OVERVIEW REPORT

DOMESTIC HOMICIDE REVIEW 6 - 2015

Author - Chris Few

June 2016

CONTENTS

PERSONAL PERPECTIVES OF C **3**

INTRODUCTION **5**
- Summary of circumstances leading to the review 6
- Terms of Reference 6
- Review Process 7
- Family Engagement 8

THE FACTS **9**
- Family Background 9
- Summary of Events 10

ANALYSIS **21**

CONCLUSIONS **27**

RECOMMENDATIONS **30**

Appendix A - Terms of Reference
Appendix B - Agency Recommendations and Action Plans

“C was a much loved Aunt and although I hadn't seen her for many years - as my family emigrated to Rhodesia and then moved to South Africa - she kept in contact with my parents and after my parents died in 1986 she kept me updated with all the family matters sending photographs, holiday postcards, birthday cards etc.

In 2012 I returned to live in the UK and set up home close to a cousin and within easy distance of C and D and we were able to visit them often and take C out for lunch and shopping and these outings were so enjoyable for C and she would reminisce about the five sisters growing up.

She was just such a lovely lady and I miss her so much - even at 95 she was quite active and 'with it' it's such a tragedy that she was unable to spend her final years in a calm happy atmosphere - if D had had the treatment he desperately needed then C would have had that peaceful end to her long life.”

“C was a wonderful aunt, warm and friendly and totally reliable. She was very creative and enjoyed sharing her skills with others. She taught me to use a sewing machine and then regularly talked me through making curtains, putting zips and piping in cushion covers and when my work commitments were too great for me to do them myself she would do these things for me. We both loved art, C was much better than I was in producing good amateur paintings but we spent time discussing our shared creative hobbies.

She cared for all of her nieces and nephews, there were always treats when we visited, when we were young it was her own home-made ice lollies and later on beautifully prepared food which had been put together with love. There was always a "little something" to come away with, a pot of jam, some cake or special chocolate.

C was a very caring mother to D, always patient and compassionate and wanting the very best for him, D in return, would always have his mother high on his priorities. C was a wonderful sister to her elder sisters. She was my mother's "wheels" and when their respective husbands had died the two of them enjoyed an excellent social life. She was very patient with my mother. C had always been an immaculate dresser and was quite trendy even in her later years but in the last few months of her life she "downgraded" to being casual and comfortable but her hair and makeup would still be done. She was a very proud woman.

We were on holiday when we were informed by the police of C's death, that holiday to celebrate my husband's big birthday will forever be tainted by my aunt's untimely death. C was a kind, thoughtful and loving aunt whom I adored and her death and the arrest of my cousin D have halved my family members. The fact that D killed his mother is abhorrent and difficult to understand as he loved her so much. I feel that if D had received the medical treatment which he so obviously needed and asked for then my aunt would still be alive and D would have a worthwhile life and would still be part of our family. It makes me very angry that C and D are victims of a system that I feel failed them.

Although C was 95, she was great fun. She loved us to take her out and we loved to do it. She could walk with an arm to support her. She could reminisce and would enjoy hearing about the lives of others. I had taken photographs on our recent holiday to show C on our return, they were of places that C and I had visited many years before when we were soaking up the culture of Italy, they are now a permanent reminder of her tragic death.

The mental images of the violent last few minutes of my aunt's life continue to haunt me, as does the level of desperation that both C and D must have felt at the time. She is, however, now at peace and free from D 's mental torment.”

INTRODUCTION

1.1 Domestic Homicide Reviews were introduced by the Domestic Violence, Crime and Victims Act (2004), section 9.

1.2 A duty on a relevant Community Safety Partnership to undertake Domestic Homicide Reviews was implemented by the Home Office through statutory guidance in April 2011. The 'Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews' was updated in August 2013 and that revision provided the framework within which this Review was conducted[1].

1.3 A Domestic Homicide Review (DHR) is defined[2] as:

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 person to whom he was related or with whom he was or had been in an intimate personal relationship, or
- a member of the same household as himself,

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

1.4 The purpose of a DHR is to:

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

1.5 DHRs are not inquiries into how the victim died or into who is culpable; that is a matter for Coroners and criminal courts. They are also not specifically part of any disciplinary enquiry or process; or part of the process for managing operational responses to the safeguarding or other needs of individuals. These are the responsibility of agencies working within existing policies and procedural frameworks.

[1] www.homeoffice.gov.uk.
[2] Domestic Violence, Crime and Victims Act (2004), section 9 (1).

2 Summary of Circumstances Leading to the Review

2.1 The perpetrator D is the son of the victim, C. Although having a home of his own D had resided with his mother for much of the time from 2010 onwards and from May/June 2014 had done so almost exclusively.

2.2 In April 2015 D contacted Staffordshire Police and reported that he had killed his mother at her home address in Stoke-on-Trent. Attending Police Officers found C deceased with head injuries. D informed the officers that he had killed his mother by hitting her with a wrench wrapped in a sock some time previously. This was established as having happened two days earlier.

2.3 A homicide investigation was commenced by the Police. D was arrested at the scene and subsequently charged with the murder of C. D's mental health later deteriorated and he was transferred to a secure hospital ward.

2.4 A post mortem examination confirmed the C had died as a result of blunt force trauma to her head and suggested a minimum of six blows to the back of the head.

2.5 On 11 May 2015 a Scoping Panel convened on behalf of the Stoke-on-Trent Responsible Authorities Group considered the circumstances of the case and concluded that the criteria for conducting a Domestic Homicide Review were met. A recommendation to commission a Domestic Homicide Review was endorsed by the Chair of the Responsible Authorities Group.

2.6 In September 2015 D pleaded guilty to the manslaughter of C on the grounds of diminished responsibility. He was ordered to be detained in a secure hospital.

2.7 HM Coroner for Stoke-on-Trent and North Staffordshire opened and adjourned an inquest pending the outcome of the criminal trial. That inquest will not now be reconvened.

3 Terms of Reference

3.1 The full Terms of Reference for this Review are at Appendix A. The following is a summary of the key points.

3.2 The Review considered in detail the period from 1 July 2014 (when C's GP made the first adult safeguarding referral in respect of her) to the date in April 2015 when C was found deceased. Summary information regarding significant events outside of this period was also considered.

3.3 The focus of the Review was on the following individuals:

Name	C	D
Relationship	Victim	Son of victim
Gender	Female	Male
Age (April 2015)	95 years	73 years
Ethnicity	White British	White British

3.4 In conjunction with the areas for consideration outlined at Section 4 of the Statutory Guidance the Review specifically considered the following issues:

- Mental Health of D and the effectiveness of services provided
- Identification of C as a vulnerable adult in need of safeguarding and the effectiveness of responses to this.
- The relevance of the research base in respect of suicide pacts to this case.

4 Review Process

4.1 Requests to confirm the extent of their involvement with the subjects of this Review were sent to all statutory and voluntary agencies in Stoke-on-Trent and Staffordshire who may potentially have had such involvement. This scoping process was used as the basis for more targeted requests for Management Review and Summary Information Reports.

