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
BDHR2012/13-03

Report produced by Malcolm Ross MSc
Independent Chair and Author
Presented to Birmingham Community Safety Partnership
on 23rd August 2013

Glossary

AMHP: Approved Mental Health Practitioner
BCC: Birmingham City Council
Birmingham East & North Primary Care Trust: Primary Care Trust responsible for commissioning mental health services in Birmingham
Birmingham & Solihull Cluster: Primary Care Trusts responsible for commissioning local health services (until 2013 when statutory responsibilities transferred to the new Clinical Commissioning Group)
BCSP: 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
EIS: Early Intervention Service in Birmingham & Solihull Mental Health Foundation Trust
HTT: Home Treatment Team in Birmingham & Solihull Mental Health Foundation Trust
IMR: Individual Management Review – reports submitted to review by agencies
MHA: Mental Health Act
NAIS: Neighbourhood Advice and Information Service, Birmingham City Council
OASIS: log used by Police
RIO: electronic database and recording system used by Birmingham & Solihull Mental Health Foundation Trust

CONTENTS ..... **Page**

SECTION ONE: INTRODUCTION AND BACKGROUND

1.1 Introduction

This Domestic Homicide Review (DHR) examines the circumstances surrounding the death of a Birmingham woman. Her son was arrested and charged with her murder. He appeared before Birmingham Crown Court, was found unfit to plead and was given an indefinite hospital order.

1.2 Purpose of a Domestic Homicide Review

The Domestic Violence, Crimes and Victims Act 2004, establishes at Section 9(3), a statutory basis for a Domestic Homicide Review, which was implemented with due guidance[1] on 13th April 2011. Under this section, a domestic homicide review means a review "*of the 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 house hold 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 DHR is to:

- Establish what lessons are to be learned from the 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 the policies and procedures as appropriate; and
- Prevent domestic homicide and improve service responses for all victims and their children through improved intra and inter-agency working

1.3 Process of the Review

West Midlands Police notified the Birmingham Community Safety Partnership (BCSP) of the death immediately after the homicide. The Birmingham Domestic Homicide Review Steering Group, a sub-group of BCSP, reviewed the circumstances of this case against the criteria set out in Government Guidance and recommended to the Chair of BCSP that a Domestic Homicide Review should be undertaken. The Chair ratified the decision.

[1] Multi-Agency Statutory Guidance For The Conduct of Domestic Homicide Reviews - Home Office 2011 *www.homeoffice.gov.uk/publications/crime/DHR-guidance*

The Home Office was notified of the intention to conduct a DHR within one month. An independent person was appointed to chair the DHR Panel and to write the Overview Report. Terms of reference drafted, within a month of this date.

Home Office Guidance[2] requires that DHRs should be completed within 6 months of the date of the decision to proceed with the review. The Home Office was informed of delays arising from the criminal proceedings. The DHR report was presented to BCSP on 23rd August 2013.

1.4 Independent Chair

Home Office Guidance[3] requires that;

"The Review Panel should appoint an independent Chair of the Panel who is responsible for managing and coordinating the review process and for producing the final Overview Report based on IMRS and any other evidence the Review Panel decides is relevant", and "…The Review Panel Chair should, where possible, be an experienced individual who is not directly associated with any of the agencies involved in the review."

Mr Malcolm Ross was appointed at an early stage, to carry out this function. He is a former Senior Detective Officer with West Midlands Police and has many years' experience in writing over one hundred Serious Case Reviews and chairing that process and, more recently, performing both functions in relation to Domestic Homicide Reviews. He has had no involvement either directly or indirectly with the members of the family concerned or the delivery or management of services by any of the agencies. He has attended and chaired the meetings of the panel, the members of which have contributed to the process of the preparation of the Report and have helpfully commented upon it.

1.5 DHR Panel

In accordance with the statutory guidance, a DHR Panel was established to oversee the process of the review. Mr Ross chaired the Panel and is also the author of the Overview Report. Other members of the panel and their professional responsibilities were:

- Lead Nurse, Birmingham and Solihull Mental Health Foundation Trust
- Senior Strategic Commissioning Manager NHS and Birmingham City Council
- Senior Service Manager, Face to Face Channel, Birmingham City Council
- Detective Sergeant, West Midlands Police
- Senior Service Manager for Violence Against Women, Birmingham Community Safety Partnership

The following two members joined the panel as from 24th January 2013

- Designated Nurse – Safeguarding Adults and Children, Mental Capacity Act Lead, Solihull Clinical Commissioning Group, acting as health advisor to the Panel
- Operations Manager, Birmingham MIND

[2] Home Office Guidance page 8
[3] Home Office Guidance page 11

Further representation for the Panel was sought from Birmingham City Council Adults and Communities Directorate but was not available.

None of the Panel members had direct involvement in the case, nor had line management responsibility for any of those involved.

The Panel was supported by the DHR Administration Officer. The business of the Panel was conducted in an open and thorough manner. The meetings lacked defensiveness and sought to identify lessons and recommended appropriate actions to ensure better outcomes for vulnerable people in these circumstances are more likely to occur as a result of this review having been undertaken.

1.6 Parallel proceedings

The Panel were aware that the following parallel proceedings were being undertaken:

- BCSP advised the Coroner that a DHR was being undertaken.
- The review was commenced in advance of criminal proceedings having been concluded and proceeded therefore with awareness of issues of disclosure that may arise.
- As the alleged perpetrator was in receipt of services by Birmingham and Solihull Mental Health Foundation Trust at the time of the homicide, the Trust alerted BCSP of their intention to undertake a Serious Incident Review and shared their draft terms of reference with the Panel. These key lines of enquiry were incorporated into the DHR terms of reference and the two reviews were to be conducted consecutively.

1.7 Scoping the Review

The process began with an initial scoping exercise prior to the first panel meeting. The scoping exercise was completed by the Birmingham Community Safety Partnership (BCSP) to identify agencies that had involvement with the victim and alleged perpetrator prior to the homicide. Where there was no involvement or insignificant involvement, agencies advised accordingly.

Thirteen agencies responded as either having no recorded contact with the victim or the alleged perpetrator or that any contact was out of scope and was not of relevance to the review.

- Birmingham City Council Children's Social Care
- Birmingham City Council Homelessness & Housing Needs
- Birmingham City Council Legal Services
- Birmingham City Council Safer Communities Team
- Birmingham Drug and Alcohol Team
- Birmingham MIND
- Birmingham & Solihull Women's Aid
- Heart of England NHS Foundation Trust
- Rape & Sexual Violence Project
- Royal Orthopaedic Hospital
- Sandwell and West Birmingham Hospital

- Staffordshire & West Midlands Probation Service
- Trident Reach
- University Hospital Birmingham

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

- Birmingham City Council Adults and Communities
- Birmingham City Council Neighbourhood Advice & Contact Centre
- Birmingham Community Health Care Trust
- Birmingham & Solihull Mental Health Trust
- Birmingham Women's Hospital
- Primary Care
- St Basils
- University Hospital Birmingham
- West Midlands Ambulance Service
- West Midlands Police

1.8 Time Period

Concerns over the alleged perpetrator's mental health were first raised in June where his behaviour was reported to have changed over the one year period beforehand. Agencies were asked to focus on events from June leading up to the date of the death in the same year, unless it became apparent to the Panel that the timescale in relation to some aspect of the review should be extended.

The review also considered relevant information relating to agencies contact with the victim and the alleged perpetrator outside that time frame as it impacted on the assessments in relation to this case.

1.9 Individual Management Reviews

An Individual Management Review (IMR) and comprehensive chronology was received from the following organisations:

- Birmingham and Solihull Mental Health Trust
- Birmingham and Solihull NHS Safeguarding Team in respect of General Practice
- Birmingham City Council Adults and Communities Directorate
- Birmingham City Council Neighbourhood Advice and Information Service

Information reports were received from St Basils and West Midlands Ambulance Service
Guidance[4] was provided to IMR Authors through local and statutory guidance and through an author's briefing. Statutory guidance determines that the aim of an IMR is to:

[4] Home Office Guidance Page 17

- Allow agencies to look openly and critically at individual and organisational practice and the context within which people were working to see whether the homicide indicates that changes could and should be made.
- To identify how those changes will be brought about.
- To identify examples of good practice within agencies.
- Agencies were encouraged to make recommendations within their IMRs and these were accepted and adopted by the agencies that commissioned the Reports. The recommendations are supported by the Overview Author and the Panel.

The IMR Reports were of a high standard providing a full and comprehensive review of the agencies' involvement and the lessons to be learnt.

1.10 Subjects of the Review

[*redacted – sensitive information*]

1.11 The Area

[*redacted – sensitive information*]

1.12 Summary

[*redacted – sensitive information*]. The victim and her ex-husband had three children: the oldest a girl, the middle child a boy and the alleged perpetrator, the youngest and a boy. The alleged perpetrator was charged with his mother's murder. [*redacted – sensitive information*]

Some 15 years ago the victim and her husband separated and divorced. Her husband moved away leaving the victim and her youngest son in the family home.

A year before her death, the victim became aware of her son demonstrating unusual behaviour and she had some concerns that he was developing mental ill-health problems. He was diagnosed as having depression by the family GP but his behaviour became more aggressive and he was believed to be paranoid, believing that his mother was trying to harm him. His aggression was aimed at his mother.

