or was seen by others, in general terms, as a 'vulnerable adult' as defined by Birmingham Safeguarding Adult Board multi-agency policy and procedures.

In summary, based on the correspondence received from specialist mental health services, the practice had no reason to believe that the perpetrator posed a risk to the victim. Nor had the practice reason to believe, from his presentation at the practice on such occasions they did have contact with him, that he was a risk to the victim or others. He did not mention his mother, or disclose anything that might have been cause for concern. He presented as mentally well. A letter from the Consultant Psychiatrist to the practice dated [six weeks before the homicide] [*redacted – sensitive information*], stated: *'I am delighted to report that he is really well… he is confident in managing his mood at the moment….. I have arranged to see him again in about 3 months but he has my mobile number and will give me a ring straight away if he notices any features of a worsening of mood'*.

The Practice Manager believes there was a good relationship with the mental health clinic responsible for the perpetrator's care, which is geographically situated very close to the practice. The records evidence that there were regular updates being received from specialist mental health services - this includes correspondence from the perpetrator's Consultant Psychiatrist, copies of correspondence indicating that the perpetrator had been referred to Clinical Psychology, and correspondence from his key worker. The GP was invited to attend his CPA review (although was not able to attend – this is not unusual). From the practice's point of view they were receiving assurance that the perpetrator's mental health needs were being actively monitored and managed by the specialists in this field. This information formed the basis of their reviews of his mental health needs, and the communication received from the mental health trust was an example of good cross agency working.

Lessons Learnt

(a) Good Practice

- The practice was kept regularly informed of the perpetrator's progress by specialist mental health services responsible for his care.

(b) Areas for Improvement

- There were no policies for safeguarding vulnerable adults or domestic abuse at the practice which would have acted as a reference for staff to follow, had abuse been suspected.

- There were no systems for identifying potential vulnerability to abuse, nor pathways for responding to concerns and assessing level of risk.

- Staff had received no training in safeguarding adults or in domestic abuse

Agency Recommendations

- The practice to review existing policies on safeguarding adults and domestic abuse, and ensure that these policies reflect the newly developed pan-West Midlands Safeguarding Adults Policy and the recent guidelines from the Royal College of General Practitioners on domestic abuse

- The practice to source training for staff on safeguarding adults and on domestic abuse.

- The practice to identify named leads for adult safeguarding and domestic abuse and to establish clear pathways for responding to concerns and assessing level of risk and establish clear pathways for responding to concerns and assessing level of risk.

2.4 Birmingham City Council Adults Social Care

Birmingham City Council offers a comprehensive range of adult social care services for the population of Birmingham. Adult social care services work in partnership with BSMHFT to deliver an integrated health and social care mental health service. During the period of involvement, 2005-2008, this was delivered in the form of a legal partnership agreement under Section 75 of the NHS Act 2006 that has subsequently been rescinded.

Summary of Involvement

The perpetrator was known to adult social care services through the mental health service which is delivered jointly with BSMHFT. People with severe mental health problems have their care co-ordinated under a Care Programme Approach (CPA). This is a particular way of assessing, planning and reviewing someone's mental health care needs. During this period social care records would have been recorded on the health files.

Mental Health Act Assessments (MHA) were undertaken on the perpetrator as follows:

- 01-10-2002, CPA Assessment Closure
- 04-11-2002, MHA –Legal Status Under MHA Prior to Assessment Section 5
- 18-12-2003, MHA –Legal Status Under MHA Prior to Assessment Section 2

- 09-12-2004, MHA-Legal Status Under MHA Prior to Assessment – Hospital – informal admission
- 09-12-2004 Request for Mental Health Assessment at the clinic – went to duty

The perpetrator's case was allocated to a social worker within the Community Mental Health Team (CMHT) for a period of three years, from April 2005 to March 2008. All case recording related to the perpetrator and there were no separate records held on the victim. There were a number of statutory reports held on the local authority file.

Key events and records of contact with the victim were included in hand written case recording. On 3rd October 2002, there was a referral for social work support with finding accommodation for the perpetrator. On 9th October 2002 it was recorded that a carer's assessment was to be completed on the victim and subsequently records that the victim declined the offer of a carer's assessment. The case was closed when the perpetrator said that he was leaving for USA. Subsequently on 30th October 2002, the perpetrator was detained under Section 2 of the Mental Health Act at an airport trying to board a plane to the USA. He was subsequently placed on a Section 3 of the Mental Health Act and discharged from Section in December 2002.

In February 2003 there was a reference made of the perpetrator being on leave at his mother's address and in March 2003 that he was keen to move from his mother's address. There was some subsequent contact with the perpetrator and his mother until he settled into his new accommodation, recorded as 25th April 2003.

In 2005, there was a reference to the perpetrator having seen his mother but keeping himself to himself. Concern was noted that he was not taking his medication. On 4th June 2006 it was noted that he had new accommodation with no further significant reference to the victim in notes ending 3rd March 2008.

