Safer Waverley Partnership

Domestic Homicide Review

Mrs A

Died 2017

Review completed February 2020

Reviewer

Brian Boxall

BDB Consultancy Ltd

Contents

1. INTRODUCTION

1.1. In October 2017, police and paramedics attended an address in Godalming. There they found an elderly female Mrs A (79 years old). She had suffered several stab wounds. Mr B (her son 57 years old) had a severe cut to his throat, believed to have been self-inflicted. Mrs A died as a result of her wounds whilst on the way to hospital. Her son was taken to hospital where he had emergency surgery.

1.2. Mr B was arrested by the police. He admitted inflicting the fatal injuries on his mother, and was charged with her murder. In April 2018 he pleaded guilty to manslaughter on the grounds of diminished responsibility, and was sentenced to a hospital order under section 37 of the Mental Health Act. [1]

1.3. Domestic Homicide Reviews (DHRs) came into force on 13th April 2011. They were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004). The Act states that a DHR 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 she was related or with whom she was or had been in an intimate personal relationship or

(b) A member of the same household as herself;

with a view to identifying the lessons to be learnt from the death.

The purpose of a Domestic Homicide Review is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.
- Identify clearly what those lessons are, both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.
- Apply these lessons to service responses including changes to policies and procedures as appropriate.
- 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.
- Highlight good practice.

Domestic Homicide Reviews are not inquiries into how the victim died or into who is culpable; that is a matter for coroners and criminal courts respectively, to determine as appropriate.

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[1] The **Mental Health Act** is the law which **mental health** professionals use **section 37**/41 to bring you to hospital for treatment. This is also known as being 'sectioned'. ... The criminal courts can use **section 37** if they think you should be in hospital instead of prison. **Section** 41 is a restriction order.

Timescales

1.4. The Safer Waverley Partnership commissioned a Domestic Homicide Review on 29th November 2017, having identified that the circumstances surrounding the death of Mrs A met the requirements as set out in the Guidance for the Conduct of Domestic Homicide Reviews (Home Office 2013). [2] The Home Office were notified of the Domestic Homicide Review by letter on 5th December 2017. The report was submitted to the Home Office on 4th February 2020.

1.5. The review was subject to delay for several reasons. The initial panel meeting did not take place until April 2018 following the completion of the of criminal justice process. Identification of Individual Management Review (IMR) authors was subject to delay and the initial IMRs were not completed until September 2018. The author challenged the conclusions of the original Surrey and Borders Partnership NHS Foundation Trust (SaBP) Serious Incident (SI) review. The Trust reviewed and amended their original Serious Incident Review. This was not completed until June 2019. (This is subject to further comment in the report).

1.6. The final draft report was completed in October 2019, but the author was not able to meet with the family member, in order for them to review and comment on the report, until January 2020.

Confidentiality

1.7. The findings of this Overview Report are restricted. Information is available only to participating officers/professionals and their line managers, until after the Review has been approved for publication by the Home Office Quality Assurance Panel.

1.8. As recommended within the 'Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews' to protect the identities of those involved, pseudonyms have been used as set out below.

Name	Gender	Age at the time of the murder	Relationship with victim	Ethnicity
Mrs A	F	79	Victim	White British
Mr B	M	57	Son and Perpetrator	White British

The Executive Summary of this report has also been anonymised.

[2] Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews. Home Office (Dec 2016)

2. DOMESTIC HOMICIDE REVIEW METHODOLOGY

2.1. The author of this report was commissioned to undertake the review in line with principles set out in the Home Office guidance.

2.2. The independent overview author is Brian Boxall, a retired Detective Superintendent who served with Surrey Police for 30 years. Since his retirement in 2007, he has worked as an independent consultant, and undertaken a number of domestic homicide reviews and children and adult serious case reviews. He is currently the Independent Chair of a London Borough Safeguarding Children and Adults Board. He has no connection with the Community Safety Partnership.

A Domestic Homicide Review panel was appointed to work with the lead reviewer. They represented the following agencies:

Name	**Job Title**	**Organisation**
Debra Cole	Safeguarding Adults & Domestic Abuse Lead	Surrey and Borders Partnership NHS Foundation Trust:
Wendy Hale	Area Director	Surrey County Council Adult Services
Kelvin Mills	Head of Commercial Services	Waverley Borough Council:
Helen Blunden	Designated Nurse	Surrey Wide CCG Safeguarding Team
Jane Lord	Manager, Major Crime Review Team	Surrey Police
Alessia Mestrone	DA outreach worker	South West Surrey Domestic Abuse Services
Jennifer Parsons	Probation Officer	National Probation Service
Dr Gisela Unsworth	Clinical Service Manager	Mind Matters (SABP)

Panel members had no direct involvement with Mrs A or Mr B.

2.3. The review panel met on five occasions.

April 2018

November 2018

January 2019

March 2019

August 2019

Scope of Review

2.4. The panel identified that the review should focus on the period of time between 1st October 2016 and 29th October 2017. The 2016 date was selected as it corresponded to the major break down suffered by Mrs A's daughter. It was this event that placed additional pressure on Mrs A and her son.

The Terms of Reference

2.5. Terms of Reference (Appendix A) were agreed. They set out the lines of enquiry to be addressed within the agency Individual Management Reviews (IMRs) and the overview report

- *In the knowledge that both the victim and the perpetrator were known to services, was the information available and did the individual agency act upon it in a timely manner?*
- *Was there any involvement of the Multi Agency Risk Assessment Conference?*
- *In services where there was involvement with the victim or perpetrator, were there adequate safeguarding and domestic abuse policies and procedures and were they followed?*
- *Was there sufficient good quality information sharing and communication between agencies in place to address the level of risk and safeguarding concerns?*
- *Were the appropriate actions taken to identify risk and were risk assessments conducted and robustly managed?*
- *Were there any opportunities for professionals to routinely enquire as to any domestic abuse experienced by the victim that were missed?*
- *What training was undertaken or available to staff?*
- *Are there any training or awareness raising requirements that are necessary to ensure a greater knowledge and understanding of the services available?*
- *Give appropriate consideration to any equality and diversity issues that appear pertinent to the victim, perpetrator and dependent children?*
- *Was a "Think Family' approach adopted?*

2.6. In addition to the above, the family requested that the following issues should be further explored:

- *Where did Mr B present and what was the outcome?*
- *Were risk assessments produced and shared with Mr B and the GP?*

- *Did he report thoughts about harming others, was risk to others assessed and documented?*
- *What were the risks to himself, suicidal thoughts and supporting risk management plans?*
- *The impact of Counsellor Miss C?*
- *Was there adequate sharing of information between significant services?*
- *Was there a Health Serious Incident Review?*

2.7. Section 7 of this report provides a summary of the findings of the lines of enquiry.

Individual Management Reviews

2.8. Agencies were contacted and requested to search their records and identify any contact they may have had with Mrs A or Mr B. Whilst a number of agencies had contacts, it was agreed by the Panel that the only agencies that had significant contact were:

- The GP Practice
- Surrey & Borders Partnership Services:
  (Community Mental Health Recovery Service (CMHRS)
  Improving Access to Psychological Therapies (IAPT))

These agencies produced full IMRs.

2.9. The overview author met with the Individual Management Review authors in July 2018 to explain the process. The authors were invited to a number of the Panel meetings, in order to discuss their findings. The Panel reviewed the Individual Management Reviews and challenged accordingly.

Additional documents

2.10 The author was provided with additional documents from:

- Action for Carers Surrey
- Community Mental Health Recovery Service (CMHRS)
- Centre for Psychology
- Adult Social Care section 42 enquiry

Interviews

2.11 The author undertook interviews with the:

- Waverley CMHR manager and supervisor.
- CMHR practitioner involved with Mr B.
- Action for Carers practitioners supporting Mrs A.

Involvement of family, friends, work colleagues, neighbours and wider community

2.12. The brother of Mrs A wished to be involved with the review. The author met with him at the start of the review and then at its conclusion. The Terms of Reference where shared with him and as a result he requested addition lines of enquiry to be

added. He was regularly updated during the enquiry. The author ensured that he received a copy of the Serious Incident Investigation report.

2.13. The family was supported by a specialist advocate from Hundred Families org. They also spoke with the lead investigator for Mental Health Homicides. In October 2019 the family, including the advocate, were supplied with a copy of the draft report. They responded with feedback and met with the author in January 2020. Amendments to the report were discussed and agreed.

2.14. Information from neighbours and friends was obtained from police interviews. The Cathedral Cannon who was friendly with Mrs A was interviewed by the Dioceses of Guildford Safeguarding Lead.

2.15. The author was intending to try and speak with Mr B's father but unfortunately, he died before this was achieved.

2.16. The author did invite Miss C the friend/counsellor of Mr B. She failed to reply to the request.

Perpetrator Involvement

2.17. Mr B was invited to and agreed to speak with the author. He was interviewed at a secure facility. He supplied the author with a copy of his diary.

Parallel Processes

2.18. **Criminal justice process**: In April 2018 he pleaded guilty to manslaughter on the grounds of diminished responsibility and was sentenced to a hospital order under section 37 of the Mental Health Act. [3]

Health Serious Incident: The original SI was reviewed as a result of the questioning by the author. The reviewed document was not completed until June 2019.

Care Act 2014 Section 42 enquiry into the post incident role of Miss C.

