Community Safety Partnership

DOMESTIC HOMICIDE REVIEW

Into the death of Max

March 2018

OVERVIEW REPORT

Report Author

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Preface

The Domestic Homicide Review Panel and the members of the Hammersmith and Fulham Community Safety Board would like to offer their sincere condolences to the victim's wife, his children, his family members and friends both in the United Kingdom and abroad. The magnitude of his loss to his wife and children in particular cannot be underestimated.

The chair and Review Panel are most grateful to the members of the family and friends who have contributed to this Review. They have greatly enriched the content of this report and helped present the parties involved as individual people and not simply as a victim and perpetrator of a terrible crime.

The Review Panel have been mindful throughout of their responsibility to thoroughly examine the information before them without fear or prejudice to fulfil the purpose of a Domestic Homicide Review. The Panel has constructively challenged systems or service delivery where necessary as well as identifying good practice where it has taken place. The independent chair is grateful for their diligence and active contribution to the Review.

The key purpose of a Domestic Homicide Review (DHR) is to enable lessons to be learnt where the relationship of those involved in the fatal incident falls within the definition of domestic abuse. For these lessons to be learnt as widely and thoroughly as possible, professionals need to be able to understand fully what happened, and most importantly, what needs to change to reduce the risk of such tragedies happening in the future. The victim's death met the criteria for conducting a Domestic Homicide Review according to Statutory Guidance[1] under Section 9 (3)(1) of the Domestic Violence, Crime, and Victims Act 2004. The Act states that there should be 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 household as himself, held with a view to identifying the lessons to be learnt from the death".

The Home Office defines domestic violence as:

> *Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse: psychological, physical, sexual, financial, and emotional.*
>
> *Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour. Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.*

The term domestic abuse will be used throughout this Review as it reflects the range of behaviours encapsulated within the above definition and avoids the inclination to view domestic abuse in terms of physical assault only.

[1] Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (Revised August 2013) Section 2(5)(1)

DOMESTIC HOMICIDE REVIEW

1. Introduction

1.1 This report of a Domestic Homicide Review (DHR) examines agency responses and support given to Max, a resident in Hammersmith and Fulham at the time of the fatal incident which resulted in his death in March 2018.

1.2 In addition to agency involvement the review will also examine the past where possible to discover any relevant background before the homicide, whether support was accessed within the community and whether there were any barriers to accessing support. By taking a holistic approach the review seeks to identify appropriate solutions to make the future safer.

1.3 The circumstances that led to this review being undertaken are that the victim was killed by his half-brother, a family member, thus the homicide came within the definition of a death occurring as a result of domestic violence.

1.4 The review will consider agencies' contact and involvement with the victim and the perpetrator between January 2006 when the perpetrator was first referred to Mental Health Services and the homicide in 2018.

1.5 As outlined in the preface on the previous page, this Review is to enable lessons to be learned from homicides where a person is killed as a result of domestic violence and abuse in order to reduce the risk of such tragedies happening in the future.

Timescales

1.6 The Police informed the Community Safety Partnership of the homicide 4 days after the fatal event. In discussion with the Hammersmith & Fulham Community Safety Partnership, the Police, and the Community Safety Team the decision was taken that the criteria for a Domestic Homicide Review was met. The Home Office was informed on 27 March 2018, thus meeting the timescales within the statutory guidance for the conduct of a DHR.

1.7 The review process began in April 2018 with agencies being contacted to establish which had involvement with the parties to this Review. Agencies confirming contact were asked to secure their records. The first Panel was held on 6 June 2018. The Review report was concluded on 29 May 2019. Reviews, including the overview report, should be completed, where possible, within six months of the commencement of the review. It has not been possible to meet this timescale due to the time taken to contact family and friends for their contributions and to allow time for the final draft of the report to be shared. Some family members live abroad, and this included the victim's wife. Contact with her needed to be at a time and pace which was appropriate for her given the loss she had suffered. There was a delay of 4 months following the completion of the written report whilst agencies completed and had signed off their action plans prior to the review documentation going to the Community Safety Board for their sign off.

Confidentiality

1.8 The findings of this review were confidential and information has been only available to participating officers/professionals and their line managers until the Review has been approved by the Home Office Quality Assurance Panel for publication.

1.9 To protect the identity of the victim, perpetrator, and their family members the following pseudonyms have been used throughout this report.

The victim: Max aged 42 years at the time of his death.
The perpetrator: David, aged 32 years at the time of the offence.

1.10 Both the victim and perpetrator are of white British ethnicity.

Terms of reference of the review

1.11 **Terms of Reference for the Review: Statutory Guidance Section 2(7) states the purpose of the Review is to:**

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;
- Apply these lessons to service responses including changes to policies and procedures as appropriate;
- Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working;
- Contribute to a better understanding of the nature of domestic violence and abuse; and
- Highlight good practice.

Specific Terms of Reference for the Review

1. The review will identify and examine in detail agency contact with the victim and the perpetrator between January 2006 when he was referred to Mental Health Services and March 2018. Agencies with contact before 2006 are to give a summary of that involvement to provide context.

2. What risk assessment processes were undertaken with the perpetrator by services with whom he had contact to establish his risk to others and were risk assessments:

   a) Thorough and in line with procedures; if not, why not?
   b) Informed by background history and information from other agencies?
   c) Informed by information from any family members?
   d) Reviewed regularly and when the perpetrator's circumstances or mental wellbeing changed were risks escalated; if so, how was this done and what decisions were made and recorded?

3. Are the risk assessment tools and procedures designed to support decisions and assessments judged to be effective by the practitioners using them, or are there any adjustments which may enhance practice?

4. How did liaison with family members take place concerning assessments, treatment and relapse plans, and any risks identified?

5. If the perpetrator is found to have rejected or resisted support from services what changes could take place to improve engagement in similar cases in the future?

6. Were any members of perpetrator's family identified as a carer and if so, were they:

   (a) informed about carer's assessments and the support which might be available?
   (b) offered a carer's assessment?
   (c) signposted to appropriate voluntary or statutory services for support relating to their roles as carers, as victims of crime or domestic abuses?

7. All agencies are to examine communication and information sharing between and within their agencies to establish whether:

   (a) it was adequate, timely, and in line with policies and procedures?
   (b) there were any gaps in information sharing or breakdown in systems which impeded the effective treatment or management of the perpetrator's behaviour and health?
   (c) effective information sharing was undertaken to inform a safety plan to protect family members?

8. Were there any resource issues, including staff absence or shortages, which affected agencies' ability to provide services in line with procedures and best practice? Include caseloads, management support of staff, supervision, and any impact of changes due to restructures or to service contracts.

9. Had the staff in contact with the perpetrator and family members undertaken domestic abuse training which included, adult family abuse, risk assessment, safety planning, and how and when to refer to MARAC? What training had they received on their own agency's policies and procedures?

10. Are there any cultural issues or barriers which may have impacted upon the family's engagement or interactions with services and were these given due consideration?

11. Over the period of time covered by this Review two criteria applied for assessing an adults' vulnerability. Up to March 2015 a 'vulnerable adult' was defined by the Department of Health 'No Secrets' guidance as:

    "An adult (a person aged 18 years or over) who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or serious exploitation." No Secrets, Department of Health 2000

    Under the Care Act 2014 which was enacted in April 2015 the term 'an adult at risk' was adopted. An 'adult at risk' is considered in need of safeguarding services if she/he:

    a) *has needs for care and support (whether or not the authority is meeting any of those needs),*
    b) *is experiencing, or is at risk of, abuse or neglect, and*
    c) *as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.*

    Were any family members or the perpetrator assessed as a 'vulnerable adult' pre- 31 March 2015 or an 'adult at risk' post 1 April 2015? If not were the circumstances such that consideration should have been given to such an assessment?

Methodology

1.12 Following the decision to undertake a Domestic Homicide Review as outlined in the Timescales section of this report (paragraph 1.6), a total of twelve agencies providing services in the area were contacted to establish which had been involved or had contact with the parties in this review. Six agencies reported no contact, six confirmed contact and they were asked to secure their files.

1.13 Although the review timescale is from 2006 the decision was taken to include only background information from the family GP practice with whom the perpetrator was registered from February 2011. Sufficient relevant information was available from Mental Health Services from 2006 -2013 from whom he received regular support services, and to gain access to archived earlier GP records would have involved delay and cost which would have been disproportionate to the information achieved and its relevance to the events in 2018.

1.14 The chair and author of the review was appointed in May 2018 and agencies confirming their involvement were asked to provide a chronology of their contact. The chronologies were combined by the review author to form the narrative chronology within this review.

1.15 At the first Panel on 6 June 2018 the review Panel drafted terms of reference. Individual Management Reviews or reports were requested of the agencies that had contact with the parties in the review. These were submitted to the Panel after the criminal proceedings had completed to avoid compromising that process.

1.16 In addition to following the Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Review as revised December 2016, the Review has accessed a range of research and literature which is cited within the body of the report. Agency Individual Management Review authors have accessed their records, relevant policies and procedures, and their training records to address the Review terms of references. Practitioners and staff involved have been interviewed where possible, although due to the time span under review a number of staff are no longer employed in some of the agencies concerned. The Review Panel was provided with copies of risk assessment tools and templates used by the agencies with significant contact. They have also viewed the current discharge documentation used by the Mental Health Service providers, and the process used for forwarding Police vulnerable person notification.

Involvement of Family, Friends, Work Colleagues, Neighbours and Wider Community

1.17 The wife and family of Max (the victim) live in Spain. Max's wife is a Spanish national. The initial introductory letter written by the chair explaining the DHR process included the terms of reference and the Home Office DHR leaflet. This was delivered to her in Spain by two Police officers who were making a planned visit before the trial. One of the officers spoke Spanish, however officers reported that Max's wife spoke very good English and an interpreter would not be necessary to communicate with her.

1.18 Perhaps understandably at that time she did not respond to the chair's letter. In the autumn following the conclusion of the criminal trial the chair emailed Max's wife and then used an online application to message her to which she responded. She was sent updates on the progress of the DHR by this method and via email. The update included the learning identified during the review and the recommendations which

had been made. She was invited to choose a pseudonym for her husband to be used in this report, but the chair did not receive a response to this message. At the final draft stage Max's wife was emailed once more and offered a copy of the report. At the time of this final version no response had been received.

1.19 Letters were sent to the victim and perpetrator's mother, the first of which contained the terms of reference, the Home Office DHR leaflet, and a leaflet explaining the support offered by Advocacy After Fatal Domestic Abuse (AAFDA).[2] No response was received to these letters. The chair therefore liaised with the Victim Support Homicide Team support worker in an attempt to communicate with her. However, the Victim Support worker was also unable to achieve engagement.

1.20 Similar correspondence with the terms of reference was sent to the victim's brother who lives abroad which offered a variety of contact methods with the chair, but no response was received. The same correspondence was sent to the victim's sister and eventually contact was established via text, email and phone call. A copy of the AAFDA leaflet was emailed to her and she has been updated on the review's progress at regular intervals and has kindly contributed to this review including the selection of pseudonyms. The chair sent a copy of the final draft of the report to Max's sister and met her 4 days later to hear her views and comments. Some small corrections to information were made, and her comments and ideas have been included in the report.

1.21 One of the victim's oldest friends was contacted via text and email and he has contributed via email with a valuable written picture of his friend which is included in this report. He also kindly collated friends' comments about Max into his contribution.

The Perpetrator

1.22 The chair corresponded with the perpetrator's solicitor on two occasions, firstly to inform him of the Review and to formally seek his consent to access relevant personal information to assist the process. His solicitor responded that he was not well enough to respond. The second correspondence was to ascertain whether there had been any change in his condition to enable him to contribute, but there had not.

1.23 Following his trial, the perpetrator was sentenced to a Hospital Order with Restriction under Section 37/41 of the Mental Health Act (1983)[3]. On this basis it was decided not to attempt further contact for interview. Relevant information for the Review has been accessed 'in the public' interest and in the hope that any learning will prevent further such serious crimes.

[2] Advocacy After Domestic Abuse (AAFDA) https://aafda.org.uk/ a charity specialising in peer support to families who have experienced fatal domestic abuse through Domestic Homicide Reviews, Inquests, Mental Health Review, Police Complaints Inquiries.

[3] A Section 37 Hospital Order is made by the Court requiring a person's detention in hospital. Section 41 is a Court Order preventing a person from being transferred to a different hospital, granted leave or discharged without consultation with the Secretary of State for Justice. It is made if the Court considers it necessary to protect the public from serious harm. Anyone convicted of an imprisonable offence and the Judge considers hospital the most suitable option can receive a Section 37/41. Section 41 is usually made without a time limit. Where there is a Section 41 order without a time limit, it is not possible to have the restriction removed from the order.

Contributors to the Review

1.24 The following agencies and the nature of their contributions are shown in the table below:

Name of Agency	Chronology	Individual Management Review	Report
1. West London NHS Trust (for Mental Health Services)	√	√	
2. Metropolitan Police Service	√	√	
3. GP Practice	√	√	
4. Shepherds Bush Housing	√		√
5. Hammersmith & Fulham Adult Social Care	√		√
6. London Ambulance Service	√		

1.25 The authors of agency Independent Management Reviews (IMRs) and reports were all independent of the case, had no management responsibilities for the frontline staff who provided services to the parties involved, nor did they have personal contact with the parties to this review.

1.26 The IMRs required some points of clarification, but overall, they were judged to be of a high standard and had been appropriately probing in their enquiries and analysis. Where learning emerged pertaining to the individual agency a number of actions had already been taken before the IMR's submission to the Panel. Where early learning took place, this has been referenced within this report.

The Review Panel Members

1.27 The following were members of the Review Panel undertaking this review:

Name	Role	Agency
Gaynor Mears	Independent Review Chair and Report Author	Independent
Felicity Charles	Victims' Programme Coordinator	Hammersmith & Fulham Council Community Safety Unit
Russell Pearson	Review Officer (IMR author)	Metropolitan Police
Dr Pamini Ledchumykanthan Dr Amisha Patel (2 Panels)	GP Mental Health Lead Doctor - Registrar	The Family GP Medical Practice
Benn Keaverney	Chief Executive Officer	MIND Hammersmith & Fulham (Mental Health Support Charity)
DCI Sebastian Adjei-Addoh (1 panel) replaced by DI Nicki Beecher	Safeguarding Lead Tri-Borough	Metropolitan Police
Sally Jackson	Partnership Manager	Standing Together Against Domestic Violence (Specialist Domestic Abuse Service)

Name	Role	Agency
Parminder Sahota	Director of Safeguarding Children and Adults	West London NHS Trust (Previously called West London Mental Health NHS Trust)
Angela Middleton	Patient Safety Lead Mental Health	NHS England
LaToya Ridge	Senior Operations Manager	Victim Support
Victor Nene	CCG Safeguarding Lead	CWHHE Clinical Commissioning Group
Peter Lowe	Neighbourhood Manager	Shepherds Bush Housing Group
Christopher Nicklin	Interim Head of Adult Safeguarding (& IMR author)	Hammersmith & Fulham Council
Dr Anna Wilson	Clinical Director & GP (IMR author)	Hammersmith & Fulham Partnership
Jeremy Mulcaire (2 Panels)	Social Care Lead for Mental Health Services (IMR author)	London Borough of Ealing

1.28 The Panel had the benefit of specialist voluntary sector contributions from the mental health charity MIND Hammersmith & Fulham, and the domestic abuse charity Standing Together Against Domestic Violence. The Panel is grateful for their time and contribution.

1.29 The authors of the Individual Management Reviews attended the Panel meeting convened to discuss their reports. The Panel found their expertise and insights to be particularly helpful concerning some key issues from the findings. The IMR authors for Mental Health Services and GP practice were invited to further Panels to assist in discussions concerning how to resolve the matters arising.

1.30 A total of 6 Panels were held during the review process.

Author of the Overview Report

1.31 The chair and report author for this review is Gaynor Mears OBE an independent Domestic Homicide Review chair and report author. The author holds a Master's Degree in Professional Child Care Practice (Child Protection). During this degree she made a particular study of domestic abuse and its impact, the efficacy of multi-agency working and the community coordinated response to domestic abuse. The author also holds an Advanced Award in Social Work in addition to a Diploma in Social Work qualification, and it was her experiences of cases of domestic abuse as a Children and Families Team senior practitioner which led her to specialise in this subject.

1.32 Gaynor Mears has extensive experience of working in the domestic abuse field both in practice and strategically, including roles as county domestic abuse reduction coordinator; in crime reduction as a community safety manage working with Community Safety Partnerships and across a wide variety of partnerships and agencies, both in the statutory and voluntary sector. She was also regional lead for domestic and sexual violence at the Government Office for the Eastern Region and

was a member of a Home Office task group advising areas on the coordinated response to domestic violence. During her time at Government Office she worked on the regional roll-out of IDVA Services, MARAC, Sexual Assault Referral Centres, and Specialist Domestic Violence Courts, supporting Partnerships with their implementation. As an independent consultant Gaynor Mears has undertaken research and evaluations into domestic violence services and best practice, and since DHRs were introduced in 2011 she has undertaken a large number of reviews. She has also served as a trustee of a charity delivering community perpetrator programmes. Gaynor Mears meets the requirements for a DHR chair as set out in DHR Statutory Guidance 2016 Section 4(39) both in terms of training and the experience required for the role. She has not previously worked for or had any connections with any agency in Hammersmith and Fulham.

Parallel Reviews

1.33 A coroner's inquest was opened at West London Coroner's Court at the end of March 2018. It was adjourned pending the outcome of the criminal investigation and did not resume thereafter.

1.34 The family GP practice held an immediate internal review of the care given to the parties in this DHR and considered any actions which might be required. No poor practice was identified; specifically, no immediate concerns were raised in relation to an individual's actions or omissions, nor were any concerns raised by current internal systems and processes regarding patient care with serious mental illness. The internal review did conclude however that there was potentially a missed opportunity when David failed to engage with GP mental health reviews and treatment to refer him back to the Mental Health Services. This risk had been mitigated by a robust call and re-call system, but this had failed to result in satisfactory engagement by David. Immediate responses to the review by the GP practice along with other early learning arising during the Review process are highlighted within this Review Overview Report.

Equality and Diversity

1.35 The Equality Act 2010 places a duty on local authorities to eliminate unlawful discrimination, harassment and victimisation; to advance equality of opportunity between people who share a protected characteristic and people who do not share it; foster good relations between people who share a protected characteristic and people who do not share it. The protected characteristics covered by the Equality Duty under Section 4 of the Act are: age, disability, gender reassignment, marriage and civil partnership (but only in respect of eliminating unlawful discrimination), pregnancy and maternity, race which includes ethnic or national origins, colour or nationality, religion or belief which includes lack of belief, sex, and sexual orientation.

1.36 Max, the victim in this review, was married but the review is unaware of any evidence that he experienced discrimination or unequal access to services for this, or any other reason.

1.37 The Equality Act defines a disability as a physical or mental impairment that has a substantial, adverse, and long-term effect on a person's ability to carry out normal day-to-day activities. The condition must be deemed to last more than 12 months, and the focus is on the effect of the mental health problem, rather than the

diagnosis[4]. With his mental health diagnosis of Schizophrenia which required medication and years of input by the Mental Health Service, David, the perpetrator, may have fulfilled this category as having a disability. However, it is difficult to define whether his day to day living was impacted by his mental ill-health, or whether his difficulties in managing day to day life, such as retaining work placements or college, was due to his diagnosis, drug use, or his character and natural disposition. Nevertheless, there is no indication that he experienced any discrimination from services indeed, as the review will show, for the most part services did their best to engage him with the support they offered.

1.38 As far as is known the parties to this review held no specific religious belief, and none of the protected characteristics are relevant for consideration by the services that had contact with them.

Dissemination

1.39 In addition to the family members the following will receive a copy of the review:

- Family
- All Organisations & Services Represented on the Panel.
- Members of the Community Safety Partnership
- Commissioner, Metropolitan Police
- London Mayor's Office for Policing & Crime
- NHS England
- Hammersmith & Fulham Adult Safeguarding Board
- Hammersmith & Fulham Health & Wellbeing Board
- Director, Hammersmith & Fulham Adult Social Care

2. Background Information (The Facts)

2.1 Max lived in Spain with his wife and children, but he came to London for approximately two weeks in every four for his work. On these occasions he stayed in his mother's home, where his half-brother David, the perpetrator, also lived. On his last visit Max had arrived towards the end of February 2018 for 2 weeks work in and around London.

2.2 One day in March 2018 during his stay working in central London Max returned to his mother's home from a meeting at approximately 15:00hrs. The Police investigation found that Max sent his last email at 16:46hrs to a work colleague. David, who was the only person at home at this time, was known to Mental Health Services between 2006 - 2013 as someone who experienced mental illness having been diagnosed with schizophrenia in 2007; at the time of the fatal incident David was not under Mental Health Services, his mental health was managed by the GP practice. He was unemployed and spent most of his time in his room watching television. David had been a long-term user of cannabis and skunk, he also admitted to drinking alcohol regularly during the day.

2.3 Max and David's mother returned home from work at approximately 17:30hrs. On her way to the kitchen she was greeted by David who was on the landing. On finding Max lying on the floor in a pool of blood she immediately phoned the Ambulance Service; the Service phoned the Police at 17:42hrs to report that they were attending an address where it was claimed that a male had been murdered by his brother. The

[4] https://www.mind.org.uk/information-support/legal-rights/disability-discrimination/disability

Ambulance Service attended the property at 17:44hrs and efforts were made to resuscitate Max to no avail. David had locked himself in his bedroom but was extricated by the Police and taken into custody.

2.4 The post mortem found the cause of Max's death was a stab wound to the chest. Max had sustained a single horizontal stab wound to the chest entering beneath the sternum and penetrating the chest towards the heart nicking the pulmonary vein.

2.5 David was examined by a doctor whilst in custody and found to be fit to be detained, interviewed, and charged with the assistance of an appropriate adult. He admitted to the doctor that he was psychotic, but denied being schizophrenic, and he said he was no longer under the care of a psychiatrist. He also reported that he was not taking his medication and he had been drinking that day. David admitted stabbing Max but gave no reason for his actions at that time or since. He was remanded in custody.

2.6 David was transferred from prison to a psychiatric hospital where he was started on anti-psychotic medication. Following psychiatric assessments David was found to be fit to stand trial, however, it was recommended to the court that a plea of Manslaughter on the grounds of diminished responsibility be accepted. David was subsequently sentenced to a Hospital Order under section 37 of the Mental Health Act (1983, amended 2007) to be detained in a secure hospital. In addition, taking into account the nature of the killing and the risk of serious harm that the defendant presented when mentally ill, he was made subject to a Restriction Order under section 41 of the same Act.

The Victim:

2.7 Before moving on to the chronology in this report it is appropriate to note that Max was not known to any agency in the UK, apart from attending a few GP appointments for what would be considered straightforward healthcare matters relating to minor exercise related injury. These will not be discussed as they have no relevance to the Review, and there are no notes of him discussing his half-brother at these appointments, nor would that have been expected in such consultations. He also spent a significant amount of time outside the UK with his family. Much of the information provided in this report is about the perpetrator of this very tragic homicide as he was known to services over a significant period of time. It is therefore important that the reader remembers Max as the person whose death has left his wife and children without the person they love most in the world. His death has also left his other family members and friends bereft.

2.8 Max has older twin siblings, one of whom lives and works in the Netherlands, the other lives and works in London. He has two half siblings the youngest of whom is David who is 10 years his junior. His sister describes Max as bright, meticulous, and driven. He was successful at school, going on to university where he gained a 2:1 degree in business. He worked for a software company, working remotely in Spain as well as coming to the UK on a regular basis. Max met his wife during his gap year when he was around 17 years old and they have two children together. His sister described Max as a most caring father who always looked after his children.

2.9 The following contribution comes from Max's best friend who has also combined the views from other friends within the following paragraphs. It is quoted here rather than summarised to stay true to the source. (real names have been removed and the review pseudonyms used where required):

"I knew Max from secondary school, we were best friends since then, and I was best man at his wedding in 2005. The additional information here also comes from friends that have known him this long. We were a close-knit group. Although many have left the part of West London that we grew up in, we are still in close contact.

First, to give an idea of Max's character. Max was gentle, loyal and very kind. People often use the phrase, "he wouldn't hurt a fly", but in Max's case this was genuinely true, he purposely stayed away from conflict or violence of any kind. Even during the teenage phases that most young boys go through where they feel the need to prove themselves physically, I do not remember Max ever getting into a fight. That's not to say he wouldn't stick up for his friends if we were harassed, however his way of dealing with things was to talk the offender down rather than escalate matters. Paradoxically, I do remember Max being physically strong, and I recall him speaking about boxing prior to us meeting, and he was quite confident - which may have helped in talking others down. For example, I remember a night where a group of teenage girls were being harassed by a much older and larger man. Most others were walking past this incident pretending not to notice or keep their head down, Max walked up to the group and managed to talk the man into leaving them alone - never in an aggressive way, but more in a 'are you aware that you're really upsetting them?' manner.