The victim sought assistance from the mental health services and her son was prescribed medication which he took in a spasmodic fashion. Arrangements were made for him to be admitted into hospital for treatment but he objected to this. Nonetheless, a bed was eventually made available and the victim was informed that her son was going to be admitted into hospital.

The Police Investigation revealed that the alleged perpetrator had recently bought a 'weight lifting bar' (but no weights) that was at home. He attacked the victim with the bar causing substantial head trauma injuries.

On the day of the homicide, the victim's step-daughter called the police stating she was concerned about the welfare of the victim. Officers attended and found the victim dead in her

home. A murder investigation was launched and her son was arrested near to the scene very quickly. He was charged with the murder of his mother and was given an indefinite hospital order at Birmingham Crown Court after being found unfit to plead.

1.13 Terms of Reference

In addition to the generic terms of reference provided by the national guidance, case specific terms of reference sought answers to the following key lines of enquiry:

- What knowledge did your agency have that indicated that the alleged perpetrator might present a risk to others? What knowledge/information did your agency have that indicated that the victim might be vulnerable? To what extent had risks related to the victim been fully assessed and acted upon.
- What information and/or concerns did the victim or alleged perpetrator's family, friends or associates have about any indication of risk or abuse and what did they do? How did your organisation respond?
- Were there issues in relation to capacity or resources in your agency that impacted on the ability to provide services to the victim, the alleged perpetrator or any to other members of the family and also impacted on the agency's ability to work effectively with other agencies?

The terms of reference required additional specific issues to be addressed by some of the key agencies.

Birmingham & Solihull Mental Health Trust
In addition to the points above, Birmingham and Solihull Mental Health Trust should address:

- Whether changes in the service user's behaviour to clinicians and/or lack of contact with the victim on the day preceding should have been escalated and merited a more urgent response
- Whether risks assessed on the days immediately preceding the incident were fully reflected in treatment and actions
- Whether delays in accessing/prioritising a bed were appropriate in relation to the risk of the assessed service user. Whether appropriate procedures were followed to manage this and whether the procedures available were appropriate to meet the needs of the service user.
- In relation to bed management arrangements whether access to an Approved Mental Health Practitioner impacted on the ability to respond appropriately to the service user's needs and if so whether actions should have been taken to respond to this.
- Whether the risk history relating to the service user had been appropriately identified and recorded and whether these were appropriately reflected in actions taken and treatment provided.
- The extent to which risks relating to the victim had been fully assessed.

Birmingham City Council
In addition to the points above, Birmingham City Council should address in relation to customer service and homeless service provision:

- Whether the alleged perpetrator's approach to the City Council for assistance with homelessness addressed his needs and identified any risk to himself or others. This should include an analysis of how vulnerability is identified in young people who approach the City Council's customer service centres and homeless service and an analysis of the six day wait for an appointment in this case.

1.14 Individual Needs

Home Office Guidance[5] requires consideration of individual needs and specifically, "were procedures sensitive to the ethnic, cultural, linguistic and religious identity of the victim, the perpetrator and their families? Was consideration for vulnerability and disability necessary?" Section 149 of the Equality Act 2010 introduced a public sector duty which is incumbent upon all organisations participating in this review, namely to:

- eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;
- advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
- foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

The review gave due consideration to each of the protected characteristics under the Act. In particular the review took into account the alleged perpetrator's young age as a person with a diagnosis of a serious and enduring mental illness, together with the victim's gender, caring responsibilities and vulnerability. Whilst concerns have featured in the literature[6] that there is a disproportionate number of young black males in hospital treatment, there was no indication from the IMR authors or directly from staff that this had any direct or indirect bearing on their responses in this case.

The fact that the victim was not assessed as a vulnerable person within the terms of 'No Secrets', is considered more fully in the Report.

1.15 Family Involvement

Home Office Guidance[7] requires that:

> *"members of informal support networks, such as friends, family members and colleagues may have detailed knowledge about the victim's experiences. The Review Panel should carefully consider the potential benefits gained by including such individuals from both the*

[5] Home Office Guidance page 25
[6] McLean, C.et al (2005); Keating, F., (2007)
[7] Home Office Guidance page 15

victim and perpetrator's networks in the review process. Members of these support networks should be given every opportunity to contribute unless there are exceptional circumstances",
and:
"Consideration should also be given at an early stage to working with family liaison officers and senior investigating officers involved in any related police investigation to identify any existing advocates and the position of the family in relation to coming to terms with the homicide."

In this case the Overview Report Author made contact with the Senior Investigating Officer (SIO) from West Midlands Police at an early stage. Contact with the family was initially made by a letter sent, via the Police Family Liaison Officer, to particular family members explaining the review process and inviting them to contribute to the review should they wish to do so. The Chair/Author of this report together with Birmingham Community Safety Partnership's Senior Service Manager, visited the extended family of the victim. Four members of the family and a very close friend were present and a summary of their comments and concerns is contained within the analysis section of this report.

SECTION TWO: SUMMARY OF KEY EVENTS AND ANALYSIS OF AGENCY INTERVENTIONS

June - August[8]
The alleged perpetrator's mental health deteriorates and concerns are raised

It was on 30th June that the victim first raised concerns with her GP about her son saying that he is increasingly isolating himself, talking about things that did not make sense and talking about religion. She stated that she was not aware of him being addicted to any drugs. He had woken her up in the night stating that he thought people were coming to the house. There were no signs of him self-harming.

An appointment was made for her son to see the GP the following day but the victim warned that he might not attend. She was advised to seek assistance from the Emergency Department of the hospital if his condition worsened during the night.

The alleged perpetrator did attend his GP's surgery the following day. He went with his mother. The GP recorded that he saw no paranoid ideas, delusions or hallucinations. The alleged perpetrator admitted that he smoked 'weed' twice per month. He was described as being jolly and maintained good eye contact with the Doctor. The alleged perpetrator stated that he had no problems with the law or with finances. He was requested to have a blood test and his mother was advised to contact the surgery if she needed any further help.

On 23rd July the alleged perpetrator had a consultation with the lead GP for the surgery. He explained his home situation and the fact that he had given up his job as a carpenter and he had

[8] Actual dates have been redacted

been stressed since. He described how he stares at himself and talks to himself and does not sleep well. He explained that he did not want his father to be in the consultation at the same time and declined the offer to see a psychiatrist and requested something to help him sleep. He was prescribed Quetiapine tablets. Quetiapine is an atypical antipsychotic approved for the treatment of schizophrenia and bipolar disorder.

Whilst this consultation was on-going, his GP spoke to a consultant psychiatrist from the Home Treatment Team and he saw the alleged perpetrator whilst at the GP's surgery. He decided that the alleged perpetrator's treatment needed reviewing the following week.

On 27th July, the lead GP spoke with the psychiatrist who had seen the alleged perpetrator that day. The diagnosis was that he had 'drug induced psychosis'. It is noted that the alleged perpetrator said he had taken cannabis two to three months previously.

According to the GP IMR, on 20th August, the lead GP referred the alleged perpetrator to the Home Treatment Team (HTT). The referral mentioned that the alleged perpetrator had erratic behaviour and was verbally abusive to his mother, the victim, who was scared of him. According to the Mental Health IMR, the alleged perpetrator was becoming paranoid and suspicious of his mother. He thought that she was trying to poison him and was cautious about eating the food that she had prepared for him. He had been prescribed anti-psychotic medication. His family were encouraging him to take his medication but at this point his family had reduced the amount he was to take due to his restlessness and agitation. The alleged perpetrator had stopped taking the medication totally. The referral goes on to say that both his parents were concerned with his behaviour.

On the same day, the alleged perpetrator's father called the surgery saying that his concerns had increased. He reported that his son was listening to strange music, but he had not become violent. His GP told him that he would speak to the consultant psychiatrist and would ring the alleged perpetrator's father back at 2.0 pm.

Later that afternoon the victim was seen with her ex-husband by a Community Psychiatric Nurse (CPN) from the HTT as well as two doctors. The alleged perpetrator told his father that his mother was possessed with demons and he had ringing in his ears. He also claimed that he could influence the weather. He agreed to take his medication.

The initial diagnosis by the HTT and the doctors present was that the alleged perpetrator was suffering from prodromal schizophrenia (early stages of the illness), and that he would deteriorate if he was left untreated. It was decided that he was to be taken on by the HTT for treatment and the team would supervise his medication on a daily basis.

Over the next couple of days the GP attempted to ring the family home to speak to the victim about the consultation on 20th August.

At 10.0pm on 21st August, the HTT spent 40 minutes trying to persuade the alleged perpetrator to take his medication, however he refused to take it.

At 9.45pm on 22nd August, there was a visit to the victim's house by a CPN. The alleged perpetrator told his mother that if another person came to the house he would leave home. The victim explained that his behaviour was due to him being timid.

At 6.0pm on 23rd August, a CPN called the victim and explained the options about her son's treatment. Hospital admissions, with or without consent, were discussed and arrangements were made to discuss the matter again the following week.

The victim called the HTT at 7.30pm, concerned because the situation had changed. The CPN at the HTT could detect tension in her voice as she explained that her step-daughter had spoken to him and she too was very concerned and thought that things had gone too far to wait until the following week for something to be done. the alleged perpetrator had expressed the wish to go for a walk with 'a big dog'.