Equality and Diversity

2.19. The Governments Equality Act 2010 guidance [4] describes the duty as follows

The Equality Duty is a duty on public bodies and others carrying out public functions. It ensures that public bodies consider the needs of all individuals in their day to day work – in shaping policy, in delivering services, and in relation to their own employees.

[3] The **Mental Health Act** is the law which **mental health** professionals use **section 37**/41 to bring you to hospital for treatment. This is also known as being 'sectioned'. ... The criminal courts can use **section 37** if they think you should be in hospital instead of prison. **Section** 41 is a restriction order.

[4] Government Equalities office 2011: EQUALITY ACT 2010: PUBLIC SECTOR EQUALITY DUTY WHAT DO I NEED TO KNOW? A QUICK START GUIDE FOR PUBLIC SECTOR ORGANISATIONS: Crown

*The Equality Duty has three aims. It requires public bodies to have **due regard** to the need to:*

- ***Eliminate unlawful discrimination**, harassment, victimisation and any other conduct prohibited by the Act;*
- ***Advance quality of opportunity** between people who share a protected characteristic and people who do not share it; and*
- ***Foster good relations** between people who share a protected characteristic and people who do not share it.*

2.20. The review did consider the protected characteristics under the Equality Act 2018:

- Age
- Disability
- Gender Assignment
- Marriage and Civil Partnership
- Pregnancy and Maternity
- Race
- Religion and Belief
- Sex
- Sexual Orientation

2.21. The protected characteristics relevant to these individuals were age, sex, religion and belief and disability. In respect of age and sex there is no evidence that indicates that they were subject to any discriminatory practices linked to these characteristics.

2.22. Both were white British and there is no evidence that they were subject to any discrimination due to their ethnicity. Both were members of the Christian religion, Mrs A being very involved with the church. Again, this not lead to any discriminatory practice.

2.23. In respect of disabilities

Section 6 of the Act defines ‘disability’ as: [1] A person [P] has a disability if—

[a] P has a physical or mental impairment, and

[b] The impairment has a substantial and long-term adverse effect on P's ability to carry out normal day-to-day activities.

2.24. Whilst both Mrs A and Mr B had mental health difficulties. Neither had a recent formal mental health diagnosis. No agency held information that indicated that Mrs A or Mr B lacked capacity and there is no indication from the material seen by the review panel that a formal assessment of capacity was ever required for either of them. There is no evidence that they were subject to any discriminatory practice in respect of the disability characteristic.

2.25. Agencies have in place Equality Statements/Policies. The needs of the individuals were considered. There is no evidence to indicate that any of the protected characteristics impacted on the services provided by agencies to Mrs A and Mr B.

Dissemination

2.26. The final report was disseminated to the Safer Waverley Partnership Membership:

Name	Role	Organisation
Helen Blunden	Surrey Wide Designated Nurse Safeguarding Adults	Guildford & Waverley CCG
Graham Barnett	Supt Operations	Surrey Police
Melanie Bessant	Deputy Director of Quality and Nursing	North East Hampshire & Farnham CCG
Graham Mitchell	Group Commander Response	Surrey Fire & Rescue Service
Annie Righton	Strategic Director	Waverley Borough Council
Andrew Smith	Head of Housing Delivery & Communities	Waverley Borough Council
Gary Smith	Waverley Neighbourhood Inspector	Surrey Police
Cllr Martin	Local Committee Representative	Surrey County Council
Louise Gibbins	Community Safety Officer	Surrey County Council
Gillian Trippner	Managing Director	Guildford & Waverley CCG

Name	Role	Organisation
Alastair Lee	Senior Probation Officer	National Probation Service
Katie Webb	Community Services Manager	Waverley Borough Council
Katrina Burns/Eve Budd	Community Safety Officer	Waverley Borough Council
John Cooper	Waverley Borough Commander	Surrey Fire & Rescue Service
Clare Arnold	Community Services Support Officer (admin)	Waverley Borough Council

3. BACKGROUND HISTORY

3.1. The following will provide a brief history of Mrs A and Mr B, taken from documentation and additional information provided by the family.

Mrs A

3.2. Mrs A at the time of her death was 79 years of age. It is evidenced from information supplied by the family that she had suffered from mental health problems since her early years, suffering her first breakdown whilst she was a university student. The exact details of her breakdown are unknown.

3.3. She was married and then divorced a few years later. From this marriage she had two children, Mr B and a daughter. Her mental health problems continued until the 1970's, but then she stabilised and became independent and trained as a nurse.

3.4. Mrs A's daughter developed mental health difficulties, having her first breakdown whilst at university. Mrs A helped to support her daughter and became her recognised carer, although her daughter had long periods of time when she was stable and was able to function at a high level.

Mr B

3.5. Mr B was born in Nottingham. At the age of five he moved with his family to Africa where he lived for 4 years. His parents divorced when he was eight years old. He was married, but was divorced in 1988. He was self-employed and worked mainly on his own undertaking property maintenance/ gardening. He felt unable to work during 2017 due to the increased anxiety that he was experiencing. He rented a flat in the local area and lived there until June/July 2017 at which time he started to

stay with his mother. In August 2017 he went to stay with one of his mother's neighbours.

3.6. Unlike other members of his family, there is no evidence that he suffered from any recorded mental health issues prior to 2017. The only health concern impacting on Mr B was a neck injury which he sustained during an assault in 2007.

3.7. In May 2017 he stated that he felt responsible for both his mother and sister. It is evidenced that his relationship with his mother was strained. She appeared to blame him for his sister's situation, and he felt that the way she interacted with his sister was not helpful.

4. CASE CHRONOLOGY

4.1. As part of the review, agencies provided the author with chronologies of contact that both Mrs A and Mr B had with services. The following is a summary of the significant contacts. Additional information has also been obtained from Mr B's diary.

4.2. In October 2016, Mrs A's daughter was admitted to hospital and Mrs A met with her daughter's Community Psychiatric Nurse (CPN) [5] and consultant on a number of occasions. These meetings were to address Mrs A's concerns about her daughter's discharge.

4.3. On 13th January 2017 Mrs A's GP received a letter from the Centre of Psychology [6]. It stated that Mrs A had only had one session and she felt she had managed to reduce her anxiety. On the same day Mrs A met with her daughter's consultant to discuss the care plan. Mrs A was upset, and it was agreed that the CPN would arrange a visit to her daughter's next placement.

4.4. On 31st January 2017 Mr B attended his GP. It is recorded that he was not sleeping and suffering bad anxiety. Mr B stated there was a lot going on with his sister who had long term health problems, and he was looking out for his elderly mum.

4.5. During February 2017, Mr B consulted his GP twice. It is recorded that he was feeling better.

4.6. In March 2017 Mrs A was contacted by a Mental Health Social Work Assistant to arrange a carer's assessment. This was a joint visit with her daughter's CPN. A meeting took place in April 2017 when Mrs A stated she was tearful and was finding it difficult to come to terms with her daughter's decision to no longer have contact with the family. She no longer wanted to be her carer as she was too old. She

[5] A community psychiatric nurse (CPN) is a fully trained staff or charge nurse who has had several years of experience working on psychiatric wards in hospitals.

[6] Centre for Psychology: It provides psychological therapies for common mental health disorders such as depression and anxiety. They are funded by your local NHS Commissioning Group.

declined counselling, stating that she was finding the support of a Canon at her church useful.

4.7. On 15th March 2017, the GP of Mrs A received a discharge letter from Psychological Well-being. Mrs A had attended a Mindful CBT [7] carers group.

4.8. On 31st March 2017 Mr B attended his GP. He stated that he was feeling better in himself, but was aware that he worked alone too much. His mother was still fragile and his sister more stable.

4.9. On 11th April 2017 a social work assistant, CPN and staff from ACE [8] met Mrs A to discuss her daughter. She had concerns about her discharge. She stated that she was nearly 80 years old and she did not want to be her daughter's carer any more as it was a lot to take on. Counselling was suggested as Mrs A was finding her daughter's decision not to have any contact with family difficult. Mrs A stated that she had had CBT and had been speaking to a Cannon at the Cathedral, which she was finding helpful.

4.10. On the 23rd April 2017 Mrs A saw her GP. During the consultation, Mrs A mentioned that her daughter was in long-term care due to mental illness. She was very upset about this.

4.11. In April 2017 Mind Matters [9] who were providing a talking therapy service, contacted Mr B by phone to make an initial assessment. He stated that he had been assaulted 10 years ago which resulted in tissue and bone problems. He had divorced 10 years ago. His goals for therapy were to experience another normal relationship with a woman and to be happier with life.

4.12. Mind Matters sent a letter to Mr B's GP the same day. It set out the findings from his assessment - GAD 7 score 16 (anxiety) and PHQ 9 score 6 (depression). The outcome graph highlights that his anxiety level was severe but his depression was mild. He had been placed on the waiting list for talking therapies. It is of note that the GP did not receive this letter until 14th June 2017, so would have been unaware of the initial assessment findings.

4.13. On 3rd May 2017 Mr B attended his first talking therapy session. His second session was on the 17th May. No risks were identified. These were face to face sessions.

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[7] **Cognitive behavioural therapy** (**CBT**) is a talking **therapy** that can help you manage your problems by changing the way you think and behave. It's most commonly used to treat anxiety and depression, but can be useful for other mental and physical health problems.