He was loyal to his friends without exception. If someone was in trouble, he would be the first to offer assistance, no matter the effect on him. A few months before Max was married, I lost my job. Of course, Max had many expenses at that time in terms of financing a wedding and all the associated costs that come with such a major event, but he was the first to offer me money to keep things going - even though he had practically nothing left to give. If anyone of us had issues whilst at school, Uni, or even after, he would be the person we would confide in. His sense of doing the right thing was apparent in everything he did and said. I don't know if you have spoken to his wife or seen their children, but I'm sure you'll hear what a great father and role model he was to them. At work, he was hardworking and, again, loyal, sticking with the same company through the good and bad times, rather than jumping ship no matter how terrible the situation.

On to his relationship with his brother, David. I was genuinely shocked when I heard the news. Max could be a private person and he did keep certain elements of his family background away from the wider group, but the impression I had from Max was that he looked after 'David'. I did not know the full extent of David's illness; however, Max had mentioned before that David had 'issues' and he (Max) was trying to help him. I recall reading in Trial notes that David had hated Max from a young age - I never heard or received this impression from Max. That's not to say this wasn't the case, however I'm sure if Max was aware of this he would have mentioned. He talked highly of his family, and when I had seen Max and David together, I did not pick up on any negativity. The last time I was with them both was at Max's wedding (2005), and David was fine around Max then from my memory, although quiet as usual".

3. Chronology

3. 1 The earliest contact reported to the review Panel is by the Police on 17 March 2004 which references David being stopped and searched at a train station. No crime was found, and no further action was taken. He would have been 19 years old at the time and he was living at the home address.

3. 2 Mental Health Services record their first contact with David, the perpetrator, on 23 February 2006 when he presented to Hammersmith & Fulham Emergency Psychiatric Service. He was 21 years old. This was a short contact which ended the following day. There was a second presentation to the Service on 20/21 April 2006 following which he was referred to the West London NHS Trust Crisis Resolution Home Treatment Team.

3. 3 An assessment took place with his GP and family members (which family members is not recorded). David had a 2-year history of increasing withdrawal, isolation and reduced appetite; symptoms of depression and suicidal thoughts had become worse over the previous 2 months. David felt he was not alive and was not eating. This was his first presentation to Psychiatric Services. He reported that several months prior to the psychiatric involvement he thought about grabbing a knife with a view to stabbing himself in the heart, he did not know what stopped him. There was no history of deliberate self-harm. The GP had commenced David on Citalopram 5mg, however his family reported he did not take this regularly and he was either taking too many tablets or non-compliant. The family and David did not think that this helped him. He was diagnosed with Schizophrenia prescribed Fluoxetine 40 mg and Olanzapine 20mg and discharged to the Community Mental Health Team with an allocated care coordinator. He was to remain with the Community Mental Health Team until January 2013.

3. 4 Mental Health records show that on or about 6 November 2006 David's older half-brother attempted to force David to take his medication and an assault ensued. David was punched in the face and had a bleeding nose; there were no other injuries.

3. 5 Two days later on 8 November 2006 a home visit took place by the Community Resolution Home Treatment Team (CRHTT). David asked them to leave. They witnessed him pushing his mother out of his way. He was assessed as guarded, hostile, perplexed and had poor concentration. He was referred for a Mental Health Act Assessment (MHA), arranged for the following day. However, his mother called and said David was not at the property. The Community Mental Health Team were informed, and they agreed to visit David and re-refer to the approved social worker (ASW) on duty if appropriate.

3. 6 On 18 November 2006 David was stopped and spoken to by the Police in the vicinity of his home. No further action was taken.

3. 7 David's mother contacted the CRHTT on 22 November 2006 with concerns about his deteriorating mental state. His appetite had decreased, and he had not been sleeping for four days. His mother and the younger of his two sisters explained that David seemed confused in his thoughts saying at points "I'm dead"; he would sit on the floor in the corners of the sitting room (which sister was not recorded, but Max's elder half sister believes it was David's sister). They said he seemed to be having difficulty articulating what he meant and if asked to repeat himself he became irritated. His mother and sister also reported the incident where his brother had attempted to force medication down his throat about two to three weeks previously (3.4 above). They felt he was not at risk of harming himself, suicide, or violence, although he may be aggressive in tone. David's mother agreed to a Mental Health Assessment but felt David may resist and not want to be admitted. CRHTT gave feedback to David's care coordinator and suggested that he was referred for a Mental Health Assessment.

3. 8 A Mental Health Team professionals meeting attended by 2 approved social workers, care coordinator 1, a doctor and David's mother took place on 9 December 2006.

David's brother, Max (the victim) was staying for a week to support their mother with encouraging David to comply with his medication; David was taking his medication from his mother and his mental state had improved. A referral was made for psychotherapy and it was suggested that a male worker be allocated. Frequent visits by CRHTT followed.

3. 9 On 20 December 2006 a home visit took place by two doctors from CRHTT. Following discussion with a consultant psychiatrist. Medication was reviewed and changed as the current prescription was concluded to be ineffective. David appeared quite detached during the assessment, he was not engaging in any conversation nor giving specific answers to questions. David said that the team were annoying him; he refused to comment on his persecutory beliefs and did not engage when asked about auditory hallucinations, he asked for a doctor's ID to ensure that he was a doctor. The doctors ended their assessment as David appeared quite irritable and unmotivated to engage in any useful conversation. The plan from the assessment was: 1. Introduce Risperidone slowly. 2. Discuss David's compliance with medication and symptoms with his mother. CRHTT was to discuss risks frequently and offer office visits to the family. The plan was to be reviewed and consideration given to detention should risks increase or psychosis return. Accommodation was to be discussed and the Community Mental Health Team was to be encouraged to allocate a support worker and await the First Incident of Psychosis Recovery and Support Team (FIRST) and their psychology assessment.

3. 10 On 22 December 2006 a home visit was made by two members of CRHTT. David presented as perplexed and thought disordered. Discussion took place regarding his request for anti-depressants and he was advised that medication would be reviewed once Risperidone was established. David became increasingly hostile. He appeared to have little insight saying that he wanted the anti-psychotics stopped and anti-depressants started, that it was his choice and nothing to do with CRHTT. He became increasingly aggressive and threatening telling the team members to leave, and at one point stated, "I'll kill you". His mother attempted to intervene, but he was hostile and challenging towards her. His mother called his brother. David was reminded that CRHTT was an alternative to admission (to hospital) and that both CRHTT and his family wanted him to remain at home. He refused medication even with prompting from his brother. David's mother requested that the medication be left with her to see if she could prompt him to take it. She said that he had been settled all day prior to the CRHTT visit. David's mother was advised that they would discuss the situation with the team. An Emergency Duty Team referral was to be considered as there was currently a risk to staff, and staff were to visit in pairs.

3. 11 The following day on 23 December 2006 a further home visit took place by two members of the CRHTT. David was seen with his mother, brother Max, and Max's wife present. David was taking his medication with prompting. He agreed to continue having visits from CRHTT.

3. 12 The next CRHTT visit took place on 27 December 2006, two doctors and David's care coordinator attended, his mother, brother Max and his wife, and a small baby were present. A summary of this visit notes: onset of negative mood and psychotic episodes over a period of a few years. Low self-esteem and risks to others; were also a concern; psychotic episodes were now either much reduced or lacking. He presented as low, ambivalent and unpredictable at times and felt abandoned by the absence of a father figure and resentful of help. He was assessed as possibly depressed, socially isolated, and pessimistic. There remained a low but unpredictable risk of harm to others. David had limited insight and could become angry when asked to take medication. It was noted that David's family tended

(especially mother) to minimise the risks and problems. Risks could be managed by not confronting him if irritable or refusing medication, and staff were visiting in pairs. The plan was to be reviewed if risks increased or if he was non-compliant. Indicators of increased risk might be psychosis and irritability.

3. 13 On 24 January 2007 two doctors from CRHTT made a home visit. David was at home alone. He was pleasant and co-operative during the visit. His mood was subjectively "better", objectively blunted and perplexed at times. He reported that his thoughts were clearer in comparison to the point of his admission to the CRHTT, but he was generally guarded and unable to fully express current thoughts despite several prompts from the doctors. At one point he seemed suspicious about their intentions and questioned the need for the visit despite some attempts to explain their roles and purpose of the visit. He was vague about incidents/events leading to current admission to CRHTT (i.e. aggression towards family when being encouraged/asked to take medication) and had minimal insight into his mental state. However, he was agreeable to continue taking medication and was left with Risperidone for two days.

3. 14 Three CRHTT staff saw David with his mother on 15 February 2007. When they arrived David's mother became tearful and David appeared a little shaken. They explained there had been an altercation between David and his elder brother who was currently at home with David and he had been feeling wound up by David's behaviour. That day they had argued, and his brother had picked up a knife and threatened to kill David or himself as he could not take much more. The incident was discussed with David and his mother to look at ways to deal with the situation. David seemed to find it difficult to think how he might do this. It was suggested that he spend time away from his brother. He agreed and said he was thinking of going to the gym or getting a job. The steps it would take to get a job were discussed and his care coordinator said she would look at his CV and consider interview techniques. However, his mother said he had not attempted to go to the gym. Motivation and a befriending group were discussed as David said he wanted to meet people. It was explained that this was separate to mental health services and may help to motivate him, but David declined and was unable to articulate why. He stated that he thought he did not take things in; he said he watched mouths but does not really know what's being said. His care coordinator said she would speak to Social Services about emergency accommodation and put together a case for him. David agreed to this then mentioned wanting to go to the pub. He was advised that this was not a solution. His care coordinator was also to arrange an outpatient appointment to see a doctor in the community to review medication. David had also begun early intervention groups and within the next month would transfer to a staff member who was the Early Intervention specialist at Gloucester House. David was now discharged from the Crisis Team and he and his mother were made aware that they could call the team if needed. They were also advised to contact the Police should the home situation escalate. A Fax was sent to his GP notifying of discharge.

3. 15 On the 20 April 2007 a Mental Health Act Assessment took place which assessed David as suffering from the early onset of a mental illness. He was refusing medication and community treatment and refusing CRHTT and CMHT support. He had become increasingly withdrawn and self-neglecting, increasingly hostile, and his family were finding it more and more difficult to manage him. A decision was made to formally admit David to hospital for assessment, as he refused informal (voluntary) admission. The Police were called to the home address to assist and they recorded that 'Doctors believed that he had stopped taking his medication and may pose a risk to himself and others'. David agreed to attend the Mental Health Unit and Police action was confined to that of escort only. He was detained under Section 3 of the Mental Health Act (1983) and admitted to a Mental Health Ward.

3. 16 A review of David's progress on 16 May 2007 noted that since admission he had been treated with Olanzapine. He had been reluctantly compliant with medication but remained guarded and hostile. His Review Tribunal on 2 May decided not to rescind his Section. David was exhibiting negative symptoms of Schizophrenia and was isolating, self neglecting and insight-less. He was accepting medication reluctantly and was clear that he did not intend to take medication, engage with services or stay in hospital informally.

3. 17 A Care Programme Approach meeting took place on 10 July 2007. David started overnight leave, and the plan was for him to return during the day to attend groups and return home in the evening as a trial until Friday 13 July. If settled after review with a doctor David would be taken off Section 3 (MHA 1983). A family holiday to Spain was to take place on 16 July 2007 and his mother was to contact CMHT on return to arrange an appointment with a team doctor. A community psychiatric nurse would make contact for a 7-day discharge follow up. When this took place on 27 July 2007 David reported he enjoyed the holiday and his mood was "alright". Asked about disturbing thoughts, he replied "yes, just one, when I tasted it (medication) and I realised I wasn't an anti-psychotic person". David was unable to explain what he meant by this. He asked when he could stop taking the Olanzepine. David's mother reported no concerns while on holiday.

3. 18 On 16 August 2007 David had the first of 6 extended assessment sessions with a trainee psychologist. He admitted to the use of ecstasy from the age of 15 years and cannabis use shortly after. He would buy it whenever he had money. It was very difficult to pin point abnormal experiences, and difficult to ascertain whether it was because of his concerns about telling the psychologist, or whether he did not understand or remember them. He acknowledged an element of paranoia, which he said he no longer experienced, and he could remember the medication he was taking. He did not want to return to hospital but agreed to attend a second session.

3. 19 The second session with the psychologist took place on 23 August 2007. David made it very clear that he did not want any association with mental health. He acknowledged that he was much better than he used to be, understood that he needed to take his medication, and wanted to get on with his life and try to forget about his time in hospital. David explained that he did not interact with anyone in the hospital because he was worried that may have made things worse, so he thought it best to keep himself to himself. When asked if he would like to do a cognitive assessment, he was extremely reluctant. He said that he did not think there was anything wrong with him in that sense. Following this discussion, David was reluctant to continue with the session. The psychologist continued to ask about his psychotic symptoms, which in his mind amounted to paranoia associated with cannabis use, which he had stopped. David was asked if he would mind his mother attending, in order to gain a different perspective, however, he was mindful that she has to work in the day and was unlikely to be able to attend the sessions. David had been helping to decorate his home with his mother and wanted to start an electrician’s course at college in order to get a job. He was offered an appointment with a vocational worker; however, he reiterated his wish to cut himself off from any association with mental health services. He agreed to return to continue the assessment with the psychologist.

3. 20 David's next appointment with the trainee psychologist on 6 September 2007 was also attended by another psychologist. The session was spent discussing his historical background, which seemed uneventful. Initially David presented as incredibly nervous, however he managed to relax by the end of the session and

engaged appropriately in conversation. At this point, David had only disclosed minor paranoid thoughts in relation to his cannabis use, for which he had insight.

3. 21 The next session on 21 September 2007 was also with the two psychologists present. This session was taken up exploring David's psychotic symptoms which included both visual and tactile symptoms such as being killed by his friend, having part of his spine and heart removed. He believed that he was dead. David was assessed as having no insight into these as psychotic symptoms. He visually hallucinated in the room, and it seemed that he lived with these experiences on a daily basis. His understanding of the medication he was taking was to make him alive again. He wanted to have "my life back".

3. 22 There was a Care Programme Approach (CPA) review meeting with care coordinator 2 for David on 8 October 2007. He attended with his mother. The review became side-tracked when discussion about his medication and symptoms started; David was still suffering from distressing symptoms as before but had no insight into these as psychotic symptoms. David insisted he was complying with medication although he did not believe it had any effect on him; it was noted that neither David nor his mother would consider a change to depot medication[5] (his mother was very insistent on this point). The discussion around medication and symptoms ended up detracting from the real purpose of meeting i.e. to discuss David's care plan. The fact that David needed to be doing more was discussed and college and 'Cityfix' remained options to look into. However, during the meeting David maintained he wanted nothing further to do with Mental Health Services.

3. 23 On 10 January 2008 David attended on time for review with a CMHT doctor after missing a few appointments previously. He reported remaining well and had kept in contact with his care coordinator 2. He was spending most days at home watching TV and helping his mother with house work. He planned to see an educational advisor regarding returning to adult literacy and numeracy classes and said he planned eventually to go to college and university. He had recently started seeing a chiropractor for neck problems; he felt more relaxed following the treatments. He denied any delusional preoccupations and dismissed them as all "from the past". David appeared to be spending a large amount of time on the computer using chat rooms and was keen to meet his old school friends with whom he has lost contact. David said he was taking his medication and reported no side effects. The doctor noted that although possibly still harbouring his psychotic symptoms there was no evidence of distress and he had maintained some stability and engagement. He was to maintain regular contact with care coordinator 2 and was to meet an educational advisor about attending English and maths courses. The possibility of attending Recovery group as well as social skills and football group was discussed. Progress was to be reviewed again in a CPA meeting on the 7th of April 2008.

3. 24 There is no evidence that the meeting with a vocational worker took place the day after the review above. The CPA review meeting on 7 April 2008 was attended by David, his mother, psychiatrist and social worker. David reported feeling well and denied any symptoms, but he was ambivalent about medication asking if it could be stopped. He was attending college twice a week to learn maths and English in preparation for GCSEs; but he was not very keen and was bored easily. His social worker had also referred him to an advisor to guide him on vocational training and preparation for employment. David's mother reported a significant overall improvement in him; he had been helping her with the house work and cooking.

[5] Depot medication is a particular form of a medication which is given by injection, usually into a large muscle like a buttock where it is released gradually over a period of weeks.

Examination of his mental state and risk assessment judged that despite residual psychotic symptoms in the form of somatic delusions/hallucinatory experiences, he remained stable with euthymic[6] mood, but retained deficits in his motivation and insight.

3. 25 David met with a vocational worker in April 2008 and by his CPA review meeting on 6 October 2008 he was attending a vocational course weekday afternoons run by a voluntary organisation and was finding this useful. The meeting was attended by David and his care coordinator 2. It was reported that his sisters visited regularly, and he and his mother planned to visit his brother in Spain at Christmas. He enjoyed going out for walks and had made a few friends at the local church he attended regularly. David was looking forward to starting work and getting on with his life. He remained unhappy about taking his medication but maintained that he was taking it regularly. However, he was insight-less and could not acknowledge any improvement in his behaviour. Enquiry into his mental state and risk assessment found that despite residual psychotic symptoms in the form of somatic delusional hallucinatory experiences, he appeared less preoccupied and distressed by them and was stable in his mood with no associated symptoms. An improvement in his motivation was noted, however, David persisted in the view that he did not need to continue with medication and had hoped to stop after the meeting. He became irritable and impatient towards the end and left saying he no longer needed medication even though the doctor agreed to reduce it to 600mg at night only. His care coordinator 2 was to continue to monitor him despite his reluctance to engage and was to stay in touch with his family to encourage compliance with medication as well as educational and vocational opportunities. A further follow-up appointment was offered to David on 22 January 2009. There is no evidence that this meeting took place.

3. 26 Between January and March 2009 efforts were made to assist David with work experience with the mental health charity MIND. He attended interviews and expressed an interest in joining a gardening project. His care coordinator also agreed to pursue independent living schemes with him.

3. 27 The next agency contact recorded with David is 6 April 2009 when he was seen by Royal Parks Police officers trying to take coins out of the fountain at the Queen Victoria Memorial opposite Buckingham Palace. He was given advice by officers and no further action taken.

3. 28 In July 2009 David was accepted for a tenancy in a supported living project for which he had applied, and his mother was pleased with this outcome.

3. 29 On 22 July 2009 David was seen by Police in Shepherds Bush Road waiting to cross the road. On seeing the Police, he acted suspiciously so was stopped. No crime was identified, and no further action taken. David was stopped and spoken to once more by the Police on 2 September 2009 in the Hammersmith bus garage. He was in possession of a Freedom Pass which was not in his name. David gave his home address as a flat in a supported living project. No crime was identified, and no further action taken.

3. 30 On 5 September 2009 David attended Hammersmith Police station and reported that he had accidentally left a large bag in the luggage area on a bus. When the bag was found at the lost property office some food and photographic equipment was

[6] Euthymic is the state of being in euthymia, which is a relatively neutral mood that is neither extremely happy nor extremely sad.

missing. The reporting officer noted that David struggled with dates and times of the offence and seemed to have trouble recalling events. With no independent witnesses, forensic or CCTV evidence no further action was taken by Police. David gave his home address as a different number in the supported living project than before.

3. 31 A CPA review meeting took place on 22 September 2009. In attendance was David, his care co-ordinator 2, and a psychiatrist. David reported enjoying his placement at the supported living project, but there had been some concerns about noise nuisance for which he was responsible. David agreed not to cause any more noise problems, and to meet with a worker at MIND to explore voluntary work. He had made friends with some of other residents in his accommodation. Under 'Carer's View' it was noted that David's mother appeared pleased with his progress; David did not want her present at review. His placement was judged to be working well, but he remained doing little during the day.

3. 32 On 23 September 2009 David was stopped in the SW6 area of London and spoken to by Police after being seen to walk away from Police holding a mobile phone. No criminal offences were disclosed, and no further action taken by Police.

3. 33 David's care coordinator 2 noted on 3 November 2009 that he had stopped attending MIND the previous week. His care coordinator phoned him to ask why and he said that he did not think it was worth going for just half an hour's work. David was reminded that he and the MIND worker had been due to talk about this with a view to increasing his hours. His care coordinator arranged a meeting between themselves, David and the MIND worker for the following week.

3. 34 The above planned meeting at MIND took place on 12 November 2009. David was given some positive feedback regarding his work at MIND reception by the worker and told of their disappointment that he had not continued. He expressed his frustration that it was only half an hour's work a day (this was due to be reviewed as David was aware). David saw himself getting a job in a coffee shop or any shop with a busy atmosphere; the MIND worker was to accompany David to Oxfam the following week and in late November it was arranged for him to start work there. However, by January 2010 he had ceased attending.

3. 35 On 23 March 2010 a CPA review meeting was held. In attendance was David, his care co-ordinator 2, a GP from his previous practice, and a psychiatrist. His daytime activity was very limited, and he was reluctant to engage with anything. David had been referred for some motivational work with the worker at MIND, but so far had not attended any of the appointments. He reported experiencing side effects from his medication and an additional prescription was added to counteract them. David's mother appears to be absent from the review. The 'Carer View' section notes that staff at his supported accommodation were happy with David's progress and reported no recent problems with his tenancy. Noted under the section concerning what was not working well was David's lack of engagement with any day time activity and also only seeing his care coordinator 2 sporadically.

3. 36 In early July 2010 David was visited by his care coordinator and the vocational manager from MIND to engage him in further activities. A course in horticulture was discussed and David was accepted for interview the following month. He did not attend the interview saying he wanted to go to college instead.

3. 37 On 27 July 2010 the Police were approached by a member of the public who said a male, matching David's description, had been in the lift at Holland Park station approaching women and trying to start conversations with them. The women

appeared uncomfortable with this. David was seen nearby and spoken to about his behaviour. He said he did not remember doing this as he had a disorder. He was given words of advice and no further action was taken by Police.

3. 38 Police had contact with David once more on 21 September 2010 when he was stopped and searched. The reason for the stop is not recorded. No further action was taken.

3. 39 A CPA review was held on 19 October 2010 with attendance by David, his care co-ordinator 2, GP from his previous practice, and psychiatrist. David was not engaging with any structured day time activity; he did not identify this as a problem, but he had expressed some interest in the Chelsea Football Club group (Men's Health Project). He agreed to be referred to a vocational worker to think more about this. David felt that things were going "ok", and he had a better routine. Regarding medication he said, "I like it now". No carer was identified under 'Carer Views'. Staff at his supported accommodation were happy with his progress and were now nominating him for independent housing. Supported housing appeared to have helped David with learning to live independently. Initially there were some problems related to alcohol and noise nuisance, but there were no such issues in recent times. It was noted that David had been under the care of the FIRST team for over 3 years and, in line with policy and practice, it was explained to him that he would be transferred to the Recovery team. David showed reluctance to engage with a different care coordinator.

3. 40 In January 2011 David moved from his supported accommodation into his own independent flat. His care coordinator 2 assisted with various aspects of the move including successful applications for charitable grants, repairs, and his income support claim. He settled in well and his mental health remained stable and did not give rise to concerns. He continued to be offered daytime activities which he declined. David registered at a new GP Practice on 3 February 2011. Among the new patient details it was noted that he did not have a carer.

3. 41 A CPA review took place on 7 June 2011. This is shown as a Referral Review to transfer David's care to the North Hammersmith Recovery Team. In attendance were David, care co-ordinator 2, his new care coordinator 3, and a consultant psychiatrist. His mental state was reported to have been generally stable although he occasionally had increases in a preoccupation with parts of the body, for example at times being concerned that one eye was bigger than the other or concerns about his spine. In discussions about his medication David acknowledged that he had not taken medication other than occasionally since he moved into the current independent accommodation; he linked medication use with mental health services which he did not wish to have. He reported that he had had a discussion with his mother about medication. David said that he used alcohol at weekends, drinking up to 24 cans of strong lager with friends or drinking in pubs. He admitted that after having been abstinent from cannabis for a long time, he tried smoking some recently with friends and afterwards he had unusual experiences, hearing voices and feeling "weird". He did not respond directly to questions about other drug use. On review of risks, he acknowledged that sometimes when he had a drink he felt like hitting things but does not do so and emphasised that he has no thoughts of harming others or himself. The need for ongoing treatment in terms of reducing risk of relapse was discussed. He was able to give some commitment not to continue cannabis use. There was concern that despite regular contact with his previous care coordinator he had not felt able to share the situation with regard to medication adherence. It was the view of his consultant that initial work to build a good therapeutic relationship with his current care coordinator (3) and themselves as consultant would be important. Also

discussed was his care coordinator speaking with David's mother and this was to be considered. It was noted that previously David had not wanted to receive copies of letters from the FIRST clinic as this had been a reminder about Mental Health Services, and work with his care coordinator about this was considered helpful. In terms of medication options, David declined the option of a depot antipsychotic, but was willing to consider restarting oral medication. Confirmation of dosage from his GP was recorded. David's care coordinator was to have two weekly contact and a joint review for 9 August was offered.