At 11.0pm the victim called the HTT again and explained that her son had calmed down. She was advised to contact the HTT if there were further concerns. The plan was to re-assess and, if necessary, use the provisions of the Mental Health Act 1983.

The CPN called the victim at 4.0am the following morning and the alleged perpetrator was reported to be settled. The victim requested that her son be allowed to stay at home over the weekend and to take things from there at the beginning of the following week. She also mentioned an assessment that was to be carried out on her son the following day on 25th August.This assessment never took place.

At 01.30am on 25th August, the victim called the HTT again to say that her son had agreed to take his medication that day due to pressure from the family, but she requested a home visit to supervise. The alleged perpetrator did take his medication and another visit was arranged for the following evening. At 9.15pm that day a CPN went to the victim's house and supervised the alleged perpetrator taking his medication. Initially he refused, questioning why he had to take it, but eventually was persuaded and he agreed to take it. The victim reported no major concerns apart from what she described as bizarre behaviour and isolating himself in his room. The alleged perpetrator expressed the view that he would rather see the consultant psychiatrist as he knew and trusted him.

On 26th August. the alleged perpetrator again refused to take his medication, but after a home visit by a CPN and a student nurse he finally took it. He stated that he had faith in the doctors.

By 28th August, the alleged perpetrator felt better for taking his medication and expressed a desire to see the psychiatrist. An appointment was made for him to do so the following week.

A case review involving the CPN and a medic was held during which it was ascertained that the alleged perpetrator was doing reasonably well. There was no thought disorder. His mood was stable and his paranoia had reduced. He, however, still believed that he could control the weather. His medication was to continue, which he accepted.

The following day, due to his improvement over the previous couple of days, his medication was increased which he accepted. No further concerns were raised.

During the 30th August and the following day, the alleged perpetrator remained stable and agreed to take his medication.

September - November
Problems administering medication
Suspicion of mother's motives.

However, on 1st September, the victim reported that he had had an unsettled night but settled down again after taking his medication.

On 5th September, the alleged perpetrator said that he was not happy to take an increase in his medication. He was worried about being like a 'zombie' and said he thought the tablets would kill him. Following reassurance from the HTT he actually took his medication.

Over the next few days the alleged perpetrator took his medication without a problem but on 8th September, the victim reported that her son was sensitive to sound and he prevented her from using the vacuum or washing machine. He was still spending a lot of time in his bedroom. However, by 10th September he had refused to take his medication and only did so after more advice from the HTT.

On 11th September r, the victim reported an improvement in her son's mental condition and stated that she was willing to administer the medication to which apparently her son had agreed. However, three days later the alleged perpetrator alleged that his mother was putting 'something in his food' and was suspicious of her intentions.

On 17th September, arrangements were made by the Early Intervention Service Team to see the alleged perpetrator in nine days time on 26th September.

On 25th September, a CPN made a home visit and reported that they had no concerns. They had left 'a supply of medication with him' (the alleged perpetrator). There is no record to say how much medication was left with him.

On 26th September, an initial assessment was made by the Early Intervention Service (EIS). The victim's ex-husband wanted to be present during the assessment but his son refused. The EIS were told by the alleged perpetrator that his mental condition had been deteriorating for 4 years. (This was to be confirmed in a letter of 9th October) On the same day, 26th September, the victim called the HTT stating she was having problems with her son taking his medication. He was feeling unbalanced and had paranoid ideas about his mother putting 'stuff in his food'. A note in the mental health chronology raises the pertinent point of why his mother was left to administer the medication, when firstly he was not happy to take it and secondly he believed she was putting 'stuff' in his food and poisoning him. The result of this call was that the alleged perpetrator was to be medically reviewed after the weekend.

On 3rd September, a multi-disciplinary team meeting took place where the EIS accepted the alleged perpetrator under their team and he was allocated a Care Co-ordinator. The same day the victim was discharged from the Home Treatment Programme and the EIS were to then follow up his care and the GP was to take over prescribing his medication. Although the HTT file was closed on 3rd October, visits from that team continued until 16th October.

On 7th October, both the victim and the alleged perpetrator called the CPN asking about side effects of his medication. Her son was feeling weak from taking it, and a request was made for them to see a Psychiatrist. A similar claim was made on the following day when a home visit was made by mental health services. The alleged perpetrator was very suspicious of his mother and had to be encouraged to take his medication. He suspected that his mother was trying to poison him and he was cautious about eating the food she prepared for him. There is nothing to indicate that a request to see a Psychiatrist was adhered to.

On 9th October, a Consultant Psychiatrist with EIS forwarded a letter regarding the assessment of the alleged perpetrator on 25th November which summarised his history and mental condition. The overall diagnosis is that he was suffering from paranoid schizophrenia and the plan was to allocate a worker from EIS to engage with the victim regarding further history in order to complete the assessment.

On 15th October, mental health case records indicate that the alleged perpetrator was refusing to take his medication that had been left with his mother and was still showing paranoid behaviour, saying he didn't need the medication and he got very angry with his mother when she tried to encourage him. Again the comment appears in the chronology that the author of the Mental Health IMR was unsure as to why the medication had been left with his mother to administer.

An entry in the Mental Health chronology of 25th October indicated that there had been a ten day gap where the alleged perpetrator was not seen at all. There had been a phone call after five days but no evidence of any other contact. The alleged perpetrator is described as having no insight regarding his mental health problems and stated he didn't want to see anyone from EIS and was going to enrol at a college. According to a CPN and an Assistant Care Coordinator from EIS, he appeared cognitively confused. The IMR Author considers that there did not appear to be a robust medication monitoring plan in place on the basis that the alleged perpetrator considers he does not need the medication as well as his suspicion regarding his mother trying to poison him.

On 26th October, a CPN took seven days of medication to the alleged perpetrator. He mentioned that he was worried about the medication and that his friends made fun of him. He was given advice on the side effects of the drugs which were erratic behaviour if he didn't take them. Again the question is raised as to why the drugs were left.

Three days later, 29th October, a Vocational Worker collected the alleged perpetrator and took him to a football activity group. The alleged perpetrator lasted 45 minutes before deciding that he wanted to leave. He didn't understand why he had been taken there, and he didn't trust the Vocational Worker. He would not take any more medication. The following day he met his worker from EIS and discussed his state of health. He was adamant he wanted to go on some courses. He agreed to see his worker again but on 6th November cancelled the appointment. The Vocational Worker called the victim and heard the victim's concerns about her son who had taken to starting to cook his own food and isolating himself in his bedroom. He was still under the belief that he was not ill at all.

The following day, the alleged perpetrator expressed the wish to his GP that he wanted to be discharged as he didn't want any more involvement with Mental Health Services. The victim tried to reason with him and he became irritable with her. He reluctantly agreed to see the HTT who

formed the impression that he was suffering a relapse of illness with irritability and possible delusions of persecution. He wanted to move out of the home. The arrangements were to refer to the HTT and consider admission under Mental Health Act 1983 if there was a continued decline in his mental health. It is usual practice that the Early Intervention Service would seek additional input from the Home Treatment Team in order to ensure more robust support and monitoring (particularly outside of office hours and at weekends) and to enable admission to inpatient care should this be indicated (Early Intervention teams do not have access to general adult beds.)

November - December
Assessments and 'the bed list'.

On 7th November, the alleged perpetrator went to a Birmingham City Council Customer Service Centre and said he had been asked to leave his home because he had been smoking in the house and had been sleeping rough. He was referred, utilising a local authority service pathway, to the Youthhub, which is a multi-agency project serving young homeless people run by St Basil's, and spoke to the Youthhub by telephone whilst in the Customer Service Centre. During the conversation with the Youthhub, the alleged perpetrator said that he would be able to stay with his Aunt until they could find him accommodation and made an appointment to see them on 13th November.

During that same evening, the HTT saw the alleged perpetrator with his mother. He was verbally hostile towards his mother and the HTT staff. He made the comment that he knew where the HTT base was and he could send people round to them. HTT staff took this as a threat. It is recorded that the victim did not feel at risk at this time as her ex-husband had arrived and was supporting her. The HTT records show an entry: *'The entry indicates that the alleged perpetrator was hostile towards professionals [from HTT]. He said that he did not want to be seen by mental health services and did not want his medication. He stated he wanted only to be seen by his GP. He became hostile and asked the staff to leave and said if they did not leave he would send 'people' after them. He said he knew where the team were based. It is recorded that the [alleged perpetrator's] mother did not feel at risk and as they were leaving, his father arrived.'*

By 9th November, the victim reported that her son had started to take his medication.

On 11th November, Mental Health Services contacted a Mental Health Hospital with a view of admitting the alleged perpetrator but there were no beds available. Whilst he was taking his medicine at this point, the victim described the relationship between her and her son as fraught and he was fluctuating between being hostile and apologetic. The plan was to carry out a mental health assessment when a bed became available. At 8.45pm that night HTT Manager telephoned the victim who reported no concerns as her son was taking his medication.

The following day on 12th November, an EIS Manager made a home visit and found the alleged perpetrator calm and taking his medication. Due to this, he was taken off the bed waiting list. The plan was to visit him the following Thursday. The Mental Health Chronology points out a telephone contact at 4.0pm with a family lead carer. No other details are recorded.