[8] **ACE** work with people with **mental health** needs who have found it difficult to access mainstream services.

[9] Mind Matters Surrey (previously Improving Access to Psychological Therapies - IAPT) service is open to anyone aged 18 over living in Surrey and experiencing mild to moderate mental health difficulties

4.14. On 22nd May 2017 Mr B attended his GP. It is recorded that he still had anxiety, was panicky and had stepped away from sister's issues. He was a carer for Mum. Arthritis was causing neck pain and he was seeing a therapist at Mind Matters.

4.15. On 23rd May 2017 Mr B attended his third talking therapy session. He stated that he felt responsible for both his sister and his mother and was concerned about how it was that impacting on his own ability to form and maintain a relationship. He was planning a holiday but felt obliged to hide his feelings from others.

4.16. On 31st May 2017 Mr B attended his fourth talking therapy session. He spoke about hiding feelings from friends. He spoke about his mother and that he had a strong caring relationship and did not want to hurt her in any way.

Nevertheless, he craved a separate adult life of his own.

4.17. On 12th June 2017 Mr B saw his GP. He stated he was sleeping better and had been away for a week in Wales.

4.18. On 14th June 2017 he attended his fifth talking therapy session. He appeared to be coping better and talked about determining barriers to manage his relationship with his mother.

4.19. On 21st June 2017 he attended his sixth and final session at Mind Matters. He was coping better but was still troubled by his relationship with his mother.

4.20. On 2nd July 2017 Mrs A's social work assistant sent Mrs A a letter offering a meeting with RETHINK [10] for a carer's assessment. This assessment did not take place as Mrs A did not attend.

4.21. On 3rd July 2017 Mr B's GP received a discharge letter from Mind Matters. It stated that Mr B had attended 6 sessions scoring GAD 7 score 5 (anxiety) and a PHQ 9 [11] score 9 (depression) at his final session. On the outcome graph this score relates to mild anxiety and mild depression, both below the recommended threshold. This indicates that his level of anxiety had reduced since the initial Mind Matters assessment. The results were received by his GP on 6th July 2017. On 5th July 2017 Mr B attended his GP and stated that he felt increasingly anxious. He was given a prescription for medication, Propranolol, a non-sedating anxiety relieving medication.

4.22. Mr B again attended his GP on 7th July 2017. He stated that he was having panic attacks, had lost motivation and had neck pain but not feeling suicidal. He was referred to physiotherapy for his neck pain.

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[10] Rethink is dedicated to improving the lives of everyone affected by severe mental illness, whether they have a condition themselves, care for others who do, or are professionals or volunteers working in the mental health field.

[11] The PHQ-9 and GAD-7 are standardised measures used to monitor clinical outcomes as part of Efficacy's Clinical Governance strategy. These are increasingly used in robust mental health research to indicate a diagnosis, a classification of severity and outcome monitoring within national CBT therapy services.

4.23. On 14th July 2017 Mr B attended his GP. Ongoing anxiety overwhelmed him, but he was not suicidal. It was planned to arrange CBT.

4.24. Mr B referred himself to the Centre for Psychology. [12]

4.25. On 24th July 2017 Mr B attended his GP. He stated that he was not well enough to work and was sleeping on the floor at his mother's flat. '*Counselling was not working*'. The GP referred him to the Waverley Community Mental Health Recovery Service [13] (CMHRS). The referral letter was not sent until 3rd August 2017.

4.26. On 25th July 2017 Mr B was triaged (via phone) by the Centre for Psychology. He stated that he was feeling down, stressed, anxious and hopeless following the hospital admission of his sister. He had moved in with his mother. A risk assessment was undertaken but no concerns were raised. He was allocated to a Psychological Wellbeing Practitioner (PWP) for therapy.

4.27. On 27th July 2017 Mr B attended his first therapy session at the Centre for Psychology.

4.28. On 3rd August 2017 Mr B attended his second therapy session. He reported that he had attended a mindfulness session the night before. He expressed worries about being alone and that his own mental health might deteriorate like his sister. His neck pain was a source of stress.

4.29. On 10th August 2017 Waverley CMHRS received a routine referral from Mr B's GP in respect of Mr B's ongoing low mood panic attacks and "fleeting" suicidal ideation. (This is thought to be the referral in the letter sent by the GP on 3rd August 2017). A rapid assessment social worker (RAW) made telephone contact with Mr B the same day in order to undertake a screening assessment. Mr B reported that he was living with his mother and had stopped work due to anxiety, poor sleep and not functioning. He also stated that medication had made a slight improvement, and he was attending psychology sessions but would prefer group sessions. He denied having any suicidal thoughts or intention to harm himself.

4.30. On the same day he attended his third therapy session at the Centre for Psychology.

4.31. On 7th August and 14th August 2017 during Mr B's GP appointments, he stated he had dark thoughts, suicidal in nature. He considered he had safety netting as he was staying with mother. He had contacted Waverley CMHRS who advised him to speak with his GP.

4.32. The referral and the screening were discussed at the Waverley CMHRS multi-disciplinary team (MDT) referral meeting held on the 14th August 2017. A Waverley CMHRS doctor documented that Mr B did not appear to meet the criteria for services

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[12] Centre for Psychology: It provides psychological therapies for common mental health disorders such as depression and anxiety. They are funded by your local NHS Commissioning Group

[13] Community Mental Health Teams in the United Kingdom, support or treat people with mental disorders in a domiciliary setting, instead of a psychiatric hospital.

at that time. The plan was to discharge him back to primary care. There is no evidence that this decision to discharge was communicated to the GP. This was a morning meeting.

4.33. On 14th August 2017 after Mr B had seen his GP, his mother Mrs A contacted Waverley CMHRS (afternoon) to say her son was feeling suicidal. The RAW who had spoken to him on the 10th August contacted Mr B. Mr B confirmed that he was feeling suicidal and was overwhelmed by '*very intense and distressing thoughts'*. He stated that he had a GP appointment that day. The RAW contacted him after his GP appointment. Mr B confirmed that he had been prescribed Sertraline [14] (Depressive Illness). The RAW gave Mr B details of a local Safe Haven, [15] and advised him to go for walks and engage in activities that would keep him busy. No risk assessment was recorded.

4.34. The following day (15th August 2017) Mr B spoke with his GP by telephone. He was in a state of wanting to kill himself. The CPN had already called, and low doses of Diazepam [16] (Anxiety) had been given. His mother and neighbour were keeping an eye on him.

4.35. On the same day 15th August 2017, Waverley CMHRS received a follow up letter from his GP requesting support as he was 'quite suicidal'. The RAW contacted Mr B who stated that he had had a bad night and felt life was not worth living any more. He stated that he had supressed his feelings for a long time but could not do it anymore. The RAW arranged for an assessment to take place. The assessment was undertaken by an agency CPN the following day at his mother's home. Mrs A also supplied additional information. He was assessed to be a low risk across all domains.

4.36. The biopsychosocial [17] assessment carried out at Mrs A's house by the CPN states the following:

Outline of assessment: Came back from physio, felt like ending it all. GP home visit on 15th August due to being very agitated, unable to think clearly and threatening to end his life. 2-3 weeks of thinking of ending life with no plan. Trigger - thinking about

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[14] **Sertraline** is a type of antidepressant known as a selective serotonin reuptake inhibitor (SSRI). It's often used to treat depression, and also sometimes panic attacks, obsessive compulsive disorder (OCD) and post-traumatic stress disorder (PTSD).

[15] Safe Havens provide out of hours help and support to people and their carers who are experiencing a mental health crisis or emotional distress.

[16] **Diazepam** is used to treat anxiety, alcohol withdrawal, and seizures. ... **Diazepam** belongs to a class of drugs known as benzodiazepines.

[17] The **biopsychosocial approach** systematically considers biological, psychological, and social factors and their complex interactions in understanding health, illness, and health care delivery.

www.urmc.rochester.edu/MediaLibraries/URMCMedia/education/md/documents/biopsychosocial-model-approach.pdf

sister and how unwell she is. Also she does not want to see members of the family. Has been involved in her care over the years.

Flat is noisy so difficult to live in and has been with mother for 5 weeks. Risk to self, others and suicidal ideation are all assessed as low.

Plan: He wants to integrate his mind so that he can function properly, and be able to go back to work, able to make decisions without clouding his mind. He feels he cannot cope anymore and wants to return to his flat.

He wants to live independently in shared accommodation where there will be other occupants around.

He is currently attending sessions facilitated by IAPT. To present in the MDT.

4.37. On 17th August 2017 Mr B attended his fourth therapy session at Centre for Psychology. He reported that he had had a visit from the Waverley CMHRS. He gave permission for his therapist to contact Waverley CMHRS. He also reported that he had attended his GP. Following this session, the Centre for Psychology contacted Waverley CMHRS. They spoke to the agency CPN. They recorded that they stated '*in light of Mr B's vulnerability and worsening presentation, CMHRS would like to treat Mr B and we agreed to discharge from our service'*.

4.38. On the same day, the agency CPN made an entry in the electronic case recording system that he had had a phone contact from IAPT stating that Mr B had attended his 4th session today, and that no progress was being made after 4 sessions. Reference had also been made to IAPT sessions in his Biopsychosocial assessment. These sessions where those being supplied by the Centre of Psychology following Mr B self-referral. He had not been referred by Waverley CMHRS.