3. 42 On 9 June 2011 David was stopped and searched by Police in Uxbridge Road W12. He fitted the description of a male wanted for serious offences. Enquiries revealed David was not the wanted male; no further action was taken. His address at this time was given as his independent living flat in London.

3. 43 David's GP received information from Mental Health Services on 11 June 2011 arising from the CPA meeting. This included:

- poor concordance with taking medication.
- high consumption of alcohol after which he feels like hitting things.
- specific comment made that he did not have thoughts of harming others.
- previous cannabis consumption noted and he had retried this recently after which he had "unusual experiences" and hearing voices.

3. 44 David was stopped again by the Police on 18 June 2011. He appeared nervous and smelt of drugs; no further action was taken. He was also stopped and spoken to by Police on 30 June 2011 along with another male. David said he had a slight mental health problem and was living alone for the first time after living in hostels or with his mother. He said a male had recently been using his flat, but he had managed to get rid of him. David appeared nervous and told the Police he only knew the other male from drinking on Shepherds Bush Green. The officer noted that David was of small build and may be taken advantage of by drinkers using his flat to drink and take drugs; no further action was taken by Police.

3. 45 The following day on 1 July 2011 David reported to Police that he had woken up to see a male on scaffolding outside his flat peering in through a window, after which he had left. David thought the purpose was theft. David said he had moved into his flat in December and various people from the estate visited him. He felt that because of this he may be a target for drug dealers and users on the estate as he is vulnerable due to his mental health issues. There were no independent witnesses, forensic or CCTV evidence, therefore no further action was taken by Police.

3. 46 On 15 July 2011 David saw GP7 in the practice at which he registered in February of this year. He was issued with a repeat prescription for 60 Amisulpride 400mg tablets - one to be taken night and morning. David said he had been on Amisulpride since diagnosis, has a social worker, is under the Recovery Team and was sectioned a year ago. At this appointment he said he felt 'alright'. GP7 made a note for a member of the practice staff to contact the Community Mental Health Team for information. This suggests that no contact had been made with the GP by the Team, no medical notes had arrived from David's previous GP practice since he transferred 5 months previously, or, his notes had not been uploaded for the GP to see which should include the information described in paragraph 3.43 above.

3. 47 On 20 July 2011 care coordinator 3 spoke with David's mother. Relating to this conversation the following was recorded: It seemed that the issue with David's jaw freezing open was either a reaction to the medication or stress. His mother had

taken David to the hospital who said that he should take diazepam when he started to have signs of this. Care coordinator 3 confirmed that David had an appointment with the team consultant psychiatrist on 9th August. The 'friend of a friend' who had been staying at David's flat had tried to gain entrance again. The security guard at the building was aware; he would deny them access and call the Police if they climbed the scaffolding. The Police gave David another direct number should they return. Care coordinator 3 said they would contact the Police to establish what can be done. David had gone to stay with his sister in the Midlands for a few days. It was believed that he was now taking his medication.

3. 48 The following day, 21 July 2011, care coordinator 3 had a conversation with David's sister. She said that they had discussed the whole situation and David would like to move closer to her in the Midlands. She said that he would be able to become part of her business run from home and have support from her extended family who live in the area. David was in the background and was in agreement. David's sister was going to contact the housing department to find out what the procedure was regarding transferring housing benefit etc. Care coordinator 3 provided details of Homeswapper and explained that the service would not do anything in terms of transfer until David had an address there.

3. 49 On the 29 July 2011 there was an urgent review at the North Recovery service where David was seen by the consultant psychiatrist with his mother and care coordinator 3. It appeared that his medication dose had been inadvertently increased from 200mg twice daily to 400mg twice daily and David had developed problems with muscle spasms, been diagnosed with acute dystonia[7] and treated with diazepam. He had attended Accident & Emergency in a Midlands hospital as a result of these side effects. Following a period of intermittent treatment adherence, he had been taking medication more regularly. David was advised to miss the morning dose of medication. He felt more irritable that day and acknowledged some thoughts of slapping people on the head although he was resisting this. He said that he had been thinking more about his father and the lack of a father figure after seeing some workmen that day. There was no evidence of hallucinations or delusional ideas; his mood was down recently, appetite less, although his sleep pattern was good. He had no thoughts of self- harm. In terms of plans David had some interest in possibly looking into work opportunities and also expressed a wish to move closer to his sister and his care coordinator 3 was to offer support with these areas. Concerning medication, his consultant suggested resuming treatment with Amisulpride 200mg twice daily which David had tolerated without side effects, along with procyclidine 2.5mg as needed to a maximum of twice daily. The consultant psychiatrist also noted that they would be grateful if the GP could continue the prescription and also monitor glucose, cholesterol, and lipids in view of the potential metabolic effects of antipsychotics and consider offering a physical review.

3. 50 On 29 July 2011, GP notes record information from the Mental Health Service regarding the urgent review above and the Amisulpride being inadvertently increased to 400mg which caused side effects. David was to remain on 200mg and procyclidine 2.5mg under review. His social worker's name was given, and that David was on mental health review Enhanced CPA level.

3. 51 Care coordinator 3 met with David's mother on 9 August 2011 when she confirmed that he was well. Once again, the topic of daytime activity arose, and the care coordinator arranged for another vocational assessment which David did not attend.

[7] Dystonia is the name for uncontrolled and sometimes painful muscle movements (spasms). https://www.nhs.uk/conditions/Dystonia/

Efforts to engage him in daytime activities ceased in November 2011. Further attempts were made in February 2012 to offer him suitable activity, but by April 2012 David had declined all support in this respect and the referral was closed.

3. 52 Information from Mental Health Services regarding David's failure to attend the psychiatry review above was recorded on his GP notes on 9 August 2011. The 'did not attend' letter stated that his mental health care coordinator would be arranging further outpatient reviews "as required". No further correspondence was received by the GP practice from the Mental Health Service until David was discharged at the beginning of 2013.

3. 53 A CPA review was held on 5 December 2011 which was attended by David, care coordinator 3, and GP7. It was recorded that David continued to spend most of his time at his mother's home. He did this as it was easier, and he could go home when he needed to have a break. It was noted that this was his choice, but his independence was considered compromised. David had refused to engage with any courses or vocational work. He felt that he was very well mentally and was getting on with his life. He did not feel that he needed very regular input but would like to meet up every month or so. There was no record under 'Carer View'. David was concordant with medication and was judged to be mentally very well. He was not drinking much alcohol or smoking cannabis at all; his mood was much better than when he first came to the recovery service. David was still considering moving away from London and starting again somewhere else. These ideas were intermittent, and he was to let his care coordinator know should he wish to go ahead.

3. 54 On 8 April 2012 care coordinator 3 discussed with David and his mother that Mental Health Services were now doing very little for him in terms of maintaining his mental health. The next stage of his recovery i.e. entering employment or training needed to have a certain willingness and impetus from him and up to that point there had been neither. David's mother did not want him to be discharged but understood that keeping him on an enhanced care plan could not be justified given the pressure on the services. However, David was given one more option to engage with something to occupy his time. MIND was running a football training initiative with Chelsea football club and his care coordinator was to apply with MIND.

3. 55 David was seen by Police cycling along a road on 27 June 2012 looking into parked cars, so he was stopped and searched. Two days later on 29 June he was seen by Police cycling on a footpath in an area known for vehicle crime, so he was stopped and searched. No further action followed these contacts.

3. 56 Care coordinator 3 spoke to David's brother who was staying at his mother's home on 10 July 2012. It is probable that this was Max, but it is not recorded. He said that David was fine and mentally stable but did not want to be associated with Mental Health Services. Care coordinator 3 explained that David had disengaged with the service and was to be discharged as he was compliant with his medication which he accessed via his GP. Apparently, David would welcome this, but he did have an interest in the MIND run Chelsea football coaching scheme.

3. 57 On 23 July 2012 a CPA review meeting took place. Only David and care coordinator 3 attended. GP7 is noted as contributing, how is not recorded. David's view was that he did not require assistance from the Recovery Team. He was very independent and required limited intervention from the Recovery Team. He obtained his medication from his GP and was noted as diligent about taking it. David's life was seen as very limited and his routine only involved going to coffee shops during the day. He had no interest in broadening his social circle, training, or getting a job. A

referral for Chelsea football training had been completed and MIND was to contact David.

3. 58 On 3 November 2012 David's mother, attended Hammersmith Police Station and reported that a male known to her son had stolen his mobile phone while he had been visiting their home. David was unwilling to come to the station or provide a statement, the suspect was a friend, but he was also scared of him. On 12 November David's mother confirmed that he would not speak to the Police as he has mental health issues. She was advised to speak to their key worker or housing officer to get help with preventing the male going into their house. David was identified as being vulnerable, but the report noted that his mother took an active role in protecting his interests, so he was sufficiently supported.

3. 59 Care coordinator 3 discussed David's case in a team meeting on 7 November 2012 regarding his disengagement from the service, his continuing stability, and his not having a requirement for the service. A home visit was made to see David, but no one was at home. The following day care coordinator 3 spoke to David's mother on the phone. She said that although David did not want to remain in contact with Mental Health Services, he did require some help. She reported that he had again been having issues with his flat with various individuals turning up and drinking etc. She said that David had a Blackberry stolen from him but did not want to go to the Police for fear of reprisals. His mother stated that she had called the Police who are investigating. Care coordinator 3 said that although David was to be discharged it would be good to have another meeting whereby she could also attend; she would be informed of the time and date. However, there is no indication that David's mother was informed of the meeting appointment.

3. 60 The following day on 9 November 2012 David was seen by Police with a male who was acting suspiciously who was known to break into cars. No further action took place.

3. 61 Following a discussion between coordinator 3 and their supervisor on 10 January 2013 the decision to discharge David was confirmed. A final CPA review discharge meeting took place on 17 January 2013. In attendance was David, care coordinator 3, and a psychiatrist. David had been apathetic to any suggestions regarding education, work or training. He felt that he did not require the assistance of the Recovery Team or mental health support in general. He felt stigmatised by his contact with Mental Health Services and given his stable mental state, he wanted no further contact. David said he wanted to get a girlfriend and would not want her to know that he has mental health issues. There is no record of 'Carer View'. David was mentally stable and compliant with his medication. He was happy with his life and had refused all offers of additional social interaction, work or training opportunities. Areas which were not going well were that David's life was fairly limited and his friends could at times have a negative influence on him, however this was his choice which had to be respected. His medication at this time was Amisulpride - 100mg. The decision was taken to discharge David to the care of his GP.

3. 62 The letter of discharge to David's GP was not typed up until 28 February 2013. The letter informed his GP that he was prescribed Amisulpride - 100mg which he took regularly, and his mental state was stable. The letter stated the plan was:

- He is discharged back to your care.
- To prescribe Amisulpride - 100mg as repeat prescription.
- GP to kindly re-refer David back if there are any concerns in the future.

3. 63 On 27 February 2013 GP3 recorded on David's notes a request for medication: 'Amisulpride - last issued in December not taking'. David's last repeat prescription had been a month's medication on 20 December 2012, thus he would have run out of his medication on 19 January 2013. The following day on 28 February GP7 undertook a medication review and issued a repeat prescription. The gap in medication and whether David was taking it regularly is not commented upon. It was recorded that he was staying with his mother temporarily while his electrics were fixed, and he was discharged from Mental Health Services 1 month ago (no letter). Letter to be chased up.

3. 64 The GP practice received the letter from Mental Health Services on 4 March 2013 discharging him to their care dated following the clinic held on 17 January 2013.

3. 65 Throughout 2013 repeat prescriptions were issued to David. An appointment reminder was sent on 20 November 2013, but it is not noted if this was attended.

3. 66 Repeat prescriptions for a 28-day supply of Amisulpride 100mg tablets continued on a regular basis. During an appointment with GP1 on 22 January 2014 a discussion took place about David thinking about training or work. It is stated that he was doing voluntary work (not known where), and ideally he would like to work again but he felt he had few skills. He was given a MED 3 certificate signing him off work for 3 months.

3. 67 On 20 May 2014 David saw GP2. He was recorded to be keeping well and taking his prescribed Amisulpride regularly, following his discharge from the Psychiatric Team. A summary of his health was given for the Job Centre as requested. The practice routinely texted David to remind him about GP appointments.

3. 68 At his next appointment on 10 June 2014 David was seen by GP3, the practice lead GP for mental health, when he requested a medical certificate as this had run out on 22 April; he asked that it be started from that date. GP3 explained that as he was discharged from the Psychiatric Team this may not be appropriate as if discharged by them and his symptoms were controlled why could he not seek work and why was the practice giving a certificate saying he was not fit to work. The issuing of a short certificate on this occasion and to review further at the next appointment was discussed; David said he only wanted a certificate from 22nd April to that day. He also said that if his certificates stopped he would stop taking his medication. The GP explained that this was using the threat of non-compliance with medication to manipulate the practice to issue further certificates. An appointment was offered with the primary care mental health worker[8] to discuss mental health medication, additional support, and ability to work, but David declined this. A medical certificate was issued up to 10 June and he was advised to see a different doctor to discuss further medical certificates.

3. 69 David did not keep a GP appointment on 24 June 2014 despite the usual two text reminders. He was texted to cancel in future if he could not keep his appointment. David next attended the surgery on 21 July 2014 when he saw GP4 for a review, a different GP to the one seen in May. He refused blood tests to monitor for medication side effects as part of the review. He was issued with a medical certificate covering up to 22 October 2014 with the specific condition noted as psychotic disorder. At his next GP appointment on 16 October with GP5 David was advised to have blood tests, but he declined. He was issued with a medical certificate for a further 3 months off work.

[8] The primary care mental health worker is a mental health practitioner employed by the West London NHS Trust. They work alongside GPs in primary care, but are not employed by, or clinically supervised or managed by the practice.

3. 70 On 22 January 2015 David saw GP3 in need of a medical certificate. He reported poor sleep in the last week and hallucinations at night afterwards. Simple sleep hygiene measures were discussed. The problem was now resolved, but David was to monitor and be reviewed if there was a reoccurrence. A medical certificate was issued valid to 22 July 2015 as unfit for work. David next saw a GP, GP2, on 21 July 2015 for a further medical certificate which was issued up to 15 October 2015. He reported keeping well and had no problems with medication.

3. 71 David saw a different GP, GP6, on 15 October 2015 requesting a new medical certificate. He reported living with his mother and said things were stable at the moment. He denied hearing voices; he was appropriately dressed and appropriate in his interactions. He was advised that he should have annual blood tests as he was on Aripriprazole, but he refused saying he did not like needles. A new medical certificate was issued confirming David as unfit for work valid until 15 April 2016.

3. 72 On 12 February 2016 the practice tried to contact David regarding a blood test which was required and to arrange an appointment with GP3 in the mental health clinic. The telephone numbers phoned did not go through, therefore a letter was sent.

3. 73 On 21 April 2016 David saw GP3; he needed a further medical certificate. He said he was doing well at present and was recorded as stable. GP3 discussed the need for annual blood test and ECG. David said he was not keen and did not know why the doctors keep trying to do these things. He was advised that it was to ensure that medications were safe, that he was well and whether he was developing any medical problems. David would not agree to any kind of assessment that day but agreed to be called to have this done. The plan was to book him in for ECG/bloods and then mental health review. A medical certificate was issued up to 15 October 2016. A phone call on 22 April to arrange an appointment was not answered. An attempt to book an appointment for an ECG for David by the practice via a telephone call on 3 May 2016 was unsuccessful; he said he did not want one done. The following day a letter was sent to David requesting that he book an appointment for a mental health review.

3. 74 On 26 May 2016 GP7 had a discussion with David's mother. She said she would like David to be followed up by a primary care nurse in the GP practice. She said he would not come into the practice, but she would like to speak to GP3 who may then refer to a community psychiatric nurse. The following day, 27 May, David's mother saw GP3. She was very concerned about David; over the past few months he was increasingly withdrawn, not going out for coffee as he would normally or coming out of his room to watch TV. He was not eating and was losing weight. He would come out of his room, which he locks, to make tea but otherwise says he doesn't want to speak to her. It was reported that he seemed down, was smoking skunk, and not sleeping. It is recorded that she did not think he was hearing voices and he would not engage due for fear he would be sectioned. His mother was concerned that he would be taken away from her also. GP3 explained that if David did not engage and continued to deteriorate, they may not have much choice but to refer to the Community Mental Health Team, but there were options before that. He could see GP3 (mental health lead GP); a health check was booked with GP3. Despite text message reminders David did not attend the health review with GP3 on 1 June 2016, but on 7 July he requested medication and a prescription for one month was issued.

3. 75 The practice tried calling David on 14 July 2016 unsuccessfully, and sent him letters regarding the need to see a doctor for a review. On the 4 August he cancelled an appointment for a review.

3. 76 On the 9 August 2016 David requested medication and he was called by the practice pharmacist to advise him that he needed to attend for a mental health review including an ECG. David hung up during the conversation. A prescription for one month was issued.

3. 77 David was next seen at the surgery by GP7 on 28 October 2016. His prior history of psychosis and discharge on Amisulpride by psychiatrists 3 years ago was noted. He was recorded as stable, living with his mother and was taking medication. He came for a certificate. GP7 explained to him that he was due blood tests, and ECG, and review with GP3. The GP opportunistically used the appointment to explore his symptoms and David admitted he still heard voices but was reluctant to say what the voices tell him. He had no thoughts of self-harm. The plan was for him to see GP3 at their mental health clinic. A medical certificate was issued until 16 January 2017. On the 3 November David did not attend his appointment with GP3 for review. He was sent a reminder text message, but message delivery failed.

3. 78 On 8 November 2016 the practice tried phoning David unsuccessfully and a letter was sent regarding the need for an appointment with GP3 for review. David requested medication on 21 November and a 2-week prescription was issued. On 29 November David's mother called the surgery regarding the recent letter sent to him. She reported that he had put it in the bin as it mentioned mental health. His mother found it and asked for a new letter to be sent without stating anything to do with mental health. Letters were sent to David by his GP practice in November and December 2016 inviting him for mental health review. Voicemail messages were also left on his mobile phone. During this time he was collecting his prescriptions.

3. 79 On the afternoon of 21 November 2016 Shepherds Bush Housing Group (SBHG) received a phone call from a tenant at the address where David and his mother lived. The name of the person calling is not recorded, but it is assumed to be David's mother who held the tenancy. The caller wanted information relating to the new tenant who had moved into a neighbouring flat. The housing officer replied that they could not discuss other residents' private matters with her. The tenant was advised to contact Shepherds Bush Housing Group or Police if she has any issues with her neighbours.

3. 80 In her statement to the Police during the investigation into Max's death his wife described a visit they made in December 2016, when on returning to the home address she noticed swelling under Max's eye. He told her that David had punched him after an argument about the washing up. This was not reported to the Police.

3. 81 Max registered with the family GP practice used by David on 6 February 2017. There had been no agency contact with or by Max before that date as far as the enquiries for this review is aware. Max's contact with his GP was minimal and records show standard GP care for minor injuries or illness. There are no references to his brother David during consultations, and no references which could imply a potential risk to Max by his brother.

3. 82 On 15 March 2017 the mental health lead GP, GP3, undertook a 'virtual review' of David's case noting his repeat failure to engage with follow-up appointments, but still requesting medication. His medication was removed from repeat on the basis of his poor engagement. Letters requesting David make an appointment for review continued to be sent in January, February, March, May, September, and November 2017. Text message reminders were also sent on a frequent basis, but these repeatedly resulted in a message of delivery failure.

Police Incident Involving David and Max:

3. 83 Police received a call at 17:39hrs on 16 March 2017, from Max reporting that David had threatened him with a sword, was suffering from a mental health condition and he was not sure if he had been taking his medication. His brother had now locked himself in the bedroom. Police attended the home address and spoke to both parties. Max said that they had had a verbal argument over the washing up and David had punched him in the face. After this David had gone to his bedroom where he had retrieved a ceremonial samurai sword and waved it at Max. David returned to his bedroom and locked himself in but came out when asked to by Police. The London Ambulance Service (LAS) were called but decided that David did not require medical attention. The sword was seized and David was arrested and taken to a Police station.

3. 84 On reception at the custody suite David was risk assessed as suffering mental ill-health, having consumed alcohol, but was not obviously drunk, and that he had prescriptive drugs he would require during detention. When asked if he had consumed alcohol or drugs within the last 24 hours and if so when, he said he had drunk 5-6 vodkas and energy drinks around 5pm that day.

3. 85 At 20:14hrs David was examined by a Police health care profession following his arrest for Affray and Common Assault. The nurse recorded that David was alert to time, place, and arrest circumstances. He was calm, quietly spoken with slow guarded speech and poor eye contact. He reported having been sectioned in the past but could not remember when. David also reported having heard voices and experienced visual hallucinations on a daily basis for a very long time, but these were no worse than usual. He found them funny rather than frightening, and he had no current feelings of self-harm or suicidal ideation. David told the nurse about his medication. He was noted to smell of alcohol and admitted drinking 250ml of vodka and energy drinks before being arrested. He denied being alcohol dependent but said his intake had increased over the past weeks. The nurse confirmed that David was fit to be detained with 30 minute checks and fit to be interviewed after 22:00hrs with the presence of an appropriate adult. The nurse advised that if David was to remain in custody until the following morning his fitness to be detained should be reviewed by a Police liaison mental health nurse.

3. 86 The following day on 17 March having been detained overnight David was seen by the custody psychiatric liaison nurse. He was observed to have good eye contact and his speech was appropriate in rate, volume, and content. He was slightly dishevelled in appearance. David described his mental state as stable at the moment; no thoughts of self-harm. He described feeling angry at his brother during an argument but had no thoughts of harming him at the moment. He said that the incident occurred whilst he had been drinking alcohol and he admitted daily alcohol use over the recent few weeks, but he did not want to be referred to services as he said he will just stop drinking. David admitted experiencing hallucinations when not on medication but said that taking Amisulpride prevents this. He did not wish further support from Mental Health Services at the moment. He said he collects his prescription from a pharmacy but does not see his GP on a regular basis.

3. 87 David was given a 24-hour Helpline card & encouraged to call it if thoughts of self-harm or harm to others should arise. He was also given contact details for Community Alcohol support in Hammersmith and advised to see his GP. The GP was to be emailed regarding this interview. However, there is no evidence that this email was sent.

3. 88 David was interviewed in the presence of a solicitor and appropriate adult. His solicitor presented a prepared statement indicating self-defence and David made no comment to all questions.

3. 89 On 17 March 2017 David's brother Max provided a statement saying that he did not feel threatened by David with regard to the samurai sword, he believed that David was acting in self-defence with regard to the punch, adding that he just wanted his brother home and did not want to support a prosecution. Max told the investigating officer that it was the first time David had done anything like this; he was happy to have him home again and did not believe that another incident was likely to take place. A Vulnerable Adult MERLIN[9] was risk assessed as Green[10] on the 'London Continuum of Need', and after further risk assessment using the Metropolitan Police Service Vulnerable Adult Framework, this was shared through the borough Multi-Agency Safety Hub (MASH/FH) with Hammersmith & Fulham Adult Social Care on 23 March 2017.

3. 90 The allegation was recorded on the Crime Recording and Information System (CRIS) as a Domestic Abuse allegation of Assault and Affray. The CRIS record notes that the investigating officer would be speaking to David's Mental Health Team but does not record the outcome of that liaison. There is no record of such contact being received in the West London NHS Trust chronology records (to note David was not under a Mental Health Team at this time). During a DASH[11] risk assessment which was judged to be 'Standard' risk, Max said that normally David was calm and kind, but when he does not take his medication or drinks alcohol he could become verbally aggressive. He also stated that David's mental ill-health condition had not been clarified, but he was on anti-psychotic medication which, when he was on them, makes him 'normal'. Max thought he smoked cannabis occasionally.

3. 91 Mental Health Services were made aware of David's arrest for Affray and Common Assault via the Police custody psychiatric liaison nurse, and the Single Point of Access (SPA Service) located centrally at St Bernard's Hospital received the Police MERLIN report on 23 March 2017 about the incident forwarded by Adult Social Care who had recognised David was previously known to Mental Health Services. No further action was deemed necessary as the documentation reported that the GP had been notified and the incident was seen as alcohol related. There is no record that the GP practice received information about David's involvement in the assault incident.

3. 92 No further action was taken against David and he was taken home by the Police and left in the care of his mother and brother.

3. 93 Victim Support appear to have received a referral following the incident on 16 March, for on 21 March 2017 they tried unsuccessfully to contact Max via mobile phone. After two unsuccessful attempts they managed to achieve contact on 24 April 2017. However, Max said he did not want support at the time, but he consented to being sent Victim Support's support line number via text.