4.2 Management Review and Summary Information Reports were submitted by:

- Shropshire Clinical Commissioning Group (CCG) on behalf of NHS England, Stafford and Surrounds CCG and Stoke-on-Trent CCG (Primary Care Services)
- South Staffordshire and Shropshire Healthcare NHS Foundation Trust
- Staffordshire Police
- Stoke-on-Trent City Council
- University Hospitals of North Midlands NHS Trust

4.3 Other sources of information accessed to inform the Review included a review of the research literature on suicide pacts conducted on behalf of the Review Panel by a South Staffordshire and Shropshire Healthcare NHS Foundation Trust Practitioner. The Review Panel is very grateful for this assistance.

4.4 The Review Panel was chaired and this report of the Review was written by Chris Few, an Independent Consultant. Mr Few has chaired review panels and written overview reports on behalf of numerous Community Safety Partnerships, Local Safeguarding Children Boards and Local Authorities in connection with Domestic Homicide Reviews and Serious Case Reviews[3]. He has no professional connection with any of the agencies and professionals involved in the events considered by this Review.

4.5 The Review Panel comprised the following post holders:

- Head of Safeguarding Adults
  Shropshire CCG on behalf of NHS England, Stafford and Surrounds CCG and Stoke-on-Trent CCG (Primary Care Services)

- Deputy Director of Nursing
  North Staffordshire Combined Healthcare NHS Trust

- Risk and Claims Manager
  South Staffordshire and Shropshire Healthcare NHS Foundation Trust

- Senior Investigating Officer
  Staffordshire Police

[3] Under the Children Act (2004) and its associated statutory guidance.

- Manager
  Investigative Services Policy, Review and Development Unit
  Staffordshire Police

- Safer City Partnership Manager
  Stoke-on-Trent City Council

- Personal Crime Programme Lead
  Stoke-on-Trent City Council

- Adult Safeguarding Team Manager
  Stoke-on-Trent City Council

- Lead Nurse Adult Safeguarding
  University Hospitals of North Midlands NHS Trust.

4.6 The Review Panel met on two occasions in July 2015 and April 2016 to consider contributions to and emerging findings of the Review.

4.7 Completion of the Review was delayed from the original timescale owing to the criminal prosecution of D and then in order to secure his involvement once he was well enough to contribute. This Overview Report was endorsed by the Review Panel on 1 July 2016 and forwarded to the Chair of the Stoke-on-Trent Responsible Authorities Group. On 22 July 2016 the report was presented to and endorsed by the Responsible Authorities Group.

5 Family Engagement

5.1 C's next of kin is D. The only other known family members are 3 nieces and one nephew of C, two of whom had no recent contact with her. Members of C's family were advised of the Review at its outset and invited to contribute.

5.2 On 4 December 2015, following conclusion of the criminal proceedings, a niece of C, who had had considerable contact with D and C during the period under review, met with the Review Panel Chair and the Stoke-on-Trent City Council Personal Crime Programme Lead. The Review Panel is grateful for the valuable insight provided by C's niece, which has informed and been incorporated into this report.

5.3 D was informed of the Review at its outset and invited to contribute. No response was received. In April 2016 the Review Panel Chair was advised by South Staffordshire and Shropshire Healthcare NHS Foundation Trust that D was then well enough to contribute to the Review. The Review Panel Chair consequently contacted D and met with him on 11 May 2016. The perspective of D on events during the period under review has been incorporated into this report.

5.4 All members of C's family were given sight of this report on completion and prior to its submission to the Home Office. Two of C's nieces asked that their personal views of her be included in this report and their contributions are reproduced verbatim.

THE FACTS

6 Family Background

6.1 C was born in 1920, the fourth of her parents' five children.

6.2 She married at a relatively young age and the couple had one child, D, born in 1941.

6.3 In 1966 the couple purchased a house in Stoke-on-Trent which she occupied for the remainder of her life. Her husband suffered poor health in his later years and following a stroke, he became paralysed and was unable to speak. He died in 1986.

6.4 C had long standing diabetes and from 1984 had received treatment at University Hospital of North Staffordshire (now the Royal Stoke Hospital) for heart problems, in relation to which she had been fitted with a pacemaker.

6.5 In 1974 D was treated as an inpatient on a psychiatric ward with a diagnosis of schizo-affective disorder[4] and his health records contain a psychiatric assessment from 1975 which describes long standing recurrent depressive episodes. At various times thereafter D was treated with medication by his GP for anxiety and depression as well as having periods of inpatient psychiatric care.

6.6 In 1979 D married and lived with his wife in the Stafford area. The couple did not have children and during the 1980s they separated then divorced. The Review was informed that this relationship ended because of D's mental ill health. D continued to live at the house formerly occupied by the couple.

6.7 Around 2005 D retired early from his work as a government vehicle inspector on medical grounds associated with his mental health.

6.8 In 1997 D became friendly with S, a Thai national, and her husband. When S's husband died in 2009 the friendship between D and S continued and some twelve months later it developed into an intimate relationship. The relationship between D and S has been described by her as 'off and on' between 2010 and 2014. During this period it is understood that the couple spent considerable periods living with C and only occasionally living at D's home address.

6.9 In May or June 2014 the relationship between D and S ended and in December of that year she returned to Thailand. By that time D had become almost permanently resident with his mother at her home address.

6.10 D has no criminal convictions and his only contact with the Police prior to his arrest for murder was in relation to a theft from his car in 1999.

6.11 D had attended the Emergency Department of University Hospital of North Staffordshire (now the Royal Stoke Hospital – part of the University Hospitals of North Midlands NHS Trust) on two occasions, once in 2008 for a laceration to the hand and once in 2010 for a fracture to his hand.

[4] Schizo-affective disorder is a mental disorder characterized by abnormal thought processes and deregulated emotions. The diagnosis is made when the patient has features of both schizophrenia and a mood disorder—either bipolar disorder or depression.

6.12 C had attended the hospital Emergency Department and then had out-patient follow up for injuries resulting from falls in 1984 and 1999. Neither of these attendances is considered relevant to this Review.

7 Summary of Events

Material in italic text was provided by C's niece. It was not shared with any professional prior to the death of C.

Information provided by D to the Review Panel Chair in May 2016 is provided in text boxes.

7.1 On 2 July 2014 D visited his GP[5] and reported suffering with anxiety and panic attacks, attributed by him to concerns about having insured himself to drive his mother's car. His previous medication was restarted and arrangements were made to keep this under review.

7.2 **Safeguarding referral from C's GP and Social Care assessment – July 2014**

7.3 On 9 July 2014 D contacted C's GP surgery and informed them that he was the main carer for his mother and that he had to go away (to prison). He stated he had not been arrested and was vague over what he had done. The GP telephoned C who was recorded as being shocked by this and arranged to visit the surgery on 11 July 2014.