4.39. On 17th August 2017 Mrs A attended the GP requesting more diazepam for Mr B. On 18th August the GP made a home visit. Mr B was still feeling suicidal and was seen by the CPN. An urgent referral was made by the GP.

4.40. A RAW contacted Mr B. Mr B stated that he had moved in with his mother as he did not feel safe in his own flat. He had taken time off work (he was self-employed) due to his anxiety and sleeplessness. This had been exacerbated by the news of his sister moving into a care home.

4.41. Mrs A's neighbour stated that Mr B stayed with her between 14th August and 7th October 2017. (Information supplied to police post the attack).

4.42. On 21st August 2017 Mr B attended his GP. It was recorded that he was looking better in himself, and less suicidal. He was feeling floaty and drunk. He was planning a trip to Devon.

4.43. The agency CPN assessment of Mr B was discussed at the Waverley CMHRS team assessment feedback meeting (MDT) held on 21st August 2017. The consultant psychiatrist recorded (on the electronic case recording system) the plan as:

- *The CPN to confirm where Mr B was living, as there was an entry from Mole Valley CMHRS on the Friday.*
- *Allocation for care coordination.*
- *To complete his ongoing psychological therapies through IAPT.*
- *To consider MTI for supported living.*

There is no evidence that this agreed plan, or the supporting assessment was communicated to the GP. There is also no evidence that a care coordinator was ever allocated, or that the Centre for Psychology were contacted regarding his therapy sessions.

4.44. On 21st August 2017 Mrs A was visited by an Action for Carers support worker. Mrs A stated that she was concerned about her son, he was very low and unable to function. He was not living at his flat as he found it too difficult, he was staying with Mrs A's neighbour. He had given up his job and was not seeing any friends. He had been in contact with Waverley CMHRS and was referred to look at his housing situation. There was some talk of him going to supported housing. Mrs A felt that he needed more help. The support worker met with Mr B at the next-door neighbour's premises. He presented as being very low, finding it difficult to process information and was struggling to have contact with Mrs A. The support worker discussed the 'Welcome Project' [18] as a starting point, to build some structure into his day and she encouraged him to contact Waverley CMHRS again. Mrs A was encouraged to send a letter to Waverley CMHRS.

4.45. On 24th August 2017 Mr B attended his fifth session of therapy at the Centre for Psychology. He reported that he was finding it difficult to engage in therapy. It was agreed that he would be discharged the following week and CMHRS would be arranging the next steps for his treatment.

4.46. On 29th August 2017 Mr B attended his GP. He stated he was not doing much, and waking early morning. He was not suicidal and still sleeping at Mum's neighbour.

4.47. On 30th August 2017 the CPN made a joint visit to Mr B with the Move to Independent (MTI) for supported living. The conclusion was to wait to hear from the MTI, send a booklet and application for the recovery college and send a letter to his GP to transfer his care. This was not in line with the plan from the MDT on 21st August 2017.

4.48. On 31st August 2017 Mr B attended his sixth and final therapy session. Following this session, the Centre for Psychology sent a discharge letter to his GP.

4.49. On 4th September 2017 the agency CPN recorded that the entry for 21st August 2017 MDT meeting should read: CPN to refer Mr B to MTI and Recovery College. CPN to write letter of transfer of care to his GP.

[18] Welcome Project team work in partnership with other charities and volunteers across Surrey to provide a variety of activities, guidance and opportunities for people who need support with their emotional wellbeing.

4.50. On 7th September 2017 the MTI social work assistant met with Mr B and his friend who appeared to be the neighbour. It is recorded that it appeared that he did not need level of support MTI provides, as Mr B had a rented flat and intended to return to it gradually following his holiday with the friend. He stated he was not having suicidal thoughts but did have dark thoughts. It states it was unclear if he was still attending IAPT. The application to MTI was closed.

4.51. On 25th September 2017 Mr B attended his GP. Mr B stated that he was still up and down. He was still living at his neighbour's house but had had a nice break in Devon. He was having physio on his neck and was still stressed.

4.52. On 28th September 2017 Mr B attended his GP. The GP record states that he was having suicidal thoughts, no plans, but no protective factors. He had been declined Waverley CMHRS, and at the last few referrals he was provided with Crisis and Samaritans numbers. An urgent letter was faxed to Waverley CMHRS by the GP.

4.53. On 28th September 2017 Mrs A attended an Action for Carers well-being course. On the same day Mr B called the Crisis line. Mr B thought that they would be able to arrange an in-patient admission. He was advised of the criteria for admission and advised to attend his local Safe Haven for a face to face assessment. There is no record of Mr B attending.

4.54. On 29th September 2017 a letter was received by SaBP from Mrs A. The letter was sent at the suggestion of the Action for Carers support worker, and was dated 28th September 2017. In the letter Mrs A expressed concerns that the CPN Mr B had recently seen was also supporting his sister, and she was concerned that her daughter may have a problem with this given that she did not want any contact with the family. She asked that Mr B be allocated another male CPN "X" as she felt he would relate better to a male worker. She also believed that the current CPN had missed a vital part in the required home support other than just housing issues, and reference to the recovery college, she believed he was too ill to investigate on his own. She also stated that Mr B was not caring for himself, not eating/washing, and was saying that he was so despairing that he was walking across the road regardless of the outcome.

Mr B was saying that he felt numb, not caring as he couldn't stop his mind whirling around like a washing machine. He did not see Mrs A as his mother but as just another therapist.

4.55. A diary entry by Mr B indicates that on 29th September 2017 he visited a local individual who indicated that they were a counsellor (Miss C).

4.56. On 2nd October 2017 Mr B attended his GP stating that he had dipped again. He was seen in the evening centre (believed to have been the Safe Haven). He did calm down. He was getting follow up by Waverley CMHRS. He was keen to have a 'back to work' strategy.

4.57. The same day a RAW undertook a telephone risk assessment. Mr B stated that he attended the Safe Haven Friday and Saturday, but it was closed. A friend had called a paramedic out last week. It is recorded that he appeared low risk but would be discussed at next MDT.

4.58. Mr B's diary entry indicates that on 5th October 2017 he visited Miss C.

4.59. On 5th October 2017 Mrs A was contacted by the Waverley CMHRS clinical team leader. This was in response to a letter Mrs A had sent dated 28th September 2017. She described that she was struggling with Mr B who was "*unmotivated to do anything and just sits and staring into space"*. Mrs A asked that the RAW or the CPN should contact Mr B to discuss the MDT meeting of the 9th. It was indicated that this would be done within the week. There is no evidence that this was followed up.

4.60. Mr B was discussed on 9th October 2017 at the Waverley CMHRS Multi-Disciplinary Team meeting. A plan was agreed to offer Mr B another assessment. It was again discussed at the MDT meeting on 11th October. The electronic case recording system entry starts '*HIGH RISK DISCUSSION'*

On behalf of the team: Booked in for an assessment with Waverly CMHRS. Seems RAW spoke on the phone and did not think he met with criteria. All of this seems to have crossed in communication. Team said to keep booked assessment so he can be assessed face to face.

There is no reference to previous assessment discussed at the August MDT.

4.61. Mr B's diary entry indicates that on 11th October 2017 he visited Miss C.

4.62. On 15th October 2017 Mr B collapsed at his mother's neighbour's home. He was taken by ambulance to local Accident & Emergency. He was assessed by the psychiatric liaison team manager. The assessment concluded that Mr B did not require intensive support in the form of the home treatment team, but would benefit support from CMHRS. He was referred to health psychology for help with him managing his neck pain.

4.63. A letter was received by his GP regarding Mr B's hospital attendance. It stated that Mr B had collapsed at home and was feeling unsafe with suicidal thoughts. He was observed to be unsure and having fleeting thoughts of suicide. It was requested that Mr B be referred to pain clinic for neck pain. This referral was not progressed prior to the assault.

4.64. Mr B's diary entry indicates that 16th October 2017 and 19th October he visited Miss C.

4.65. On 20th October 2017 Mr B telephoned his GP. He was hesitant and vague on the phone, but stated that he was having chronic neck pain and that he had had a Waverley CMHRS assessment the previous day. This was the last contact with his GP.

4.66. Entry on 20th October 2017 following communication between Psychiatric Liaison Services and Community Health Psychology about potential support for pain relief.

He has been referred to the pain clinic where he can access a multi-disciplinary approach to pain management. Psychologist notes main factor is on-going mental health issues and is concerned he is falling between the gap of primary and secondary health services. Will follow up with Psych Liaison.

4.67. On 24th October 2017 the Waverley CMHRS social worker assessed Mr B at his mother's address. The assessment concluded that Mr B was reported low mood, fleeting thoughts of suicide with no protective factors and poor concentration which affected his decision making. The assessment identified a number of stressors. Significant financial indebtedness and devastation regarding his sisters worsening mental health. He also reported weight loss, lack of concentration and inability to continue work due to these stressors. "*Mr B is struggling to manage his emotions and regulate his feelings relating to his sister*". The social worker made a note to discuss Mr B at the MDT meeting due to take place on 30th October 2017.

4.68. Mr B's diary entry indicates that on 27th October 2017 he visited Miss C.

4.69. On 27th October 2017, Mrs A sent a text message to the Canon which referenced Mr B confessing to a priest and exorcism. The Canon saw the text the following day and responded to it. She never received any further response from Mrs A. This was the only mention of exorcism.