3. 94 On 19 May 2017 David attended the GP surgery and demanded Amisulpride. It was decided to give a one-week supply and for him to book an appointment to see GP3. On 23 May David was sent a letter asking him to book this appointment for review.

[9] MERLINs were also brought in as a result of Lord Adebowale's report recommendations on 2 April 2013 the Adult Come to Notice MERLIN (ACN) record was brought in which is shared with Adult Social Care via the Multi-Agency Safeguarding Hub (MASH).
[10] The London Continuum of Need has four levels of classification - Green is Level 2 Low risk to vulnerable. This level can be referred to the MASH manager for consideration.
[11] Domestic Abuse Stalking and Harassment - An evidence based risk assessment tool used in addition to professional judgement to assist risks faced by victims of domestic abuse.

David failed to attend an appointment arranged with GP3 on 4 July. A letter was sent to him.

3. 95 David attended the surgery in need of a medical certificate on 26 September 2017 and saw GP8. It was noted that he had not attend his mental health review. This appointment was a pre-booked appointment and was not a mental health review. It was recorded that he was fairly inconsistent with medication; only uses when voices get too much. He told GP8 that he sees things every day that are not real (this had become natural to him). He was noted to be able to engage with the doctor and respond to questions, but did appear a bit fidgety, wiggling his foot, and looking off behind the GP on occasion. David reported that: he had 'visitations' from a 'guy' from his old school who he had not seen in years; hears daily voices: they keep recounting what is happening around him; at that time he was not hearing voices but was currently seeing an image of where he lives in front of him. David denied any suicidal ideation. He tended to stay indoors and lived with his mother who was supportive. He reported drinking 250ml of vodka per night which he was advised to reduce. There were no apparent current risks to self or others (the common assault in March was unknown to the practice and David did not mention it). A new medical certificate was issued valid from 1 August 2017 to 1 February 2018 confirming that David was unfit for work due to a diagnosis of psychotic disorder. A prescription for 1 week of his medication was issued. This is the last record of a prescription being issued. The GP booked a mental health review with the mental health lead GP3 for 9 October 2017.

3. 96 David's mother phoned the practice asking to speak to a doctor on 29 September 2017. The first call back resulted in no answer and a message was left. GP8 phoned again later that morning and spoke to his mother who reported that his medical certificate had run out for January 2017 - September 2017 so he needed a backdated script. David's mother said she looks after appointments and will make sure he attends to see GP3 as arranged. A new medical certificate was issued: Not fit for work - Valid from 16 Jan 2017 to 26 Sep 2017.

3. 97 David failed to attend an appointment arranged for 9 October 2017 with GP3 for review. As was routine, messages were sent to David regarding the missed appointment and to notify the surgery in advance if he could not attend.

3. 98 On 17 October 2017 the Shepherds Bush Housing Group received a telephone call from a resident at David's address (no details recorded which resident) regarding loud music coming from a neighbouring flat. The complainant added that the occupant of the flat throws rubbish into the garden and does not clear it up. The resident reported that they had spoken to the occupant of the flat, however the behaviour had not changed. The complainant was advised by the housing officer to keep a diary of dates and times and to notify the local authority who could act as an independent witness.

3. 99 On 14 November 2017 David's GP practice sent him a clinic letter.

3. 100 At 21:08hrs and 23:16hrs on 2 December 2017 David called the Police twice to report that he had seen two people being raped at an address in the Borough. The attending officers would not have known that the address where the incident was said to have been seen was David's home address 6 years previously. The Police attended David's home and established that he had not been to the address where he alleged he had seen the crimes. He said he had witnessed the offence whilst lying in bed. Officers believed he was suffering from mental ill-health, but not a risk to

himself or others at that time. A MERLIN/ACN[12] was risk assessed as Green by the Borough MASH[13] and shared with Adult Social Care on 5 December 2017. There is no record that the MERLIN was forwarded to Mental Health Services by Adult Social Care as had been done previously.

3. 101 At 08:06hrs on 19 December 2017 David called Police once more to report his neighbour had told him she was being 'pimped out' and he could hear her screaming through the walls. Police attended and spoke to David at home. There was no evidence of any such incident having taken place, but David said that prostitutes had told him and that they were talking in his head. He said he was schizophrenic but was not taking any medication at present. He was not assessed as being in need of immediate care or control in his home. No further action was taken other than to give David words of advice regarding his use of 999. It is not clear from the record whether anyone else was at the home with David. A MERLIN/ACN was risk assessed as Green and shared via the MASH with Adult Social Care on 20 December 2017. The MERLIN recommended that David "received at least a home visit from a mental health professional to assess his medication" and that while at the time of attendance David "was not in need of immediate care or control, but there are longer term issues which need to be addressed". There is no record that this MERLIN was forwarded by Adult Social Care or received by Mental Health Services.

3. 102 The GP practice tried unsuccessfully to phone David on 3 January 2018 to arrange an appointment with GP3. A letter was sent to him. On 10 January the practice notes a universal credit form to be completed and faxed, and a text reminder was sent to David on 29 January to come for review. A letter was recorded on 30 January for a completed Department of Work and Pensions report; David's poor engagement was included in that report. This is the last entry in David's GP notes.

3. 103 At 08:06hrs on 22 January 2018 David called Police saying his daughter had spoken to him in his mind, told him she had been abducted, and taken to an address with the number 12 on the door. Whilst being spoken to on the phone to Police David could not give details of his daughter (date of birth, where born, where living, etc). He said that he last spoke to her in his mind 15 years ago and rang Police then and has not seen her since. The Police did not attend as previous similar calls were identified. The information was sent to the Hammersmith & Fulham Borough Police 'Grip and Pace Control'[14] with a request that the Local Police Team make a follow-up visit. This was judged to be the correct and proportionate response. The same day an officer passed the request for a follow-up visit to the dedicated ward officers by e-mail, and this contact was entered on the record notes. There is no record of the result of this request on Police systems. No MERLIN appears to have been submitted for this call.

3. 104 At 17:40hrs on a day in March 2018 a 999 call was received by the Ambulance Service. It was reported that one son had killed the other. Several vehicles, including the Helicopter Emergency Medical Service (HEMS) were dispatched between 17:40 and 18:50, the first arriving at the address at 17:44. The Police were called to the address by the London Ambulance Service at 17:42hrs. Paramedics immediately made efforts to resuscitate Max which continued under the guidance of the Helicopter Emergency Medical doctor on their arrival. Treatment continued until life was pronounced extinct at 18:20hrs.

[12] Adult Come to Notice notification
[13] Multi-Agency Safeguarding Hub
[14] Grip and Pace Control is the name given to the local borough control room which dealt with incoming requests and call at the time of this incident.

3. 105 David was arrested and taken to a Police station where a short risk assessment was undertaken during which it was established that David was not up to date with his medication; he stated his medication was at the doctor's to be collected (the last prescription issued shown in the GP notes is 26 September 2017). He was examined by a Police doctor and admitted being psychotic but denied being schizophrenic; he said he was no long under the care of a psychiatrist and no longer taking his medication. David was assessed as fit to be detained and interviewed. An attempt was made to interview him in the presence of his solicitor and an appropriate adult, however he refused to leave his cell; he was asked questions through the doorway. He made admissions that he had stabbed Max but refused to say why or give more detail. The following day David was charged with the murder of Max and detained to appear at court later that day.

3. 106 A special post mortem took place by forensic pathologist Dr Olaf Biedrzycki. His report found that Max sustained a single horizontal stab wound to the chest which passed through his heart nicking the pulmonary vein.

3. 107 At his trial in August 2018 David's plea of Manslaughter on the grounds of diminished responsibility was accepted. He was later sentenced to be detained under a Hospital Order with Restriction under Section 37/41 of the Mental Health Act (1983).

4. Overview

Overview of Information Known to Agencies:

4.1. Detailed information concerning David and his mental health was held by Mental Health Services from early 2006 when he was referred due to his deteriorating mental health. This culminated in his admission to hospital under Section 3 of the Mental Health Act (1983) in April the following year. Information about his family members however, appears brief, although it would appear that David's mother was very supportive of him. He continued receiving support under the Care Programme Approach until his discharge into his GP's care in February 2013. During this time the teams managing his care were aware of his psychotic symptoms such as hearing voices. They also knew of his poor compliance with taking his medication, his high alcohol consumption at times which could lead to aggressive thoughts, and his cannabis use. David's resistance to engaging with training, education, or work was also well recognised, as was his strong ambivalence to receiving support from Mental Health Services which he felt were stigmatising. Five years after discharging David Mental Health Services were made aware via a forwarded Police MERLIN in March 2017 that he had assaulted his brother, although this was viewed as alcohol related and no further action was taken.

4.2. In between the 2 years of registering with his GP practice in February 2011 and the practice taking over his mental health care in February 2013, communication from the Mental Health Service to David's GP is limited. The first communication appears in June 2011 when his GP was informed of his poor concordance in taking medication, and his high use of alcohol after which he felt like hitting things, although they were informed that he did not have thoughts of harming others. His GP was also made aware of his cannabis use, a recent 'unusual experience', and hearing voices as a consequence. The GP practice were also made aware of the time David had a reaction to an accidental over prescribing of his mediation and the urgent review by psychiatry which followed. This appears to be the extent of their knowledge until they assumed responsibility for his care when they became more fully aware of his resistance to appointments related to his mental health. For example, between

February 2016 and January 2018 the practice sent 14 letters, and made 8 phone calls, plus text messages to David either making appointments for mental health review or reminding him of appointments. He did not attend these appointments. David's mother's contact with the GP practice would also have indicated the concerns she had for his wellbeing and the measures she was trying to take to encourage him take up appointments. The practice and their pharmacist were also aware of David's medication and when prescriptions were made, and the practice was also aware that David was on benefits and not seeking work. They knew little of Max as his visits to the practice were infrequent and for minor matters.

4.3. The Police held information about their earlier stop and searches of David as well as his or his mother's reports of him being a victim of crime (alleged theft), and of course they were the main holders of information about the assault on Max in March 2017. The Police were called out to assist when David was sectioned under the Mental Health Act in 2007, and this prior involvement and their response to David's three 999 calls, two in late December 2017 and one in January 2018, regarding his claims to have seen or heard serious crimes taking place, made them aware of his mental ill-health to the extent that they undertook Vulnerable Adult assessments and shared these assessments with Adult Social Care via MERLIN notifications.

4.4. Adult Social Care were aware of the assault on Max by David in March 2017 through the MERLIN sent by the Police. However, this was forwarded to Mental Health Services as David was known to be previously involved with that service. The MERLINS shared by the Police electronically with Adult Social Care on 5 and 20 December 2017 were not forwarded. The IMR provided to the review by Adult Social Care indicates that these were not opened. This will be explored in the Analysis section.

4.5. The mental health charity MIND had involvement with David in coordination with Mental Health Services as part of his care programme approach. A family member remembers David attending MIND for several months. However, given the time which has passed they have been unable to find records relating to their contact. Their electronic data system came into operation shortly after their contact with David and the case notes were not transferred. Staff in place at that time are no longer with the organisation.

4.6. Shepherds Bush Housing Group although providers of housing to the family, did not have contact with David or Max. It is assumed that their contact was with their mother regarding problems with the occupant of a neighbouring flat.

Overview of Information regarding the Victim and Perpetrator:

4.7. In her statement to Police, Max's wife said she had known him since he was about 17 years old and David was then aged about 11 years old. She explained that the first time she noticed David acting 'strangely' was during a visit she and Max made to the family home about 12 years ago. She described him as being a bit like a zombie; catatonic. It was during this visit that she, Max and his mother took David to hospital and that on this occasion they admitted him.

4.8. Max's wife also described a visit they made in December 2016 which is included in the chronology, when on returning to the home address she noticed a swelling under one of Max's eyes. He told her that David had punched him after an argument about the washing up, this was not reported to Police. Max's wife said she stopped visiting the family home with their children after July 2017 as she felt afraid of David and for the children, describing how David would just stand and stare at them.

4.9. When interviewed for the Police investigation David's mother reported that David had been suffering mental ill-health for about 10 years. She said he had been sectioned at Charing Cross Hospital and diagnosed with Schizophrenia. He was on medication, but she did not think this was supervised. He had a key worker or mental health worker and was supposed to go to his GP every three months, but he did not go and had missed his last two appointments. From this statement David's mother appears unaware that he no longer had a mental health worker or anyone with a key worker role, or that he had missed more than two GP appointments.

4.10. In her statement David's mother said that Max had come to stay at the house on 26 February 2018, and on that day David had said to her that "Max shouldn't have a door key as he doesn't pay any rent". Max had replied to David, "You don't pay rent either". The following day Max told his mother that when David had come in earlier that day he had said something like "You're still here then".

4.11. In their statements to Police during the investigation both David's elder brother and sister said that they were aware of David's mental ill-health problems. They said that when he was in his mid-teens David had gone to live with his sister who lived in Essex at the time, and that while there he had started to use 'recreational drugs including LSD and Ecstasy'.

4.12. David and his sister had a different father to Max. A family member thinks that David's father was in the army, but had been medically discharged due to attempting suicide, or so they were told. As far as the family member is aware there was no mental illness in his father's family, but he left the family home when David was around the age of 2 years. David told his assessing psychiatrist that he had no contact with his father after he left. David's mother formed a new relationship and the family member believes that David and his sister were somewhat neglected over the next 10 years. A family member has confirmed that David never hated Max at all whilst growing up, and that Max did try to help David on many occasions, as did his elder sister.

4.13. The family member contributing to the review explained that as children they had a difficult family background and a disrupted childhood. Children's Services were involved with the eldest two children. In their view they should also have been involved for David and his sister. David's attendance at school was sometimes erratic and he left school at 16 years old with no qualifications. It was shortly afterwards that he went to stay with his sister in Essex. Apart from small unskilled jobs, Max's elder sister thinks he had no 'proper job' after leaving school with which he could engage, and as far as she knows he did not have any girlfriends and was not very skilled socially.

4.14. Although he is the youngest of the siblings and half-siblings, a family member suggested that David may have seen himself as 'the man of the house' and Max's stays at the house unsettled that view. The family member thought the incident with the samurai sword was a warning sign and remembers saying to their mother that she was brave to sleep in the house as nothing was inconceivable.

4.15. During his psychiatric assessment conducted by Dr Joseph for his trial, David said he got on with his siblings, but always had a problem with Max who was 10 years older. This is contrary to the view expressed by a family member and Max's friend. It also ignores the tensions between David and his elder half-brother when there were clearly difficulties between them in the early stages of David's mental illness when he would not take his medication.

4.16. David told Dr Joseph that he and Max did not communicate, he said he tried to, but Max gave nothing back. He said he was not jealous of his brother, his brother did not bully him, but things got worse as they got older and Max never spoke to him. Given that Max went away to university and then to Spain, it is highly likely that David actually saw very little of Max in his teens, it is therefore possible that his perception of his relationship with Max and that Max hardly spoke to him may have been affected by this. After Max moved to Spain David was the only sibling left at home, and he admitted to Dr Joseph that *"Max came back too frequently for my liking"*. David's mother described him as being withdrawn and spending most of the day in his room, therefore sharing the house at these times probably disrupted his isolation and routine. It is telling that David told Dr Joseph that when Max was in the house [he felt] he tended to take over the sitting room. Occasionally they would bump into each other in the kitchen, but otherwise David said he would avoid Max. David appeared to resent Max staying at the house; he reported to Dr Joseph that no one told him that Max was coming to stay, he did not like him being there. However, David said that he was OK mentally, even though he had not taken his medication for some months and had been drinking heavily. David said they argued a lot, but he felt Max showed him a lack of respect and so he tried to avoid him.

4.17. There are many contradictions in the content of what David told Dr Joseph, what he told previous professionals, and the facts as described from agency contacts in this report. For example, he stated that he had never been told what his mental illness was, and yet he reported to Police officers on 19 December 2017 that he had Schizophrenia. His memory appears unreliable, possibly due to his mental illness.

4.18. In his assessment for his trial, asked to describe his personality, David said he was not an aggressive person, he was placid. Before developing signs of mental illness he had some friends, but he was never very sociable. David reported suffering from psychiatric problems from the age of 22 years; he did not know what caused them, but he thought that it may have been due to smoking cannabis regularly. In recent times he had started drinking alcohol more heavily to compensate for the lack of cannabis which had stopped because he realised it was illegal and he did not want to go to prison. He was drinking nearly every day and said that he was *"getting towards becoming an alcoholic"*. Dr Joseph noted in his report that in contrast to cannabis which made him feel depressed, David said alcohol lifted his mood and made him feel happier and more sociable. However, he acknowledged that alcohol could make him feel more aggressive if he was angry about something, but generally he felt OK.

4.19. In the months prior to the murder David told Dr Joseph that he was getting on alright with his mother, although she would nag him about his failure to pay rent which stressed him out, but he maintained he was never violent to her. He denied that he blamed Max for his previous admission to psychiatric hospital. David said that it was his mother's fault.

5. Analysis

5.1 This analysis will follow the Review terms of reference. It is informed by the Individual Management Reviews and reports submitted and the deliberations of the Review Panel members.

Term of Reference 1: *The review will identify and examine in detail agency contact with the victim and the perpetrator between January 2006 when he was referred to*

Mental Health Services and March 2018. Agencies with contact before 2006 are to give a summary of that involvement to provide context.

5.2 This term of reference has been addressed in the Chronology at Section 3 of this report and the overview of agency involvement.

Term of Reference 2: What risk assessment processes were undertaken with the perpetrator by services with whom he had contact to establish his risk to others and were risk assessments:

a) Thorough and in line with procedures; if not why not?
b) Informed by background history and information from other agencies?
c) Informed by information from any family members?
d) Reviewed regularly and when the perpetrator's circumstances or mental wellbeing changed were risks escalated, if so, how was this done and what decisions were made and recorded?

The West London NHS Trust:

5.3 (a). The West London NHS Trust IMR confirms that the mental health risk assessments expected to be undertaken during their period of involvement (2006 to 2013) were completed, recorded on David's RiO progress notes, and were in line with procedures. His final risk assessment on 14 January 2013 notes that threat of harm to David came from his older brother in 2006 and 2007 (due to tensions about David's behaviour and not taking his medication - see paragraphs 3.4 and 3.14). Any threat of harm from David was in relation to his threat of violence towards staff in the Crisis Resolution Home Treatment Team when his mental health was relapsing and administration of his medication via Depot injection was being discussed in 2006. The summary in his records concluded in 2013 that David was a low risk to others, but he could present a risk to self if he stops medication, resumes using cannabis, and subsequently deteriorates in mental health.

5.4 The Police MERLIN, forwarded to the Mental Health Service's Single Point of Access by Adult Social Care, contained the information that Max was punched by David who then stood in the doorway waving a samurai sword at Max. This information appears to be overlooked; it is primarily noted that David punched Max and he (David) had been drinking rather than any possible deterioration in his mental health.

5.5 The Single Point of Access covers three London boroughs including Hammersmith & Fulham. It receives over 200 MERLIN reports per month for people who are not currently receiving treatment under the West London NHS Trust services. The screening of MERLINS by a senior nurse includes reviewing previous notes held by the Trust. There are no formally agreed procedures with Adult Social Care or the Police as to the Trust's responsibilities in respect of a MERLIN received, which are considered as 'not consented to' referrals and treated as information rather than formal referrals. It is reported that the Single Point of Access often receives MERLINS significantly after a Police concern has been raised; sometimes in excess of 4 weeks. This can mean that a mental health professional has already addressed the situation for example in Police custody by a Police liaison nurse, by a hospital psychiatric liaison in A & E, or by a Section 136 Mental Health Act assessment[15]. However, there

[15] Section 136 gives the Police the power to remove a person from a public place to a place of safety when they appear to be suffering from a mental disorder and they are deemed by the Police to be in immediate need of care and control as their behaviour is of concern. The person is not under arrest. The Police power is to facilitate assessment of their health and wellbeing as well as the safety of other people around them. https://www.legislation.gov.uk/ukpga/1983/20/section/136

was no delay in the receipt or handling of the MERLIN in this case, although seeing the incident as simply alcohol related was only part of the picture.

5.6 (b) & (c) Information from other agencies included the Police MERLIN forwarded to the Single Point of Access. This provided a good level of information and followed the headings of the Police Vulnerable Adult Framework[16], it also included information from a family member, namely Max. Under the heading of 'DANGER' it is recorded that Max said they had never had any physical altercations before. On the one hand Max appeared to know little of David's mental health condition; he stated that David had never been given a definitive diagnosis (he was diagnosed with schizophrenia in 2007) and was on 'unknown anti-psychotic medication'. On the other hand Max appeared to show a good degree of insight and compassion when hypothesising why David might have threatened him with the sword. Max was recorded as being convinced that his brother was acting in self defence as when the punch was thrown (by David hitting Max), David had fallen backwards on the staircase and Max was trying to help him up; Max believed that his standing over David in the context of the argument meant David felt threatened. Max had explained to the Police officer that as he had restrained David, he believed that David went to fetch the sword as a show of force or warning to Max that he could defend himself. As the MERLIN, stated this was an immediate escalation to a trivial matter.

5.7 This information in the MERLIN might have had the effect of 'playing down' or rationalising the incident to the extent that David's mental ill-health was overlooked in favour of drink being the catalyst for his behaviour. The fact that Max did not support David's prosecution and wanted him returned home may also have minimised its seriousness in the eyes of agencies. This is not an uncommon perception in cases of adult family violence and abuse where there is often a reluctance to criminalise a family member. In this respect there are commonalities with intimate partner abuse where a reluctance to criminalise a partner for similar reasons is often accompanied by fear of reprisal [17]. We have no way of knowing whether Max thought prosecuting David may have also cause tension or resentment by his brother, but he may also have been concerned about his mother's reaction to seeing her youngest son in court as well as that of the rest of the family.

5.8 Further information on the incident above was received from the Police liaison nurse who interviewed David in custody. Within the information it is stated that David described his mental state as 'stable at the moment'. He had no thoughts of self-harm and he described feeling angry at his brother during an argument, but he 'had no thoughts of harming him at the moment'. He admitted that the incident occurred whilst he had been drinking alcohol. David confirmed that he had hallucinations but said these stopped when he took his medication. This information probably contributed to the decision of the Single Point of Access that risk was such that to refer back to the Recovery Team was unnecessary. Risk assessment appears to be based on professional judgement weighing up the information available.

5.9 The chair is informed that the Single Point of Access screened the information from the Police liaison nurse and decided not to refer on to a Recovery Team. There would not normally be any consultation with a Recovery Team before the decision to close the referral. The Recovery Team would not therefore have been aware of the

[16] In recognition of the impact mental ill health has, and to improve the Police response in this area, the Metropolitan Police Service commissioned an independent report led by Lord Victor Adebowale (published in 2013). The report made 28 recommendations to ensure that people with mental ill health receive the same response as those with physical health conditions. Among the changes made as a result of those recommendations is the introduction of the Vulnerability Assessment Framework (VAF), a simple checklist that helps officers recognise vulnerability and mental health.

[17] Mullender A, Hague G *Women Survivor's Views* in Taylor-Browne J (ed) (2001) What Works in Reducing Domestic Violence? Whiting & Birch Ltd., London

incident. The exception is when the person has been discharged from a Recovery Team recently i.e. within the last three months, when there is an option to have them referred speedily back to a Recovery Team. However, this is only likely if it is evident that the patient is relapsing i.e. that their mental health is deteriorating and requires further input from a psychiatrist.

5.10 When David was under the care of the Mental Health Service risk assessment was informed by case history notes which records the informants as the mental health professionals involved in David's care. Information also came from family members. The IMR reports that there was no contributing information from other agencies informing assessments, although one would hope that feedback from his supported lodgings staff would have been sought to gain a rounded picture of his progress during the time he was in that accommodation.

5.11 (d) When David's mental health deteriorated and risk levels increased whereby he was threatening to mental health staff, the IMR found that this was escalated appropriately by a referral to approved social workers and assessment under the Mental Health Act. There were no incidents of risk of harm from David whilst he was under the care of the Recovery Team. Risk of harm from David relapsing was responded to promptly and dealt with speedily. For example, when David's family or mental health professionals were concerned or aware of his lapses with medication urgent appointments were made and matters were addressed rapidly. It is the view of the IMR author that this responsive approach played a part in preventing any readmissions to hospital occurring. The consistent reassurance given to David around his medication issues also ensured a level of compliance that kept him reasonably well. The IMR observed that David was prone to be erratic with his medication, but over time he became more reliable and the indications were that this contributed to his stability and wellness.

GP Practice:

5.12 (a) The GP IMR detailed the normal practice for routine risk assessments which take place as part of the "Recovery and Stay Well" plan which is undertaken as part of a standard annual review carried out by the mental health lead GP. In this case the review was unable to be carried out as David continually failed to keep appointments and he ignored repeated requests and reminders for him to attend. This meant the routine review had not taken place in the year prior to the fatal incident.