Analysis

Birmingham City Council found evidence of a pattern of hospital admissions between 2002 and 2004, with 3 admissions each year due to non-compliancy with medical treatment. No information contained within the file indicates that there were any concerns requiring the need to escalate the level of involvement that Birmingham City Council had with the perpetrator.

The victim was identified as the next of kin on file and referred to as a carer. In 2002 reference was made to the victim declining a carer's assessment and then to one being completed later in 2002. In 2003, reference was made to a carer's assessment being completed by a student nurse. The Care Co-ordinator recalled completing a carer's assessment, possibly in 2006, but believed it was under CPA and placed on the health file. There is no copy of a carer's assessment on the file.

The definition of a "carer" is contained within legislation. The Adult Social Care document 'Support for Carers" states that:

You are a carer if you look after a friend relative or neighbour who has a long term disability, mental health difficulty, or is frail due to old age, and you are not paid for the care you provide (Support for Carers, 2010)

Supporting the victim to see herself as a carer would have ensured her contribution was recognised; that she was involved in planning individual care for the perpetrator and that her own needs were considered. A carer's assessment would have taken into account the effect caring was having on the victim and if she felt she was able to continue caring. The victim should have been supported to ask for a separate carer's assessment as she was providing substantial care or regular care and this may have affected her health, her ability to look after her home and her social life.

While the perpetrator was often ambivalent about support from mental health services, the victim should have been offered the opportunity to talk separately to a social worker as she may have felt unable to talk freely in front of her son. The victim seems at times to have wanted her son in hospital and believed he needed medical treatment.

The Carers Strategy (2010) sets the standard that carers should have an assessment of their caring, physical and mental health needs on at least an annual basis. Carers should have their own written Care Plan which is given to them and implemented in discussion with them. The Carers (Recognition and Services) Act 1995 gives carers the right to an assessment.

The victim seems to have made little or no use of formal health or social care support and managed by herself but did appear to know how to contact mental health services.

***Lessons Learnt*:**

Local Authority files should contain up-to-date CPA care plans and risk assessment. A copy of the Care Plan must be placed on file. There is a need to improve the detail regarding important personal relationships. There was no detailed information in relation to the 'difficulties' that the victim may have been experiencing on occasions. Records stated that the victim was finding it difficult to cope with the perpetrator. Their relationship was recorded as being 'problematic' at times but at other times their relationship was described as 'good'.

Local Authority procedures require that, if an assessment is completed under the Carers Act or under CPA establishing that regular / substantial care is provided, it should be opened as an event (important when there are separate Health and Local Authority files).

A carer's assessment might have identified a potential risk regarding the perpetrator deciding to stop taking his medication and his ability to 'mask' his symptoms.

There should be an annual discussion to check with the carer their physical and emotional health and any changes in the care provided. In this case, the victim had said she was unable to provide care in her own home.

Agency Recommendations

Birmingham City Council identified the need for their organisation to:

- To improve recording practice to ensure that the detail regarding important personal relationships is included in records.

- To ensure that in cases where the service user is on enhanced CPA, the Local Authority file contains a copy of the CPA current care plan and risk assessment.

- To ensure that Local Authority procedures are followed in every case – these require that an assessment completed under the Carers Act or completed under CPA and establishing that regular / substantial care is provided should be opened as an event (important when there are separate Health and Local Authority files).

- To ensure that carers are offered a carer's assessment and are supported and encouraged to have an assessment.

- To ensure that a copy of the carer's assessment is retained on the file.

- To ensure that carers have their own file if assessed as requiring services.

- To ensure that carer's assessments are annually reviewed and up-dated.

- To review the information sharing and record sharing protocol with BSMHFT to ensure that there is effective sharing of records across the two agencies when both are involved in supporting a service user and their carer.

- Birmingham City Council Carer's Strategy should ensure an audit of case files to ensure carers assessments have been offered where appropriate

2.5 Information from friends of the family

During the police investigation of the homicide, statements were taken from family members, longstanding acquaintances and neighbours. Family and friends of the victim were identified from the police investigation and invited to contribute to the review. The victim's only direct relative did not wish to be involved as she had no contact for many years. A further six friends and acquaintances were contacted of which three responded and were interviewed [*redacted – sensitive information*].

This summary is based on evidence from family and friends who were interviewed by the police during the investigation, and the interviews completed by the panel chair and panel member. Friends and acquaintances were consistent in their views and information.

The victim had lived at her address for over forty years, initially with her husband but after his death ten year's previously, on her own. She had acquaintances rather than close friends. The victim had a sister but they stopped contacting each other around 1991, although according to her sister there was no specific catalyst for this estrangement.

The perpetrator had been married for twelve years. [*redacted – sensitive information*]. There was no history of domestic abuse in his relationship [*redacted – sensitive information*].

The perpetrator was reported as having a very close relationship with his mother but an 'unusual' relationship with his father who was described as trying to control the perpetrator, *"whatever (the perpetrator) did was never good enough in his dad's eyes".* [*redacted – sensitive information*].