4.70. A friend of Mrs A reported that on 28th October 2017 Mrs A had informed her that Mr B had had a terrible morning, was crawling around the floor complaining about headaches and his neck was hurting.

4.71. The fatal attack occurred.

5. OVERVIEW FROM FRIENDS AND FAMILY

5.1. As part of the police investigation, officers interviewed a number of friends and neighbours. They provided the following additional information. These individuals were not re-interviewed as part of this review as the information provided by police was on the basis that it would be anonymous. It was hoped to speak with Mr B's father unfortunately, he passed away before that was possible.

5.2. A friend of Mrs A reported that Mrs A had told her in September 2017 that Mr B's mental health had got worse, he was going downhill, worried about finances and wanted to claim employment support allowance, but was worried that he would get arrested as it might be fraudulent. Mrs A stated that she was helping Mr B through the church and wanted an exorcist to see him.

5.3. His father stated that in January 2017 Mr B was in low spirits about his job and accommodation. He was struggling to work due to his neck injury. He dipped in October 2017 due to money issues. He had inherited some land from his Grandmother in 1988.

5.4. One of Mrs A neighbours stated that Mr B moved in with her between 14th August and 7th October 2017. He was suffering depression with issues about his sister's accommodation and work. He was suicidal and visited the safe haven [19] in September /October 2017.

[19] The aims of the Safe Haven are to reduce emotional and psychological distress and to offer an alternative to attending A&E when people are experiencing or at risk of escalating to a mental health crisis.

6. ANALYSIS

Domestic Abuse.

6.1. Whilst this review has been commissioned as a DHR, it became clear whilst undertaking the review, that there is no recorded evidence or verbal evidence that would indicate that prior to the fatal attack, Mr B had been abusive towards his mother or his mother towards Mr B.

6.2. The Serious Crime Act 2015 creates a new offence of controlling or coercive behaviour in intimate or familial relationships (section 76).

The 2015 Home Office [20] guidance states:

This offence is constituted by behaviour on the part of the perpetrator which takes place "repeatedly or continuously". The victim and alleged perpetrator must be "personally connected" at the time the behaviour takes place. The behaviour must have had a "serious effect" on the victim, meaning that it has caused the victim to fear violence will be used against them on "at least two occasions", or it has had a "substantial adverse effect on the victims' day to day activities". The alleged perpetrator must have known that their behaviour would have a serious effect on the victim, or the behaviour must have been such that he or she "ought to have known" it would have that effect.

6.3. There is evidence that Mr B was conflicted between his desire to live his own life and his devotion to his mother. Friends and supporting services such as Action for Carers do suggest that Mrs A was a strong character but there is no evidence to indicate that she was subjecting Mr B to coercion or control associated with domestic abuse or that he was controlling Mrs A.

6.4. What does arise is the impact that Mr B's relationship with females may have had on him. He was married but divorced in 1988. There are indications from the family that Mr B may have been the subject of abuse, but they have no verified evidence of what form the abuse took. Due to the length of time it was not possible to establish if abuse within the marriage was ever reported to the police. He did not report any abuse to any services. How this may have impacted upon him is unclear. He indicated to his mother that he wanted to have a male CPN rather than a female, she stated this in her letter dated 28th September. In a telephone conversation with the Mind Matters service, he states his goals for therapy were to experience another normal relationship with a woman, and to be happier with life.

6.5. There is no evidence to indicate that any professionals involved with Mr B explored the possibility of him having been subject to abuse at some stage in his life. His relationship with his mother was strained as she appeared to blame him for his sister's situation. Had this been identified, then the impact on his response to females, be it the family such as his mother or professional, may have been subject to greater exploration with Mr B.

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[20] Home Office 2015: Controlling or Coercive Behaviour in an Intimate or Family Relationship Statutory Guidance Framework

6.6. Whilst the review has not identified any significant issues in respect of domestic abuse, the DHR Panel agreed that Mr B's and Mrs A's interaction with services such as mental health required further examination, and that this review should be shared with the Surrey Adult Safeguarding Board.

Other Issues.

6.7. Whilst Mrs A had suffered for many years with mental health problems, there was no evidence prior to 2017, that Mr B had shown any indications of mental health difficulties similar to his sister and mother. Whilst Mrs A's daughter is not the subject of this review, it is clear that her daughter's increased mental health difficulties appear to have been the catalyst for the unfolding events of 2017.

6.8. In late 2016 her daughter had a major breakdown, and this clearly impacted upon Mrs A and Mr B who felt that he needed to look after his mother.

6.9. The initial impact was that both of them were unsure when she would be able to return home. Mr B indicated that not knowing, especially in respect of Christmas 2016, was placing significant strain on his mother. This is evidenced by the Action for Carers who had been supporting Mrs A for many years. They confirm that Mrs A was significantly impacted by her daughter's breakdown.

6.10. This stress significantly increased in March/April 2017 when the family were informed that she did not wish to have any further contact with the family.

6.11. During the period up to July 2017, the main support for Mrs A was Action for Carers, the CPN and her daughter's care co-ordinator. They had been working with Mrs A for a number of years, acting to support her as the carer for her daughter. During this period, she had been allocated an Action for Carers support worker and had attended monthly support groups.

6.12. As part of the review, the author spoke with the Action for Carers staff who had supported Mrs A. They confirmed that her daughter's action of cutting off contact with the family had a devastating effect on Mrs A. They described it as being similar to a bereavement. As is their policy, they continued to support Mrs A even when she was no longer technically her daughter's carer.

6.13. They were aware of Mrs A's concerns about her son, although they were concerned about the way that she spoke about him. She appeared to blame him for her daughter's plight. This was linked back to her own relationship with her mother and how her mother, (in Mrs A's eyes) had favoured Mr B over her daughter. She believed this was demonstrated by her mother leaving Mr B money (understood to be in the form of land) and not providing the same for her daughter.

6.14. This situation was confirmed by Mr B who felt his mother blamed him. He wanted to look after his mother, but believed that the way that she had interacted with his sister did not help his sister's situation.

Action for Carers

6.15. Despite Mr B's indications that he was caring for his mother, he was never registered with Action for Carers as a carer. They did have some contact with him

through Mrs A. He visited the support group on one occasion to make sure Mrs A was getting good support.

6.16. Mrs A's support worker identified that whilst Mrs A wanted to talk about her daughter, and she had a house which contained many photographs, Mr B did not wish to talk about his sister, he felt he could not cope. This posed a problem for them both and may have been a reason for him moving out from his mother's home in August 2017 to live with a neighbour.

6.17. The support worker and the support group worker also stated that Mrs A could get very angry about Mr B having advantages that her daughter did not have and she would express this anger at the support meetings. At one meeting of 90 minutes in length Mrs A spoke for over half of the meeting. They felt that she needed to have this time and was supported by other carers attending the group. They did try to highlight what the impact of her anger may be having on Mr B, and that maybe she should try a different approach when speaking with him.

6.18. Mrs A was described as a strong willed individual but was very supportive and caring. She had a very strong faith but this was tested when her daughter ceased communication. She told the group that she had lost her faith and was having a candlelit vigil for her daughter.

6.19. Action for Carers provided strong support for Mrs A over many years. Their continued support after her daughter's breakdown was very important. They clearly had significant information about Mrs A's concerns for her son, and it was the group support worker who advised Mrs A to send a letter to SaBP.

Church

6.20. It was evident that Mrs A was an active member of the church. This was explored as part of the review, and a Cathedral Canon who provided Mrs A with pastoral support was interviewed. Mrs A used to be involved with her local church but had fallen out with them. She had taken to attending services at the Cathedral with her daughter.

6.21. The Canon became involved when Mrs A requested to see a priest. She expressed concerns about her son as he was depressed about his sister refusing to see the family. She informed the Canon that he had become depressed, given up work and had moved in with her. Mrs A stated that she had to look after him. The level of concern that Mrs A had is evidenced in the text that she sent the Canon the day before the fatal attack. The text message referred to confessing to a priest and exorcism. The Canon did not see the text until the morning of the attack. She replied but received no response.

6.22. What emerges, is a confusing picture influenced by many complex factors present in all the family members' lives stretching back many years. Mrs A whilst blaming her son, also demonstrated that she was a loving mother who wanted to care for him, and at the same time despite having concerns about her mother's impact on his sister, Mr B had great concerns about his mother 's impact on his sister and wanted to care for her.

6.23. What is reinforced by the Canon, Action for Carers support worker, friends and family is, that at no stage did any of them see any evidence or believe there were any indications that Mr B would in any way harm his mother.

Health Services

6.24. The main focus of this review has centred on the support/interventions that Mr B was receiving, especially from April 2017 onwards. The previous section sets out how complex the family situation was, and it was this complexity that the health professionals in particular had to deal with.

6.25. As part of the internal investigation post death, the SaBP undertook a statutory Serious Incident review [21] (SI). The author had access to a copy of the review.

6.26. It was assumed and not challenged at any of the DHR panel meetings, that the SI originally supplied had been authorised by the CCG or that recommendations had not been actioned. During the review the author identified that the Waverley CMRHT did not seem to be aware of the SI's findings and had not implemented any changes. The author was then informed late in the review process that the SI supplied had not been authorised and was going to be subject of further review prior to authorisation. The SI was finally authorised in June 2019. The author has been informed that there is now in place quality control processes.