5.13 The IMR found there were robust operational systems in place in relation to identifying David as a patient who needed an annual mental health review, identifying that he was not engaging well, and for attempting to contact him to make and keep appointments. Therefore, although procedures were followed, they were not effective with someone like David who simply ignored all forms of communication; a risk factor in itself.

5.14 What the GP IMR describes as an opportunistic risk assessment was carried out when David came for a routine physical health GP appointment and to collect a signed Medical Certificate on 26 September 2017, 5 months prior to the fatal incident, when at that point the risk was assessed as low. This appointment was not with the mental health lead GP but was nevertheless good practice in the continuing absence of David's attendance for formal mental health assessments. The GP also made an appointment for David to see the mental health lead GP, but again he did not attend.

5.15 A prescription was issued at this 26 September appointment for 7days worth of medication. According to the medical notes this was the last prescription issued. Given

that David was on the practice serious mental illness register this should have been noticed. It represented a warning sign that he was no longer taking his medication which would inevitably result in a deterioration of his mental health. This was a risk factor which should have been discussed with the Mental Health Service. The author is aware of a very similar DHR[18] where the perpetrator of matricide, also on a practice serious mental illness register, stopped collecting his prescriptions some months before the murder which was also not noticed and acted upon.

5.16 (b) David's risk assessment at the GP practice was not informed by information from other agencies. The content of a letter from Mental Health Services of 11 June 2011 (paragraph 3.43) which at that time noted his poor concordance with medication, high alcohol consumption, and previous cannabis use which he had retried resulting in 'unusual experiences', appears not to be carried forward as important patient history. The discharge letter from the Mental Health Service in 2013 was very short and did not contain any background history, risk assessment to guide the GP, or set any criteria to indicate when a re-referral would be appropriate. The GP practice was unaware of events involving the Police when David waved a samurai sword at Max (this will be covered under term of reference 7). Therefore, this could not be included in a risk assessment at the GP practice. The two attendances to David by the Police in December 2017 also did not get through to the GP practice or Mental Health Services. Had the GP received notification of these visits it could and should have caused them to check his notes and flagged the absence of repeat prescriptions since September 2017. This would surely have raised the level of risk in the eyes of his GP. A recommendation has been made regarding the absence of information to David's GP practice.

5.17 There is a need for GPs to be able to see key information or events history as easily and quickly as possible prior to a patient consultation. The Panel was informed that the current system makes it difficult to put information in one place. However, the practice has started coding forensic histories which allows a GP to see the codes on a 'problems list' which can be seen on the first page. It is only on a practice level and is dependent on individuals inputting the information. There can be thousands of documents on the system and the mental health lead GP receives approximately 50 letters per week and in order to code the letters, they have to be read and coded manually. The annual review provides an opportunity to review information, however, in cases such as David's where the patient does not attend this potentially weakens the system.

5.18 (c) David's mother said that she was very concerned for his mental health in a visit to the mental health lead GP in May 2016. Her concerns included that he was withdrawn, not eating and was losing weight, he seemed 'down', not sleeping, and possibly smoking skunk. The first five of these observations can be symptoms of depression[19], and some can be an effect of cannabis use[20]. They are also negative symptoms related to David's diagnosis of Schizophrenia. The Mental Health Service had highlighted that the use of skunk would increase risks, however the GP chronology has no reference to this in their information received from the Service. Consideration of this and the symptoms described would have justified a referral or discussion with Mental Health services.

5.19 David's mother also said he did not engage due to his fear of being sectioned, although she did not think he was hearing voices. However, given that he failed to attend review appointments with the mental health lead GP the concerns expressed

[18] https://www.kingston.gov.uk/downloads/download/855/domestic_homicide_review_2011_kathleen
[19] https://www.nhs.uk/conditions/clinical-depression/symptoms/
[20] https://www.talktofrank.com/drug/cannabis#the-risks

by his mother were not able to be considered in person with David for a review risk assessment. It is not clear whether the GP who managed to carry out an opportunistic risk assessment in September 2017 had seen on the notes what his mother's worries had been in the previous year, and whether they were considered in the questions asked of David at that appointment.

5.20 Other contacts with David's mother on 29 November 2016 and 29 September 2017 regarding David putting GP letters in the bin because they mentioned mental health, and his need for a replacement Medical Certificate respectively, were noted and responded to. Following her request for an alternative format the mental health lead GP wrote a handwritten letter removing reference to a mental health review. This was a proactive and sensitive response to David's mother's request. The GP practice IMR points out that these contacts did not reach a threshold requiring escalation over and above the normal persistent attempts to contact the David.

5.21 (d) The GP IMR found there were no known concerns about the deterioration in David's mental wellbeing, other than those raised by his mother in May 2016 which required escalation. This risk was escalated by arranging a mental health review 5 days later with the mental health lead GP, but David did not attend. There was no further escalation as a result of this. The GP leading on mental health has been holding this position since April 2016. The IMR author noted that since that time clear and attentive re-call attempts in response to non-engagement have been evidently in place. Nevertheless, this system of repeated attempts was failing to successfully achieve David's attendance for review. This is a difficult problem for GPs to solve. Whereas an allocated mental health care coordinator can use the assertive approach with their patient and follow up failed compliance with repeated home visits if necessary, a busy GP does not have the capacity to replicate this practice.

The Police:

5.22 (a) The Metropolitan Police Service Vulnerable Adults Framework risk assessment was used in face to face contacts with David after 16 March 2017 when he assaulted Max and produced a samurai sword. A DASH domestic abuse risk assessment was also completed as it was rightly recognised that the incident met the definition of domestic abuse i.e. it was an incident between family members in the same household. This was a thorough approach to this incident and in line with procedures.

5.23 (b) The IMR author found evidence that the risk assessments undertaken in March 2017, and after the December 2017 and January 2018 callouts were informed by background history from recent mental health presentations by David. This is particularly clear regarding the MERLIN completed on 20 December 2017 the wording of which is quoted in the IMR (see paragraph 3.101), and clearly indicates the officer's concerns that he was in need of a mental health assessment. In all the Police shared three MERLINs; on 23 March 2017, 5 December 2017 and 20 December 2017. There is no evidence that information from other agencies informed risk on those occasions. Information held by the Police from the assessment undertaken in custody on 16 March 2017 by the Police liaison nurse was intended to inform the decision regarding whether David was fit to be questioned and detained at that time. This decision would have been available to view by any officer.

5.24 (c) Where the Police had contact with family members their information augmented officer's risk assessments. For example, when David's mother reported the theft of his mobile phone in November 2012 his mental ill-health was discussed, and during their contact with Max when David assaulted him in March 2017 Max provided

information about his mental health, his alcohol and cannabis use, and their effect on David's behaviour.

5.25 (d) The Police do not have a role in the long-term regular assessment of a person's mental wellbeing. They assess when they come into contact with an individual and assess risk at that time. However, when there are a series of contacts officers do have the opportunity to assess escalation in risk in those circumstances. The fact that there were two 999 callouts by David in 17 days in December 2017 where he was clearly mentally unwell, appears to have been recognised by officers as escalation of risk given their recommendation in the MERLIN completed after the second callout that he should have at least a home visit from a mental health professional.

Adult Social Care:

5.26 The Adult Social Care report for the Review explains that a 'safeguarding hub' was introduced in April 2018. Prior to this date, the time-span covered by this Review, MERLINs received by Adult Social Care were screened in the Intake and Advice Team by an experienced qualified social worker. This was also under the guidance of a manager who has experience in this area of work. They operate under the legal framework for determining an 'Adult at Risk' using the following thresholds:

1. Is the person experiencing risk of abuse/neglect
2. Does the person have care and support needs
3. As a result of this, are they unable to protect themselves from risk of abuse

5.27 If, after a telephone check has been made with an agency, the subject of a MERLIN was known to another service or team as in this case, the MERLIN would be forwarded by secure email to that service or team for them to take the appropriate action i.e. the West London NHS Trust Single Point of Access. Risk assessment does not take place by Adult Social Care where a person is known to another service.

5.28 The Adult Social Care report found there were no specific procedural guidelines for the handling of MERLINs. However, the process for managing 'concerns' is clearly described in the Standard Operational Procedures, and a MERLIN would be managed as a concern under this procedure. The absence of specific procedures to deal with MERLINS is perhaps indicative of the MERLIN's introduction process which will be discussed later.

5.29 The provider of housing to the family did not have occasion to undertake a risk assessment. Their contact concerned complaints about a neighbouring tenant.

5.30 ***Term of Reference 3:*** *Are the risk assessment tools and procedures designed to support decisions and assessments judged to be effective by the practitioners using them, or are there any adjustments which may enhance practice?*

5.31 The West London NHS Trust IMR assisted the Panel by providing examples of the risk assessment tool in use by Community Mental Health Services at the time of their involvement with David up to 2013, and a screenshot of the assessment used today. The assessments cover Harm to Self, Harm from Others, and Harm to Others, and includes Safeguarding Children considerations. The assessment used today has an additional question of 'Domestic Abuse' under the heading of 'Evidence of risk of harm from others' which addresses victims of domestic abuse. The Panel learnt that changes to the risk assessment are currently underway with a view to streamlining information. Changes being considered include adding information about multi-agency

meetings, making certain fields mandatory, and reviewing the domestic abuse component. It is hoped that this will include enquiry to establish domestic abuse behaviour on the part of the service user as well as inquiry concerning their victimisation. The Panel noted that such changes to the system will also require staff training and auditing by management.

5.32 The GP IMR helpfully provided a screenshot of the mental health assessment completed by GPs at patient mental health review. The risk section of the assessment tool is predominantly tick boxes covering Suicide Risk, Aggression Risk and Safeguarding Risks. In the list of tick boxes under Aggression Risk there is just one tick box question asking, 'Violent acts towards others'. It does not ask to whom any violent acts might be towards i.e. family members, partner or carer. Nowhere is there a question asking about family composition and relationships; any tensions in the family home, what they are, or how arguments or disagreements are settled. The mental health lead GP advised the Panel that there is a question on the risk assessment in the annual review tab around problematic substance use, but the follow up template does not specifically ask about this. From the standpoint of informing an assessment of risk, especially risk to those close to the patient, it is of little value. The assessment is more a contract management database recording what the GP does with a patient rather than an aid to GP assessment. Indeed, one GP commented "we serve it, not it serving us". As a tool to assess risk, particularly to others, it is the view of the Panel that the current mental health assessment for GPs does not support busy doctors in their decision making and is totally inadequate. A further difficulty is that there is no device on the GP database SystemOne which enables a GP to view a picture of cumulative risk.

5.33 Both the mental health risk summary and the GP risk template have an important omission; the lack of a prominent direct question on substance misuse. Substance misuse and alcohol appear in the GP assessment template on a page among health-based questions such as smoking and blood pressure, not on the risk page. The West London NHS Trust has a Clinical Risk Policy which highlights the use of alcohol and illicit drugs as increasing risk, but these are reported under the 'dynamic factors' section of the patient summary. Ideally these questions need to be separate and immediately visible on the template. Why is this important? Drugs and alcohol and their effects can increase irritability, volatility and/or aggression. Use of substances when living with psychotic illness can have a detrimental effect on a person's wellbeing and those around them. David was a long-term user of cannabis. He also admitted during psychiatric assessment for his trial, that he had recently started replacing cannabis with alcohol and had been drinking vodka and a stimulant drink from late morning on the day he killed his brother.

> *Recommendation:*
> That the West London NHS Trust review the current risk summary with a view to having specific questions listed on illicit drugs and alcohol which are easily visible, rather than recording these substances in the 'dynamic factors' section of the risk assessment.

5.34 Whilst the research on cannabis use and its links to psychosis is a contested area of academic study there is longitudinal research such as the Dunedin 2002 research[21], which followed a large cohort from birth and which supports the findings of an earlier

[21] Arseneault L, Cannon M, Poulton R, Murray R, Caspi A, Moffit T E, "Cannabis use in adolescence and risk for adult psychosis: longitudinal prospective study" BMJ. 2002 Nov 23; 325(7374): 1212–1213. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC135493/#B4. Accessed 19.01.19

large cohort historical study[22], that whilst there may yet to be an emphatic proven causal link, there is an association between cannabis use and an increased risk of experiencing schizophrenia symptoms. The research also found early cannabis use by the age of 15 brings a greater risk for schizophrenia outcomes than later cannabis use by the age of 18. It is suggested that the youngest cannabis users may be most at risk as their cannabis use becomes longstanding. In the Dunedin research of those using cannabis by age 15 a tenth developed schizophreniform disorder by the age of 26 compared with 3% of the remaining cohort. The risks identified was specific to cannabis use. In family statements to the Police during the investigation it was reported that David started using drugs in his mid-teens; he first came to the attention of Mental Health Services when he was 21 years of age.

5.35 The research study from Dunedin cited above also found that young male cannabis users were nearly 4 times more likely to be violent than non-users, the risk for alcohol users was around 3 times. Violence appeared to be linked to the psychosis or the withdrawal from the drug. According to David he had recently stopped taking cannabis and started using alcohol. The Dunedin study found parents and siblings may be injured and homicides were not uncommon[23]. For context analysis of UK Domestic Homicide Reviews (DHRs)[24] found that of the 40 Reviews analysed, 7 were familial homicides: All the homicides were committed by a male perpetrator, mental illness was an issue in all 7 cases, and substance use by the perpetrator was present in all but one case. The victims in these cases were mothers and one a father. Other analysis of DHRs[25] makes similar findings with a quarter of the Reviews being familial homicides; 5 cases involved sons killing mothers (matricide), 2 cases involved sons killing fathers (patricide) and 1 case involved a brother killing his brother (fratricide).

5.36 When first involved with Mental Health Services David was volatile and aggressive; he threatened staff and was physically rough with his mother when he was seen to pushed her out of the away. Once compliant with medication he was, as far as we know, stable in mood. If, as he stated to his assessing psychiatrist that he had recently exchanged cannabis for alcohol this could have increased his risk of being violent. This information was not known to services.

5.37 David's mother reported to his GP, that he was using skunk, the more potent variant of cannabis. Research in 2015[26] by the Institute of Psychiatry, Psychology & Neuroscience at King's College London, found that 24% of all new cases of psychosis were associated with the use of high potency 'skunk-like' cannabis. The risk of psychosis was also three times higher for potent 'skunk-like' cannabis users, and five times higher for those who used it every day.

5.38 Research by Short et al (2013) found an increased risk of violence in those living with schizophrenia, compared to the general population, finding a significantly higher risk of violence offences and involvement in family violence[27]. The 2009 meta-analysis by Fazel (2009)[28] also found a robust body of evidence that an association between

[22] Zammit S, Allebeck P, Andreasson S, Lundberg I, Lewis G "Self reported cannabis use as a risk factor for schizophrenia in Swedish conscripts of 1969: historical cohort study" BMJ. 2002 Nov 23; 325(7374): 1199. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC135490/ Accessed 19.01.19
[23] Cannabis Effects & How It Works - How it works in the brain. https://www.cannabisskunksense.co.uk/the-facts/how-it-works-in-the-brain. Accessed 20.01.19
[24] Home Office (December 2016) Domestic Homicide Reviews: Key Findings from Analysis of Domestic Homicide Reviews.
[25]Sharp-Jeffs N, Kelly L (June 2016) Domestic Homicide Review (DHR) Case Analysis. Report for Standing Together.
[26] Di Forti, M. et al. 'Proportion of patients in south London with first-episode psychosis attributable to use of high potency cannabis: a case-control study' published in *Lancet Psychiatry* DOI: http://dx.doi.org/10.1016/S2215-0366(14)00117-5. Accessed 19.01.18
[27] Short T. et al (2013) 'Comparing violence in schizophrenia patients with and without comorbid substance-use disorders to community controls' Acta Psychiatrica Scandinavica, Feb 4 DOI 10.1111/acps.12066 [Epub ahead of print]
[28] Fazel S. et al (2009) 'Schizophrenia and violence: systematic review and meta-analysis' PLOS Medicine, Vol 6: Issue 8. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2718581/ Accessed 21.01.19

the psychoses and violence exists, and where substance misuse also existed violence was estimated to be around four times higher compared with individuals without co-morbidity. However, the increased risk of violence was the same as those abusing substances alone. In other words, schizophrenia and other psychoses did not appear to add any additional risk to that conferred by the substance abuse alone.

5.39 The Fazel research highlighted the importance of risk assessment and management for patients with substance abuse co-morbidity. However, a factsheet produced by the mental health charity Mind in 2014[29] reports that despite the attempts of several experts, no violent risk assessment tool had yet been developed which took into account mental health to adequately identify those who will be violent, partly because such incidents are not very common. It is suggested that whilst tools can predict who is at risk of carrying out violent crimes, they cannot accurately tell who among these will actually go on to kill or harm someone so that extra support and management can be put in. Admittedly the picture is complex, but the various research discussed here, along with the context of a patient's life, family background, relationships, and stressor points need to be factored into risk assessments to give practitioners the information they need to inform decisions.

5.40 David disclosed that he had started drinking instead of using cannabis; he drank a significant amount of vodka and a stimulant drink each day. Alcohol is a well-known disinhibitor, and misuse and dependence are commonly associated with violent crime. In a detailed review of 39 Domestic Homicide Reviews by Alcohol Concern and AVA's Stella Project[30], 69% of the Reviews were found to have varying levels of alcohol use involved, with 56% of the perpetrators having problems with alcohol.

5.41 The above findings from research appear pertinent to this case. However, it is not suggested that all those experiencing schizophrenia or psychotic symptoms and who are managing their symptoms effectively will go on to be violent. A majority of people living with this condition will not be violent; those experiencing mental ill-health are in fact often more likely to be a victim of violence[31]. However, research findings although nuanced and challenging need to be taken into consideration when designing risk assessments which need to be holistic in content.

5.42 Whilst it is most welcome to see a question about domestic abuse appearing in the mental health risk summary template, there is still scope for improvement to support busy practitioners in their decision making and in evidencing those decisions. Above all research finds that professionals agree that the most helpful element to effective risk assessment is experience, a good relationship with service users and knowledge of them, including their strengths and abilities, gained over time[32]: Realistically it must be acknowledged that for GP's managing patients with mental health treatment needs, they do not have sufficient time, and frequent and regular contact with patients, to enable them to know their patient really well and to establish a relationship of trust with someone like David. Faced with a resistant patient such as David is an additional barrier. Thus, GPs need a more relevant and accessible tool for risk assessing patients in the community.

[29] Mind Factsheet Violence and Mental Health. https://www.mind.org.uk/media/998781/Violence-and-mental-health-Mind-factsheet-2014.pdf
[30] Ward M, et al (June 2016) "Domestic abuse and change resistant drinkers: preventing and reducing the harm: Learning lessons from Domestic Homicide Reviews". Alcohol Concern & AVA's Stella Project.
[31] Mind Factsheet Violence and Mental Health. https://www.mind.org.uk/media/998781/Violence-and-mental-health-Mind-factsheet-2014.pdf
[32] Langan J, Lindow V. (2004) 'Living with risk mental health service user involvement in risk assessment and management'. The Policy Press, Bristol

5.43 The provider of housing to the family confirmed that they have risk assessment in place to manage domestic abuse and anti-social behaviour. These are deemed to be effective and appropriate.

5.44 It has to be acknowledged that risk assessment is only as good as the information gathered to inform it, and this needs to include information from families and carers[33], and other services involved with the service user, but it is only a snap-shot of risk at the time of its completion; risk is dynamic and needs to be reviewed when circumstances change. Well designed risk assessment tools can act as a helpful prompt or aide memoire for practitioners and serve as a useful adjunct to the essential element of sound professional judgement[34] informed by relevant research.

Recommendation:
All practitioners and their managers working in the community involved in the assessment and management of those with mental health treatment needs with co-morbidity substance misuse should ensure that assessments are; informed by family or carer contributions where safe and appropriate; take into account and consider research on psychosis, schizophrenia, and coexisting substance misuse in risk assessments. When circumstances change in such cases they should be discussed in supervision, or via peer support as appropriate to organisational structures.

Recommendation:
When a review of the SystmOne database takes place, it is recommended that NHS England take steps to establish whether a page viewable only by GPs which records information giving a picture of accumulative risk factors to or from a patient could be included on the system to optimise risk assessments and improve visibility of risk factors. Consultation with GPs is recommended when this takes place.

5.45 ***Term of Reference 4:*** *How did liaison with family members take place concerning assessments, treatment and relapse plans, and any risks identified?*

5.46 The Mental Health IMR author found good contact took place between David's care coordinator and family members during the time he was receiving support from the West London NHS Trust, particularly between his mother, and his sister who lived at home at that time. David's mother attended reviews with his permission, however, on one occasion he declined to have her present. Telephone contact was also used, but care coordinators consistently noted that phone calls went unanswered on occasions or were not returned despite persistent attempts. However, what was perhaps not considered was that David's mother was at work during the day and probably returned home outside office hours to enable her to return calls. The office opening hours are 9am to 5pm.

[33] The assessment of clinical risk in mental health services. National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH). Manchester: The University of Manchester, 2018.
[34] The assessment of clinical risk in mental health services. National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH). Manchester: The University of Manchester, 2018.

5.47 David's care coordinator had intended to invite his mother to attend his discharge meeting in 2013, however there is no evidence that she was informed or invited. The West London NHS Trust IMR makes a recommendation concerning this omission. Her absence from this meeting and lack of follow-up correspondence meant she was not informed of future or relapse plans for her son when she had previously played an active part.

> *Recommendation:*
> Where contact by telephone with carers has not been successful, then a letter and/or an email should be sent, with the details of any CPA meetings or reviews to which they are being invited. (IMR recommendation)

5.48 David's mother was recognised as an important person in his life by his GP practice and that in recent years he lived with her. Following her phone call to a GP in May 2016 to let them know that David would not attend a review appointment, she was invited in to speak to the mental health lead GP in his place which she did to express her concerns about him. Her concerns were recorded, and a further attempt made to engage David for a review appointment, but again without success. The concerns raised by David's mother were indicative of his deteriorating mental wellbeing, but whether sufficient to have fulfilled the criteria for referral to secondary mental health services is debatable. In any event such a referral would have needed his consent, unless the grounds of increased risk or mental capacity could be met. As an adult David would have the right to self-determination, and his previous resistance, as already discussed, would undoubtedly have resulted in his refusal to accept a referral.

5.49 David's mother did not attend the appointment with him which resulted in the opportunistic assessment by a GP in September 2017, but her phone call 3 days later regarding an additional medical certificate was responded to as she was seen as a supportive family member and the certificate was provided. There is no indication that David's mother or the mental health GP considered him a risk to others at this time.

5.50 ***Term of Reference 5:*** *If the perpetrator is found to have rejected or resisted support from services what changes could take place to improve engagement in similar cases in the future?*

5.51 It is clear from the chronological information provided by the health services with whom David had contact that he continually resisted, or outright rejected, the support and care offered to maintain his mental and physical health. His resistant stance was evident from the first involvement of Mental Health Services in 2006. The West London NHS Trust IMR found that David often mentioned his reluctance to accept the initiatives offered to him and the feelings of stigma he felt by having Mental Health Services. His elder sister confirms that David felt this most strongly. Later when he was under the care of his GP he rejected all attempts to engage him in regular reviews of his mental wellbeing and check-ups of his physical health for any side effects of his medication. His mother asked that any letters sent to him did not mention 'mental health' as he put them straight in the bin.

5.52 Mental Health Services addressed his resistance by the care coordinators taking what is described as a 'sensitive and persistent' approach which helped to achieve a degree of engagement and successful compliance with his medication. The persistent follow up by care coordinators was successful in supporting David into

independent accommodation and voluntary work, although these were not sustained over time. David's sister is of the view that he was not ready for fully independent living and continuing in supported housing would have been preferable.

5.53 The Mental Health IMR is of the view that the assertive approach[35] with hard to engage service users can be effective and specialist teams have in the past existed in order to provide a service to these clients. However, it is suggested that it is doubtful whether David's level of engagement would have warranted a transfer to such a team. The expectation was that the practitioners supporting him would adopt an assertive approach when required which they did.

5.54 Whilst David was a patient with the Mental Health Service these approaches were possible as part of their support options. However, once he was transferred to the care of his GP this intensity of support was never going to be possible. It is arguable that once free of the oversight of mental health professionals David would inevitably slip back into noncompliance with his medication, and his already low motivation for work, training, or outside activities would see him withdraw from the world outside his home even further. David's entrenched resistance resumed leading to total withdrawal with anything to do with his mental health. He rejected referral to the mental health nurse attached to the GP practice, and ignored numerous appointments and reminders. His mother's attempts to achieve his attendance were unsuccessful. David also rejected a referral to alcohol services after his arrest for assaulting Max.