7.4 *In July 2014 D called C's niece and told her to contact the Metropolitan Police as C was going to be abducted. He could not say who was going to do it but held himself responsible.*

7.5 *During the months following this call D made further calls to C's niece, 2-3 per day and each lasting exactly 59 minutes, during which he described concerns about things that had happened in the past or were going to happen. D had a series of supposed misdemeanours, some dating back to when he was a child, which he expected to be punished for. C's niece concluded that most if not all of the matters raised by D were fantasy and attempted to disabuse him of his delusional beliefs.*

7.6 *During one of these calls, in July 2014 D told C's niece that he was going with C to see her GP for a routine appointment and asked that the niece inform the GP that he posed a risk to C. D was advised to tell the GP about this himself.*

7.7 On 11 July 2014 C attended her GP's surgery accompanied by D. D stated he had looked after mother for the last two years and was worried who would do this when he went away to prison. D also said he had given his mother's banking details to another person and insured himself on his mother's car. C was confused about this, did not know what D had done and stated that no one had been in contact with her about this. C informed the GP that D had anxiety episodes. The GP noted that D appeared very overprotective of C and took the view that the extent of the control exercised might constitute a safeguarding issue.

7.8 Advice was given on changing passwords for C's internet banking and she was invited to telephone the GP if she needed to.

[5] The GP practices with which D, as well as C, were respectively registered both have a number of GPs and other staff. During the period under review contact with the practices was not confined to a particular GP at each. There is no evidence that this, which is common practice within primary care services, adversely affected services. Nevertheless NHS England makes a recommendation for discussion of such cases at practice meetings to ensure effective information sharing and coordination.

7.9 C's GP thereafter contacted the Stoke-on-Trent Adult Safeguarding Team highlighting the vulnerability of C and the potential for financial abuse. A safeguarding referral was confirmed in writing by the GP.

7.10 Stoke-on-Trent City Council Adult Social Care reviewed the referral and on the basis that there was no evidence of money having been taken decided that a welfare check would be the most appropriate response. C's GP was contacted and informed of the decision. He was advised to re-contact Adult Social Care if he had any further concerns.

7.11 *After the GP appointment C was asked about it by her niece. She responded that D had spoken with her GP who was then abrupt with her and that she had been told by D that the GP was out to get her. C's niece advised the Review that thereafter C avoided going to see her GP unless it was absolutely essential.*

7.12 On 14 July 2014 D visited his own GP and reiterated his concerns about having insured himself on his mother's car. He told his GP that his mother's GP had stopped him seeing her. He was advised to write to C's GP and express concern that his mother would be at risk if D was unable to support her.

7.13 On 16 July 2014 D contacted C's GP by telephone and said he wanted to check that by moving C's bank account to a local branch he would not be breaking any rules. D stated that he had had no contact from Social Care. He was advised to do what was best for his mother. D then again called the GP and the conversation was repeated. The GP contacted Adult Social Care, was advised that they would visit C the following week and asked that he be updated on the outcome of their visit.

7.14 On 18 July 2014 Adult Social Care made contact with C by telephone and she was visited on 24 July 2014 by two Social Workers. D was present but offered to leave the room so they could speak to C alone. C stated that she was happy with the support that D provided, describing how D took her out, cooked for her, and earlier in the year he had taken her on holiday to Thailand. Both Social Workers felt there were no safeguarding concerns. An offer to assess C's support needs was turned down by C and the Social Workers viewed her as having capacity to make this decision.

7.15 When D returned to the room, both he and C were advised of the support available to them and offered an assessment. This was declined. The Social Workers agreed to send information and telephone numbers to D, so that if the circumstances changed in the future their support needs could be assessed. It was recorded that no further assessment was necessary at that time.

D informed the Review Panel Chair that Adult Social Care services were declined because those offered did not include what was required. He cited the example of a suggestion that someone could do C's shopping for her, stating that although she was unable to do her own shopping she was also not able to either prepare a shopping list, access money to pay for it or even put in her hearing aid.

7.16 On 25 July 2014 C's GP was informed of visit outcome and the case was closed by Adult Social Care.

7.17 *C's niece was made aware of the contact with Adult Social Care. She advised the Review that at that time D could be lucid when he wanted to be and was capable of giving the impression that everything was fine. Also that C went along with D's presentation as he was*

the more dominant character. She is therefore unsurprised that D and C managed to convince the Social Workers that no services were needed.

7.18 From August 2014 to January 2015 C was seen by her GP on a number of occasions for routine appointments. No issues were raised by her or identified.

7.19 **D contact with his GP and other professionals – September to October 2014**

7.20 *In the summer of 2014 C was visited by her niece (accompanied by another of C's nieces), who spent around 5 hours there. During this visit D was very agitated, talking incessantly to the point where C was unable to speak, and pacing up and down. D was particularly agitated about the car insurance. D contacted the insurance company and was heard by C's nieces to receive reassurance that his cover was in order, but he refused to believe this. D was advised by C's niece see his own GP. C was also advised to go with D to see his GP and inform the doctor about D's behaviour and how this affected her. She agreed to do this and subsequently told her niece that she had done so[6].*

7.21 On 12 September 2014 a "biopsychosocial" assessment of D was conducted by his GP. It was noted that his mental state had improved following the change in his medication but had then plateaued.

7.22 On 30 September 2014 D again saw his GP and reported memory problems, forgetting to take his medication and having left his mother in a supermarket. He referred to dwelling on the past, being anxious and having a low mood. The GP referred D to the Memory First service[7] , obtaining an appointment in October 2014.

7.23 On 15 October 2014 D again saw his GP. He requested a referral to a Neurologist as a private patient, stating that he felt his mental problems may have a physical cause and mentioned porto-systemic encephalopathy. D reported to the GP that he had been making bad decisions which caused problems for others and felt he was "dragging a second person around constantly".

7.24 *C's niece advised the Review that D first attributed his mental health problems to liver disease after reading the contra-indication advice notice for constipation medicine that he was taking.*

7.25 The GP agreed to refer D to a Neurologist and also to the private practice of a Psychiatrist. D was seen by these professionals on 22 October and 28 November 2014[8] respectively.

7.26 D's GP subsequently received notification from the Neurologist (on 27 October 2014) that metabolic encephalopathy had been ruled out and it was suggested that further psychological assessment be pursued.

7.27 There was an unexplained communication breakdown between the Psychiatrist and D's GP. The psychiatrist sent a letter dated 15 December 2014 to the GP requesting details of previous contact with mental health services. This did not arrive until 9 February 2015 when the requested records were dispatched. By this time D was receiving secondary mental

[6] There is however no record of C visiting D's GP with him until January 2015.
[7] Memory First is an integrated dementia service run by a consortium of 41 GP practices in Staffordshire. Its pioneering joined-up approach to care has cut diagnosis times from 3 years to 4 weeks and led to major improvements in patient experience.
[8] 28 November 2014 was the date recorded by D's GP from the Psychiatrist's correspondence. D, when interviewed was certain that the appointment had actually been in December 2014.

health services from SSSHFT and the involvement of the private practice Psychiatrist was no longer required.