Again on 18th November a telephone contact with family / carer had no details recorded. It appears that the planned visit did not take place, although no reason has been provided to the Panel why this did not take place.

On 18th November r, a multi-disciplinary team meeting took place where the EIS Worker said that she had been in touch with the victim. The alleged perpetrator had stopped taking his medication over the weekend and was refusing to be seen by anyone. The plan was for Home Treatment Team to try and see him and arrange an admission. On 19th November, another telephone contact was held with no details recorded.

On 20th November, two Community Psychiatric Nurses (CPNs) saw the victim at home. Her son refused to see them and left the house. The victim conceded that her son needed treatment in hospital and he had not taken any medication for 4 days. The plan was to put him back on the bed list. A Mental Health Act assessment was arranged for the following day. There is nothing to indicate that the assessment took place the following day.

At 4.0pm on 24th November, a CPN made a house visit, but the alleged perpetrator left the house as soon as the CPN arrived. The victim was seen and told the CPN that her son was still isolating himself, not eating the food she was preparing and making unusual suggestions and ideas. He was complaining also of balance problems. He was becoming obsessed with aliens and religion and certain music. In the Mental Health chronology a comment is made at this stage that the balance problem that the alleged perpetrator was complaining about was 'an early warning sign', but the comment does not expand on what the early warning sign referred to.

On the following day there is comment to say that an assessment had been arranged for 26th November. On that day an EIS manager and consultant together with an Approved Mental Health Practitioner (AMHP) and a HTT consultant visited the family home. The alleged perpetrator had to be persuaded by his mother to come downstairs to see the visitors. However, he commented that he was refusing to discuss any matter further and that he had been forced to take his medication by his parents. He then left the house. The victim expressed her concern that it had been ten days since he had taken his medication. Nonetheless, the alleged perpetrator was deemed not to be detainable under the Mental Health Act 1983 at that time, and a plan was put into place to the effect that he would have daily visits for one week to offer him medication and for a professional to liaise with the victim. There were no beds available. Should the alleged perpetrator not comply, detention into hospital would 'once again' be considered. The risk to self and to others and of self-neglect was deemed low but this would be constantly monitored. He would remain on the bed waiting list.

The Adult Social Care chronology indicates that the alleged perpetrator had 'capacity', presumably to make appropriate decisions although there is nothing to indicate that he was specifically questioned about capacity. Indeed there did not appear to be any opportunity to question him before he left the house. The decision taken by the Mental Health Assessment that he had 'capacity' came from a conversation with the victim. It is not clear what 'capacity' this comment in the chronology was referring to. The alleged perpetrator was not seen so there was a reliance on his mother's opinion about his capacity. Comment continues that the victim was supportive of a hospital admission for him and she felt that 'this has gone on long enough'. The victim stated that her son did not talk to her about his mental condition and she was concerned about his suspicion of her. When asked for clarification about this issue the AMHP concerned replied: ''*We had little face to face contact with the [alleged perpetrator]. I would estimate it to be 4-6 minutes. We all talked to mother for much longer. The [alleged perpetrator] completely denied there were any issues and could not see why there was any concern. During this short period of*

time we did not witness any acute mental disorder. We, (HTT doctor, colleague and I) felt at that point there was not enough evidence to detain him. The risks at that point were highlighted on my CR6B and were not considered to be high at the time of assessment. We did however feel there was enough evidence for increased community support - Home Treatment involvement. The improvement was going to be measured by the daily visits.'

On 27th November, a CPN from EIS made a house visit and although there is no indication that the victim was seen, there is a presumption that she was because the chronology states that the alleged perpetrator shouted down from his bedroom that he was refusing to come down stairs and he intended to report the CPN to the police for harassment. He then slammed his bedroom door. He was refusing to take his medication. The CPN stated that they would continue to visit daily to offer medication.

The following day, the victim telephoned the EIS. She was on her own. The alleged perpetrator had gone out to avoid the visits and the victim stated that he was starting to smell due to his personal hygiene deteriorating. A doctor completed the first medical recommendation for a Mental Health Act assessment and the HTT were informed that when a bed was available the assessment was to be completed. It is clear then, that the alleged perpetrator now fitted the criteria for admission. The ward at the hospital commented that the alleged perpetrator would be 'put back on the bed list'.

There is nothing to indicate that he had 'come off' the bed list since 26th November, but clearly he had for some reason. It was recommended that the alleged perpetrator was to be detained under Section 2 Mental Health Act 1983, which is an admission for an assessment for a maximum period of 28 days. It was recommended that the alleged perpetrator was detained for further assessment and treatment.

On 29th November, a CPN called to the family home. There was no reply. The duty social worker was contacted and stated that there was no AMHP available and therefore it was unlikely that the alleged perpetrator would be assessed that day and that there was still no bed available. There is nothing to indicate why there was no AMHP available. It was left that a Duty Emergency Social Worker should be contacted over the weekend if necessary. The HTT confirmed that the second part of the medical recommendation had been completed and it is clear that the only thing stopping the alleged perpetrator being admitted was the lack of bed availability.

The victim was informed of the latest position and she stated that she and her husband had seen the alleged perpetrator at bus stops. She wanted him to be in a safe place and wished that he be admitted. It appears that Adult Social Care attempted to identify an AMHP for the alleged perpetrator but both professionals on call were not available. The reason is not indicated in the Adult Social Care IMR. Later that day Adult Social Care indicated that police and ambulance would be needed as it was considered that the alleged perpetrator would not voluntarily go to hospital.

However, the following day, on 30th November, a CPN made a visit to the family home. The alleged perpetrator refused to come down to see the CPN and whilst the CPN was talking to the victim, the alleged perpetrator left the house. The victim described how his behaviour had deteriorated. He was now coming down stairs on his bottom and crawling across the floor. His personal hygiene was worse and he was staying out on the streets until 4.0am. The victim

considered that he required urgent admission to hospital. The victim was told about the process to get her son admitted to hospital and it was stated that HTT needed to prioritise when a bed became available.

On 30th November, the Mental Health Trust's chronology shows liaison with other professionals but there are no details of what that liaison consisted of.

On 2nd December, a conversation between the CPN and the consultant indicates concerns about the alleged perpetrator's mental health but indicates that there was still no bed available, despite liaison with the Bed Manager. Eventually the AMHP was informed that a bed had been made available for the alleged perpetrator. At 4.0pm that day the doctor and the AMHP went to the home address to inform both the victim and her son. Attempts had been made to contact the victim by telephone which failed.

There was no reply at the home address or on the telephone so the decision was made that another attempt would be made the following morning. There had been a brief discussion about forcing entry to the family home under Section 135(1) Mental Health Act 1983, but it was decided not to proceed with this order or call the police for them to enter under Section 17 of the Police and Criminal Evidence Act.

When the practitioners were asked for clarification about this issue, the reply was: *"At the time of my assessment, myself and the doctors had no reason to believe that the alleged perpetrator was alone in the property or that his mother was dead. Therefore as [the victim] had a key to the property and lived with her son we would not be able to gain access through 135 (1) Warrant of* the Mental Health Act (1983*). The mental health act says that; 'being unable to care for himself, is living alone in any such place, the justice may issue a warrant authorising any constable to enter, if need be by force, any premises specified in the warrant in which that person is believed to be, and if thought fit, to remove him to a place of safety with a view to the making of an application in respect of him under Part II of this act, or of other arrangements for his treatment or care'. (I351(a) Mental Health Act, 1983). Without this warrant we could not force access into the property'*

There appeared to be a lack of appreciation at that time that where there are reasonable grounds to believe that a person is at risk of harm, the Police can use Section 17 PACE to force entry to save life and limb, so entry could have been gained without the use of Section 135(1) Mental Health Act 1983

At 10.35pm on the day of the homicide, the victim's step daughter called the police stating that she was concerned that she had not heard from the victim for a while. She added that her son had mental ill health. Police officers attended to the home address and forced entry, under Section 17 as above, and found the body of the victim. Her son was identified nearby and was arrested.

A murder investigation was launched by West Midlands Police. The alleged perpetrator was charged with the murder of his mother. He appeared before Birmingham Crown Court. He was found unfit to plead and was given an indefinite hospital order.

Agency Involvement

As stated earlier in this Overview Report the agencies that had significant involvement with the victim and her family are:

- Birmingham and Solihull Mental Health Foundation Trust
- The General Practitioner
- Birmingham City Council Adults and Communities Directorate
- Birmingham City Council Neighbourhood Advice and Information Service

It may be useful to summarise the involvement each agency had and give a brief overview of the recommendations that have been made respecting individual agencies.

2.1 Birmingham and Solihull Mental Health Foundation Trust

Home Treatment Services provided by Birmingham and Solihull Mental Health Foundation Trust aim to provide a flexible, responsive, proactive, coordinated and integrated service to individuals with severe and complex mental and behavioural disorder. The aim of the service is to provide rapid assessment and robust support to individuals and their carers for episodes of psychiatric crisis. The teams are multidisciplinary and operate a 24 hour, seven day a week service. They aim to support the individual in the least restrictive setting possible (usually their own home). If necessary, Home Treatment can facilitate admission to adult inpatient care. Home Treatment provides a gate-keeping function for all admissions to general admission beds. By the nature of its crisis support function, individuals remain under the care of Home Treatment for short periods of time.