Lesson

6.27. It is important that the SI process is robustly monitored to ensure that reports reach a quality threshold, and that recommendations are implemented.

6.28. RECOMMENDATION

Surrey and Borders Partnership NHS Foundation Trust:

To ensure they have a robust SI review process in place that ensures SIs are tracked and are subject to quality control before being released.

6.29. GP records were also obtained for Mr B with his permission. Mrs A's records had to be retrieved from the archives. Retrieving these records caused considerable delay to the completion of the GP IMR.

6.30. The reason for the delay was explored. There was a period of 7 months between the death and contact with the GP practice requesting information. If a practice is unaware that a review may be undertaken, the patient is de-registered in the weeks after death, and the records then become the property of NHS England (with the contract for this held by Capita). Despite all attempts to speed this process up (including national escalation), it takes many weeks for Capita to release the notes for the purposes of the review.

[21] An **incident** requiring investigation is defined as an **incident** that occurred in relation to **NHS**-funded services and care resulting in unexpected or avoidable death, harm or injury to patient, carer, staff or visitor.

Lesson

6.31. It is important that all agencies who possibly hold information are informed of the potential for a DHR review as soon as possible. As a direct result of this case GP practices are now contacted as soon as it is apparent that a review may be undertaken and asked to secure records.

GP Contact

6.32 Mrs A's contact with her GP for her own health was limited. In January 2017 and March 2017, the GP was informed that Mrs A had attended the Mindful CBT carers group. It stated that she had scored as depression moderate at the end of the programme. She scored very low on both assessment tools. This supports the Action Carers indication that Mrs A was very upset by her daughter's condition.

6.33 Other than these entries, Mrs A did not consult her GP for any significant issues.

6.34 Mr B's contact with his GP has far more relevance. It is noted that he had minimal past medical history until the start of 2017. It is significant that during 2017 there are many references to his neck pain. The related injury was a result of an assault that had occurred some 10 years previously. In the 10 years prior to 2017 he only consulted his GP once in relation to his neck (September 2016).

6.35 Mr B's worsening mental health is evidenced in his GP record. Between January and June 2017 he was seen 6 times. It was recorded that he was experiencing anxiety, and his sister's health problems were mentioned. He was treated with anti-depressants and talking therapies. His discharge letter from the therapies in July 2017 detailed his depression and anxiety (after 6 sessions) as very low.

6.36 Between July and October 2017 there were 17 contacts. It is noted in the GP IMR, that Mr B's deterioration coincided with the completion of his six Talking Therapy sessions which ended in June 2017. As a result of this deterioration, the GP referred Mr B to secondary care mental health services on 24th July 2017. Mr B's reaction to one to one talking therapy is of note when considering later in this report the impact on Mr B of his involvement with an unqualified counsellor.

6.37 He was seen again by his GP on 14th August 2017, when it was first recorded that he was having suicidal thoughts. As a result of this information the GP faxed the mental health services with the additional information.

6.38 During August 2017 he was seen on a frequent basis. The GP recorded that he had been seen by a CPN on 15th and 18th August 2017. This information appears to have come from Mr B. There is no record of correspondence having been received from the secondary mental health service, and it is of note that no such correspondence was ever received on any occasion.

6.39 During August and September 2017 there were indications that things had improved and he was able to get a break in Devon. It is also noted that he was staying with his mother's neighbour, which might have been considered as a protective factor. By the end of August 2017 his condition had begun to deteriorate again with suicidal thoughts. There is a note in the records that he felt he had been

“declined treatment by community mental health team on last few referrals”. Once again, there was no correspondence indicating that he had been discharged.

6.40 It is evidenced that the GP practice was very involved with Mr B, and they responded when Mr B contacted his GP, especially between the July to October 2017 period. The assessment undertaken by the GP was a clinically based and assisted in highlighting concerns.

6.41 At no stage did any of the GPs consider that his mental health problems posed a threat to anyone else. His presentations or behaviour did not indicate that he was a risk to others. This is in-line with the conclusions by all individuals who came into contact with him during this period of time.

6.42 His GP practice referred him twice to mental health services. The IMR author explored the issue of follow up and was informed by a GP that they had phoned the service a number of times to follow up. He unfortunately did not document these contacts so it is not clear what was said or agreed.

Lesson

6.43 All contacts that GP’s have with other agencies relating to a patient should be accurately recorded.

6.44 RECOMMENDATION

Surrey Heartlands CCG’s Safeguarding Team:

To communicate findings of this review to GPs, to emphasise that all contacts including follow up telephone conversations are recorded.

6.45 It is of note that in the referral letter 28th August 2017, it mentions that Mr B felt rebuffed by mental health services during his contact with them. This comment is important when considering the response by the mental health team.

Mental Health Services

6.46 Both Mrs A and her daughter had been in receipt of mental health services at various periods of time in their lives, and it has been referenced that her daughter had a major breakdown in late 2016 leading to her cutting off all contact with her family in April 2017.

6.47 Mr B had not been known to secondary mental health services until the referral by his GP received on 10th August 2017. This was a referral to Waverley CHMRS. He was described as having a seven month history of increasing anxiety, recurrent panic attacks, sleep deprivation and fleeting suicidal ideation. A RAW undertook an initial telephone screening. This was discussed at a MDT meeting on 14th August 2017. This clinical meeting concluded that Mr B had not reached the threshold for CMHRS support and he would be discharged back to his GP.

6.48 This decision was not communicated to the GP either verbally or as required by formal letter.

6.49 On the same day Mrs A contacted Waverley CMHRS stating that Mr B was in low mood and was suicidal. The RAW contacted Mr B after he had seen his GP and advised him to go for walks and keep busy, and provided him the contact details of local Safe Haven. The following day a second referral was received by Mr B's GP.

6.50 An agency CPN undertook a face to face assessment with Mr B at his mother's address. Mrs A provided information.

6.51 The assessment explored the following areas

- Reason for referral
- Current situation
- Past psychiatric history
- Personal history
- Medical history and medication
- Forensic history
- Substance misuse
- Allergies
- Mental State Examination – includes appearance, behaviour, mood, affect, speech, cognition, memory, concentration, sleep, appetite, abnormal perceptions, thoughts, insight and capacity
- Impression
- Risks to self, others and suicidal ideation
- Accommodation
- Plan

6.52 They found Mr B's risk to be low across all key domains. The SI highlights that the CPN conclusions did not reflect the depth of concern reported to the RAW the previous day, or that the CPN had given sufficient weight of the information provided by Mrs A.

6.53 The agency CPN assessment was discussed at the MDT held on 21st August 2017. It was agreed to allocate a care coordinator for Mr B and to refer him to Move to Independent (MTI) for supported living. This agreed action would have potentially supplied a care co-ordinator as in line with CPA.

6.54 The SaBP, Care Programme Approach (CPA) [22] policy states the following in relation to the role of the Care coordinator:

6.55 *A Care coordinator can be any qualified member of the Multi-Disciplinary Team (MDT).*

They will:

a Coordinate the on-going assessment of the person using services and to respond accordingly.

[22] Feb 2018 SABP/EXECUTIVEBOARD/0051 *Care Programme Approach (CPA)*

b *Ensure people and carers are central in planning and agreeing the plan of care.*
c *Consider any Advance Directives the people who use services may have made.*
d *Ensure that the care plan is regularly reviewed. In collaboration with the person using services, organise and arrange review meetings.*
e *Act as a reference point for other professionals, relatives, carers and advocates.*
f *Maintain contact with the person wherever they are e.g. in hospital.*
g *Ensure a dynamic risk assessment is undertaken and a crisis, relapse and contingency plan is established – updating these after every review (or sooner if necessary).*
h *Record care plans and assessments including changes, decisions and goals on SABP's electronic patient records (EPR).*
i *Ensure consistency in care during planned or unplanned absence by ensuring that there is a clear handover for the person covering (where possible), plan of care /recovery plan / safety plan information is up to date and accessible on SABP's EPR.*
j *Arrange reviews for person using services unless they are on the acute care pathway (acute mental health ward or under care of the Home Treatment Team), where a designated nurse working in collaboration with Care Coordinator will take responsibility.*
k *Ensure that when there is a change of care coordinator, this must be agreed and the rationale recorded in the person's progress notes.*
l *Ensure that the person receiving care is informed of any changes in Care Coordinator, preferably well in advance and wherever possible, a handover period agreed to allow the person to get to know their new care-coordinator.*

6.56 The above description of the role demonstrates that a care coordinator would have provided closer care and support for Mr B and would also have been a point of reference for his mother. Unfortunately, a care coordinator was never allocated.

Change of MDT Decision

6.57 On 4th September 2017 an entry was made in electronic case recording system by the agency CPN. It states that:

The entry by the team consultant psychiatrist on the 21.8.17 to allocate a CC to N should read as follows: CPN to refer (Mr B) to MTI and recovery College. CPN to write letter of transfer of care to his GP.

It is not clear if this was a change of the record of the original MDT on the 21st, or as a result of a decision made at further MDT, following review, held in or around 4th September 2017.

6.58 This entry is significant as it effectively stopped the planned allocation of a care co-ordinator and referred Mr B back to his GP. The GP never received any formal letter setting out the decision.