The perpetrator lived with his mother for about two years following his divorce. During this period his father died. After the perpetrator moved into his own accommodation in 2002, it would appear that he was not a regular visitor although friends knew that the victim supported him with very regular phone calls. Friends all reported that the victim said she had no support with her son. When he was staying with her, she chose to distance herself from friends with whom she was in regular phone contact, asking them not to call for fear of disturbing him.

Although one particular friend was asked not to call when the perpetrator was with the victim, it was recollected that the victim had an extra lock put on her front door so that her son could not get in unannounced.

Friends described the victim as a very private, reserved and self-sufficient person. She was also independent, strong minded, loyal and with a good sense of humour but rather 'prickly' at times. Friends said that she had become very isolated when she became a widow, only leaving the house very occasionally, and most of her contact with friends was by telephone.

In relation to the perpetrator, she was thought to be relieved when her son was in hospital. Friends thought that she was not fearful of her son and had never referred to any physical violence, but she had a wariness of him due to his demanding money and a wariness of his unpredictability.

Their friends could provide no evidence of the victim being offered support and turning it down and were unanimous in their view that she was, and felt, unsupported by agencies. The victim had told them that she had no support and felt that nobody, including the GP and Psychiatrist wanted to know and spoke to one friend of feeling badly let down. They described a repetitive cycle: as soon as the perpetrator had 'settled down' after being discharged from hospital he would stop taking his tablets, start drinking, have to go back into hospital and the cycle started again. It was suggested that it was well known that he didn't take his medication and that his mother would tell him about taking his medication. When the perpetrator moved in with his mother when he was unwell, she would ask friends not to telephone and tended to whisper, presumably so that her son could not overhear what she said.

The Responsible Clinician for the perpetrator's care was interviewed in relation to his current mental state and capacity to be interviewed by the DHR team. *[redacted – sensitive information]* It was recommended that at present and for the foreseeable future the perpetrator should not be interviewed by the DHR panel.

The Consultant Psychiatrist confirmed that he had only recently become the perpetrator's Responsible Clinician. However, what was evident from previous clinical teams and multi professional assessments is that the perpetrator had not previously posed any major risks of violence especially to those close to him - his index offence being clearly linked to his mental state at that time. *[redacted – sensitive information]*

2.6 Summary/overview of what was known to agencies

The perpetrator was well known to, and actively engaged with, mental health services and came to the attention of police and other agencies as a direct result of mental health episodes. He suffered from an enduring mental illness and relapse was usually associated with failing to take his medication. He could become ill very quickly, and could mask the true extent of his illness, and didn't usually disclose that he was not taking medication. Increasing the use of alcohol was a recognised symptom of relapse, as was the onset of delusions relating to black magic and visual hallucinations. He often heard voices and these worsened during times of relapse. The perpetrator, when unwell, was considered a risk to himself rather than to others. Though his behaviour could cause anxiety with the public, and he could become aggressive (with staff and with police officers detaining him) he had never posed a risk to others.

Though much is known about the perpetrator, very little is known by the agencies about the victim, who had little or no contact with agencies, despite playing a significant supporting role when he was unwell. Agency records are contradictory, variously suggesting a close and positive relationship and a problematic one. The perpetrator had made a disclosure of abuse by his mother during childhood and a suggestion that the voices were linked to controlling parent figures. However, the evidence suggests that they had regular contact – daily telephone calls and weekly or fortnightly visits. The perpetrator had his own flat close to his mother's address and had moved in with his mother prior to the homicide because he said he felt safe there. There is clear evidence that he had been unwell and had not been taking his medication for some time prior to the homicide, and that the homicide was driven by acute and florid psychosis. There was no known history of domestic abuse within their relationship and the victim was not identified as a vulnerable adult – indeed, she appears to have been relatively fit and healthy for her age.

2.7 Analysis

With regard to the first three terms of reference:

TOR 1 To establish whether it was known, or could have been suspected, that the perpetrator posed a serious risk to his mother, the victim, and whether any action could have been taken to prevent the homicide. To establish whether the domestic homicide was predictable or preventable.

TOR 2 To identify how effective agencies were in identifying the victim's vulnerability to domestic abuse and whether risks were identified and appropriately managed

TOR3 To identify how effective agencies were in identifying the risks that the perpetrator posed to the victim or others, and how effectively such risks were managed

There was no evidence to suggest that the perpetrator posed a risk of violence towards his mother. When he became unwell he was usually a risk to himself, because of the risk of self-harm or suicide. He could become hostile and aggressive in circumstances when he was being detained or restricted by police officers or hospital staff, but there had been no risks of violence to the victim or the public. There were incidents of damage to property and on one occasion throwing bottles at passing cars. The victim was not present during these incidents and there had been no reported incidents of assaults on his mother or on others. It is the view of the panel therefore that the homicide could not have been predicted.

However, the lack of involvement with the victim by agencies makes it very difficult to be certain whether the homicide was preventable given the contradictions about their relationship and lack of an assessment of risks**.** Agency intervention may not have prevented the homicide but would have impacted on the victim by reducing her isolation and supporting her better in her caring role.