Unlike the Home Treatment Service which provides focus short-term intervention, the Early Intervention Services provides longer term support to young people who have experienced a first episode of psychotic illness. They provide support for the individual's recovery over a three year time span with a greater emphasis on engaging the individual in their recovery and promoting their self-esteem through social inclusion and goal setting.

The Trust became involved with the victim and her son following a referral from her son's GP on 23rd August, to the Home Treatment Team (HTT). It was noted that the alleged perpetrator had become abusive towards his mother and he had been having problems with his mental health for the preceding twelve months. The alleged perpetrator was initially diagnosed as suffering from Prodromal Schizophrenia, which, if left untreated, his mental state would deteriorate. The HTT were involved on an almost daily basis and were responsible for the administration of the alleged perpetrator's medication, albeit he often refused to take it. In April the victim agreed to administer the medication.

Later in August, the HTT visits were reduced and a referral made to the Early Intervention Service (EIS). The EIS assessed the alleged perpetrator as having delusions of persecution, control, reference and grandeur. A Care Co-ordinator from EIS was to be appointed. By November of that year, the alleged perpetrator was taking his medication in a sporadic manner and HTT became involved again.

In November, an assessment was made under Section 2 Mental Health Act 1983, where it was decided that the alleged perpetrator was not detainable, although he walked out of the house before he could be seen by the assessment team. His personal hygiene deteriorated and he was

not eating. He became paranoid about his mother trying to poison him and refused to eat any food she prepared. Both EIS and HTT were involved with the alleged perpetrator and attempts were made to get him into hospital but as indicated within the analysis section of this report there were substantial problems in that area.

There are issues around risk assessments of both the alleged perpetrator as a patient and also about his mother as a carer and her ability and mental capacity to continue to be a carer for her son whose mental state was worsening.

The BSMHFT recommendations touch on informing the carers/family of their rights to a carer's assessment, the creation of a clear plan and monitoring of the carer's assessment and finally the risk assessment process around the family that are living with a mentally ill person as well as the person themselves being a risk to others.

2.2 The General Practitioner

The GP's Surgery has a patient population of 7943 and employs eight GPs, one trainee Doctor and two Advance Nurse Practitioners. There were no contextual issues that may have impacted on patients during the time period being investigated.

The family GP became involved with the alleged perpetrator and his mental health problems in January of the year in question, and following that date there were some fourteen contacts prior to the homicide. Most of the contact concerned discussions with relatives and letters from BSMHFT. A referral was made from the GP to BSMHFT and a consultant psychiatrist. There was no record identified of any risk that the alleged perpetrator may have posed to his mother or anyone else, albeit the GP did recognise a risk that the alleged perpetrator posed to himself and made the appropriate referral.

It is recorded that the victim was not identified as a 'vulnerable adult' within the strict parameters of the definition of 'No Secrets', which effectively prevented her being considered for any support a vulnerable adult would be entitled to. However looking at her life with her son, the increasing deterioration of his mental state and the increasing aggression he was demonstrating towards her, it may have been considered that although the definition criteria was not met, she was at risk of harm from her son.

It is also recognised that the GP's practice has a named lead GP for mental health issues. The practice does not have a named lead for domestic violence and has made recommendations within its individual management review to address this.

The GP IMR recommends the introduction of a robust policy for domestic violence including the training for all staff, the introduction of a frank discussion policy with the carers of mentally ill patients, a clear referral pathway to other services for such carers and the dissemination of learning from this DHR to all GP practices and Clinical Commissioning Group leads.

2.3 Birmingham City Council Adults and Communities Directorate

Birmingham City Council Adults and Communities Directorate, now People Directorate, provides services throughout Birmingham for adults who are deemed to be in need of care and support due to various reasons, especially those that are considered vulnerable. Vulnerable adults are defined in the Government document 'No Secrets' and services are allocated in accordance with that definition. As mentioned within this Overview Report the victim was not considered a Vulnerable Adult as neither she nor her circumstances were deemed to fit the criteria for support.

Birmingham City Council Adults and Communities Directorate were involved with the alleged perpetrator from March until July. Primarily the involvement was around the provision of a AMHP on 29th November. The IMR indicates that competing priorities was the reason why no AMHP was available on that night to assist in the completion of the admission of the alleged perpetrator to hospital. There had been a suicide case in Solihull that had engaged the available AMHP. The following day the alleged perpetrator was seen 'crawling down stairs on his bottom' and although his mental state had deteriorated there was no indication of risk to others recorded.

Birmingham City Council Adults and Communities Directorate IMR recommendations are numerous. They include issues around record keeping, the creation of a new AMHP rota with clarity around the availability of AMHPs, the suggestion that there should be a multi-agency professionals meeting to establish risk and an escalation process when competing demands are made for services in high risk cases.

2.4 Birmingham City Council Neighbourhood Advice and Information Service (NAIS)

NAIS had no contact with the victim beyond a request for waste removal. They had one contact with the alleged perpetrator when he attended a Customer Service Centre on 7th November, stating that he had been asked to leave his mother's home and had been sleeping rough and sofa surfing. The advisor facilitated a call to the Young Person's Hub which provides a multi-agency service of housing and children's social care for homeless young people and is run by St Basil's, a third sector organisation. During this phone call, the alleged perpetrator was asked and stated that there were no issues for him regarding his health and that he could stay with his aunt temporarily. An appointment was made for him to be seen again in six days' time, but he did not attend this appointment.

Although neither NAIS nor St Basils made further enquiries to verify the alleged perpetrator's circumstances, neither were there any concerns raised which might have given rise to do so. NAIS described the alleged perpetrator's behaviour and demeanour on the day that he attended the Centre as well mannered, though reserved, but "responding well to questioning". In their IMR, NAIS described their procedures for responding to safeguarding concerns but that none were raised in this case.

The IMR for NAIS goes on to compare the homeless pathway for young people with the homeless pathway for other client groups which are delivered directly through the Customer Service Centres. Although no concerns were raised in the way that this case had been handled from the information and demeanour that the alleged perpetrator had presented, NAIS took the opportunity to recommend a review of the pathway to establish if the duty to vulnerable persons is effectively

satisfied. The IMR also considered that the pathway would be better served by better communication between NAIS and St Basils and recommended that monthly meetings with St Basils be established to enable the sharing of information and to provide feedback. The NAIS also provided recommendations to improve staff and management information and monitoring facilities and to improve the Customer Record Management system.

2.5 Views and opinions of the family

The meeting with family members took place with extended family being present. The meeting highlighted some major concerns the family had about the involvement of health and mental health practitioners.

They described the alleged perpetrator as a quiet person, almost to the point of being a social recluse and being the least confident person in their large family. Efforts to make him more outgoing had failed. He was also described as being very domineering towards his mother especially after his father and his mother separated. A family member stated that she would have to phone the victim in secret. The victim had told a member of the family that she often felt like she was 'walking on egg shells' with regard to her son. The family are content that the victim would have told them the full facts of her life with her son. [*redacted – sensitive information]*

Family members felt that professionals within mental health were aware of the feelings that the alleged perpetrator had towards his mother, but also feel that there was a lack of sharing of such information. They understood that this reluctance to share information with the family was to protect patient confidentiality. When, subsequently the family tackled the mental health professionals about this, they stated that they were protecting the alleged perpetrator's human rights.

[*redacted – sensitive information]* It was described how the victim would go to a local supermarket to ring her so that the alleged perpetrator would not be aware of the conversation.

Family members described being 'blocked out' by the alleged perpetrator, not being spoken to and not being allowed to accompany him to GP appointments. They also described the alleged perpetrator's odd behaviour where he would spend hours throwing a ball against a wall, played tirelessly with younger children and seemed to be attempting to appear as normal so that people wouldn't realise that anything was wrong with him before he was diagnosed as being psychotic.

Family members described the day that the victim could not be located. There had been talk of the alleged perpetrator being admitted to hospital and it was thought he had been and that the victim was with him. The hospital was contacted and the family were told that the alleged perpetrator was at the unit (hospital) which reassured them greatly. A later phone call to the hospital revealed that the alleged perpetrator had not been admitted yet but he was at the hospital. Family then phoned the hospital every hour and eventually were told that no-one knew where either the alleged perpetrator or the victim were. It was then the family went to the house and spoke to the alleged perpetrator by telephone. He initially said that his mother had gone out with a friend and that he was not at home himself. But family members could see signs that he was in the house and the police were called.

The family's concerns can be described as:

- After the incident, the GP admitted to the family that the alleged perpetrator had been suffering from psychosis since September. Why was this information not shared with his parents who were caring for him
- Professionals were not talking to the family: family members understood this to be because they were protecting patient confidentiality and human rights
- Not being able to find a social worker (AMHP) to sign the papers – the family couldn't believe that there were only two in the city/area at the time they were needed
- Professionals were reported to have kept ringing with apologies about not having a bed available

The victim's partner was invited to engage with the review, but he signalled that content at this stage with the views expressed by the extended family, and, other than what had been stated he had nothing more to add. The family were told that if they wished to add to what had been said they are to feel free to do so at any time.