7.28 On 21 October 2014 D was assessed for dementia by Memory First. It was noted to be a difficult assessment as D exhibited anxiety and psychological problems. It was terminated as D could not concentrate and the possibility of carer strain was noted. The GP record notes that the assessor needed further advice as "out of depth".

7.29 **Safeguarding referral from an acquaintance of D - November 2014**

7.30 On 4 November 2014 Stoke-on-Trent Adult Social Care Contact Centre received a telephone call from an acquaintance of D who expressed concern about D's behaviour and the impact it was having upon C. She stated that D had become angry at her mention of obtaining assistance with C's care and told her that he had himself arranged care for C. The acquaintance stated that she could not get to speak to C alone as D was always present.

7.31 D's acquaintance also recounted that C had said to her "it's alright, he doesn't hit me" which she took as meaning that C was being abused, although she had not seen any evidence of physical abuse and did not feel that C was being neglected.

7.32 Adult Social Care contacted the Multi-Agency Safeguarding Hub (MASH) Adult Safeguarding Team, who advised that Adult Social Care should speak to D's acquaintance again and signpost her to reporting her concerns to C's GP.

7.33 The following day Adult Social Care re-contacted D's acquaintance, who reported that she had visited C's home earlier that day and said that she would "keep an eye on her". The acquaintance also agreed to call C's GP to express her concerns regarding D and his mental health. There is no record of this call being received by the GP surgery.

7.34 *The Review was informed by C's niece that in early 2014, although 94 years old and suffering from physical ill health, C was active and very much with it. Her memory and independence of personality was however reported to have diminished from then on and she talked of being worn down by D persistently haranguing her about things which he said they had done in the past and the likely consequences of these. Towards the end of 2014 C was reported to have come to believe much of what D said to her, however far from reality this was.*

7.35 *C's niece formed the view that unless C was taken into a care home or D was treated effectively for his mental illness the situation of C and D was never going to end well. She noted that when visiting C it took an increasingly long time to calm her down and get her into a state where she could converse rationally. Also C was increasing disengaging from the small number of friends she had in order to avoid exposing them to D's behaviour; an example cited was that D had terrified a friend of C by convincing her that he was part of a terrorist sleeper cell.*

7.36 *Just before Christmas 2014 D contacted C's niece and told her that she should not visit him and C, as was customary, because C's house was full of bugs. During the conversation it was apparent that D was referring to both insects and eavesdropping devices without distinction. It was therefore arranged that they would meet at a garden centre where C's niece could give them a hamper of food which would provide for them over the holiday. When they did meet and in D's regular telephone calls prior to Christmas D said that he and C were going to kill themselves. C reported having been told by D that she was terminally ill with cancer and that although she did not believe this she did want to die because she could not cope with D's "constant bombardment" of untruths. D stated that C had asked him to end*

her misery. C's niece did not believe that D would do this but did advise C not to make such suggestions to D. C's niece managed to persuade D that he needed to seek help for his mental ill health.

7.37 **January 2015**

7.38 On 13 January 2015 D visited his GP, accompanied by C. The record entry of the consultation reads:

> "Difficult consultation. Feels he is struggling to manage with looking after his elderly mother. Mentioned that she is receiving help from her GP but is worried that she has died as her nose keeps running after putting an elastic band around her wrist for a short time – she is present today – not a patient here, registered at ….surgery and asked me if she had died – I explained no. [D] can see this is irrational but then talks about several issues. He feels he has hepatic encephalopathy as he feels his thoughts are clearer when taking lactulose. Mentioned that there are spies in both his and his mother's house - and that her house was recently raided by a Thai gang. NB he was previously in a relationship with a Thai lady which ended with problems…….
>
> Has a lot of paranoid thoughts that we (the surgery) are going to sue him for malingering. Accepts he does have some mental illness but is adamant that this is linked to his bowels. No suicidal thoughts voiced by patient, difficult to get him to answer questions with a rational answer. No hallucinations. Casually dressed, with mother – helps her to/from seat appropriately, not aggressive, good eye contact.
>
> Imp: psychosis – appears from notes to have been building for some time and other appears to be exhibiting similar symptoms. He agrees to a CMHT referral and I will try to chase private psych letter…… Note – his mother has an assessment at her own surgery on 21 Jan 2015."

7.39 On 19 January 2015 D's GP referred him to the Stafford Community Mental Health Team (CMHT), part of South Staffordshire and Shropshire Healthcare NHS Foundation Trust (SSSHFT)[9]. The GP described D to a Community Mental Health Nurse as suffering from "severe paranoia" and a summary of the GP's contact with D over previous months was provided. A letter offering a CMHT appointment on 4 February 2015 was sent to D.

7.40 *On 25 January 2015 D contacted C's niece by telephone and insisted that they meet so that she could return some documents belonging to him which she had for safekeeping. When C's niece went to C's address she was met outside by C and D, who insisted that she take them somewhere that they would not be seen. When returning the documents D stated that he and C were going to kill themselves and that he need to get their affairs in order. C thanked her niece for everything she had done and remarked "You can see what it's like." This was the last contact the C's niece had with her.*

7.41 On 26 January 2015 D telephoned C's GP surgery and asked to speak with a GP. He was noted to be anxious and said he was struggling with his mother's care. He was advised to call Adult Social Care. D then said that she had had an assessment in the past but misled them "saying she was ok when doing certain things when she wasn't". There is no indication that D contacted Adult Social Care as advised.

7.42 On 27 January 2015 D contacted the CMHT and stated that he wanted to talk whilst he had the ability. He described memory problems and difficulties expressing himself. He exhibited

[9] The South Staffordshire and Shropshire Healthcare NHS Foundation Trust is responsible for the delivery of mental health services in Stafford and the surrounding area where D's own address and his GP are located.

paranoid ideation, believing that he was being punished for things he had done in the past. He also described suicidal thoughts, saying that if he had a gun he would shoot himself, and reported that he believed his mother felt the same way. An assessment was completed by the Community Mental Health Nurse and this was summarised in a letter to D. This advised that the Nurse believed that he was suffering from depression and that he should be referred to an older adult specialist Psychiatrist to help with formulating a plan for him and his mother. D was offered an appointment earlier than 4 February but he declined this. The Nurse further explored whether D had thought about harming himself and he denied this, laughing. He was asked to call the Nurse if his suicidal thoughts got any stronger.

7.43 The Community Mental Health Nurse contacted an Adult Social Care Social Worker and was given information about D's presentation in July 2014 from their assessment at that time. The Nurse was advised that the case had been closed due to there being no concerns.

7.44 The Community Mental Health Nurse also contacted C's GP. Confirmation of the situation in July 2014 was provided but there is no indication that the Nurse was advised of D's contact with the GP on 26 January 2015 in which D reported that C had misled Adult Social Care.

7.45 On 28 January 2015 D again visited his own GP and expressed concern for C's welfare. D stated that he was making all the wrong decisions, and that if he got locked up she would not be able to look after herself. He was given contact details for Adult Social Care. As with the contact with C's GP on 26 January 2015 there is no indication that D contacted Adult Social Care as advised.