It is of concern that throughout the perpetrator's engagement with mental health services, there was little contact between the agencies and the victim and very little knowledge about their relationship. There is no record that the perpetrator did not want her to be contacted and it was known by agencies since 2002 that the victim found it difficult to cope with his behaviours when he was unwell. However, it would appear that no attempts were made to engage with her at times of assessments or reviews, or to further explore the difficulties she referred to. The facts paint a picture from the victim's perspective of an elderly woman who was isolated and unsupported in the care of her only son, and who did not trust authority.

There are contradictory records regarding their relationship, ranging from positive and supportive to allegations that she had abused him as a child. These contradictions were not explored or an attempt made to establish the true nature of the relationship, to assess what support the victim might need when her son was unwell, or to assess whether this placed the victim at risk. It is recorded that the perpetrator was seeing a psychologist to address childhood issues and he also stated that the voices were connected to childhood parenting issues, which would suggest some risk to his mother that should have been taken into account. However, this information was not shared with other members of the care team including his psychiatrist. It was unknown what impact these sessions were having on the perpetrator's mental health.

After the homicide, the perpetrator suggested that his mother had felt let down and unsupported by services, and this perception has been reiterated by the friends interviewed. Though records suggest that the victim was offered a carer's assessment, it appears that this was declined (though other records suggest one was completed, this is not on the file). It is highly likely that after he moved out of her house in 2002, the victim didn't consider herself to be a "carer". However, there is a statutory duty for professionals to offer a carer's assessment and to take into account the carer's needs during the assessment, for any carer who is offering regular and substantial care to someone who needs community care services. It can be argued that the victim's daily contact with her son and her involvement when he was unwell met this definition. However, the refusal to accept a formal carer's assessment does not mean that no consideration should be given to her needs or

establishing what support she may need when her son was unwell and this is clearly a gap in this case.

On the day before the homicide, the victim contacted the clinic to say that she was concerned about her son's mental health. This was highly significant and unusual, and the only time previously she had made contact with agencies was when her son was very unwell and these contacts always preceded serious mental health episodes. The history suggests that the victim would only make contact on the rare occasion that she was seriously worried by his behaviour. Though the telephone call was dealt with promptly and referred to his Care Co-ordinator, no-one rang the victim back or gave her an opportunity to discuss her concerns in confidence, or to identify what it was about his behaviour that was worrying her. Instead, the Care Co-ordinator rang the perpetrator to tell him of his mother's concerns. Subsequently an outpatient's appointment was offered the next day and the victim accompanied him. This again was unusual and the first time she had done so, this being the first time the psychiatrist had met her. At the appointment, it was recorded that *"she didn't want him admitted", "didn't feel he was very unwell"* and that *"he will do as I ask, he's a good man".* This was a missed opportunity to elicit more detailed information from the victim about her son's behaviour and symptoms, as well as how able she was to care for him.

The findings of the Serious Incident Review completed by the Internal Homicide Review Team of Birmingham & Solihull Mental Health Foundation Trust clearly demonstrate that the perpetrator was unwell at the time of the incident and was under the influence of alcohol. It was extremely likely that he had not been taking his medication for some time, and this incident mirrors previous episodes when he did not disclose that he was not taking his medication. He had failed to recognise early warning signs of relapse and did not seek help and the evidence suggests that he was very psychotic for some time before the incident. Whilst it is commendable to recognise patient choice and autonomy in the management of treatment, there was an over-reliance on self-reporting, particularly given his history of non-compliance. At the final appointment on the day of the homicide it was accepted that he had re-started his medication because he said that he had – there was no robust monitoring put in place for this.

At this appointment, it was recognised that there was a risk that the perpetrator could deteriorate very quickly. However, the Care Plan of utilising Home Treatment was not followed. The perpetrator was offered Home Treatment but refused it. Had he been presented with the option of hospital admission, he later indicated that he would have accepted Home Treatment as an alternative to in-patient admission. The clinical team indicated that they felt they could adequately monitor him and offered an appointment in two days, and also gave him the mobile number of his Consultant Psychiatrist for 24/7 contact (though this was not given to his mother). If referred for Home Treatment he would have had as many daily visits as required in addition to 24 hour access to staff. A further visit would have taken place on the day of the homicide. Although it is possible that staff would not have seen him as he had gone to the pub, they would have seen his mother. This was a missed opportunity as they may have picked up on further deterioration of his mental state.

Based on the evidence it is difficult to speculate whether this homicide was preventable. It is impossible to say whether the homicide was targeted at the victim or whether his psychotic experiences meant that he could have targeted any individual who was in his presence when hallucinating. What is known is that the perpetrator's violence against another individual could not have been predicted given that he had no history of violence against others. Whether the homicide

could have been prevented is debatable – Home Treatment may have presented an opportunity to pick up his deterioration and thus have prevented the homicide, but this is by no means certain as it would have been determined by staff visiting and assessing him at the right time, or by staff seeing his mother and identifying from information she provided that he had deteriorated.