5.55 The GP practice has a robust call and re-call process in place, and non-engagement with clinical review was identified by the system, hence the letters, texts, and calls to David's mobile phone. Whether he was blocking calls and texts, or simply ignoring them we do not know. The GP IMR explained that non-engagement is not normally escalated unless there are known additional risks or concerns over and above the non-engagement itself. However, David's mother said she was 'very concerned' about him when she visited a GP in May 2016, and she described symptoms indicative of relapse, plus the use of skunk, which in addition to the non- engagement justified discussion with and/or re-referral to Mental Health Services. It is now known from this Review that the practice had no knowledge of the assault on Max which involved Police attendance, or indeed the other attendances by the Police when David's behaviour suggested he was experiencing worrying hallucinations. Notice of these would have flagged further risk factors. The West London NHS Trust informs the Review that the following options are available for GPs:

- The consultant helpline which is staffed by a Consultant Psychiatrist and is a point of contact for GP's to discuss concerns.
- The West London Consultant Psychiatrist who was (or is?) is allocated time to support Primary Care (GP's) and had offered email correspondence to discuss cases.
- The CCG Mental Health Head is also a point of contact to raise and escalate cases which the GP is struggling with.
- Within the practice concerned in this Review a primary care worker has been based in the practice for over 2 years. They are a direct point of contact to discuss cases. The West London NHS Trust Service Manager confirmed there are times the worker can attend a patient's home.

[35] The assertive approach entails frequent and repeated contacts with the service user, both via telephone and visits in person in the home or away from the home. The approach was developed in the United States of America. Initially used in a team for those difficult to engage, the approach has now been assimilated into individual practitioner's practise. Practitioners may have a lower case load to enable them to accommodate this intensity of work.

The GP practice confirmed that they had tried the consultant helpline but had been unable to get through.

5.56 The GP practice also has processes in place for managing repeat prescriptions where non-concordance with medication is identified, and this was activated in David's case. The current practice is to reduce the amount of medication in repeat prescriptions to bring the patient into the surgery. Ultimately, if the patient does not engage with clinical reviews the medication will stop, the rationale being that it is riskier to continually issue medication without review than stopping the medication. How can non-engagement such as David's be addressed in future is the big and difficult question? The GP IMR suggests that patients with severe and enduring mental illness who do not engage with a review of their treatment in primary care, and where there is an absence of additional risk factors, could be referred back to secondary care for their management. As a result of early learning from this case the GP practice with whom David was registered have now implemented new practice in relation to non-engaged patients (those who do not attend for clinical review and/or do not demonstrate satisfactory concordance with medication). When identified, these patients will now be escalated to, and managed by the GP lead for mental health. The GP mental health lead's practice is now to discuss all such cases with secondary care Mental Health Services, and not just those who are judged to have higher levels of risk. As the practice has the additional resource of a mental health primary care worker it would also be advantageous to discuss a disengaged patient like David with that worker in the first instance. This would enable an interim plan to be made to try and engage the patient, and/or with their carer or family, as a first step before escalating and referring back to secondary mental health services.

5.57 A further consideration in this case is the possibility of a missed opportunity to enforce compliance with his medication, treatment, and support when David was arrested for the assault on Max in March 2017. Had he been prosecuted for the assault there would have been an option for a Mental Health Treatment Order to be made. Given that David told the psychiatrist assessing him for his trial that he had exchanged cannabis for alcohol recently as he thought he might go to prison, such an order may well have induced him to engage with services. However, Max did not support the prosecution of his brother and there was insufficient other evidence to support a victimless prosecution. This is in no way reflecting blame on Max for that decision; family members are often reluctant to criminalise their relative as previously discussed, and they are usually unaware of the positive changes achievable and the access to services available by holding a relative to account via the courts.

5.58 ***Term of Reference 6:*** *Were any members of the perpetrator's family identified as a carer and if so, were they:*

(a) informed about carer's assessments and the support which might be available?
(b) offered a carer's assessment?
(c) signposted to appropriate voluntary or statutory services for support relating to their roles as carers, as victims of crime or domestic abuses?

5.59 (a) David's mother was identified as his principle carer by the West London NHS Trust during the period of their service's care, and his sister was also known to assist with support. On 17 October 2008 David's care coordinator provided his mother with carer's information and of the carer's group. A carer's network has been running in the area covered by the Trust for the last 27 years. It has serviced the Borough of Hammersmith and Fulham for the last 6 years. The Panel heard that the Borough

provision was part of a tri-Borough arrangement and Hammersmith itself did not have a carer's network at the time David's mother was given the information; she would have needed to travel to a neighbouring Borough. The Review panel understand that a carer's network within Hammersmith and Fulham is on the path to being commissioned. At the time of the report the outcome of this process was unknown. Given that the family GP practice has 289 patients on its Serious Mental Health register and there will be others with health needs who have carers, a locally based carer's network could provide improve access to support locally for those with caring responsibilities.

5.60 The GP practice did not identify David's mother as his carer, although they were aware that she was important in his life and he lived with her in the later years of his registration with the practice. As a result, she would not have been on a practice register of carers.

5.61 (b) There is no record of a carer's assessment being undertaken by the West London NHS Trust during their involvement, which was pre- the Care Act 2014 when such assessments became obligatory. The Trust is a signatory to the "Triangle of Care" framework which is based on the findings of research undertaken by the Carer's Trust and the guidance which was developed with carers and clinicians[36]. The 'Triangle' recognises the importance of the carer, service user, professional relationship and the wish of many carers to be seen as active partners in the service users care. The practice guide points out that *"An effective Triangle of Care will only be complete if there is a willingness by the professional and carer to engage. Most carers recognise that this three-way partnership between service user, carer and clinicians, with all the voices being heard and influencing care treatment decisions, will produce the best chance of recovery. This places an onus on professionals and services to actively encourage this partnership"* (p6). Thus, the framework promotes carers and those cared for having involvement in the development and improvement of services. The Triangle of Care guidance would usefully inform practice with service users and carers across a number of services, not just mental health.

5.62 The GP practice did not offer David's mother a carer's assessment; she was not recognised as a carer. However, GPs can refer for a carer's assessment to be undertaken, but the Panel learnt that such referrals are infrequent. Greater awareness of the process is required.

5.63 (c) Although David's mother was rightly given information about the carer's network by the Community Mental Health Team, neither she nor David were signposted to other forms of appropriate voluntary[37] or statutory services for information and support by the Trust practitioners or the GP practice.

> *Recommendation:*
> *A* range of information resources (leaflets, websites etc) on specialist voluntary and statutory services which includes sources of support for family members should be given to the family of those living with mental ill-health and substance misuse, and also made available in waiting areas. Resources should be in place by July 2019

[36] The Triangle of Care Carers Included: A Guide to Best Practice in Mental Health Care in England. 2nd Edition 2013. The Carer's Trust.
https://professionals.carers.org/sites/default/files/thetriangleofcare_guidetobestpracticeinmentalhealthcare_england.pdf

[37] A selection of voluntary sector sources of support for those with mental illness and family members:
MIND - https://www.mind.org.uk/
Rethink Mental Illness: https://www.rethink.org/about-us.
Mental Health Foundation: https://www.mentalhealth.org.uk/
Mental Health Support: http://www.mentalhealthsupport.co.uk/carers.html
Advice for families of drug users: https://www.nhs.uk/live-well/healthy-body/advice-for-the-families-of-drug-users/

Recommendation:
Awareness raising should be undertaken within the Borough by Adult Social Care with GP practices to publicise the criteria and pathway for a carer's assessment referral. This should aim to be completed by the end of 2019.

5.64 ***Term of Reference 7:*** *All agencies are to examine communication and information sharing between and within their agencies to establish whether:*

a) it was adequate, timely, and in line with policies and procedures?
b) there were any gaps in information sharing or breakdown in systems which impeded the effective treatment or management of the perpetrator's behaviour and health?
c) effective information sharing was undertaken to inform a safety plan to protect family members?

5.65 (a) (b) Information sharing internally by agencies was found to be timely and in line with procedures, with one exception. The Police IMR found that although internal communication had taken place via email with the Local Police Team requesting a follow up visit to David after his third phone call in January 2018, there is no record that this took place. Ward officers could not recall the incident. The Police IMR has made a recommendation concerning this.

Recommendation:
It is recommended that officers involved in the Grip & Pace and Local Policing Team (ward officers) are debriefed regarding the recording and completion of the home visit to the perpetrator on 22 January 2018. (IMR recommendation)

5.66 The Review has found incidents where information sharing between agencies has been found to be either flawed or inadequate both on an individual and systems level. There are three key areas where this occurred. They are:

- Discharge letter from the Mental Health Service psychiatrist to David's GP:

5.67 This letter dated 28 February 2013 contained inadequate information. It was a very short letter which included a three bullet point plan simply stating: He is discharged back to your care; To prescribe Amisulpride - 100mg as repeat prescription, and GP to kindly re-refer back if there are any concerns in the future. The letter did not give any background history concerning David's 6-year involvement with the service, or guidance on what level of concern might constitute a threshold for re-referral.

5.68 The Panel learnt that in the 5 years which have passed the discharge system from the West London NHS Trust has changed. It is now policy for GPs to be sent a letter of 'intention to discharge' (see Appendix 1) for the practice to consider, followed by a more comprehensive discharge letter (see Appendix 2). This now includes progress and care received by patients, and there is often advice about a crisis plan. Practitioners have headings to guide them in the content of the discharge summary e.g. risk. Referrals, including re-referral from GPs are made through the Single Point of Access and are categorised as 'red', 'amber', or 'green'.

5.69 During a Panel meeting to discuss IMRs it became clear that, although the GP practice was aware of the changes to the written discharge system, there remained gaps in the practice's awareness of some elements indicating that further publicity

was required for GPs. The practice representatives on the Panel also felt it was important to have discharge information on the quality of the patient's engagement with Mental Health Services, as well and the support given. Information about David's ambivalence towards his medication and mental health, and the amount of support given to keep him engaged would have been helpful to his GP. These comments have been taken as early learning from the Review and the West London NHS Trust is in the process of consulting on the format of a revised discharge summary.

5.70 The Panel heard that previous liaison meetings held by the West London NHS Trust with GP practices had ceased; the GP practice lead for mental health felt these had been useful and their demise contributed to a gap in the practice's easy access to knowledge regarding changes. The Panel discussed a recommendation regarding the reformation of these liaison meetings and noted that at the time of our final DHR Panel meeting a networking group had begun which appeared to fulfilled the same purpose. However, due to the changing landscape in community and primary health delivery, it was felt important to reinforce the importance of dialogue and partnership building by including a recommendation to reinstate such a regular meeting to ensure that action takes place.

Recommendation:

That the Mental Health Lead for the Clinical Commissioning Group (CCG) and GP Practice lead for mental health liaise regarding the most effective local structure for convening a quarterly Primary Care Network meeting of mental health professionals which should include West London NHS Trust, CCG, primary care mental health practitioners, and GP mental health leads in its membership, with the aim of facilitating knowledge sharing, updates in protocols, and partnership working. This Network meeting should aim to be in place by September 2019.

Recommendation:
Mental Health Trust discharge letters to GPs to include a summary of the quality of the patient's engagement with the service, a crisis contingency plan, the patient's next of kin (or carer if different) and their level of involvement, whether a carer's assessment has been completed, and if not why not. This will be dependent on the next of kin or carer's consent. Discharge summaries to include this information from July 2019 onwards.

- Information sharing relating to assault incident March 2017:

5.71 The incident in March 2017 involving David assaulting Max saw two incidents of individual human error and one systems error where procedures were not followed.

5.72 On David's arrest for Affray and Common Assault he was detained overnight. As advised by a health care professional he was assessed by the custody psychiatric liaison nurse the next morning. The custody record does not show details of the assessment and only records the first name of the nurse concerned; for a formal record one would perhaps expect a full name and job title. On completion David's GP was to be advised of the assessment, however, no trace of any correspondence has been found in Mental Health Service notes or the GP's records. It is therefore concluded that it was not sent. A recommendation has been made in the West London NHS Trust IMR for the Trust's Criminal Justice Liaison & Diversion Team as a result of this gap in information sharing.

5.73 It is not clear whether the assessing psychiatric nurse has to complete a database record of the assessment in custody, but if that is the case a systems change could perhaps support a busy practitioner to avoid such oversights in future. For example, the database could ensure that the GP is not missed by having a required field to complete linked to GP's email addresses which will not allow the closure of the note until an email is sent.

5.74 Relating to the same incident a Police record noted that the investigating officer was to speak to David's mental health team, but the Police IMR author could find no record of the outcome of this liaison. The West London NHS Trust chronology also found no record of receiving the call. In the absence of these records we have to assume that the call was not made, and there appeared to be no supervisory oversight in the system which might have made it noticeable that the contact with Mental Health had not occurred. The fact that the officer thought of contacting the Mental Health Service to share concerns shows a good intention to work in a multi-disciplinary manner, it is therefore unfortunate that the call did not take place.

5.75 As David was recognised as having mental health problems and met the criteria on a number of points in the Police Vulnerable Adult Framework, the Police sent a MERLIN report dated 21 March 2017 which was received by Adult Social Care on 23 March 2017. This was forwarded to the Mental Health Single Point of Access on the same day. It was assessed as no further action as the documentation stated that the GP had been notified of the incident by the psychiatric nurse. This we now know was not the case and the GP was unaware of the nature of the assault and David's arrest. Normal practice would be for the Single Point of Access to notify the GP that their patient had been seen, but because this was thought to have already been done by the psychiatric nurse this did not happen. Normal procedures should have been followed regardless; better for a GP to have two notifications than none at all.

5.76 The West London NHS Trust IMR points out as per General Data Protection Regulation (GDPR) that information can only be shared with external agencies if there is a legitimate reason to do so. The Trust Criminal Justice Liaison & Diversion Services draft operational policy includes the guidance that consent to share information should be obtained before assessment. "If consent is not obtained information may still be shared if there is sufficient concern regarding risk to self or others. Liaison & Diversion practitioners are expected to contact GPs to inform them that their patients have been assessed and to share any concerns".

> *Recommendation:*
> Regardless of whether MERLIN information indicates that a GP has been informed, the Single Point of Access should notify a patient's GP that they have been assessed by a member of Trust staff and give details of the MERLIN content, the nature and place of that assessment, risk identified, and whether weapons have been involved in an incident.

5.77 The MERLIN notification has within its heading in bold text the warning that *"THIS INFORMATION IS SENT IN CONFIDENCE AND IS RESTRICTED. IT MUST NOT BE PASSED ON TO A THIRD PARTY WITHOUT THE EXPRESS PERMISSION OF THE POLICE".* This raised a certain amount of disquiet within the West London NHS Trust since (a) it is forwarded to them from Adult Social Care yet they have no formal confirmation that this is with the consent of the Police, and (b) should they contact the Police for consent to forward the information to a GP or team within the Trust, and if so with whom should contact be made? There is no contact number or email on the notification. Such an additional process would undoubtedly place a significant

burden on both the agency wishing to act on the MERLIN and the Police who would be receiving calls from third parties seeking consent to share the MERLINs. Clarification is needed regarding this process.

> *Recommendation:*
> The current children's 'Multi-agency Safeguarding Hub' (MASH) and vulnerable adult 'Safeguarding Hub' arrangements within the Borough should be reviewed by September 2019 to ensure that a multi-agency information protocol is established to share information, which identifies risk to inform actions by the appropriate agency. This should be compliant with current safeguarding and data legislation.

- Information sharing concerning calls to the Police by David:

5.78 David made three 999 calls in 6 weeks to the Police; two in December 2017, and one in January 2018. He was having hallucinations the content of which were concerning. Officers attending the two calls in December generated MERLIN reports on 5 December and 20 December which were sent as usual to Adult Social Care. The second MERLIN contained the recommendation that David at least receive a home visit from a mental health professional. However, enquiries by the author of the Adult Social Care report found neither MERLIN was opened.

5.79 It was discovered that some MERLINs were unable to be opened due to there being no mutually agreed confidential communication system between the Police and Adult Social Care. Adult Social Care receive over 200 MERLINs per month, not all of which contain serious levels of concern. The MERLIN system between the Police and Adult Social Care is shown at Appendix 3. The secure email system used by Adult Social Care has a history of intermittent problems in relation to opening MERLINs received in the Intake and Advice Team inbox. One MERLIN for the 5 December 2017 was eventually found in the system and a copy has been seen by the Panel. The West London NHS Trust Panel member confirmed that had this reached the Single Point of Access its content was such that it would have resulted in action.

5.80 The early learning gained following the discovery of the secure email problems by the Adult Social Care report author resulted in action being taken, and the Panel was informed that a suitable and secure replacement email system has been purchased.

5.81 The emergence of this 'technical' systems difficulty in sharing information opened up a wider discussion in the DHR Panel about the MERLIN process, for if there was no mutually agreed confidential system for the transferring of MERLINs between these two agencies, is there wider mutual understanding of MERLINs and their purpose? And if not does this indicate a need for multi-agency discussions to clarify and strengthen procedures.

5.82 The MERLINs process was created in April 2013 for the purpose of sharing information about vulnerable adults who came to the notice of the Police. The system was previously developed for the notification of vulnerable children in 2004, which, as it involved children, is within the Working Together[38] safeguarding framework of statutory multi-agency information sharing. The same legal framework for information sharing does not exist for vulnerable adult notifications within the Care Act 2014 since Data Protection, Human Rights, and Crime and Disorder Act

[38] Working together to safeguard children A guide to inter-agency working to safeguard and promote the welfare of children. March 2015. HM Government. (now superseded by Working Together 2018)
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/592101/Working_Together_to_Safeguard_Children_20170213.pdf

legislation already provides this framework in addition to the Mental Capacity Act[39]. The MERLINs sharing information concerning David could be justified under the various Acts highlighted.

5.83 The General Data Protection Regulation is not a barrier to sharing information; it provides a framework to ensure that personal information about living persons is shared appropriately and sharing information should ideally be with consent where appropriate[40]. It is arguable that when David was seen by Police officers suffering from disturbing hallucinations that he may not have had the mental capacity to consent to information sharing at that particular time. However, attending officers would not have had the relevant expertise to undertake a mental capacity assessment, indeed as mentioned previously, one of their 'unopened' MERLINs recommended that he "received at least a home visit by a mental health professional to assess his medication". They were therefore acting on their concerns for David's wellbeing as a vulnerable person on those occasions. One of the key considerations for deciding on whether information should be shared is the safety and wellbeing of the person and others who may be affected by their actions[41].

5.84 During further Panel discussions it became clear that there were problems with the MERLIN process at the time of this Review. Adult Social Care pointed out that MERLINs are not equivalent to a referral as some professionals and members of the public think, and they are not the best system for raising a situation which requires a prompt response. Despite the shortcomings of the system, it is clear that MERLINs were brought in with the best of intentions to share information between agencies where there are concerns for the wellbeing and safety of vulnerable adults. The process has proved valuable in the sphere of child protection; therefore, it is reasonable to assume the system could help prevent vulnerable adults slipping through the net. One of the most common findings of DHRs[42] and other Reviews is that information was not shared with the result that important gaps in agencies' knowledge were left unfilled, risk assessment was inadequate, and victims died.

5.85 The impact of the GP practice and the Mental Health Service not having the information concerning the incidents which involved the Police contact with David undoubtedly impeded the effective treatment and management of his behaviour and his health. Had the full extent of his deteriorating mental health been known in December 2017 and again in January 2018, it is highly likely that a discussion with mental health services would have ensued with a possible referral for a mental health assessment.

5.86 It was very quickly clear to the Panel that the early learning concerning the flaws in the MERLIN system needed to be addressed without delay. Therefore, at the November 2018 Panel meeting where the full problem came to light, it was agreed that a focus group of the relevant agencies would be formed, and agencies Merlin processes would be reviewed. The Interim Lead for Adult Safeguarding who sat on the DHR Panel agreed to take this forward.

5.87 The Review author recognises the challenges involved in introducing or changing multi-agency protocols and ways of working, and with the Metropolitan Police

[39] Social Care Institute for Excellence. https://www.scie.org.uk/safeguarding/adults/practice/sharing-information#sixprinciples
[40] Social Care Institute for Excellence. https://www.scie.org.uk/safeguarding/adults/practice/sharing-information#sixprinciples
[41] ibid
[42] Neville L, Sanders-McDonagh E (2014) 'Preventing Domestic Violence and Abuse: Common Themes and Lessons Learned from West Midlands' DHRs'. Middlesex University.
Home Office (December 2016) Domestic Homicide Reviews: Key Findings from Analysis of Domestic Homicide Reviews.

covering 32 London Boroughs (33 if the City of London is included) each with their own individual services, some of which are cross-Borough, this adds to the complexity. Nevertheless, rather than dismissing it as fatally flawed, a pragmatic approach to the vulnerable adult MERLIN process would be to bring adult safeguarding practitioners into the existing MASH to filter and forward the notifications as appropriate. As the Panel's Police representative advises the whole point of a MASH is the early sharing of information in a secure 'bubble' away from agencies' operational systems in order to improve risk assessment. By including vulnerable adults in the MASH not only could information be shared in a timelier manner to make it more relevant to assessments, but by having multi-disciplinary adult services practitioners within the MASH would build up an increased level of expertise bringing consistency of approach, improved inter-agency professional networks, and reduce inappropriate referrals to partner services. The corollary of this would also be financial and time savings.

5.88 (c) The West London NHS Trust IMR found no substantive risk existed towards family members during the time of their involvement up to David's discharge from their service in 2013, the incidents involving David's elder brother trying to force him to take his medication, could have been seen as a risk to David and indicated tensions in the family, and David pushing his mother out of the way evidenced his capacity to be rough and confrontational. These incidents happened in 2006, very early in the Trust's involvement, this was not referenced in the discharge plan. The GP practice was completely unaware of the assault on Max and the other Police contacts with David, therefore they had no information on which to base concerns that a family member may be at risk.

5.89 The Review discussed a recommendation to integrate adult safeguarding resources into the MASH as a means of increasing fast information sharing and expertise. However, bearing in mind that Review recommendations should aim to be achievable and realistic, being mindful of scarce resources, and an update received regarding changes which have been made to the system, this was reconsidered. Whilst the Review has learnt that there are no immediate plans to develop a MASH, the safeguarding Hub is reported to have greatly improved the response to safeguarding concerns. The management of MERLINs is included within those improvements with better links with the Police and the prompt opening of MERLINs. The chair would however, wish the recommendation on reviewing the MERLIN process to stand and action to be taken.

5.90 ***Term of Reference 8:*** *Were there any resource issues, including staff absence or shortages, which affected agencies' ability to provide services in line with procedures and best practice? Include caseloads, management support of staff, supervision, and any impact of changes due to restructures or to service contracts.*

5.91 None of the agencies contributing IMRs to this Review identified any resource issues which affected the delivery of their services to David or his family. However, of note is the record that David's mother did not want him to be discharged from the Community Mental Health Service in late 2012, but she understood that keeping him on an enhanced care plan could not be justified given the pressure on the services (paragraph 3.54). Sadly, once discharged from the Community Mental Health Team David's compliance with medication became erratic, his mental ill-health deteriorated, and his substance misuse appears to have escalated.

5.92 David's GP practice has 289 patients on its Serious Mental Health Register, and as David's case indicates, a GP practice does not have the necessary structure or resources to practise the type of assertive working with patients used by the Mental

Health Team to maintain David's mental health before his discharge. The Government's Shifting the Balance of Care health plan aims to move the emphasis of patient care from hospital to community-based care, as a result secondary care services such as Mental Health Services, have also been reviewing how they work. This is exemplified in the West London NHS Trust's Shifting the Setting of Care programme where those judged to be stable are discharged to their GP and community mental health workers are based within practices for patients to access. This type of service provides easier access for patients who are stable and engaged. However, as this case has shown, resistant patients such as David can refuse the offer of an appointment with the practice based mental health worker. If the system is requiring GPs to take on a higher volume of mental health work particularly with a higher level of need and complexity such as a patient like David, and the risk such cases inevitably carry, then they will need to be supported by more specialist training and workforce resource to deliver this. GPs need the knowledge to understand when patients need referring back to secondary care and clear protocols to enable easy and fast access to those specialist services. The ideal provision for those experiencing serious and enduring mental illness who have David's challenges would be to be managed, maintained, and supported by mental health professionals in a dedicated service where the skills exist to best maintain their health and ensure relapse and risk are addressed.

Recommendation:
That the Department of Health provide resources to support the safe and effective working of the Shifting Settings of Care policy by the provision of:

a) increased access to specialist mental health resources to support Primary Care in managing patients deemed sufficiently stable for this level of care.

b) resources to Community Mental Health Teams to increase their capacity to support Primary Care in their management of those with serious and enduring mental health treatment needs, and to facilitate threshold levels suitably calibrated for patients to be returned to their care who cannot be managed in Primary Care.