7.46 **February 2015**

7.47 On 2 February 2015 D contacted the CMHT to change the date of the arranged visit but declined bringing it forwards as he was "putting things in order" in the belief that after the appointment he and his mother would no longer be together. D denied any suicidal thoughts or plans. He stated that over the previous 12 months they had got in a "bit of a state" and he felt he was not coping with life as well as usual. D explained that he was struggling with online banking for himself and his mother and with keeping track of her medication.

7.48 D reported that both he and C were forgetful, and cited an example of when he collected a prescription from C's GP and put it in at the pharmacy, forgot he had done this and then requested another prescription from GP. He said he and C then thought that he would be prosecuted for receiving two lots of medication as sometime later the pharmacist reminded D that the medication was there. D denied depression and stated he had had a memory test which he said was ok. D said that he had intrusive thoughts/'flashbacks' about things he had got wrong in the past and felt isolated and alienated. The Nurse noted that the delusion of being in trouble appeared to be shared between mother and son.

7.49 D told the Nurse that C was worried about losing him, that he felt he made a mess of things and that she needed to be made a Ward of Court to protect her from him. The Nurse noted that D sounded concerned about his mother's welfare and as if he was doing all he could to help her. D did not acknowledge the impact on him of being a full time carer and declined a referral to the Carers Association.

D informed the Review Panel Chair that when he mentioned C being made a Ward of Court to protect her he was referring to management of her finances which she was unable to undertake through the complexities of internet and telephone banking, and which he also felt incapable of doing properly and within the law.

7.50 D was asked if he wanted a referral for C to Adult Social Care. He replied that they were both wary as they had heard stories about mistreatment.

7.51 D did agree to the Nurse speaking with C's GP with a view to having her medication dispensed in blister packs as an aid to managing it. The Nurse subsequently arranged this with C's GP and the local pharmacy.

7.52 It was agreed that the Community Mental Health Nurse would visit D on 10 February 2015. The Nurse and a CMHT Social Worker in fact made an unannounced visit to D on 5 February 2015 at the home of C. D reiterated to the Nurse that he felt he would be prosecuted for requesting additional medication from his mother's GP. D avoided talking about suicide but suggested he felt very isolated and persecuted. He expressed worry about his money in the bank and being able to follow what was happening with it

7.53 D also told the Nurse that he was experiencing pain in his side and back due to radiation from living close to an army firing range. He said that he was in "trouble with the Asians" and that they had infested his mother's home with insects; he never saw them other than the shells they left behind but he felt them biting him. D showed the professionals his back which had a number of moles visible. D was noted to have some insight into his difficulties but was not recognising that his thoughts were irrational.

D informed the Review Panel Chair that he was aware that he was acting irrationally at this time and felt that he was "losing his marbles" but could not bring himself to disclose this to the Community Mental Health Nurse and showed her the marks on his back as a distraction from his real issues.

7.54 No immediate risks were identified by the Nurse or Social Worker. D agreed to see a Psychiatrist but did not think he was mentally unwell and did not feel it would help. A further visit was arranged for 10 February 2015.

7.55 *Following the visit by the CMHT professionals D telephoned C's niece and told her about it. He said he was going to get the next home visit cancelled because of the bugs at C's home and that he would not go to see the Psychiatrist because there was no parking there and he would have to park on a yellow line which was wrong. C's niece advised him that there was a nearby car park, offered to give him a lift and urged him to accept any appointment that was offered.*

7.56 On 10 February 2015 the Community Mental Health Nurse telephoned D to advise that she would be visiting an hour later than planned. D stated he did not want the Nurse to visit as he felt unwell. The visit was re-arranged.

7.57 *On 17 February 2015 D telephoned C's niece and informed her that the Community Mental Health Nurse was going to visit. He also said that he had been in touch with Adult Social Care and was arranging for C to go into a care home. C's niece believed that he had done this but there is no record of him doing so. This was the last contact that C's niece had with D.*

7.58 Later on 17 February 2015 the Community Mental Health Nurse visited D and completed a Care Programme Approach[10] (CPA) review.

[10] The Care Programme Approach provides a framework within which services for individuals with complex mental health difficulties can be effectively managed. It provides for the appointment of a professional to act as Care Coordinator and prompts engagement of all agencies involved with the individual in sharing information and coordinated care planning. See Refocusing the Care Programme Approach: Policy and Positive Practice Guidance. Department of Health, 2008.

7.59 D's speech was rapid and the content included what appeared to be delusional beliefs and thoughts that he had been targeted and was being persecuted. D reported forgetting to pay for his shopping at the local shop and that he was now avoiding going there; he believed his past would catch up with him and he would be prosecuted and put into prison. He also felt that his identity was at risk of being stolen and continued to believe he had an illness, although the causes of this varied from radium exposure to the saccharine he used.

7.60 The Nurse noted that C believed many of the things that D was saying. The risk assessment completed as part of the CPA review identified low levels of risk to D relating to hopelessness, social isolation, malnourishment, exploitation by others and confusion. The Nurse formulated that D was not presenting an immediate risk to himself as the risks identified were balanced against his need to address a number of issues including internet banking, C's medication and the physical health needs of himself and C. The review did not identify D as posing a risk to others.

7.61 The Nurse suggested that D register with a GP local to his mother's address but he stated that he believed the surgery would not accept him because of past "trouble". The relevant GP surgery is unaware of any such issue with D.

D informed the Review Panel Chair that when visiting C's GP previously he had enquired about registering there but was informed by the receptionist that he would need to provide a utility bill to prove that he was resident in the area. As all of the utilities at C's address were in her name he was unable to do this and therefore did not pursue it further.

7.62 D was asked if he would complete a memory assessment but declined. He did however agree to attend an outpatient appointment with a Consultant Psychiatrist. This was arranged by the Nurse for 12 March 2015. D did not attend the Psychiatrist appointment as the invitation letter had been sent to D's own address instead of to C's address where he was residing.

7.63 **March 2015**

7.64 On 23 March 2015 the Community Mental Health Nurse telephoned D who stated that he did not want the Nurse to visit as he was struggling to manage his appointments. D said he was ok but expressed a belief that he would need to go somewhere and his mother would be left alone, which C was worried about. D reiterated that he was willing to see a Psychiatrist if an appointment was arranged. D stated that he felt he was "barmy" but did not report any thoughts about ending his life.

7.65 On 24 March 2015 C visited her GP accompanied by D. She disclosed concerns about not being able to get access to money and was noted to have a low mood. C was not sure whether she wanted to go into care but D was adamant that she should.

7.66 The GP took the view that C was a vulnerable adult as her son seemed to be making decisions for her which might not be in her interests. The GP discussed his concerns with colleagues and decided that a referral to Adult Social Care should be made.

7.67 On 25 March 2015 C's GP telephoned her and the call was answered by D, who advised that C could not hear. D was asked to get C to put in her hearing aids and that he would call back. When the GP did so he explained that he wanted to speak to Adult Social Care and ask that they assess her wellbeing and safety at home.