TOR4 To establish how well agencies work together and to identify any gaps and/or changes that are required to strengthen inter-agency working, practice, policies or procedures to improve the identification of people subject to domestic abuse within Birmingham

There is clear evidence that within BSMHFT there was a failure to share information across the team – there was a lack of joint working across clinical services with no one professional having the full picture. Though issues had been raised during psychological therapy, these had not been shared or explored further. There are still no clear records of what work had been completed by the psychologist (who has now left the organisation) over a seven year period. Likewise, though the perpetrator had completed 'Mood on Track', the outcome was not recorded on his Care Plan and so valuable information about his relapse signs was not shared. It should be noted that the Trust has introduced a new electronic recording system – RIO – which does bring all records in one place, and makes these accessible to all members of the clinical team.

It was also noted that the perpetrator's Care Co-ordinator of 8-10 years had retired and that there hadn't been a planned handover or transitional meeting with the perpetrator to formally introduce the new Care Co-ordinator. The impact of change can be significant, and this was at a time when the perpetrator was unwell and becoming more psychotic.

The mental health service is an integrated health and social care service with social work staff employed by Birmingham City Council but working within the CMHT. The IMR process identified a lack of a joined up approach and it was difficult for the panel to make sense of the roles of each service – for examples, records appear to be held separately, and there was a lack of clarity around the roles and responsibilities of each agency. There was clear evidence that records are not adequately shared across the two agencies.

The evidence suggests that there is generally good inter-agency working between the police and mental health services and police interventions were appropriate within the working practices that were in place over the timeline (these had changed significantly between 2002 and the date of the homicide). New place of safety arrangements are reported to be working well, and people are admitted to the mental health unit for assessment rather than a police cell. However, the review identified two key areas of improvement;

- Recording of relevant information on people with a known mental health history could be strengthened so that police officers called to an incident have a better awareness of previous history, rather than managing each incident in isolation

- The safeguarding team could be used as a conduit for sharing information about vulnerable adults or where there are identified risks

However, neither or these actions would have impacted on the homicide or the outcome of this case.

The review also identified that working relationships between the GP practice and the mental health service were generally good. The GP was kept informed in a timely way of the perpetrator's mental health and treatment although there was a gap in that the GP was not aware that non-compliance with medication was a key indicator of relapse. The review identified a gap in training on safeguarding and domestic abuse, but this would not have impacted on the outcome.

SECTION THREE – CONCLUSIONS AND LESSONS LEARNT

The review panel, after thorough consideration, believes that under the circumstances it is very difficult to state whether agency intervention potentially could have or would not have prevented the victim's death, given the information that has come to light through the review. The evidence suggests that there was no known history of violence by the perpetrator against the victim or others and it is conclusive that there were no recorded incidents of domestic abuse. However, different agency intervention would certainly have reduced the victim's isolation and provided her with better support as next of kin and sole carer.

The decision to leave the perpetrator in the care of his mother on the day of the homicide was made on the basis of their stated wishes when they attended the appointment that morning– both wanted him to remain with the victim. However, no consideration had been given as to whether the victim was able to cope with him when he was unwell, and the opportunity to explore her concerns about his mental state had been missed. No risk assessment was completed and the decision was made based on accepting the perpetrator's word that he was re-starting his medication, and in isolation of information held about their relationship by other professionals. Furthermore, the Care Plan wasn't followed – had it been, then a referral to Home Treatment would have been pursued and it is possible that the perpetrator and the victim would have been seen again later that day or evening, as well as there being increased monitoring of his compliance with medication. It is difficult to judge with any confidence whether such intervention may have prevented the homicide. However it would have provided an opportunity for further assessment through seeing the perpetrator and/or the victim. Staff may therefore have picked up his deterioration, and this could have resulted in action being taken that better protected the victim. It is also possible that staff may not have found him, or seen him at the point of deterioration, and it is important to remember that there was no predictor of violence against others.

The lessons learnt by each individual agency have been set out within the agency reports (IMRs) along with individual agency recommendations for improving multi-agency working. This section summarises the overarching lessons that have been learnt from the review. These include lessons regarding agency or multi-agency intervention that may have impacted on the outcome, as well as general lessons about how practice can be improved.

3.1 The engagement and involvement of the victim, as mother and sole carer of the perpetrator, was inconsistent and inadequate.

Mental ill health affects one in four of the adult population at some time in their lives and covers a range of conditions from mild to severe. The perpetrator has suffered from a severe mental health condition, classified as "serious and enduring illness", since 1999. The impact of mental ill health is not just confusing and difficult for the sufferer, but also has a major impact on the lives of family, friends and relatives, regardless of the extent of their caring role.

The Carers (Recognition and Services) Act 1995 provides that a local authority must take into account the results of a carer's assessment in making the decision as to whether the cared-for person's needs call for the provision of community care services.