Recommendation:
Using the facilities of the Trust Transformation Work Programme, and in consultation with GP mental health leads and West London NHS Trust, CCG mental health leads to develop a protocol which can be rolled out to all GPs in the area to ensure consistency of approach which:

a) identifies when to escalate patients failing to engage with their GP.
b) determines appropriate thresholds,
c) agrees action/care plans, and ownership of risk.
d) agrees information to be shared

5.93 ***Term of Reference 9:*** *Had the staff in contact with the perpetrator and family members undertaken domestic abuse training which included, adult family abuse, risk assessment, safety planning, and how and when to refer to MARAC? What training had they received on their own agency's policies and procedures?*

5.94 Due to the length of time which has passed since West London NHS Trust mental health practitioners were involved with the family it has not been possible to ascertain the training they had received as they are no longer with the service. However, the training listed in this term of reference is not a mandatory requirement

within the Trust. Training for staff in the Recovery Team is by request, and whilst the IMR found that Leads and Seniors have completed this training, it has not been undertaken by all staff.

5.95 The IMR noted that no referrals to MARAC were made at any time by those involved in David's care. However, given the lack of staff domestic abuse training this is perhaps not surprising, although it must be recognised that incidents taking place during their involvement in this case would not have met the threshold for a MARAC referral. Nevertheless, it is disappointing to note that mental health staff do not have mandatory training in all aspects of domestic abuse given the impact of domestic abuse on mental health and the strong correlation between mental ill-health and increased risk of experiencing domestic abuse[43], in addition to the part mental illness has been shown to play in familial domestic homicides.

5.96 The Review is informed that the West London NHS Trust now has a Domestic Abuse Policy, and training has been provided by Standing Together Against Domestic Abuse. Domestic abuse leads have also been developed. Domestic abuse is also referenced in the Safeguarding adult and children training. This remains a work in progress and the Trust acknowledge that more is needed. The steps taken by the Trust are most welcome. The chair of the Review would urge the Trust to build on this by providing regular dedicated domestic abuse training to all frontline staff and managers to impart sufficient depth of knowledge to support their practise. Using relevant Reviews as case studies such as this DHR would assist learning.

5.97 The GP practice have eight mandatory training elements of which two are Children's Safeguarding and Adult Safeguarding. Both contain references to domestic abuse in relation to safeguarding. However, the IMR author notes that it is a very brief reference in the Adult Safeguarding training which is provided via an 'online' training module, and it does not include detailed training on adult family abuse, risk assessment, safety planning or MARAC. Staff could use alternative training if they wished, and it is the practice policy that staff undertake Adult Safeguarding training every 2 years.

5.98 The GPs who had contact with David and family members had all undertaken Adult Safeguarding training between September 2016 and November 2017. The practice pharmacist undertook the training in March 2016. Staff had also received informal training on domestic abuse from the specialist domestic abuse organisation Standing Together[44]. The IMR reports that the sessions did include more detailed training on domestic violence, risk assessment, and MARAC, but children's safeguarding was the primary focus rather than adult family abuse. Detailed training on adult family violence and abuse would be advantageous for GPs and practice nurses who may see vulnerable adults, and carers on a regular basis, in addition to similar patients as this DHR presents.

5.99 The GP IMR also pointed out that GP mental health leads do not have any additional training or qualifications over and above their general GP training unless they choose to focus on mental health as part of their continuing professional development. There is a view that GPs generalist level of knowledge would be sufficient for less serious mental illness than David's diagnosis presented, but the support of specialist services is helpful and appreciated when required.

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[43] Trevillion K, Oram S, Feder G, Howard LM (2012) Experiences of Domestic Violence and Mental Disorders: A Systematic Review and Meta-Analysis. PLoS ONE 7(12): e51740. doi:10.1371/journal.pone.0051740

[44] https://www.standingtogether.org.uk/

5.100 The Police IMR confirms that the Metropolitan Police Service delivered mandatory training on domestic abuse awareness during 2015-16 to all staff, up to and including chief inspector level. This encompassed all operational, custody, and community safety officers and staff. At the end of 2017 the training of frontline officers was completed covering 10 sites per day for 3 months. There is ongoing training of all new recruits covering early and late shifts. Training packages are reviewed every 2 years giving the opportunity for revision to be made.

5.101 The incident attended by the Police in March 2017 in which David assaulted Max and had a samurai sword, was correctly identified as domestic abuse, appropriately assessed, and dealt with in line with policy indicating that the training had been successfully embedded in the attending and custody officer's practice. The incident did not reach the criteria for referral to MARAC.

5.102 Adult Social Care report that staff opening MERLINs within the Intake and Advice Team would not have had specific training, but staff involved in screening the notification's content that are relevant to Adult Social Care only, would have had training via internal safeguarding training sessions which include domestic abuse. Due to the early learning arising from this term of reference training of all staff on safeguarding has been introduced specifically for Intake and Advice Team members which included domestic abuse awareness raising. However, the Review has concerns about the depth of the domestic abuse section of Adult Safeguarding training.

5.103 The coverage of domestic abuse in Adult Safeguarding training is not adequate to equip practitioners with sufficient knowledge to identify and act on cases of domestic abuse. The words 'Domestic Abuse' first appear in the training on a slide entitled 'New Types of Adult Abuse'. Most professionals working in the field of domestic abuse would agree that domestic abuse has existed for centuries; it is not a 'new' form of adult abuse. There are just 2 further slides in the training on domestic neither of which include the full definition, for example former partners are not included. The actions for practitioners to take if they have evidence of adult abuse does not include referral to MARAC. The training slides provide evidence of why the complexities of domestic abuse need to be delivered in separate dedicated training sessions.

5.104 Shepherds Bush Housing Group confirm that their neighbourhood housing officers, who primarily have contact with residents, receive training in safeguarding and are aware of how to refer to both the MARAC and the Community MARAC within the Borough. As part of their induction staff are asked to read the company's policies and procedures on the Group's intranet. Staff have not received specific training relating to adult family abuse, risk assessment and safety planning.

Recommendation:
Training in adult family violence and abuse which includes DHR findings should be embedded in dedicated domestic abuse training in line with NICE Guidelines (2017)[1]. The course should include steps for practitioners to take, risk assessment, and referral to MARAC, whilst maintaining the issue as relevant to safeguarding. The training should be undertaken by all those whose role involves assessments, supporting service users or their carers who work in the Mental Health Services, GP practices, Children and Adult Social Care, and Housing provider staff.

5.105 ***Term of Reference 10:*** *Are there any cultural issues or barriers which may have impacted upon the family's engagement or interactions with services and were these given due consideration?*

5.106 There were no cultural issues identified by the agencies taking part in this Review. No religious beliefs were found which might have affected any decision making.

5.107 In terms of barriers which may have impacted on the family's engagement with services, we know that David's feelings of being stigmatised by having involvement with Mental Health Services played a part. His resistance to accepting services was also a major barrier. Any hope that he might have felt less stigmatised by accessing his GP instead of a mental health professional proved elusive, and his mother had no success in influencing his views.

5.108 The GP IMR hypothesised whether David's mother, who was considered to be a protective factor, might have been reticent to come forward with concerns about his mental health due to her own fears that he may sectioned for a second time. The last time she raised concerns was in May 2016. This may be reasonable conjecture; in his interview with the psychiatrist for his trial David blamed his mother for being in hospital under Section in 2007. We do not know if she knew that he blamed her at the time or since however. Alternatively, a family member believes David's mother was reaching the end of her tether with trying to cope with him around 2016, and she was spending an increasing amount of time staying with her partner, thus she may have been unaware of his deteriorating mental health. The attendance of the Police responding to David's 999 calls in December 2017 do not record any family member at home during their visits. The strain of working and coping with David since 2006 may have been a barrier to David's mother being able to carry on actively interacting with services on his behalf.

5.109 The Panel discussed the need for family 'education' about the mental illness with which their family member is suffering to increase their understanding, ability to help manage the symptoms, and to recognise behaviours which increase risk and require help. Max's elder sister was supportive of this statement and felt it was very important for families to fully understand the mental illness their relative was experiencing. There is a strong sense from the information in this Review that neither David's mother nor Max fully understood his illness. Max told an interviewing Police officer in March 2017 that he did not think that his (David's) condition had been clarified, but that he was on anti-psychotic medication. On one occasion David's mother appears to have recognised when his mental health was deteriorating for in May 2016 she discussed her concerns about him with a GP and it was noted that she thought the mental health lead GP may refer to a community psychiatric nurse (paragraph 3.74). However, her concerns did not stretch to any consideration of in-patient care (had that been assessed as necessary); she did not want him 'taken from her'. David's mother may not have had an understanding of the consequences of a relapse in David's mental health, although her previous experience when he was under the care of the Community Mental Health Team must have given her some understanding of the role of a community psychiatric nurse hence she saw such a referral as an appropriate route to support. However, in interview with the Police during their enquires his mother seemed to think he still had a key worker, which he did not, suggesting she was not fully au fait with his situation in 2017/18. Without David's mother's contribution it is not possible to gain a picture of her level of understanding about his actual diagnosis. However, lack of in-depth knowledge could have been a barrier to the family's ability to fully understand the risk level of any deterioration in David's health and when he and they needed to have support from specialist services.

Recommendation:
All Services, both statutory and voluntary, involved in supporting those with mental ill-health and their families should ensure that family members are given sufficient information about their relative's diagnosis which contains, how to best support them; a relapse plan including when and who to contact in the event of deterioration in the service user's mental health, and which explains and identifies

5.110 ***Term of Reference 11:*** *Over the period of time covered by this Review two criteria applied for assessing an adults' vulnerability. Up to March 2015 a 'vulnerable adult' was defined by the Department of Health 'No Secrets' guidance as:*

> *"An adult (a person aged 18 years or over) who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or serious exploitation." No Secrets, Department of Health 2000*

Under the Care Act 2014 which was enacted in April 2015 the term 'an adult at risk' was adopted. An 'adult at risk' is considered in need of safeguarding services if she/he:

a) has needs for care and support (whether or not the authority is meeting any of those needs),
b) is experiencing, or is at risk of, abuse or neglect, and
c) as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.

Were any family members or the perpetrator assessed as a 'vulnerable adult' pre-31 March 2015 or an 'adult at risk' post 1 April 2015? If not were the circumstances such that consideration should have been given to such an assessment?

5.111 As David was discharged from Mental Health Services in 2013 the Department of Health No Secrets definition of a 'vulnerable adult' applied at that time. The Service's IMR found that no member of the family or the perpetrator were identified as such during their involvement. However, the IMR considered that the incident in November 2006, where David's brother tried to force him to take his medication (paragraph 3.4), should have been reported as a Safeguarding matter. The incident was indicative of the frustration and friction developing in the family and if reported may have led to further support at a time of crisis for all the family. However, it is arguable that the stress in the family at that time should have brought about extra support regardless of safeguarding procedures being invoked.

5.112 None of the family nor the perpetrator were considered vulnerable adults by the GP practice. There was no reference to David being considered as vulnerable in any correspondence available to the practice. The GP IMR found that on the evidence available to the GPs he would not have reached the threshold for an 'adult at risk', notwithstanding the missing information that was available to other agencies.

5.113 In June and July 2011 David was living independently in a flat and in one contact with the Police he mentioned a male had recently been using his flat, but he had managed to get rid of him. David had appeared nervous when he told the Police that he only knew the male from drinking in a local park. The officer had noticed that David was of small build and may be taken advantage of by drinkers using his flat to drink and

take drugs (paragraph 3.44). He had also reported to Police a man on scaffolding peering into his flat, and a 'friend of a friend' had tried to gain access. The Police appear to have recognised his vulnerability; they gave David a direct number to call should they return, and the building security guard was made aware to prevent access to the building (paragraph 3.47). This was good practice. David said he felt he may be a target for drug dealers and users on the estate as he is vulnerable due to his mental health issues (paragraph 3.45). This is strongly suggestive of David being a victim of 'cuckooing'. When cuckooing takes place either force is used against a vulnerable resident, or they are 'befriended', with the primary aim of acquiring their home for the purposes of supplying and dealing drugs; dealers will specifically pursue 'vulnerable individuals who attend recovery groups, dependency units, and areas associated with those experiencing problems'[45]. Those reported as having had their homes appropriated by such dealers include those with drug dependency, disabilities, mental health issues and the elderly[46]. David had drug dependency and mental health issues.

5.114 During the thirteen times that David was stopped by the Police prior to March 2015 there was no indication that he was a 'vulnerable adult'. On the two occasions in November 2012 that his mother went to the Police on his behalf to report the theft of his mobile phone his mental health was discussed. It was evident from the report of this matter that his mother was taking an active role in protecting his interests, therefore he was judged to be sufficiently supported. Her actions at that time probably indicated that she was also not a 'vulnerable adult', nor would Max have met the criteria as an 'adult at risk' after the incident the Police attended in March 2017.

5.115 Following the introduction of the Care Act the definition of 'vulnerable adult' changed to an 'adult at risk' in April 2015. David was stopped on one occasion and the IMR reports how although his mental health issues were not identified, he was reported as having the 'appearance of a drug addict'. He was not assessed as 'at risk' on this occasion.

5.116 During the next five occasions when the Police had contact with David and/or his family his mental ill-health was clearly identified, and on four of those occasions he was judged to be an 'adult at risk'. This resulted in officers creating a MERLIN for an adult at risk which was shared with Adult Social Care as discussed earlier.

5.117 Adult Social Care had no direct contact with the family to enable vulnerability to be assessed. They forwarded the one MERLIN they opened from the Police to Mental Health Services as David was known to them. They would have forwarded the two unopened MERLINs to Mental Health Services had they been opened and the contents read.

5.118 Shepherds Bush Housing Group contact was very brief, consisting of just two phone calls from (it is assumed) David and Max's mother regarding a neighbour. Therefore, they had no cause or opportunity to assess vulnerability.

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[45] Spicer J, Moyle L & Coomber R '*The variable and evolving nature of 'cuckooing' as a form of criminal exploitation in street level drug markets'* published online June 2019, Trends in Organized Crime https://doi.org/10.1007/s12117-019-09368-5

[46] National Crime Agency (2016) County lines gang violence, exploitation and drug supply. NCA, London cited in Spicer J, Moyle L & Coomber R '*The variable and evolving nature of 'cuckooing' as a form of criminal exploitation in street level drug markets'* published online June 2019, Trends in Organized Crime https://doi.org/10.1007/s12117-019-09368-5

6. Conclusions

6.1 The death of a loved one is always tragic and painful, especially so when a young family is left without a husband and father. The killing of one brother by another brings an additional form of devastation for all the family. Max only stayed in the family home in the UK periodically, and when there he would be out at work during the day. David told the psychiatrist assessing him that he stayed out of Max's way as much as he could when he visited, thus Max may have been unaware of the extent of David's deteriorating mental health and the risk he posed.

6.2 As in so many Domestic Homicide Reviews and Serious Case Reviews, this DHR finds information which could and should have been shared was not, which resulted in professionals working in silos, without the information they needed to construct a full picture of what was taking place, in this case in the perpetrator's life. For the victim was practically unknown to services. The failures to deliver information where it was needed were partly individual oversight, but mainly systems failures.

6.3 The lack of full multi-agency understanding about the Police vulnerable adult MERLIN risk assessment notification system came to light during the Review. A lack of clarity regarding the MERLINs and the ability to share the information with third parties such as GPs was identified as in need of resolution. However, the most significant problem was the systems failure where MERLIN emails were not opened due to technical problems with secure email in Adult Social Care, plus the omission of the notification to the GP practice in March 2017 following David's assessment in custody for assaulting Max.

6.4 Risk assessment tools for use with those living with mental illness are inadequate for guiding GP's assessments, particularly for assessing risk to others, and for assessing the additional risk where the co-morbidity of substance misuse mental illness exists. The additional risk and complexity which substance misuse and mental illness brings is well recognised in Domestic Homicide Reviews, both in cases of intimate partner violence and adult family violence, as referenced in this report. It is therefore important that this is recognised in risk assessments and the tools which guide all professionals working within the field of mental illness. Risk assessment tools are not an infallible remedy for judging risk however, and they are only really relevant at the time at which they are completed; risk changes over time, however, if well designed they are a useful prompt for the areas which need to be considered; they are not a replacement for experience and professional judgement which should be informed by knowledge of the research on these matters to augment that professional judgement. This in turn needs supporting with training which covers these areas.

6.5 The perpetrator's history shows that he was resistant to mental health treatment, avoidant of support, and fervently wanted nothing to do with Mental Health Services. Where this attitude came from, we will never know. Only the assertive and persistent practice of his mental health care coordinators overcame this although even their efforts were a qualified success since no practitioner managed to secure him a sustained placement in training, work, or any activity. Faced with the need for this level of support and persistence from a dedicated mental health team, a GP practice was never going to have the capacity to replicate this practice. It is therefore not altogether surprising that a process of letters and phone calls failed to achieve his engagement in the GP review system. This lack of engagement and failure to collect prescriptions should perhaps have warranted re-referral to the West London NHS Trust. Had the information from the Police MERLINs in December 2017 been known a re-referral would undoubtedly have taken place.

6.6 Unfortunately, neither Max's wife nor his mother felt able to contribute to this Review. However, from the information we have it appears that his mother and other members of the family, including Max, did not have a full understanding of David's mental health diagnosis and symptoms, any risks which might arise, or what to do if David relapsed. David's mother did not attend all his reviews and she was not invited to his discharge meeting by Mental Health. She was also not recognised as his carer by the GP practice and referred for a carer's assessment with the attendant support that may have offered. There was a need for a 'whole family approach' as it is clear from this case that David's mental illness impacted on everyone in the family, in the end with tragically fatal results. Family members need 'educating' about their relative's illness, and how and when to find support.

7. Lessons to be Learnt

7.1 The following learning emerged as a result of the review. There was also early learning during the process and some action has already been taken or commenced without waiting for the completion of the review.

Information Sharing:

7.2 In common with the majority of DHRs this Review found that information sharing in its various forms was found to be inadequate or not to have taken place. This was either due to oversight by individuals or to a breakdown in systems, and that breakdown not being reported or picked up by management.

7.3 The importance of adequate patient discharge information by Mental Health Services to the receiving GP practice has been highlighted. GPs need to know about the nature of the support the patient has received, the level of their engagement in treatment, any relapse plan, and methods and thresholds for re-referral.

7.4 Since the perpetrator's involvement with Mental Health Services ended in 2013 discharge procedures to GPs has changed and improved as part of the Shifting Settings of Care programme which commenced in 2014. An intention to discharge letter is now sent to the GP, and the GP is given the opportunity to respond. However, the GP practice concerned was not fully aware of all of the changes, indicating that further publicity and updates are required for GP practices. Further improvements on this aspect of information sharing and discharge procedures were noted as early learning and form part of the recommendations. The West London NHS Trust is already underway with a consultation on the content of their discharge template and the findings from this Review will feed into this process.

7.5 Opportunities to inform the perpetrator's GP of his contacts with the Police did not take place. This meant his GP was lacking information about his behaviour and incident which would have informed risk assessment. This was due to individual shortcomings and lack of supervisory oversight on one occasion i.e. no email was sent to the GP as per procedures, and a systems failure where emails containing Police vulnerable adult notifications could not be opened and forwarded, and the technical failure was not reported to management. The jigsaw of pieces which would have given a picture of the perpetrator's deteriorating mental health and concerning behaviour were not visible to Mental Health Services or his GP who could have acted in an attempt to manage and change his behaviour. The importance of sharing information in these circumstances cannot be overstated.

7.6 Practitioners rely on effective IT tools to help them do their jobs. In this case a crucial email system used by Adult Social Care's Intake and Advice Team to collect Police MERLINs failed to open. This meant vital MERLINs could not be assessed and forwarded to Mental Health Services which would have alerted them to the perpetrator's deteriorating mental health in the months leading up to the homicide. This problem should have been reported immediately to management to be remedied without delay.

7.7 The discovery of this problem formed another part of the early learning in this Review, and as mentioned in the Analysis section, it has already been acted upon and a new email system has been purchased. It is vital that such important IT systems work.

The Importance of Mutual Understanding and Ownership of Multi-agency Processes:

7.8 It emerged midway through the Review that there was a lack of clarity about how the MERLIN system is perceived and understood by different professionals, agencies, and members of the public. The confusion ranged from whether the notifications were referrals through to the legality of being able to share this third-party information. An assumption was held that all MERLINs were shared with GPs, but this turned out not to be the case.

7.9 There is a strategic level lesson here for senior management. When introducing a system which requires multi-agency information sharing agreements and protocols there is a need to engage and consult with partner agencies before implementation. Adults at risk and their families deserve support and protection, therefore the MERLIN system has an important role to play and should remain, but with a more error-proof and timely system understood and agreed by all.

7.10 It is also important that MERLIN notifications are calibrated correctly, so the level of concern and the content of the MERLIN genuinely reflect the seriousness of a vulnerable person's situation. This would reduce any risk of complacency in the system.

7.11 As a result of this early learning the Interim Head of Safeguarding Adults (Adult Social Care) agreed to form a focus group with partners to explore improvements to the operational process of MERLINs.

Risk Assessment:

7.12 The risk assessment tool used by GPs forms part of the template they are required to complete when reviewing patients with mental illness; this was found to be inadequate in supporting practitioners to assess risk where mental illness and substance misuse coexist. The parts of the template guiding assessment of risk to others, particularly family members, is in need of a greater breadth of information to inform risk such as relationships, family stressors, family violence etc.

7.13 The West London NHS Trust mental health risk summary has seen improvements particularly around the identification of domestic abuse. However, illicit drug and alcohol use are recorded within a 'dynamic factors' section. A more prominent display of these risk factors would be beneficial. The existing assessments for GPs and Mental Health Teams would benefit from review so that they take account of research on psychosis and schizophrenia with co-morbid substances misuse and family violence and abuse.

7.14 Risk assessments can only really provide a picture of risk at the time of their completion. They need regular review when circumstances change, or events suggest an alteration in a service users' mental health status. Professional judgement born out of experience also plays a vital part in assessing risk. This needs valuing and supporting with training, especially relating to changes in risk assessment tools, and be backed up with knowledge of research and management or peer supervision.

Practice Challenges when a Service User Disengages:

7.15 This Review has highlighted the difficulties practitioners face when confronted with a service user who rejects support, is resistant even to accepting routine health care connected with his diagnosis, and who disengages from all services. This is compounded when the person is not unwell enough to be compelled to accept treatment under the Mental Health Act, is deemed to have mental capacity, and is a self-determining adult.

7.16 The Review has made visible the challenge faced by GPs when trying to manage such a patient as David in general practice. In addition to his rejection of GP appointments, the mental health lead GP was in the dark about his contacts with the Police, the knowledge of which would have informed their risk assessment and re-referral to secondary Mental Health Services. Whereas David's earlier involvement with the Mental Health Service was able to achieve his engagement by assertive and persistent practice, home visits etc. this approach is not possible in general practice. The best alternative has to be to re-refer a disengaged patient who is on the practice serious mental illness register back to specialist Mental Health Services. However, the Review is advised that there would need to be identified risks and further reasons for a re-referral not just a failure to engage by a patient.

Training:

7.17 Most of the agencies in the Review report that domestic abuse training is a component of Safeguarding training, both safeguarding children and adults. The GP practice and some staff within West London NHS Trust had received a separate session delivered by the local specialist domestic abuse service Standing Together the focus of which was intimate partner abuse and children. Training in adult family violence and abuse is absent.

7.18 There is a need for local training dedicated to adult family violence which includes findings from research in this area, including the case studies from the analysis of DHRs cited in this Review. Given the strong links with mental illness and substance misuse in family violence homicides, it is essential that Mental Health Team staff and GPs, in addition to all those involved in assessments have this training.

Family Support

7.19 The fact that family members appeared to be unclear about the perpetrator's mental illness diagnosis and the support he received in recent years, indicates the importance of taking a 'whole family approach', especially where the person with the mental illness is living within the family home.

7.20 Professionals working with those living with mental illness need the information and support of family members to assist with planning and the provision of effective care, but this needs to be a two-way process as identified by the Carer's Trust research and

guidance Triangle of Care[47]. Family members need to be supported with education about their relative's diagnosis, managing symptoms and relapse, identification of risk, and who to contact about any difficulties or concerns. Whilst appreciating the ethos of, and need for, patient confidentiality, if the patient is living within the family home, it seems only reasonable that the family should have all the knowledge they need to support their relative and to be able to recognise risk to themselves. This can be achieved if the information shared does not contain personalised data, for example explaining the diagnosis, providing information already in the public sphere, and the use of a carer's plan.

7.21 A family member contributing to the Review suggested that David's mother may have been reaching the end of her tether in the last few years. She and other family members had been coping with David's sometimes confrontational and difficult behaviour for at least 12 years since his diagnosis in 2006, and there are examples within the Review of tensions between David and his elder brothers resulting in assaults. In such circumstances it is not unexpected that this would take its toll and possibly result in carer stress, frustration, and inability to cope any longer. This needs to be recognised by services and meaningful support provided.