The Chair and a Panel member met with family representatives and explained in detail the contents of the report, the findings of the review and the justification for each recommendation. Overall the family were satisfied with the findings of the review but were still concerned that they were no further forward in understanding the alleged perpetrator's mental state, whether there were matters of negligence and what was to happen next. The purpose of the domestic homicide review was revisited and made clear that it sought to learn lessons for the future and not to explore notions of blame.

SECTION THREE – CONCLUSIONS AND LESSONS LEARNT

There are several areas of concern that require comment upon in this case.

3.1 Risk Assessments

The victim was living with her son and had sole care for him during the time that his mental health was deteriorating, and although there was no direct evidence of history of him physically harming her, her son was a relatively strong person and bigger in stature than his mother. He was before his illness a quiet, well-mannered young man, and before his illness, the relationship between him and his mother was described as being very close. Indeed when the Author visited family members they all expressed a view that the alleged perpetrator was a mild and likeable person.

However, it is clear that for some reason his mental stability deteriorated resulting in paranoid beliefs especially towards his mother, aggression and worrying behaviour. There was no consideration by professionals how the deteriorating relationship between the victim and the alleged perpetrator may have had an impact on the decision making by the victim and more especially the risk her son posed to himself as well as his mother.

'Refocusing The Care Programme Approach' [9] comments that 'Risk assessment is an essential and on-going element of good mental health practice and a critical and integral component of all assessment, planning and review processes' The Department of Health Guidance Best Practice Managing in Risk[10] sets out a framework of principles covering self-harm and suicide, violence to others and self-neglect to underpin best practice across all adult health settings. The philosophy underpinning this framework is one that balances care needs against risk needs and that emphasises:

- positive risk management;
- collaboration with the service user and others involved in care;
- the importance of recognising and building on service user strengths, and
- the organisations role in risk management alongside the individual practitioner's.

The Care Programme Approach (CPA) also states that mental health professionals should consider the service users' needs holistically and aim to improve their quality of life and their health.

When one examines the circumstances of the alleged perpetrator it is clear that his deteriorating behaviour posed a risk to others. Whilst the BSMHFT IMR does indicate there was no history of violence towards his mother, the evidence shows, that as time progressed and his mental condition worsened, his behaviour and verbal aggression towards his mother in particular should have been of concern, and the risk assessment as outlined above should have been completed.
The BSMHFT IMR points out that the victim satisfied the definition of a 'carer' as she was giving care to a service user on a regular and substantial unpaid basis and therefore she was entitled to be told of her rights to an assessment of her caring, physical and mental health needs.

The IMR goes on to point out the BSMHFT Care Management Policy on risk assessments that could have been used to assess the risk to the victim: '*Risk creates the need to decide about major changes in the provision of care, and assessing the competence of individuals to exercise choice and control in their lives. It is crucial to assess the degree of protection that an individual may require to live safely' and:'Practitioners will make risk decisions every day and the Trust acknowledges the difficult balancing act between risk minimisation and the empowerment of the service user. There will also be difficulties in resolving the imbalance between promoting the rights of the service users and preserving the responsibility of the practitioners to others'.*

Here the word 'others' must of necessity include the victim. The BSMHFT IMR states:
'There was no carers assessment offered and the care plan has a section for this element and yet this was blank on all care plans. This means that mum's needs were not formally considered or understood and no actions identified to offer specific support.'

This review echoes the recommendations made of BSMHFT in a recent Birmingham Domestic Homicide Review, DHR2011/12-03, which required a strengthening of assessments and management of risk for service users, their carers and significant others.

[9] 'Refocusing the Care Programme Approach – Policy and Positive Practice Guidance – Department of Health March 2008
[10] Best Practice Managing in Risk Principals and Evidence for Best Practice in the Assessment and Management of Risk to Self and Others in Mental Health Services – Department of Health 2007

Recommendation No 1.

Birmingham and Solihull Mental Health Foundation Trust Care Coordinators must ensure (as part of their organisation of care) that all carers are advised of their right to a carer's assessment. The offer must be clearly documented. If the offer is not accepted the reasons should also be clearly documented and a date set to revisit this with the carer

3.2 The Administering of Medication

There is serious concern about the manner in which the alleged perpetrator's medication was administered. It is appreciated that the alleged perpetrator made the choice on numerous occasions not to take his medication but his capacity to make that choice was not initially assessed. Efforts were made tirelessly by the EIS and other workers to coax him and persuade him to take his medication but more often than not these attempts failed. A decision was made then to leave his medication with his mother and allow her to be responsible for administering his tablets. Along with that on 26th October a CPN delivered seven days-worth of medication to the alleged perpetrator.

The CPA guidance states that '…non-concordance with medicines is a high risk indicator of relapse and as well as lack of insight into illness can be due to: dose / medicine not treating symptoms effectively; intolerable side effects / quality of life issues; inadequate information about medicines; poor communication of a treatment plan with GP's; and confusion about how to take medicines or difficulties in assessing medicines'.

It goes on to say, 'It is essential that everyone involved in the care of the service user understands who prescribes the medication, where it is obtained from, the instructions for its administration, and what other medicines are being subscribed for other physical health problems.'

The BSMHFT IMR points out: 'The Team seem to allow mum to make the decisions without using their professional reasoning and formulation – this appears to be with good intent to work with mum and her wishes, however, it does not appear that thought was given to the fact that the alleged perpetrator was paranoid about mum and yet she was the one getting him to take his medication. There is no evidence that anyone talked to mum about this and that it may be wiser for the Team to take on this role and try to maintain the mother/son relationship.'

It is considered that it was an unwise move to allow the victim to be in charge of his medication particularly at a time when his trust in his mother had deteriorated. In addition, leaving him with seven days-worth of tablets with no monitoring system as to how many he was taking at once, or if any at all, was also an unwise decision. There was no robust medication monitoring plan in force for the alleged perpetrator.

There was no statutory basis on which to compel the alleged perpetrator to comply with medication in the community. The Mental Health Act makes provision for Community Orders. These are effectively community sections which require the individual to comply with particular conditions and treatment in order to prevent a risk of harm to the individual's health or safety or to protect other people. However, for an individual to be made subject to one of these orders they

would first need to be detained in hospital for treatment (for example under section 3 of the Mental Health Act.) Therefore these were not available options at this point in the alleged perpetrator's care.

Recommendation No 2

Birmingham and Solihull Mental Health Foundation Trust to ensure that its staff recognise poor compliance with medication as an indicator of risk and that non- compliance is incorporated into the Risk Management Plan of Care Programme Approach.

3.3 Mental Health Assessments

The BSMHFT IMR indicates that the mental health of the alleged perpetrator was assessed and reviewed a number of times and included assessments made under the Mental Health Act 1983.

The first assessment is recorded as having taken place in August when the alleged perpetrator was found to be gradually deteriorating and had become socially withdrawn. He was diagnosed as suffering from prodromal schizophrenia, the early stages of psychotic illness. This assessment identified that the alleged perpetrator had been experiencing difficulties for the past four years and started with him feeling unbalanced and having coordination problems.

The next assessment was in September by Early Intervention Service staff where the alleged perpetrator was described as having delusions of persecution, control and reference and grandeur.

On 7th November, a medical review took place where it was noted that the alleged perpetrator was not taking his medication properly. The result was that a: 'Mental Health Act assessment should be considered should there be a continued decline.'

On 26th November, another Mental Health Act assessment was carried out and he was deemed not to be detainable but this was an assessment made without him being present. He left the house before he could be properly assessed.

It appears that the alleged perpetrator was the subject of numerous assessments regarding his mental health whilst there was a clear deterioration in his mental state. He had delusions about his mother; he was becoming more aggressive especially towards the victim and was demonstrating unusual behaviour. However, despite assessments he was not deemed detainable.

The BSMHFT IMR author expressed the view that; 'It is difficult to understand why he was not felt detainable at that assessment taking into account of his history up to that point, not taking his medication and the pressure that was needed to persuade him when he did, the length of time without medication and also the evidence base about early intervention, improving prognosis.'

The Mental Health Assessments appear to have been conducted in isolation of each other and there was no real connection between them. The IMRs indicate that there were a number of health professionals involved with the alleged perpetrator and his illness but it also appears that there was little coordination between agencies and professionals. The mental and physical health of the alleged perpetrator required, what in child protection terms would be called a core group. It needed someone to pull all information together and for all aspects of his illness, mother's needs and risk and the views of the extended family to be taken into account.

At the time when the alleged perpetrator's mental care was transferred from HTT to EIS there was an opportunity for a much needed formal handover meeting which could have included EIS, HTT, the GP and his two consultants. It would have been an ideal time to involve his extended family in this process. It is clear from contact with the family by the author/chair of this review that they had information to offer that may have been considered significant is deciding the alleged perpetrator's future treatment.

The lead nurse for BSMHFT and panel member described the expectation that multi-disciplinary team meetings being weekly at a minimum and with every patient or service user being the subject of discussions up to forty-five minutes each, depending upon the complexity of the case. The author suggested that there would always be a consultant/junior doctor, a community psychiatric nurse, a social worker, a Support, Time and Recovery (STR) Worker and sometimes a psychologist or occupational therapist at these meetings discussing issues such as clinical need, medication compliance, social needs and relationships with carers, if relevant. It has not been made clear during this review, whether in this case that multi-disciplinary meetings were held in the way described.