The importance of this in relation to people with mental illness was reinforced with the Royal College of Psychiatrists and Carers Trust (formerly The Princess Royal Trust for Carers) joining forces to launch the 'Partners in Care' campaign in January 2004. The objectives of the campaign were to highlight the problems faced by carers of all ages of people with different mental health problems and learning disabilities and encourage true partnerships between carers, patients and professionals. This is one example of a wealth of literature and research that emphasises the importance of involving carers and family members – with the person's permission – and emphasises the statutory responsibilities for health and social care professionals to complete carers assessments and take into account carers needs when planning care and support, as described in the Law Commission report on adult social care legislation in 2011

"…*the regulations could specify who is to be consulted in an assessment. The legal framework already sets out some requirements. In particular, the Community Care Assessment Directions 2004 require that in assessing a person under section 47(1) of the NHS and Community Care Act 1990, a local authority must consult the person, consider whether the person has any carers and, where they think it appropriate, consult those carers."*

Consultation completed by the Law Commission has confirmed the fundamental importance of this requirement. Their conclusion states: "while we generally consider that regulations provide an appropriate place to prescribe the detail of the assessment process, we agree that the exception to this should be the duty to consult service users and carers. Indeed, this would build on the statutory principle we recommend in Part 4 (Statutory Principles) that individuals should be given the opportunity to be involved, as far as is practicable in the circumstances, in assessments, planning and developing and reviewing their care and support.

The panel noted that the perpetrator had stated after the homicide that his mother had felt unsupported by mental health services and this was reiterated by friends who were interviewed. There was no recorded evidence that the perpetrator had stated that he did not want staff to contact his mother.

The review paints a stark picture of the victim as an elderly mother who was extremely isolated, with little or no involvement with mental health or social care services and the evidence suggests that her concerns were not adequately explored, or clarified as to how she found his behaviour difficult to cope with. From the victim's perspective, she was trying to cope with an only son whose

behaviour when unwell would have been worrying due to his unpredictability. The evidence suggests that the victim declined the offer of a carer's assessment (with some question as to whether one was ultimately completed, but if so, there is no copy) and that, from her perspective, she did not identify herself as a carer. This is not uncommon but should not be a barrier to exploring key relationships, listening to carers, and developing a clear understanding of family dynamics. This is especially essential when a family member such as the victim takes a more active role when someone is unwell and is central to decision making when deciding whether to treat someone in the community or as an in-patient.

What little information was recorded regarding the victim and her relationship with her son was contradictory. There had been no overview of this or further exploration to test out the contradictions. Whilst there was clear evidence of her active involvement and close relationship with her son, the allegations of abuse were significant both in terms of the inter-face between abuse and mental health, and in relation to any potential risks the perpetrator may have posed to his mother.

All health and social care agencies have a responsibility to recognise those carers whose carer's duties have a significant impact on their lives. The evidence from friends and acquaintances suggests that coping with her son's mental illness did have a significant impact on the victim's life when her son was unwell. In circumstances where there is an impact on a carer's life, further work should be done with the carer to explore their needs, even if they are declining support available to them. It is important to recognise that families may feel they have a duty to care for, or want to care for, their family member, despite the impact that this may have.

It is important to think about and explore why the carer might not want help, discussing their needs and feelings, and explaining what's on offer. There is no evidence to suggest that the victim was supported to explore her own needs or concerns.

"*Caring for someone with a mental health problem can be more varied than for other carers. A person with mental health problems may not need much assistance at certain times, but need a large amount of care at others. And, as the symptoms of mental health problems are sometimes unpredictable, it can be particularly worrying*" (National Mind, how to cope as a carer).
Carer John's Story:

"*The main casualty in our relationship has been trust. My partner often thinks that my concerns, although innocent, are a just way for me to get her into hospital. I often find myself questioning things like 'has she taken her medication?' or 'is she about to run away/attempt to take her own life'? There have also been times when members of my family have felt that there is nothing wrong with my partner; that she is only attention seeking. This has been hurtful, maybe even offensive at times"* (Carers Trust).

3.2 The victim's concerns about her son's mental state were not explored or fully understood; information about the victim's telephone call was shared with her son.

It was unusual and significant for the victim to contact mental health services and express concern about her son's mental state. No-one rang the victim back to ascertain exactly what her concerns were, what symptoms or behaviours her son was presenting or to assess how she was coping.

The perpetrator was however contacted instead, and told that his mother had rang the clinic. He complied with the request to attend for an outpatient's appointment and the victim accompanied him. This was also very unusual. Though the victim was alone with the Consultant Psychiatrist, she did not express any further concerns about her son's behaviour, and neither were these explored. She did not say that she felt she was at risk – but equally she had not been asked.

The dynamics of family relationships when someone is seriously mentally ill can be complex and sensitive. The perpetrator had previously been admitted as an inpatient and records suggest that the victim found this as distressing as her son (though friends described it as a relief or respite). The perpetrator is described as paranoid and suspicious when unwell and this could have applied to his mother as well as professionals. This paranoia could have been increased by the perpetrator being told that his mother had contacted the service, and it could have been interpreted as the victim trying to get him admitted to hospital. We do not know what the victim's motivation was in attending the in-patient clinic with her son on the day of the homicide. This could have been protective – to make sure he attended and did as he was told. It may have been that she wanted an opportunity to speak out and express her concerns but didn't do so (there is clear evidence that people subject to domestic abuse or abuse may intend to speak out, but fail to do so for various reasons, or just are not asked the right question), or the perpetrator may have coerced her into attending to assure the clinician that he wasn't that unwell and to agree to him remaining with her – this type of collusion is again not uncommon in such circumstances.