7.22 The Review learnt that previously a carer's support group had been shared with a neighbouring Borough and this meant some distance had to be travel by those in Hammersmith to reach the service. The Borough has now commissioned the Carer's Network to deliver the Carers Hub to support those over the age of 18 who provide unpaid care to residents of Hammersmith and Fulham.

7.23 The services the Carers Hub provide includes carers assessments, support plans and indicative personal budgets; legal advice; information, advice and guidance on a range of topics; and signposting to other services where appropriate. Referrals for an assessment can be made to the Carers Network from the Borough Council, other professionals or as a self-referral. Council social workers are also able to conduct carers assessments as part of their work with the cared for. Whether David's mother would have accessed such a service now that it is available locally is not known, but the fact that such support is provided locally is to be welcomed and should be publicised throughout the Borough.

Family Suggestion:

7.24 David may not have been considered a vulnerable adult or adult at risk, but his elder sister believed that in the early stages of his mental illness when he became socially isolated this could have been helped by having a mentor who was unconnected with Mental Health Services. She thought David's lack of social skills and isolation may have been gradually overcome with the help of a mentor, and this may have supported him into social activities, friendships, possibly into work, and his life and that of Max may have taken a different turn with earlier intervention. Ideally, he would have needed a mentor when he was 15 or 16 years old before his drug use became firmly entrenched. This was not an option offered to David as a teenager, however, it is a valuable suggestion and one which services could consider for young people who are in a similar position as David was years ago. Early intervention can be an effective strategy for reducing future harm.

[47] The Triangle of Care Carers Included: A Guide to Best Practice in Mental Health Care in England. 2nd Edition 2013. The Carer's Trust.
https://professionals.carers.org/sites/default/files/thetriangleofcare_guidetobestpracticeinmentalhealthcare_england.pdf

8. Recommendations

8.1 The recommendations below have been developed from the learning arising from the Review analysis, Panel discussions, and the individual agency recommendations.

National Level

Home Office:

Recommendation 1:
It is recommended that the Home Office provide a copy of all DHRs where mental ill-health is a component to the Secretary of State for the Department of Health and Social Care and the lead minister for mental health for their information and to inform policy and decision-making, and that they work on the specific area of domestic abuse and mental ill-health with the national Domestic Abuse Commissioner.

Department of Health & Social Care:

Recommendation 2:
The Secretary of State for Health & Social Care, and the lead minister for mental health to note the contents of this Domestic Homicide Review giving particular attention to the risk assessment of those with a co-morbidity of psychosis and substance misuse, and review the efficacy of current risk management tools, and the resources available to support this specific patient group.

Recommendation 3:
That the Department of Health & Social Care provide resources to support the safe and effective working of the Shifting Settings of Care policy by:

a) the provision of increased access to specialist mental health resources to support Primary Care in managing patients deemed sufficiently stable for this level of care.

b) the provision of resources to Community Mental Health Teams to increase their capacity to support Primary Care in their management of those with serious and enduring mental health treatment needs, and to facilitate threshold levels suitably calibrated for patients to be returned to their care who cannot be managed in Primary Care.

NB The Panel wish to commend the national project for all Emergency Departments called Commissioning for Quality and Innovation (CQUIN) Frequent Attenders. The project involves a health professional conducting home visits to vulnerable frequent attenders to A & E, and with close multi-agency working, aims to solve the patient's health and related social problems to prevent repeated contact with emergency services and A & E. Whilst the opposite problem was the case in this DHR i.e. failure to keep multiple appointments and concordance with medication was a problem, such a proactive assertive model as the CQUIN Frequent Attenders would have been beneficial for the perpetrator and his family, as well as services.

Local Level

Multi-Agency:

Recommendation 4:
The current children's 'Multi-agency Safeguarding Hub' (MASH) and vulnerable adult 'Safeguarding Hub' arrangements within the Borough should be reviewed by September 2019 to ensure that a multi-agency information protocol is established

to share information, which identifies risk to inform action by the appropriate agency. This should be compliant with current safeguarding and data legislation.

Recommendation 5:

All practitioners and their managers working in the community involved in the assessment and management of those with mental health treatment needs with co-morbidity substance misuse should ensure that assessments are; informed by family or carer contributions where safe and appropriate; take into account and consider research on psychosis, schizophrenia, and coexisting substance misuse in risk assessments. When circumstances change in such cases they should be discussed in supervision, or via peer support as appropriate to organisational structures.

Recommendation 6:

Training in adult family violence and abuse which includes DHR findings should be embedded in dedicated domestic abuse training in line with NICE Guidelines (2017)[48]. The course should include steps for practitioners to take, risk assessment, and referral to MARAC, whilst maintaining the issue as relevant to safeguarding. The training should be undertaken by all those whose role involves assessments, supporting service users or their carers who work in the Mental Health Services, GP practices, Children and Adult Social Care, and Housing provider staff.

Recommendation 7:

All Services, both statutory and voluntary, involved in supporting those with mental ill-health or their families should ensure that family members are given sufficient information about their relative's diagnosis which contains, how to best support them; a relapse plan including when and who to contact in the event of deterioration in the patient's mental health, and which explains and identifies risks.

Adult Social Care:

Recommendation 8:

Awareness raising should be undertaken within the Borough by Adult Social Care with GP practices to publicise the criteria and pathway for a carer's assessment referral. This should aim to be completed by the end of 2019.

West London NHS Trust:

Recommendation 9:

Mental Health Trust discharge letters to GPs to include a summary of the quality of the patient's engagement with the service, the patient's next of kin (or carer if different) and their level of involvement, whether a carer's assessment has been completed, and if not why not. This will be dependent on the next of kin or carer's consent. Discharge summaries to include this information from July 2019 onwards.

Recommendation 10:

That the West London NHS Trust review the current risk summary with a view to having specific questions listed on illicit drugs and alcohol which are easily visible, rather than recording these substances in the 'dynamic factors' section of the risk assessment.

[48] http://pathways.nice.org.uk/pathways/domestic-violence-and-abuse. NICE Pathway last updated: 03 August 2017 This document contains a single flowchart and uses numbering to link the boxes to the associated recommendations. It is designed to be used online.

Recommendation 11:
Regardless of whether MERLIN information indicates that a GP has been informed, the Single Point of Access should notify a patient's GP that they have been assessed by a member of Trust staff and give details of the MERLIN content, the nature and place of that assessment, risk identified, and whether weapons have been involved in an incident.

Recommendation 12:
That MARAC training is made available for all Team's staff and is arranged to be delivered by an external organisation on a two-year cycle. (IMR recommendation). (the author received confirmation this will be implemented by the Teams where it is not already arranged).

Recommendation 13:
That West London NHS Trust Criminal Justice Liaison and Diversion Services implement their draft operational policy in order that their practitioners are clear regarding the obligation to inform GPs of their interventions with referred clients. This will be achieved by ensuring practice issues such as information sharing with GPs remains as a standing item at their monthly Clinical Improvement Group. Furthermore, that Rio documentation is also discussed and reviewed with practitioners at their monthly clinical supervision sessions. (IMR recommendation).

Recommendation 14:
Where contact by telephone with carers has not been successful, then a letter and/or an email should be sent, with the details of any CPA meetings or reviews to which they are being invited. (IMR recommendation)

West London NHS Trust & GP Practice:

Recommendation 15:
A range of information resources (leaflets, websites etc) on specialist voluntary and statutory services which includes sources of support for family members should be given to the family of those living with mental ill-health and substance misuse, and also made available in waiting areas. Resources should be in place by July 2019.

Clinical Commissioning Group:

Recommendation 16:
Using the facilities of the Trust Transformation Work Programme, and in consultation with GP mental health leads and West London NHS Trust, CCG mental health leads to develop a protocol which can be rolled out to all GPs in the area to ensure consistency of approach which:

a) identifies when to escalate patients failing to engage with their GP.
b) determines appropriate thresholds,
c) agrees action/care plans, and ownership of risk.
d) agrees information to be shared

Recommendation 17:
When a review of the SystmOne database takes place it is recommended that the Clinical Commissioning Group takes steps to establish whether a page viewable only by GPs which records information giving a picture of accumulative risk factors to or from a patient could be included on the system to optimise risk assessments and improve visibility of risk factors. Consultation with GPs is recommended when this takes place

Clinical Commissioning Group and GP Practice:

Recommendation 18:
That the Mental Health Lead for the Clinical Commissioning Group (CCG) and GP Practice lead for mental health liaise regarding the most effective local structure for convening a quarterly Primary Care Network meeting of mental health professionals which should include West London NHS Trust, CCG, primary care mental health practitioners, and GP mental health leads in its membership, with the aim of facilitating knowledge sharing, updates in protocols, and partnership working. This Network meeting should aim to be in place by September 2019.

Recommendation 19:
That revisions take place to the GP Mental Health Assessment risk assessment page to provide a comprehensive list of areas to cover which includes substance misuse, domestic abuse, both as perpetrator and victim, and the quality of family relationships including any tensions.

Metropolitan Police:

Recommendation 20:
It is recommended that officers involved in the Grip & Pace and Local Policing Team (ward officers) are debriefed regarding the recording and completion of the home visit to the perpetrator on 22 January 2018. (IMR recommendation)

Recommendation 21:
It is recommended that Central West BCU Senior Leadership Team dip sample incidents handled within the Grip & Pace and completed by Local Policing Teams to ensure that this is effective, recorded properly and complies with MPS Anti-Social Behaviour policy. (IMR recommendation)

NB
The GP Practice made three recommendations which required a strategic level approach. Recommendations 3, 9, 16, 17 above have been developed with the aim of enabling the GP Practice recommendations to be achieved. The GP Practice recommendations concerned the following:

1. Clear guidance on what is reasonable practice in relation to patients with serious mental illness who do not engage with clinical review and treatment despite repeated attempts to make contact, and risk level is unknown was judged to be needed. This should consider the whole system around the patient, including primary care, who ultimately hold the risk of the non-engaged patient, notwithstanding the individual agency's duty of care in relation to risk.

2. There is a need for better information sharing with specific consideration for the current (unsatisfactory) system of separately held health agency clinical records. High importance inter-agency information sharing (for example a significant change in risk status or requests for action in relation to high risk patients or situations) need to be through mutually agreed safe systems with “closed” loops. This should ideally be through verbal communication to the relevant responsible individual (i.e. not simply the administrative part of the system) supported by written communication. Confirmation of receipt should be sent by the relevant responsible person to the sender.

3. A single “care plan” with collated known risk factors, mitigations, and escalation plans should be used by all agencies with a duty of care to patients with serious mental health diagnoses. Ideally this would be held as a single clinical record.

APPENDIX 1

Recovery East Team
Avenue House
43/47 Avenue Road
Acton, London W3 8NJ

Tel: 020 8483 1720
Fax: 020 8483 1790

GP Surgery
GP Address

Date

Notice to GP of Intention to Discharge
For discharge of patients from secondary mental health care to primary care

Dear Dr

Re: NAME - DOB:
ADDRESS:
NHS Number: RiO ID:

CPA Status:

I am writing to let you know that I recently talked to **…….** about being discharged from our service. We are agreed that this is now appropriate.

Discharge Summary

BRIEF DESCRIPTION OF INVOLVEMENT WITH OUR SERVICE

Psychiatric Diagnosis & ICD 10 code –

Medical Conditions:

Psychiatric Medication:

Physical health Medication:

- ☐ It is proposed to discharge to **Primary Care (normal discharge)**
- ☐ It is proposed to discharge to **PRIMARY CARE MENTAL HEALTH SERVICE (PC+ for H&F and Hounslow)**

This is a notification of the intention to discharge **……..** back to your care. If you are in agreement with this plan please return the slip on last page as soon as possible and within 2 weeks. You will be sent a Community Discharge letter/care plan on the discharge date. We will also encourage **……** to contact you on discharge to discuss their on-going care plan in primary care.

Crisis plan

Phone: 0300 1234 244
Email referrals to: wlm-tr.wlmhtSPA@nhs.net (Faxes no longer accepted)

In an emergency, e.g. highly agitated or otherwise unsafe or suicidal, make contact with mental health services in the following way:

9-5:
(1) Call 24hr Single Point of Access (SPA): 0300 1234 244
(2) Attend the Emergency Department at Ealing Hospital or nearest hospital if not in Ealing.

5-9:
(1) Call 24hr Single Point of Access (SPA): 0300 1234 244
(2) Attend the Emergency Department at Ealing Hospital or nearest hospital if not in Ealing
(3) If at home and it is an emergency and unable to attend hospital - either call 999, or call the Ealing Emergency Duty Team on 020 8825 8000.

Details of any advance decision/s

None known

If you have any concerns about the discharge plan, please contact me on the telephone number provided as soon as possible. If you would prefer me to call you then please indicate on the slip attached.

I look forward to hearing from you.

Yours sincerely

C.C: Social Worker/Discharge Coordinator, Ealing Recovery East Team
C.C: patient's name

APPENDIX 2

West London
NHS Trust

GP Name
GP Address

Recovery East Team
Avenue House
43/47 Avenue Road
Acton, London W3 8NJ

Tel: 020 8483 1720

Date [Enter Date]

Discharge Summary Letter – Secondary to Primary Care (FORM: MH5.3)

Dear Dr [Enter name of GP]

Re: **<Patient Name> - <Patient DOB>**
<Patient Address line 1>
<Patient Address line 2>

NHS Number: RiO ID
CPA Status: [Care Programme Approach or Lead Professional Care] *delete as appropriate*

Following our recent communication, I am discharging **[Patient name]** back to your care. We have asked **[patient name]** to get in contact with you and make an appointment. I hope the following information is helpful in the future management of your patient's care. If you require any further information, please do not hesitate to contact me.

Discharge Formulation
[Include as clinically relevant full/ partial remission at discharge, support in the community, social network, personal history, access to or interest in employment at time of discharge, interest or involvement in particular recreational activities, drugs and alcohol use, significant findings on mental state examination including degree of insight]

Diagnosis
ICD 10 Code: [Include both mental and physical health conditions]
<ICD 10 Code>
<ICD 10 Code>

Patient's understanding of diagnoses

Physical health
[Include weight/BMI, smoking status, drug and alcohol use, latest values of blood results]

Treatment/Care Plan

[Include specific itemised interventions e.g. referral to other agencies, advice to GP other than medication]

Medication
Known adverse drug reactions:

Medication, dose, frequency, formulation and indication:

Initiated by CNWL/WLMHT:
[Include monitoring requirements for any psychotropics, compliance, date that next prescription is due, future supply arrangements and any future management plans particularly relating to medication and its continuation/ withdrawal latest values of blood results]

Initiated by GP/other:

Risk Issues
[Current and historical risk issues including: risk of noncompliance, risk of social withdrawal, known dependents including children, self harm, harm to others, self neglect, exploitation]

Known relapse indicators
[Early warning signs of relapse]

Crisis plan
[Itemise the key actions and contacts in the event of a crisis]

Phone: 0300 1234 244
Email referrals to: wlm-tr.wlmhtSPA@nhs.net (Faxes no longer accepted)

In an emergency, e.g. highly agitated or otherwise unsafe or suicidal, make contact with mental health services in the following way:

9-5:
(1) Call 24hr Single Point of Access (SPA): 0300 1234 244
(2) Attend the Emergency Department at Ealing Hospital or nearest hospital if not in Ealing.

5-9:
(1) Call 24hr Single Point of Access (SPA): 0300 1234 244
(2) Attend the Emergency Department at Ealing Hospital or nearest hospital if not in Ealing
(3) If at home and it is an emergency and unable to attend hospital - either call 999, or call the Ealing Emergency Duty Team on 020 8825 8000.

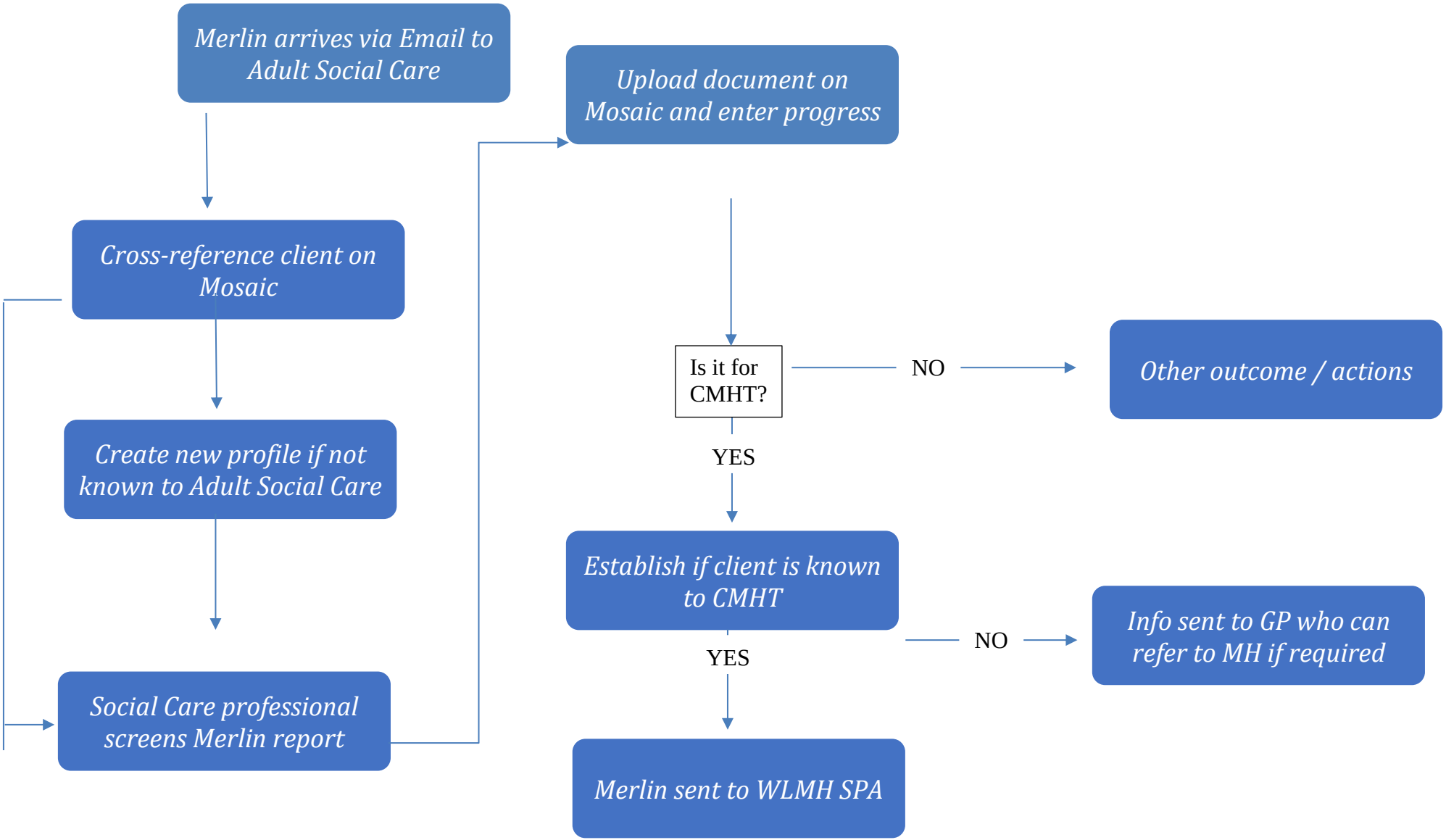
Details of any advance decision/s

None known

Yours sincerely

cc: [Patient's Name]

APPENDIX 3


Merlin arrives via Email to Adult Social Care
Cross-reference client on Mosaic
Create new profile if not known to Adult Social Care
Social Care professional screens Merlin report
Upload document on Mosaic and enter progress
Is it for CMHT?
NO
Other outcome / actions
YES
Establish if client is known to CMHT
NO
Info sent to GP who can refer to MH if required
YES
Merlin sent to WLMH SPA

APPENDIX 4

SOURCES OF SUPPORT FOR FAMILIES AND CARERS

Support for those with mental illness and for family members:

- MIND - https://www.mind.org.uk/
- Rethink Mental Illness: https://www.rethink.org/about-us.
- Mental Health Foundation: https://www.mentalhealth.org.uk/
- Mental Health Support: http://www.mentalhealthsupport.co.uk/carers.html
- https://www.nopanic.org.uk/
- https://www.mentalhealth.org.uk/our-work/learning-disabilities

Support for family/carers of those using drugs:

FRANK: https://www.talktofrank.com/get-help/worried-about-a-child
Helpline number: 0300 123 66 00

ADFAM: https://adfam.org.uk/

DRUGFAM: https://www.drugfam.co.uk
Helpline number: 0300 8883853

FAMILIES ANONYMOUS: http://famanon.org.uk/meetings/meetings-in-the-uk/
Helpline number: 0207 498 4680.

- Advice for families of drug users: https://www.nhs.uk/live-well/healthy-body/advice-for-the-families-of-drug-users/

Support and Mentoring:

The Richmond Fellowship: Richmond Fellowship's services work hand-in-hand with the people they support to give them the confidence and self-belief that they have an important contribution to make in society.
https://www.hfemploymentandwellbeing.org.uk/about-us/

Family Friends - A charity a providing a network of trained volunteers who provide befriending and mentoring services to help families and children up to 16yrs living in Kensington & Chelsea, Hammersmith & Fulham and South East Brent.
https://www.familyfriends.uk.com/about-us

APPENDIX 5

Home Office Letter

Home Office

Public Protection Unit
2 Marsham Street
London
SW1P 4DF

T: 020 7035 4848
www.gov.uk/homeoffice

Felicity Charles
Community Safety Manager
Community Safety Unit
Hammersmith & Fulham Council
Town Hall, King Street
Hammersmith
London W6 9JU

Dear Ms Charles

Thank you for submitting the Domestic Homicide Review (DHR) report (Max) for Hammersmith and Fulham CSP to the Home Office. Due to the COVID-19 situation the Quality Assurance (QA) Panel was unable to meet as scheduled on 27 May 2020 therefore the report was assessed by a virtual panel process. For the virtual panel, Panel members provided their comments by email, the Home Office secretariat summarised the feedback and the Panel agree the feedback.

The QA Panel found this to be a very thorough review. They noted that it is easy to follow and read with strong recommendations. The Panel felt the pen picture from the friends was powerful and sets a tone for the rest of the report. Whilst, understandably, much of the report is perpetrator focussed, the section from Max's friend ensures Max is at the heart of the review. The Panel commended the attempts made to engage with friends and family using the methods that best suited them and the efforts made to keep them updated throughout the review process.

The QA Panel felt that there are some aspects of the report which may benefit from further revision but the Home Office is content that, on completion of these changes, the DHR may be published.

Areas of final development include:

- The Panel thought that there are several indications that "cuckooing" was happening in this case i.e. that David was being pressured as a vulnerable person at risk by an undesirable individual looking to exploit him at his home address. The Panel thought it would be helpful to identify this as "cuckooing" and reference relevant research on

this phenomenon. The Panel also thought there could be learning identified around action to support people in David's situation and to raise awareness of "cuckooing".

- The Panel would like to see a footnote added to explain what Grip and Pace control is.
- The Panel felt that the delay in completing the report was only partly explained and would like further explanation.
- 5.47 refers to a recommendation to address a missed opportunity however the specific recommendation is not included within the report from this IMR (all other recommendations have been inserted into the tables at the point they are addressed). This is also the same for para 5.65 re: police recommendation from IMR – also missing and should be inserted.
- Report refers to appendices but these are not attached to the report e.g. para 5.79 – Appendix 3.
- The Panel would like some clarification around para 5.98. It refers to training delivered by Standing Together / Advance, however the Panel thought it would be helpful to clarify which of these two organisations delivered the training.
- Please check the following paragraphs for typos and correct tense. 3.10, 3.35, 3.36, 3.70, 5.31, 5.54, 5.55, 5.78, 5.88, 5.91.
- The Equality & Diversity section could be strengthened by reference to the impact of the perpetrator's mental health issues.
- Paragrapg 5.3 – The recommendation has been written twice.

Once completed the Home Office would be grateful if you could provide us with a digital copy of the revised final version of the report with all finalised attachments and appendices and the weblink to the site where the report will be published.

Please send the digital copy and weblink to DHREnquiries@homeoffice.gov.uk. This is for our own records for future analysis to go towards highlighting best practice and to inform public policy.

The Home Office felt it would be helpful to routinely sight Police and Crime Commissioners (PCCs) on DHRs in their local area. Due to this, the Home Office will copy this letter to your local PCC for information.

On behalf of the QA Panel, I would like to thank you, the report chair and author, and other colleagues, for the considerable work that you have put into this review.

Yours sincerely

Linda Robinson
Chair of the Home Office DHR Quality Assurance Panel