Recommendation No 3

Birmingham and Solihull Mental Health Foundation Trust to ensure that teams are complying with the BSMHFT transfer and transition policy and there is a detailed handover meeting for a service user transferring to another team for longer term care, it should involve relevant agencies and engage with as wide a range of family members as reasonable.

As far as the alleged perpetrator's mental health assessments are concerned, there were instances where practitioners made home visits and the alleged perpetrator walked out of the house without being seen. On one occasion an assessment was conducted with information solely from the victim being obtained and nothing from the alleged perpetrator who walked out. There were a number of occasions when the contact between the alleged perpetrator and the practitioners was brief and fleeting, but none the less assessments were made of his mental state and needs. Such contacts appeared meaningless and this review questions what degree of supervision the practitioners received during this period when such assessments were made? It should be the supervisor's role to question the impact of how these assessments were made with only brief contacts or no contact at all. There is no evidence of any supervision of practitioners in this case at all.

Recommendation No 4

Each assessment needs to include all relevant information from family, friends, carers and others but must include meaningful contact with the patient in order to establish their mental state and degree of risk before being considered complete.

Recommendation No 5

Birmingham and Solihull Mental Health Foundation Trust to ensure that all staff are complying with clinical and management supervision policies ensuring that the management of clinical risk is imbedded in multi-disciplinary meetings, with emphasis on the role of the carer and family members.

Another issue arises from the circumstances where the alleged perpetrator walked from the house, without being seen for assessments. Attempts were being made to get him admitted into hospital but the administration of that was preventing it happening. The alleged perpetrator walked into the street, clearly in a serious state of mental illness. He had been showing aggression towards his mother, was acting strangely and coming down stairs on his backside.

Practitioners stated that they did not witness any evidence of acute mental disorder at that time so therefore the alleged perpetrator was not considered a high risk at the time of the assessment irrespective of his recent behaviour.

As an issue of best practice, it is worth reminding practitioners, from both mental health services and the police, of police powers under Section 136 Mental Health Act 1983, which states: 'If a constable finds in a place to which the public have access a person who appears to him to be suffering from mental disorder and to be immediate need of care or control, the constable may, if he thinks it necessary to do so in the interests of that person or for the protection of other persons, remove that person to a place of safety.'

If the alleged perpetrator's mental state had deteriorated further and he had met the criteria as per the Act, he could have been detained. Mental health professionals in this case are satisfied that the alleged perpetrator's mental state had not deteriorated to the degree to justify a detention under the Act at that time.

Another occasion where the use of police powers may have properly been considered was on the occasion when Mental Health practitioners arrived at the family home as a result of a call from members of the family when the victim was 'missing.' A debate ensued where it was decided that as there was no answer at the door, to call back later. In the circumstances police officers, if called to the house at that time may well have used their powers under Section 17 Police and Criminal Evidence Act 1984 and forcibly gained entry with reasonable grounds to believe that a person was at risk of harm and to save life and limb.

It is the intention of the Police representative on this Panel to prepare for distribution a Practice Direction on the police use of Section 17, for the information of the Mental Health Services throughout West Midlands, as well as acting as a reminder to all West Midlands Police Officers. In that way, the shared knowledge will no doubt assist in situations such as those that existed in this

case, at any time in the future and encourage police and mental health services to work together in this regard.

Recommendation No 6

West Midlands Police to provide practice guidance for mental health practitioners about police officers power of entry and search of premises without a warrant, to save life and limb or prevent serious damage to property as per Section 17 Police and Criminal Evidence Act 1984

During the course of this review, West Midlands Police have established that mental health is a contributory element in eighteen per cent of all calls or requests for police assistance. It has been acknowledged that the organisation needs to ensure that frontline officers have access to reliable advice concerning mental health law, policy and procedures. To this end a core of 3-4 police constables and sergeants on every response team in Birmingham will have enhanced training concerning mental health. They will act as advisors to their team, ensuring appropriate responses to mentally vulnerable individuals or offenders. This will include timely referrals to mental health services and information sharing in line with the BSMHFT information Sharing Protocol

3.1 The alleged perpetrator's admission to hospital and bed allocation

The next issue to make comment about is the decision to admit the alleged perpetrator to hospital and what appears to be a disjointed attempt to provide the alleged perpetrator with a bed within a suitable hospital.

BSMHFT has an approved Bed Management Policy (which is due for review) for the management of adult acute admission beds. There is a central team which coordinate allocation of beds. Requests for admission to an inpatient bed can only be made by the Home Treatment team. There is a section within the policy entitled "*Bed Management Triage".* This is a process in which the Bed Management Team creates a priority list for admission to ensure that the individual most in need of inpatient care is admitted in the first instance. This is determined based on information provided by the Home Treatment Team – particularly around risk. The Bed Manager allocates either a red, amber or green rating.

When the alleged perpetrator was placed on the bed list, he was allocated a red rating. The definition within the policy for this is that one of the following types of risk must be evident from the referral information:

> "(i) Imminent risk of self-injury, with inability to guarantee safety as manifested by one of the following: recent, serious and dangerous suicide attempt, indicated by degree of lethal intent, impulsivity and an inability to reliably contract for safety; current suicidal ideation with intent, realistic plan or available means that is severe and dangerous; recent self-mutilation that is severe and dangerous; recent verbalisation or behaviour indicating high risk for severe injury
>
> (ii) Imminent risk for injury to others as manifested by one of the following: active plan, means and lethal intent to seriously injure other(s); recent episodes of assault or physical harm to another, that indicates a high risk for recurrent and serious injury to others; recent

and seriously physically destructive acts that indicate a high risk for recurrence and serious injury to others
(iii) Imminent risk for acute and serious medical status deterioration due the presence and/or treatment of an active psychiatric symptom(s)
(iv) Acute and serious deterioration from the patient's usual ability to fulfil usual responsibilities to the extent that behaviour is so disordered, disorganised or bizarre that it would be unsafe to leave the patient in a lesser level of care."

In terms of bed allocation, a red rating would require admission to any, or next available bed in the Trust regardless of whether it would be to the usual ward for the person's home area. The policy dictates that consultants and service managers will put considerable effort into creating a bed if one is not available.

In this episode there were a number of 'red referrals' with no capacity for admission. The policy provides clear guidance on an escalation process that should follow in such circumstances. BSMHFT's IMR author was not presented with any evidence to suggest that these processes had been instigated. Recommendation 4 addresses this point.
The Mental Health IMR helpfully points out the timescales of attempts to obtain a bed for the alleged perpetrator and it states 'It appears that the alleged perpetrator was taken on and off the bed list depending on his compliance with medication – there was no consistent plan and it does appear that professionals allowed [the victim] to lead this somewhat.' The IMR indicates a timetable as follows:

- 11th November - Practitioner said the bed was not needed
- 21st November - a referral made for a bed
- 25th November - confirmation bed still needed
- 26th November - stood down from bed list as the alleged perpetrator had been re-assessed
- 28th / 29th November – medical recommendations – placed back on bed list

The IMR continues:'[It was stated in] interview that he (the person receiving the referral,) felt that it wasn't a clear referral from HTT – [it wasn't] felt that there was a clear plan and he never received information of risks to [the victim].'It was also stated that the alleged perpetrator was not on a section whilst on the bed list.

As stated in the IMR, it is appreciated that some of this confusion may have been the result of the victim not wanting her son to be admitted but there came a time when she and her family were asking professionals for him to be admitted. Indeed the family members stated that by October, the victim had changed her mind and wanted him to go to hospital as the alleged perpetrator had stopped taking his medication, although it was not discussed whether she was consistent in view thereafter.

In meetings with the family it is clear that other members including his father were desperate for the alleged perpetrator to be admitted to hospital to receive the appropriate mental health treatment. Admissions were considered under Section 2 of the Mental Health Act 1983 which sets out details for a detention for a maximum of twenty-eight days in hospital for patients not involved in criminal proceedings. An application for admission can be made by an AMHP or the patients

nearest relative, and two doctors must confirm that the patient is suffering from a mental disorder of a nature of degree that warrants detention in hospital for assessment and he ought to be detained in the interests of his own health or safety or with a view to the protection of others.

With regard to bed allocation the BSMHFT IMR points out: 'There are also conflicting priorities that the bed management have to juggle such as the waiting time targets in A&E departments. If there is someone in A&E that is waiting for a psychiatric bed they cannot go over the waiting time as this is then a breach. It does appear that this occurred whilst [the alleged perpetrator] was on the bed list and someone in A&E was admitted into a male bed on 30th November.. to 1st December..'

Mental Health Act assessments should not be made depending upon whether a bed is available or not for the patient. Where the risk factors suggest that urgent admission is required, the bed management policy should be followed and if necessary escalated to a senior manager to access a bed outside of the Trust's own resources. In reading the chronology in this case it is clear that there were occasions when the alleged perpetrator ought to have been considered for a Section 2 admission and it appears that the nearest relative was considered to be the victim which on the face of facts is correct, but there were other 'near' relatives who had a contrary view and whose opinion was not sought regarding whether the alleged perpetrator should be hospitalised.