It is essential therefore, that systems are in place that ensure that carers or relatives who express concerns are contacted and able to discuss their concerns in detail and in confidence, and that these are listened to. This not only ensures effective involvement of family, but also provides clinicians with important intelligence about symptoms and behaviours.

3.3 Recording systems and working practices that were in place at the time were inadequate and resulted in information not being shared with the multi-disciplinary team

Until recently records were kept on paper files and were not shared across disciplines. The perpetrator had participated in the 'Mood on Track' programme which had identified a set of relapse early warning signs. However, this was not recorded on his Care Plan or shared with his GP. This was critical information that would have helped the clinical team recognise that he was relapsing. In addition, the perpetrator had been receiving counselling from a psychologist. The notes from this intervention are not available and the member of staff has left the organisation. It was known that this included exploring the impact of alleged abuse during childhood but no information on this was shared with the rest of the clinical team. This would have been extremely relevant given the known impact of abuse on mental health and well-being and records suggest the abuse *may* have impacted on the perpetrator's delusions. No single member of the clinical team held the full information about the perpetrator and significantly, the relationship with his mother. It is essential that information is shared across the whole team, that all information is recorded and that all clinicians can easily access the information. The panel have noted that a new recording system, RIO, has been introduced and that all clinicians are now required to input records onto this central system.

3.4 Health & Social Care Assessments and risk assessments were not regularly reviewed and up-dated

The Care Programme Approach (CPA) is the process by which specialist mental health services identify someone's needs, put in Care Plans to meet those needs, and monitor them to check that needs are met. There was evidence that the perpetrator's Health & Social Care Assessment was out of date, as highlighted in the issues raised in 3.3 above regarding recording. This also included a failure to investigate a disclosure of rape that was made when he was a hospital inpatient.

Though there was an up-to-date risk assessment, this had not been fully completed and only focussed on the risks to the perpetrator. Though there was no history of violence towards others, the perpetrator had presented behaviours that were worrying to others in the past.

There had been no risk assessment in relation to his relationship with his mother or any assessment of the risks of allowing him to live with his mother when unwell. There appears to be a degree of complacency regarding the victim's supporting role and no assessment of risk based on her concerns about coping with his behaviours – concerns which were first reported by the victim in 2002, and not just raised the day before the homicide.

3.5 There was an over-reliance on self-reporting on compliance with medication with signs of relapse being missed

The perpetrator had a history of failing to take medication and this was a key sign of relapse. It was also recorded that he could be plausible in masking symptoms and the fact that he was not taking medication. He admitted that he had not been taking medication for some time prior to the homicide and also stated that he had not disclosed this or been asked. Blood tests taken, three months before the homicide, indicated that the perpetrator was taking sub-therapeutic levels of medication. Whilst it is good practice to give people autonomy in managing their own illness and management of medication, this requires the right balance when a failure to take medication is a sign of relapse. Too much reliance was placed on trusting the perpetrator's honesty about medication, and there was no robust monitoring or close supervision, despite the worsening of his symptoms and evidence of self-altering medication levels.

There needs to be a more proactive approach when people with severe mental illness are showing signs of relapse and there are indicators of poor compliance with medication. This needs to be systematic within the CPA process and properly audited.

3.6 There was a failure to follow the Care Plan and refer to Home Treatment Team when there were clear signs of relapse

As previously identified in 3.3 above, not all information was recorded in the Care Plan. There is some evidence of confusion between what were early warning signs versus signs of florid illness. *"The care plan placed responsibility on (the perpetrator) to contact the service in the case of him identifying early warning signs or relapse, even though it was known from his previous history that he had not been able to identify early warning signs and had not contacted services when in relapse"* (Serious Incident Root Cause Analysis). The Care Plan indicated that if the perpetrator deteriorated quickly when ill, there should be a referral to Home Treatment and/or consideration of hospital admission. On the day of the homicide, there were clear signs that the perpetrator had

relapsed and the Internal Homicide Review Team were not convinced that a robust and alternative plan was in place after he had been seen that day.

It is essential that care planning includes all the relevant information on safe and effective management, is multi-disciplinary, includes next of kin/carer in planning, and the agreed care plan must be followed.

3.7 There was a lack of a transitional process to introduce the new care co-ordinator

The perpetrator had been supported for eight to ten years by his Care Co-ordinator, a CPN, and this was therefore a long standing and important relationship. A change of worker in such circumstances can have a big impact on someone, and the evidence suggests that this change did coincide with a period when he was relapsing. The perpetrator was informed the week before the change that his Care Co-ordinator was retiring and there was no planned transfer of care to the new Care Co-ordinator. It is essential that a formal procedure is put into place for the transfer of care from one clinician to another.