7.68 C's GP then called Adult Social Care and explained that C had been to the surgery a number of times with D who was not a patient there, but had mental health problems, the last visit being the day before. The GP stated that he wanted to make an Adult Safeguarding referral in relation to concerns about C:

- Her safety at home
- Her welfare and safety in terms of her son's mental health
- Her vulnerability regarding money as her son had tried to look after bank accounts, noting that C was fully aware of this but they could not access the money.

7.69 The GP was asked to complete and FAX an Adult Protection referral form, marked as urgent, and was advised that someone would deal with it straight away. There is no evidence in the GP records of an Adult Protection referral being completed or sent by FAX and there is no written referral on the Adult Social Care computer system.

7.70 The Contact Centre worker who took the GP's call contacted the Adult Social Care duty Social Worker for advice regarding the referral and in particular whether it was an Adult Protection issue. The Senior Social Worker advised the Contact Centre worker to contact D and to obtain more detail of the circumstances.

7.71 The following day, 26 March 2015, the Contact Centre worker called C's home telephone and spoke with D who reported that C was still in bed at the time. The Contact Centre worker advised D that the call was to discuss support for C and advised that there were services that could offer support to both him and his mother. D stated that at that time he and his mother were ok and they did not feel that any support was needed. D declined an assessment but was invited to get in touch if support was needed at a later date.

7.72 The Contact Centre record was closed on the basis that D had advised that everything was fine and there were no issues. There is no indication that the decision to close the case was subject to any management oversight. There is also no record of any feedback on the outcome being provided to the referring GP.

7.73 *Towards the end of March 2015 C's niece went on holiday. On 29 March 2015 D attempted to contact her through another relative and was informed that she was out of the country. D informed the relative that by the time C's niece returned he would not be there. When C's niece returned to the UK in April 2015, after being informed of C's death by the Police, she picked up voicemail messages from D which had been left on 28 and 29 March 2015. On 29 March D sounded desperate and stated that by the time C's niece returned from holiday it would be too late and it would all be over. C's niece reported this to the Police.*

7.74 **April 2015**

7.75 On 1 April 2015 the Community Mental Health Nurse was telephoned by D who was worried that he still had not received an appointment to see the Psychiatrist and that it may again have been sent to his home address rather than that of his mother. The Nurse again spoke to D about registering with a new GP practice and he agreed to explore this.

D informed the Review Panel Chair that on this occasion he told the Nurse that it was his inability to provide a utility bill as proof that he was resident at his mother's address prevented him doing so. He reported being advised that his own GP would be able to assist with a letter in support of him registering at C's GP Practice but did not have time to pursue this prior to the death of C.

7.76 D said he was feeling brighter and had decided to ignore his worries although it was clear that he continued to have the same delusional beliefs. He said his mother was much better and that they were able to get out. It was agreed that the Nurse would contact D after the Easter (3-6 April 2015) break.

7.77 On 7 April 2015 C did not attend an appointment at her GP's surgery at which it had been planned carry out a screening procedure regarding her memory.

7.78 **Death of C**

7.79 On an evening in April 2015 Staffordshire Police received a telephone call from D who stated "There has been an incident and it has resulted in me murdering my mother." He stated that he was at his mother's home address in Stoke-on-Trent.

7.80 Police Officers were admitted to the address by D and found the body of C lying on the floor in the living room with apparent head injuries. D informed the Officers that his mother had been dead for about three days and he identified the weapon he had used to cause the fatal injuries. He was arrested for the murder of his mother.

7.81 A table in the lounge had on it mortgage, financial and car documents, along with details of hospital appointments, arranged as if the affairs of both C and D had been put in order. There was also a handwritten and signed note from C which stated "I can't face living alone with [D] gone." The note also stated that D had done a good job caring for her. It has been confirmed that the note purporting to be from C was written by her.

7.82 The following day D was interviewed by Police Officers He was legally represented and was also supported by an Appropriate Adult.

7.83 D admitted to killing his mother in the evening two days before he called the Police. He explained that he had written a note recovered by the Police from C's address with the date and time on it. D explained that whilst his mother was sitting in an armchair in the living room, he stood next to her and hit her on the back of her head with a wrench which he had placed into a sock. He hit her several times, resulting in his mother sliding from the armchair onto the floor. He then placed his own blood stained clothing on a chair in the same room of the house, intending that these items would be recovered by attending Police Officers.

7.84 D spoke about several conversations that he had had with his mother about dying. He said that she wanted to die and had asked him to assist her with those wishes. She had the belief that once she had died, he would then commit suicide so that he would not get into trouble.

7.85 D stated that his mother was fully aware of what he was going to do and that she was awake at the time. He claimed that she had said; "Don't hurt me too much", that she had seen the wrench which he had purchased and knew that he was going to use it. He claimed to have said to her; "I'm going to have to do this as my life's over afterwards, if it's going to stop your distress." He stated that his mother died quickly, but not instantly and that he carried out her instruction to make sure that she did not recover.

7.86 D further explained that on a previous occasion in 2015 he had hit his mother on the head with a mallet but did not hit her hard enough and caused only minor discomfort. He claimed that his mother had said to him; "If you do it, you must go through with it, don't stop and leave me a cripple."

7.87 D stated that his intention had been to then take his own life and he considered hanging himself or travelling to a train line near to his own home address. He went on to explain how

he had travelled with his mother on a previous occasion to a train track with the intention of putting themselves in front of a train but they were unable to do so because of the security fencing.

When interviewed by the Review Panel Chair D stated that the plan for C and D to throw themselves under a train was not followed through because they were concerned about the impact that this would have on the driver of the train.

D further informed the Review Panel Chair that he had intended to commit suicide but when the time came he did not have the courage to do so. He maintained that he had not broken an agreement with his mother and that she had said to him "I leave it to you if you kill yourself."

7.88 D spoke at length about his personal circumstances, including having cared for his father at the time of his death during the 1980s. He spoke of problems that his mother had experienced involving neighbours, the Council and the general maintenance of her house. He described his mother in poor health, unable to manage her affairs and that without his help nobody could offer any continuity of care. She did not want to get out of bed in the morning and felt unpopular in her community.

7.89 He said that recently C had been relaying her past to him; things had been playing on her mind, including having stolen things, which she regretted and there were other matters that she felt unable to share with him.

7.90 During the interview D stated that he had had some mental health issues and memory problems, with being the sole carer for his mother adding to his own health issues. He was worried about his memory and stated that he believed that he had forgotten to pay for items at the local shop on a number of occasions. He was worried that he would get sent to prison for shoplifting leaving his mother without a carer. No complaints had been received by Staffordshire Police with regard to this.

7.91 A post mortem examination of C confirmed head injuries consistent with repeated blows from a heavy blunt weapon and suggested a minimum of six blows to the back of C's head. There were no other significant injuries to suggest any other form of assault and no restraint injuries.

7.92 Following the interview and consultation with the Crown Prosecution Service D was charged with murder

7.93 In September 2015 D pleaded guilty to the manslaughter of C on the grounds of diminished responsibility. He was ordered to be detained in a secure hospital.