Recommendation No 7

The Medical Director of Birmingham and Solihull Mental Health Trust assures the Birmingham Community Safety Partnership that the bed management policy is sufficiently robust, understood by clinicians and senior managers and its implementation is understood by clinicians and senior managers in a way that keeps people safe

There was an over reliance on the information being supplied by the victim rather than seeking views of the extended family. There was also an over reliance on the victim caring adequately for the alleged perpetrator in terms of his general needs and the administering of his medication, when the victim was the person at risk. There was a failure to consider the victim's position as outlined in the Care Programme Approach guidance.

It is probably not uncommon for carers of patients to be a single close relative, usually the mother, who for all emotional attachments may be reluctant to see their loved one admitted to hospital. However practitioners should not allow emotional feelings to affect judgement for what is the best care for either the carer or the patient.

3.5 Approved Mental Health Practitioners

The admission process was further aggravated when, on 29th November, a CPN had got no reply from the family home. A duty Social Worker was contacted through Birmingham City Council Adults and Communities Service and it was discovered that there was no AMHP available to assess the alleged perpetrator.

Enquiries made by the Mental Health IMR Author indicates that at that time there were only two qualified AMHPs on duty in the City of Birmingham who were both committed. Interestingly, a supervisor who was on duty at the time, and who was a senior practitioner and a duly qualified AMHP, who could have taken an active role in assessing the alleged perpetrator, decided not to. It is considered that this was a missed opportunity to admit the alleged perpetrator to hospital. The second part of the application, the assessment by two doctors, had taken place but the lack of a duly qualified AMHP was all that prevented the alleged perpetrator being admitted to hospital. The fact that no AMHP was available should have been referred back to the Emergency Duty Team.

Since this incident a new service design is being considered by Birmingham City Council Adults and Communities Service, whereby twelve AMHPs will be available to manage all referrals between the hours of 8.15am and 7.15pm. The Birmingham City Council Adults and Communities' IMR makes suitable recommendations regarding this matter, however to support the IMR recommendation:

Recommendation No 8

Birmingham City Council Adults and Communities Service, to ensure that the new service regarding Approved Mental Health Professionals be implemented as soon as possible and enshrined in training and policy with the guidance.

BSMHFT staff are currently undergoing a university validated Approved Mental Health Practitioner training course through Birmingham City Council to supplement the capacity of AMHPs within Birmingham.

3.6 The alleged perpetrator declaring himself homeless

On 7th November, the alleged perpetrator went to a local neighbourhood office stating he had been declared homeless as his mother had asked him to leave the house due to his smoking habits. He said that he had been sleeping rough but was able to stay with his aunt until accommodation could be found for him. He also said that he had been 'sofa surfing' with friends on a temporary basis. St Basils, a multi-agency youth hub for homeless young people, works in partnership with Birmingham City Council to provide a homeless service for young people. St Basils were contacted and a telephone conversation with the alleged perpetrator took place during which a risk and needs assessment form was completed.

During this conversation, the alleged perpetrator indicated he had no mental health or depression issues and that the only long term illness he had was asthma. Because he stated he could stay with his aunt, he was assessed as not being in immediate risk or need, but threatened with homelessness within the next 28 days, an appointment was made for him on 13th November which he failed to keep and no follow up enquiries were made.

No-one from St Basils or the local Neighbourhood Advice and Information Service contacted his aunt or his mother to verify his version of events, for if they had, his story would have shown to be false and may have provided further indication of his deteriorating mental health state. However,

his recorded demeanour and responses provided no indication of safeguarding concerns and would not have necessarily given rise to further probing.

The response from Neighbourhood Advice and Information Service and St Basil's Youth Hub was therefore considered by the Panel to be proportionate in this regard. Nonetheless, the Neighbourhood Advice and Information Service have identified methods of strengthening training and supervision of staff in relation to safeguarding and reviewing the homeless pathway for young people between the City Council and St Basils with due regard to the drop-out rate of referrals and increased communication and liaison between the two services.

SECTION FOUR – CONCLUSION AND RECOMMENDATIONS

4.1 Recommendation No 1

Birmingham and Solihull Mental Health Foundation Trust Care Coordinators must ensure (as part of their organisation of care) that all carers are advised of their right to a carer's assessment. The offer must be clearly documented. If the offer is not accepted the reasons should also be clearly documented and a date set to revisit this with the carer

4.2 Recommendation No 2

Birmingham and Solihull Mental Health Foundation Trust to ensure that its staff recognise poor compliance with medication as an indicator of risk and that non-compliance is incorporated into the Risk Management Plan of Care Programme Approach.

4.3 Recommendation No 3

Birmingham and Solihull Mental Health Foundation Trust to ensure that teams are complying with the BSMHFT transfer and transition policy and there is a detailed handover meeting for a service user transferring to another team for longer term care, it should involve relevant agencies and engage with as wide a range of family members as reasonable.

4.4 Recommendation No 4

Each assessment needs to include all relevant information from family, friends, carers and others but must include meaningful contact with the patient in order to establish their mental state and degree of risk before being considered complete.

4.5 Recommendation No 5

Birmingham and Solihull Mental Health Foundation Trust to ensure that all staff are complying with clinical and management supervision policies ensuring that the management of clinical risk is imbedded in multi-disciplinary meetings, with emphasis on the role of the carer and family members.

4.6 Recommendation No 6

West Midlands Police to provide practice guidance for mental health practitioners about police officers power of entry and search of premises without a warrant, to save life and limb or prevent serious damage to property as per Section 17 Police and Criminal Evidence Act 1984

4.7 Recommendation No 7

The Medical Director of Birmingham and Solihull Mental Health Trust assures the Birmingham Community Safety Partnership that the bed management policy is sufficiently robust, understood by clinicians and senior managers and its implementation is understood by clinicians and senior managers in a way that keeps people safe

4.8 Recommendation No 8

Birmingham City Council Adults and Communities Service, to ensure that the new service to be introduced regarding Approved Mental Health Practitioner be implemented as soon as possible and enshrined in training and policy with the guidance**.**

4.9 Conclusion

This is a tragic case that has affected the lives of a large family in Birmingham. The alleged perpetrator was mentally ill and needed positive treatment and ultimately, hospitalisation. His needs were complex. He did not acknowledge that he was ill and in need of support and treatment. He was inconsistent in taking his medication or co-operate with agencies. The alleged perpetrator did not understand his mental illness and therefore lacked insight for the need to take medication. He did not recognise that he had any mental illness that needed treatment. He did, however, reluctantly, take his medication and did engage, although this was poor at times.

The victim, for the vast majority of the time, wanted to care for her son herself. She did not want him admitted to hospital until his behaviour, threats and aggression became intolerable. He controlled his mother and she tolerated him as most caring mothers would. But there came a point in time when she clearly had had enough and was unable to cope. She requested assistance to have the alleged perpetrator admitted and cared for in hospital. It was at that time that the assistance she called for faltered. Assessments were carried out on the alleged perpetrator over a period of time particularly when his mental state was deteriorating but the assessments failed to identify him as meeting the criteria for admission.

When at last, it was decided to make arrangements to provide a bed for admission, his behaviour and mental state improved and he lost his place on the ‘bed list’. He was placed on and off the bed list many times and each time he was removed it appears that he started at the bottom again.

Issues around the alleged perpetrator’s carer, the victim, have been raised in this review. Health agencies assumed that the victim was in charge of her son with regard to his care and for some of the time, his medication. The fact was that the victim was not in charge of her son. Her son was in charge of his mother. It is clear that the alleged perpetrator was using his mother to keep services

at bay and in doing so there were lost opportunities for agencies to share information about the alleged perpetrator's condition with the wider family members and obtain their opinion about his circumstances.

The victim was not considered a vulnerable adult and therefore was prevented from receiving support that could have been offered if she had been a vulnerable adult. It is well recognised that there are people in similar circumstances as the victim who fall short of meeting the criteria of 'No Secrets' definition of a vulnerable adult. It is hoped that the forthcoming Adult Care Bill will provide a solution and widen the scope of vulnerability. In Birmingham it is proposed to introduce an Adults at Risk Policy that will also assist in identifying people who are just outside the 'No Secrets' definition and who can qualify for support services.

The death of the victim was not predictable. There was nothing to indicate that the alleged perpetrator was such a danger to his mother to raise concerns about him killing her. However, on the basis that the BSMHFT IMR stated it is difficult to understand why the alleged perpetrator was not detained. The conclusion must be that had the alleged perpetrator been recognised earlier as a patient requiring admission, the attack would not have occurred and therefore the death of the victim was potentially preventable.

Bibliography

Birmingham Community Safety Partnership (December 2012) *Governance and Procedural Arrangements for Domestic Homicide Reviews in Birmingham - Draft Version No 2*
Department of Health (2007) *Best Practice Managing in Risk Principals and Evidence for Best Practice in the Assessment and Management of Risk to Self and Others in Mental Health Services*

Department of Health (2008) *Refocusing the Care Programme Approach – Policy and Positive Practice Guidance*

Home Office (2011) *Multi-Agency Statutory Guidance For The Conduct of Domestic Homicide Reviews*, www.homeoffice.gov.uk/publications/crime/DHR-guidance

Keating, F., (2007) *African and Caribbean men and mental health*, http://www.better-health.org.uk/sites/default/files/briefings/downloads/health-brief5.pdf

McLean, C., Campbell, C., Cornish, F., (2005) *African-Caribbean interactions with mental health services*, LSE