6.59 It is of note that the CPN met Mr B with the MTI service on 30th August 2017. Following that meeting it was recorded that a letter would be sent to Mr B's GP transferring his care. This appears to be in line with the entry made on 4th

September 2017 so indicates that the plan to allocate a care coordinator was made prior to the entry of 4th September 2017.

6.60 At the time Mr B was receiving therapy from the Centre for Psychology. This was a self-referral. The Centre when they became aware of Waverley CMHRS involvement, sought permission from Mr B to contact Waverley CMHRS. This was good practice and they were informed by the agency CPN that they would be taking the case. The Centre for Psychology were never informed that this action was changed and as a result discharged Mr B believing he was being supported by Waverley CMHRS.

6.61 The significant change in the decision between the meeting and the entries of 30th August and 4th September was explored by the SI. They spoke to the team consultant psychiatrist who did not recall having any discussion about changing the decision at an MDT. The SI states that the agency CPN could not be spoken to, as they have since left and did not have a forwarding address.

6.62 The author contacted the agency and located the CPN and spoke to him as part of this review. He stated that the entry he made would have been as a direct result of a decision made at an MDT held on or around 4th September 2017. He stated that he would not have changed the agreed action plan without authorisation. Waverley CMHRS have been unable to identify any recorded entry in any MDT notes which confirms the action change.

6.63 The change of plan is an important point in Mr B's care as it placed Mr B back into the care of the GP, as opposed to having in place a care coordinator. The author has been unable to establish the origins of this decision so cannot confirm if it was authorised clinical decision or an unauthorised decision made by the agency CPN. It is unfortunate that the origins of the decision changing process were not explored further in the SI. It brings into question the quality and robustness of the SI in this case and reemphasises the importance of the recommendation at 6.26.

6.64 If authorised the assessment on which this decision to change the plan was based does not appear to have been documented. It must be concluded that if authorised it was not a fully assessed decision and it delayed Mr B's future treatment.

6.65 If the change was not authorised then there was a lack of case oversight/supervision. This change should have been identified and challenged.

6.66 Concern is expressed in the amended SI with regard to the agency CPN's ability. Having spoken to the agency CPN, he accepted that they were relatively inexperienced in the role, but they felt that there was a lack of supervision or support at the time they were working at the Trust. These comments are supported by the findings of the SI and are reflected in the report's recommendations, which sets out the need for a structured induction and orientation for all agency and temporary staff and the need to ensure that they are supported with ongoing supervision in line with professional requirements.

Lesson

6.67 Had robust oversight and supervision taken place at this time then the weaknesses identified in the CPN's assessment process and if unauthorised the change of plan, may have been identified and addressed.

6.68 The SI made the following recommendations:

WCRT team to ensure that all referral decisions are communicated to primary care within 7 days in line with extant policy.

WCRT team to ensure that their care coordinator (CC) and Community Psychiatric Nurse (CPN) give appropriate consideration to all additional information obtained as part of assessment.

WCRT clinical leadership team to ensure that where appropriate, information obtained from families, friends and carers are used to triangulate what is already known about people to enable a robust risk assessment and care plan that reflects people's needs at that point in time.

WCRT team to ensure clarity around their decision making process, clearly document decisions made and, implement them in a timely manner. When a decision is amended or changed, ensure that this is clearly documented and communicated, including reasons for change.

WCRT to review their assessment process to ensure a systematic and robust approach to psychiatric history taking, mental state examination, formulation, differential diagnosis and risk assessment with timely and adequate medical input as appropriate.

Waverley CRT to review risk assessment processes and need for education and training around actuarial and contextual risk factors.

WCRT clinical leadership team to ensure that, in line with Trust protocol, in all cases, all agency and temporary staff receive structured induction and orientation to their team and the local area.

WCRT Ensure that temporary and agency staff are supported with ongoing supervision in line with professional requirements to enable optimal care delivery.

6.69 RECOMMENDATION

Surrey and Borders Partnership NHS Foundation Trust:

To report to the CSP when all SI recommendations are implemented and changes made.

6.70 Whilst there were no children and young people involved in this case this was still a family unit mother and son, so all information needed to be considered assessed. There is evidence that some of Mrs A's concerns was considered which indicates that a limited 'Think Family' approach was adopted to some of the assessments undertaken. The CCG have been promoting the Think Family approach since they became an integrated Adults and Children's Safeguarding

Team in September 2016, and they state that they encourage it through their providers.

6.71 RECOMMENDATION

Surrey and Borders Partnership NHS Foundation Trust:

Should promote a 'Think Family' approach to assessments.

6.72 On 29th September 2017 the GP made a further urgent referral and Mr B contacted the crisis line at the advice of the GP. This led to a Waverley CMHRS social worker undertaking a telephone assessment. This assessment concluded that he was low risk, but noted that the case would be discussed at the next MDT meeting. It was at this time that Waverley CMHRS received Mrs A's letter setting out her serious concerns. Mrs A was contacted and told that her son's case would be discussed at the next MDT meeting.

6.73 This MDT meeting took place on 9th October 2017. At this meeting it was agreed to offer Mr B a new assessment for 24th October 2017. As has previously been recorded, at a previous MDT it had been agreed to allocate Mr B a Care Coordinator, a decision that was changed in September. This leads to a number of questions

- Why was this not picked up at this MDT?
- Why was it agreed to offer a new assessment when he had already had one?

The author has sought to identify documented evidence that might provide further insight into the decision making, but has been informed that there is no reference to the changes or previous action recorded in any of the MDT minutes.

6.74 RECOMMENDATION

Surrey and Borders Partnership NHS Foundation Trust:

That Waverley CMHRS ensure that changes to decisions made at MDT should be fully recorded and endorsed by the consultant doctor.

6.75 A further assessment was undertaken on 24th October 2017. Mr B was found to be in low mood with fleeting thoughts of suicidal ideation with no protective factors, with poor concentration which affected his decision making. The assessor agreed that the case would be discussed at the next MDT on 30th October 2017. The fatal attack took place prior to this date.

6.76 The decision not to allocate a Care Coordinator in August 2017 was critical in this case. Mr B was actively seeking help and support from someone. In his opinion he was met with rejection every time he had an assessment by Waverley CMHRS. He was falling between secondary and primary care support. It is of note that this was highlighted on 20th October following communication between Psychiatric Liaison Services and Community Health Psychology. The case note states *….Psychologist notes main factor is on-going mental health issues and is concerned he is falling between the gap of primary and secondary health services….* His mother

was also desperately looking for support for her son. She had in her view lost a daughter and did not want to lose a son to mental illness.

6.77 A consequence of this feeling of rejection was to make him vulnerable to approaches from other individuals offering support such as Miss C to be commented upon later in this report.

6.78 Not communicating decisions to the GP was a major failure. It was not a one off mistake, the GP received no communication from Waverley CMHRS in respect of Mr B. The author explored why this happened and sought reassurance that it was not still happening.

6.79 It was Waverley CMHRS practice at the time, and still is, for the CPN to have responsibility for preparing and sending the GP letter. Given the problems with staffing and workload, it would appear that busy staff were not following up on the task. When asked if this responsibility was standard across the area, it was established that at other CMHT's this task is undertaken by the admin team. This would seem to be a more appropriate use of staff time and should ensure that letters are sent.

6.80 What the author also established was that the GP contacted the Waverley CMHRS by telephone. These contacts were not recorded. All contacts should be recorded.

Lesson

6.81 It is essential that decisions taken by CMHRS, such as to discharge, are communicated in a timely way to the patients GP, and that there is a system in place to ensure letters are prepared and sent.

6.82 RECOMMENDATION

Surrey and Borders Partnership NHS Foundation Trust:

To ensure that Waverley CMHRS have process in place that will ensure that letters are prepared and sent to GPs (or other services) when decisions are made to discharge.

Impact on Mr B

6.83 Deterioration of Mr B's mental health during 2017, which rapidly declined from July 2017 to October 2017 is evidenced by his extensive contact with his GP.

6.84 The author met Mr B in the secure facility in which he is currently being held and receiving treatment. The author sought advice, and whilst he was able to discuss Mr B's feelings leading up to the fatal attack, he did not explore the final couple of days as he did not want to cause any setback in his treatment programme.

6.85 Mr B was very open about his feelings and described how he felt when his sister had her major breakdown in late 2016. He felt anxious as he was worried about his mother, but at the same time felt that her interaction with her daughter had not helped his sister.

6.86 The major change in his health which turned from anxiety to thoughts of suicide, commenced when his sister declared that she did not want any contact with her family. He felt he was to blame in some way.

6.87 He tried all sorts of treatment in Talking Therapies which he did not feel helped in anyway. His overall feeling was that he *"did not feel anyone was helping him"*

"He was going around this spiral".

6.88 If a care coordinator had been allocated as per the agreed action plan at the MDT meeting 21st August 2017, then it may have provided Mr B with a central contact to support him possibly helping to reduce his deterioration.

External Support

6.89 As well as receiving official counselling he also started to see an individual (friend of a neighbour) who claimed she was a counsellor (Miss C). This individual stated, when spoken to by the police after the attack, that she was Mr B's mental health nurse and had carried out a number of counselling sessions with him over the past two months.

6.90 This individual's impact on Mr B's deteriorating condition is concerning. From his diary entries it is clear that he was in regular contact with this person. The first contact appears to have been on 21st September 2017, then he has recorded contact with her at least twice a week from then on.