ANALYSIS

8 July 2014

8.1 Identification by C's GP of the potential for financial abuse and making a safeguarding referral quickly and effectively was effective practice and the overall response was very focussed on securing C's wellbeing.

8.2 There was a missed opportunity for his GP to challenge D's implausible statement that C's GP had unilaterally intervened to stop contact between D and his mother, whom he was supporting, and more significantly to make contact with her GP. This would have supported a more coordinated and holistic approach to dealing with the situation of D and C. In particular information could have been shared with C's GP that D's mental health difficulties went beyond the anxiety mentioned by C, and in all likelihood have led to a more robust approach by her GP and Adult Social Care in their assessment of risk to C.

8.3 The Adult Social Care response to the referral received and what they found when visiting C on 24 July 2014 was appropriate. It was effective practice to offer an assessment of support needs but having judged that C had the capacity to make a decision on this there was no reason for them to question her decision not to accept this.

8.4 D's view that potential service provision, suggested as examples by Adult Social Care staff, did not match exactly that which he thought necessary, led him and C to decline the assessment offered. It is apparent that this also affected D's response to advice that he contact Adult Social Care in January 2015 and to him declining a further offer of support in March 2015. Had an assessment been accepted it is likely that the full extent of C's support needs, which were not disclosed by D or C, would have been identified.

8.5 Informing C's GP of the assessment outcome was effective practice.

8.6 **September – October 2014**

8.7 D was seen by his GP on a number of occasions and at his request made private practice referrals to a Neurologist and a Psychiatrist as well as for a dementia assessment. The records do not indicate an overall plan here and apart from establishing the absence of a metabolic cause for D's mental health condition little was achieved.

8.8 The private practice Psychiatrist's request for details of D's mental health history arrived after D started receiving secondary mental health services from SSSHFT; as a result of which the Psychiatrist's involvement was no longer required. The reason for the delay in this has not been established. The Review Panel observed that the practice standards applicable to NHS commissioned services, as opposed to private practice, would have required more timely follow up of the assessment, formulation of need and advice on treatment.

8.9 When D reported to his GP in September 2014 that he was having memory problems the referral for assessment of possible dementia was appropriate. It is clear with hindsight that the difficulties encountered in conducting the assessment were attributable to D's developing psychosis. The Review Panel considered whether consideration of other mental illnesses should form part of the dementia screening service and concluded that to do so, given the small number of cases involved, would unnecessarily undermine the positive improvements achieved in the identification and treatment of dementia. The Review Panel noted that when the dementia assessment was carried out D had already been referred by the GP to a Neurologist and a Psychiatrist.

8.10 When D was assessed by his GP the focus was on his health needs with little recorded information about the implications for his mother. On several occasions D voiced concerns about being a carer for his mother. The GP appropriately recognised the potential for carer strain and this was documented as an issue in the GP's referral to the Community Mental Health Team on 19 January 2015.

D himself informed the Review Panel Chair that although he recognised that caring for C was putting a strain on him he did not at the time realise the full extent of this and that it crept up on him to the point where he had been a full time carer.

8.11 It would have been appropriate to request that Adult Social Care carry out a carer's assessment, particularly as the GP was apparently unaware of Adult Social Care's contact with D and C in July 2014. C did not take the advice of her niece to go with D to his GP and report the manifestation of his mental health difficulties. Had she done so it is more likely that the GP would have taken a more holistic view of D's situation.

8.12 **Safeguarding referral by an acquaintance of D - November 2014**

8.13 When, in November 2014, the call from D's acquaintance was received by the Adult Social Care Contact Centre the reported reference by C to not being hit and the previous involvement with her should have led to engagement of the local Adult Protection Procedures. The response should consequently have included lateral checks with other agencies, including D's GP, and direct contact with C to gain more information regarding the behaviours about which D's acquaintance was concerned and circumstances within the home.

8.14 These procedures were however not initiated on the advice of the Adult Safeguarding Team.

8.15 Irrespective of the Adult Protection Procedures being engaged Adult Social Care should also have contacted C's GP to alert him/her to the concerns raised rather than asking the referrer to do so, again on the advice of the Adult Safeguarding Team.

8.16 The Contact Centre worker was correct in seeking advice from the Adult Safeguarding Team. The advice given was however inappropriate and the level of professional oversight within the Contact Centre was insufficient to recognise this and challenge it.

8.17 The Review Panel was advised that as a result of the introduction of the Care Act 2014 in April 2015 a new way of working has been implemented within the Adult Social Care access point. This incorporates a first contact assessment team, comprising staff who have received additional training and are considered competent to deal with all cases except safeguarding. A first contact assessment form used has integrated safeguarding sections within the questionnaire and a co-located qualified Social Worker was also reported to be available at all times.

8.18 The Review Panel was also advised that procedures had been changed and that a direct referral to the GP would now be made.

8.19 Whilst these are positive developments it is unclear if they fully address the need for professional oversight, advice and support for the new first contact assessor staff, which is

particularly important where callers are naïve regarding safeguarding issues and response arrangements[11].

8.20 The Review Panel therefore recommend:

That Stoke-on-Trent City Council review and monitor the effectiveness of their arrangements for professional oversight of the Adult Social Care access point and for referrers wishing to discuss their concerns with a Social Worker to be afforded that opportunity.

8.21 C's niece is clear that around this time D's mental health was deteriorating significantly, its impact on C was increasing and both D's behaviour and C's concerns about exposing others to it were causing C to become increasingly isolated. The referral from D's acquaintance presented a significant opportunity to intervene which was missed. There was a possibility that professional intervention at this time might have led to C disclosing the issues which she expressed to her niece, including the embryonic suicide pact which C's niece was aware of having at least been considered around this time.

8.22 Further, partly because of the approach taken by Adult Social Care, these concerns and subsequent contact with Adult Social Care by the GP and Community Mental Health Nurse were dealt with as isolated incidents and the pattern of concerns was not recognised to provide a clearer picture of C's individual circumstances. Adult Social Care informed the Review that as a result of this and other case reviews, a new system of recording concerns, which links previous and historic concerns to the presenting issue, was introduced in April 2015.

8.23 **January 2015 CMHT referral by D's GP**

8.24 When D visited his GP with C on 13 January 2015 referral of him to the CMHT was an appropriate response to recognition that his mental health had been and was deteriorating. The referral appropriately contained a comprehensive summary of D's mental health issues including that there was an absence of suicidal thoughts or hallucinations. The appointment on 4 February 2015 offered was within the timeframe specified in SSSHFT processes for cases with no reported factors, such as suicidal ideation, which would indicate the need for an urgent response.

8.25 The subsequent use by SSSHFT of the Care Programme Approach to manage the care of D was appropriate, as was the regular feedback provided to the GP on the CMHT involvement with D.

8.26 Recognition by D's GP that C was taking on D's delusions, should however have also led to the GP making a safeguarding referral urgently in respect of C. It was clear that D was not in a condition to be able to care for her safely, whether or not he posed a direct risk to her. Viewing this as a medical issue for C, as inferred by the record that C was to see her own GP on 21 January 2015, was not sufficient on its own.