3.8 The Primary Care practice were not fully aware of the relapse signs and the significance of non-compliance with medication

Though the working relationship between the mental health service and the GP practice was good, the evidence suggests that the practice were not fully aware of the symptoms of relapse, and specifically in relation to non-compliance with medication. It is essential that this information is shared so that GPs are able to recognise signs of relapse and alert mental health services.

3.9 There are good working relationships between West Midlands Police and mental health services; these can be strengthened by enhancing police records on people known to have mental health conditions who are in contact with the police

The review has identified that working relationships across police and mental health services are good and particularly good in relation to police powers to detain under the section 136 of the Mental Health Act. It was identified that this could be improved further by better recording on police records so that officers are better informed about the previous history. However, this would not have made a difference in this case.

SECTION FOUR - RECOMMENDATIONS

1. Key stakeholders, local CCGs and NHS England Area team work jointly to promote best practice in safeguarding and supporting carers.

Recommendations for Birmingham & Solihull Mental Health Foundation Trust and Birmingham City Council Adults Social Care*:*

2. BSMHFT and BCC put in place procedures and monitoring arrangements to ensure that the assessment for specialist mental health services involves and includes all significant others living with and involved in the life of the service user.

It should be clearly stated in the records of both agencies, or any integrated records, that this discussion has taken place and if the service user does not want someone specifically involved in their care this needs to be documented with the reasons why clearly stated. This should be part of a multi-disciplinary discussion and reviewed especially if the specific person does have an active role in the service user's life when they are ill.

3. BSMHFT and BCC put in place procedures and monitoring arrangements to ensure that all health and social care assessments, risk assessments and carer's assessments are regularly reviewed and up-dated as directed by the CPA process, and at a minimum annually.

As set out in the previous recommendation, it must be ensured that significant others living with and involved in the life of the service user are involved at each review, unless it has been clearly documented that the service user does not want someone specifically involved. In the case of the latter, this decision must be reviewed as part of the Care Plan. Risk Assessments must record the risks to self and others and describe the rationale for the judgement

4. BSMHFT and BCC put in place procedures and monitoring arrangements to ensure that a carer's assessment is always offered where a significant other is offering a caring role, even if this is at specific times only.

They do not have to live with the service user or consider themselves to be a carer, but

- Must be supported to and encouraged to have an assessment.
- This should be recorded and included in the care plan and any relapse plan.
- If a carer's assessment is declined, this must be clearly recorded, and the records must record details of significant relationships.
- A copy of the Carer's Assessment must be retained on both the social care file and the health file, or the integrated file if available.

5. BSMHFT and BCC jointly review the information sharing and record sharing protocol to ensure that records are integrated to enable effective sharing of records across the two agencies when both are involved in supporting a service user and their carer.

If separate files are held, BCC must also follow Council procedures in every case ensuring that

- Carers have their own file if assessed as requiring services
- The carer's assessment is opened as an event
- The Council file contains a copy of the current CPA Care Plan and Risk Assessment

Recommendations for Birmingham & Solihull Mental Health Foundation Trust

6. BSMHFT put in place processes that ensure that relatives or significant others contacting services to express concerns about a patient's mental state are given the opportunity to share their concerns with the care co-ordinator or responsible clinician.

Relevant information elicited from significant others

- Must be shared with the clinical team
- The process for sharing of information/concerns with the service user is discussed with the carers/relatives
- The implications of sharing information with the service user is taken into consideration and discussed with the carer

7. BSMHFT put in place processes to ensure that Care Plans are followed

8. BSMHFT implement a clear protocol for monitoring medication compliance for people who are considered to require sustained (long-term) treatment with antipsychotic medication.

Whilst it is appropriate and commendable that patient choice and autonomy are recognised in the context of long term treatment with medication and patients given responsibility to manage their own medication

- Such arrangements must be subject to regular and formal reviews
- A proactive approach must be taken when patients with severe mental illness are showing signs of relapse and there is indication that compliance with medication may be poor.
- There should be a systematic method for evaluating medication compliance in such instances as part of the CPA.

9. BSMHFT implements a procedure for the transfer of care from one practitioner to another.

There is already a clear process if the transfer is to another team: this needs to be extended to transfers within teams to enable all aspects of attachment to be considered and addressed.

10. BSMHFT should improve record keeping procedures to ensure that information is available to all members of the team.

This should include the following actions:

- Continue to implement the formal audit process of CPA and further develop the audit process to improve the quality of documentation and ensure that this reflects actual practice.
- Audit the new RIO record database to ensure that it is capturing all information from services and practitioners that are involved with patients.
- Put in place a protocol that ensures that GPs are provided with information regarding signs of relapse.

Recommendations for West Midlands Police

11. West Midlands Police ensure that on each occasion a mentally vulnerable individual is moved by police to a place of safety under section 136 Mental Health Act, officers complete a WC392 in line with Force Policy

Author:

Kathy McAteer
Independent Social Care Consultant