6.91 Miss C has been subject to a Section 42 Care Act 2014 [23] safeguarding enquiry and police considered their actions, specifically around possible offences. No further action has been taken in relation to either enquiry.

6.92 It is evident from what Mr B told the safeguarding enquiry and during his interview with the author, that this individual was not helping his mental situation, in fact he clearly believes it was very detrimental. She was introduced to Mr B by a friend.

6.93 From the safeguarding enquiry it has been established that she has no medical background or qualifications. She told police that she had set up a charity following the death of her son. During one session she asked Mr B to withdraw some money. She is not a registered charity, she accepts donations.

6.94 In order to try and understand how this relationship developed and her knowledge of Mr B, the author attempted to contact this individual to see if they were willing to be interviewed. The individual did not respond so it was not possible to speak with her.

[23] The **Care Act** 2014 (**Section 42**) requires that each local authority must make enquiries, or cause others to do so, if it believes an adult is experiencing, or is at risk of, abuse or neglect. An enquiry should establish whether any action needs to be taken to prevent or stop abuse or neglect, and if so, by whom.

6.95 These circumstances evidence how an individual's desperation when statutory services fail to respond (in this case, Mr B's and his mother's growing desperation for support for him) enable a person such as Miss C to offer services such as counselling which may not be in the best interest of a vulnerable individual such as Mr B.

7. SUMMARY: LINES OF ENQUIRY

7.1. The terms of reference lines of enquiry were taken into account during the review. The following is a summary of the findings.

7.2. **In the knowledge that both the victim and the perpetrator were known to services, was the information available and did the individual agency act upon it in a timely manner?**

The level of information available and how each agency reacted is covered in in the main report.

7.3. **Was there any involvement of the Multi Agency Risk Assessment Conference?**

In this case there were no reported incidents of domestic abuse prior to the final fatal assault, so the MARAC process was not considered. It was confirmed that SaBP attends all Surrey MARAC's and Care Coordinators are invited to attend when appropriate.

7.4. **In services where there was involvement with the victim or perpetrator, were there adequate safeguarding and domestic abuse policies and procedures and were they followed?**

Each of the services involved with the family had in place safeguarding and domestic abuse policies and procedures. No domestic abuse, either historic or current, was identified by any agency or by family or friends so the appropriate application of policy was not tested.

7.5. **Was there sufficient good quality information sharing and communication between agencies in place to address the level of risk and safeguarding concerns?**

It is evidenced in the report that there was a failure of communication between Waverley CHMRS, the GP and the Centre for Psychology. At no stage did they ensure that the GP was updated. Assessments undertaken, only identified potential risks to Mr B potentially self-harming. When a risk of self-harm was identified by the GP they made the appropriate referrals to CHMRS. There is no evidence presented that indicated that Mrs A was ever at risk of harm from Mr B.

7.6. **Were the appropriate actions taken to identify risk and were risk assessments conducted and robustly managed?**

There is evidence of the application of risk assessments by the GP and the IAPT services. However, the assessments undertaken in this case were clinical assessments. At no stage was any domestic abuse identified or considered. The assessment process applied by the CHMRS was identified as lacking and failed to

consider all available information. This was compounded by the change of the decisions made in August 2017. There was a failure of supervision, so the oversight of the work of the CPN including the sufficiency of his assessments, were not robustly managed.

7.7. **Were there any opportunities for professionals to routinely enquire as to any domestic abuse experienced by the victim that were missed?**

No evidence of an abusive relationship between Mrs A and Mr B was identified or suspected by any professionals, friends or family. There was no evidence that staff lacked the confidence to make enquiries of individuals into issues of potential domestic abuse. In this case no individual identified that Mrs A was being abused by her son or that her son was abusing her so no direct enquiry was made of Mrs A.

There were indications from the family that Mr B had been in an historic abusive relationship during his marriage ending in 1988. They were not able to expand on what type of abuse he may have been subject to. No professional was aware of the possibility of abuse, so the impact this might have had on Mr B was not explored further by any agency.

7.8. **What training was undertaken or available to staff?**

It is evidenced that Domestic Abuse training was available to staff.

GPs

Domestic abuse training had been included for several years in the level 3 safeguarding training aimed at GPs, GP trainees, and more recently practice nurses. Initial training covers awareness raising, and was co-presented between the designated GP team and managers from the local DA outreach services. During 2020, training on coercive controlling behaviour has been delivered, but this has of course been interrupted by Covid 19. It is hoped to resume this training via webinar in the early autumn.

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Domestic abuse isn't currently mandatory, but it is promoted widely across the Trust as important. Domestic abuse covers approximately a third of the safeguarding adults level 2 training provided in the Trust. DASH training has been provided to staff in partnership with Outreach services. It is also included in the safeguarding children's training.

There is currently work being undertaken to ensure this becomes mandatory. The SCC academy DA training has been promoted across the Trust.

7.9. **Are there any training or awareness raising requirements that are necessary to ensure a greater knowledge and understanding of the services available?**

No additional training requirements have been identified.

7.10. **Give appropriate consideration to any equality and diversity issues that appear pertinent to the victim, perpetrator and dependent children?**

Covered at 2.20.

7.11. **Was a "Think Family' approach adopted?**

Mrs A's feedback was taken into account in some of the assessments so there was evidence that a limited 'Think Family' approach was adopted by the health agencies. The SI made recommendations that:

WCRT clinical leadership team to ensure that where appropriate, information obtained from families, friends and carers are used to triangulate what is already known about people to enable a robust risk assessment and care plan that reflects people's needs at that point in time.

7.12. **Where did Mr B present and what was the outcome?**

This was explored fully in the main report.

7.13. **Were risk assessments produced and shared with Mr B and the GP?**

There is no evidence that any of the assessments undertaken by Waverley CMHRS were shared with Mr B, and as previously highlighted they failed to share information with his GP. The GP was very responsive to his needs.

7.14. **Did he report thoughts about harming others, was risk to others assessed and documented?**

At no stage was there any indication that Mr B had any thoughts about harming others or was considered a risk to others. None of his actions apart from the final attack indicated that he was a risk to others. The family have remained supportive of him and also had no concerns that Mr B was a risk to any other person.

7.15. **What were the risks to himself, suicidal thoughts and supporting risk management plans?**

He expressed suicidal thoughts to the GP and as a result the GP followed up appointments, as well as providing details of the Crisis service and Samaritans. They also referred Mr B to secondary care mental health services on 24/07/17 and also sent an urgent fax on the 28/09/17.

The subsequent Waverley CMHRS assessment which was undertaken on 24th October 2017 did identify *'fleeting feelings of suicide'*. The case was to be discussed at a MDT meeting on 30th October. Unfortunately, the fatal attack took place prior to this date.

7.16. **The impact of counsellor Miss C?**

This has been covered in the report at 6.58.

7.17. **Was there a Health Serious Incident review?**

Yes, there was an SI which was used to inform this report.

8. CONCLUSION

8.1. The circumstances of this case are tragic, but there is no evidence that prior to the fatal attack there had been any previous incidents, which would have indicated that Mr B was, to any level, verbally or physically abusing his mother. Evidence suggests that he wanted to ensure that she was being supported. There are indications that Mr B may have been subject to some form of abuse during his marriage that ended 20 years previously, but this was never explored by any agency to determine if this had impacted on his relationship with females including his mother.

8.2. Whilst there were indications that Mr B might have had thoughts about harming himself, there were no indications that he would harm any other person.

8.3. What was evidenced in the review, was Mr B's rapidly deteriorating mental health and his mother's concern for him which was not fully addressed.

9. RECOMMENDATIONS

1. Surrey and Borders Partnership NHS Foundation Trust:

To ensure they have a robust SI review process in place that ensures SIs are tracked and subject to quality control before being released.

2. Surrey Heartlands CCG's Safeguarding Team:

To communicate findings of this review to GPs, to emphasise that all contacts including follow up telephone conversations are recorded.

3. Surrey and Borders Partnership NHS Foundation Trust:

That Waverley CMHRS have process in place, that will ensure that letters are prepared and sent to GPs (or other services) when decisions are made to discharge.

4. Surrey and Borders Partnership NHS Foundation Trust:

That Waverley CMHRS ensure that changes to decisions made at MDT should be fully recorded and endorsed by the consultant doctor.

5. Surrey and Borders Partnership NHS Foundation Trust:

To report to the CSP when all SI recommendations are implemented, and changes made.

6. Surrey and Borders Partnership NHS Foundation Trust:

Should promote a 'Think Family' approach to assessments.

10. GLOSSARY OF ACRONYMS

CBT (Cognitive behavioural therapy)

CCG (Clinical Commissioning Group)

CMHRS (Community Mental Health Recovery Service)

CPA (Care Programme Approach)

CPN (Community Psychiatric Nurse)

DHR (Domestic Homicide Review)

EPR (Electronic Patient Records)

IAPT (Improving Access to Psychological Therapies)

MDT (CMHRS team assessment feedback meeting)

MTI (Move to Independent for supported living)

PWP (Psychological Wellbeing Practitioner)

RAW (Rapid assessment social worker)

SaBP (Surrey and Borders Partnership NHS Foundation Trust)

SAR (Safeguarding Adult Review)

SI (Serious Incident Review)