8.27 In January 2015 primary care records indicate that C's GP knew that D was living with her, whereas in D's GP practice it was recorded that D was living separately. While there is a wider issue of how different GP practices are able to communicate risks and concerns regarding a family group who are registered with different surgeries it is of limited significance to the approach taken in this case. Irrespective of where he was living, D's GP had on a number of occasions been made aware that he was caring for C.

[11] This issue has also been identified in a recent Domestic Homicide Review in Staffordshire.

8.28 When D contacted C's GP on 26 January 2015, expressing concern about his care of C and disclosing that she had misled Adult Social Care he was advised to contact Adult Social Care. It would have been more appropriate for the GP to make a direct referral to Adult Social Care, and in particular to share the information about C misleading them, rather than signposting D to do so. Similar considerations apply to the advice given to D when he visited his own GP on 28 January 2015 expressing concerns about his ability to care for C.

8.29 It is unclear what the decision making process was with regard to D's ability to carry out this task or whether the professionals involved in the case considered making the referral(s) themselves. In light of D's presentation, a referral by the practice on his behalf should have been made and any decision not to do this should have been supported by a positive assessment of whether D had the ability to adequately make the referral.

8.30 When the Community Mental Health Nurse spoke with D on 27 January 2015 he disclosed suicidal thoughts and stated that he thought his mother felt the same way. This did not fully reflect the situation as outlined to C's niece two days earlier and later in the contact D retracted his statement, laughing.

8.31 The Community Mental Health Nurse's assessment viewed C as a protective factor for D, providing a reason for D to live and not to harm himself, and SSSHFT advised the Review Panel that all information collected through subsequent contacts with C, D and other agencies all supported this conclusion.

8.32 It does however appear that D was seeking help for the situation and willing to engage with mental health services. In the circumstances the Community Mental Health Nurse's decision to arrange for D to be seen by a Psychiatrist and offering an urgent appointment was appropriate.

8.33 The Community Mental Health Nurse also followed up on C's situation by contacting Adult Social Care and her GP. The contact with Adult Social Care was however framed as a request for information rather referral as a safeguarding issue, of the information included in the referral from D's GP to the CMHT, in particular regarding the GP appointment on 13 January 2015.

8.34 The picture provided by Adult Social Care also did not fully reflect the information that was held and in particular no information about the November 2014 referral from D's acquaintance to Adult Social Care was shared with the Nurse. This information should have been shared. That it was not is attributable to the contact having been dealt with within the Contact Centre and not recorded as a referral.

8.35 The focus of the inter-agency liaison appears to have been on the conclusions reached by Adult Social Care in July 2014. There is no indication that either party actively considered that the circumstances were likely to have changed and that a fresh look at whether C's situation placed her at risk should be taken.

8.36 Both Adult Social Care and SSSHFT informed the Review Panel that this was a missed opportunity for the two agencies to have done some proactive joined up work with D and C. It is also clear that this work and in particular the sharing of information would have been further improved if the GP's for C and D had been more fully engaged. The Care Programme Approach, under which D's mental health issues were to be managed, would have provided a suitable framework for this to take place in the absence of recognition that C was a vulnerable adult in need of protection.

8.37 **February 2015 CMHT - Care Programme Approach**

8.38 The SSSHFT report identifies that if the Community Mental Health Nurse had pressed D to engage within a more rigid framework in February 2015 it is likely that, given his clinical presentation, this would have led to D disengaging. The Community Mental Health Nurse therefore worked within D's framework of thinking, utilising an unannounced visit and ongoing telephone contact, to which D responded well. This approach was confirmed to the Review Panel to be in line with SSSHFT guidelines and national best practice.

8.39 The Review Panel was informed that at the CPA review on 17 February 2015 and throughout the SSSHFT engagement with D the risk of harm to others was considered but there was nothing to indicate that D did pose such a risk and no aggression had been witnessed by any professional.

8.40 This was an appropriate conclusion to draw in respect of D potentially harming others through aggression. It does however reflect only a partial consideration of the risks which D might pose. There is no indication that an adverse impact on the mental wellbeing of others, in particular C who had been noted by the Nurse (and others) to share at least some of D's delusional beliefs, or of harm resulting from D's inability to safely care for C and refusal to accept support in that regard, was considered.

8.41 There was no further information provided to the Community Mental Health Nurse prior to the death of C which would have or did prompt a reconsideration of risk levels or the nature of SSSHFT plans under the CPA.

8.42 On 17 February 2015 D agreed to attend an outpatient appointment with a Consultant Psychiatrist. This was arranged by the Nurse for 12 March 2015 but D did not attend the appointment as the invitation letter had been sent to his own address instead of to C's address, where he was residing. The SSSHFT report makes an appropriate recommendation for inclusion in their computerised patient records of an additional correspondence address field, intended to help ensure that patients not living at their home address receive appointments and other letters.

8.43 The SSSHFT report states that it is doubtful that D not being seen by the Psychiatrist, owing to this administration error, had any material effect on the outcome. This is on the basis that antidepressant medication, which the SSSHFT Psychiatrist who would have seen D has advised would be the treatment of choice[12], would have taken 4-6 weeks to have any positive impact and during the intervening period would have increased the likelihood of him harming himself. Second, that while D was technically detainable under the Mental Health Act 1983 this would not have been the approach of choice with the assessed level of risk presented by D. This position is accepted by the Review Panel.

8.44 It is clear that if D had changed his GP practice to that of C, as suggested by the Community Mental Health Nurse, a more holistic picture of the situation within the household was likely to have been arrived at by primary care professionals, particularly taking into account the lack of effective communication between the two practices.

D informed the Review Panel Chair that in his view the one thing that may have changed the eventual outcome would have been for one GP, aware of the full circumstances, to have been responsible for both him and C.

[12] Anti-depressant medication had previously been prescribed to D by his GP but he was not compliant with the treatment regime. It was successfully used following the hospital admission of D from Police custody in 2015, which enabled compliance to be secured.

8.45 That this was not achieved is attributable to D taking a narrow view of the measures which he might take to prove residence with his mother and not exploring with the receptionist at C's GP practice alternatives to using a utility bill. By the time that this was addressed by the Community Mental Health Nurse in April 2015 it is highly unlikely that any possible improvement in coordination of primary care services would have changed the outcome.

8.46 **Safeguarding referral from C's GP March 2015**

8.47 The referral of protection concerns in respect of C to Adult Social Care on 25 March 2015 was appropriate practice by her GP and in line with relevant procedures. The Primary Care report discusses the one day delay in making this referral caused by consultation with colleagues and advising C that the referral was to be made and concludes that this was justified, not least because it enabled the GP to speak with C away from D and to fully take into account her wishes and capacity. The Review Panel concur with this judgement.

8.48 When the GP contacted Adult Social Care he was under the impression that he was talking to a Social Worker and was unaware that the call had been, as in the case of D's acquaintance in November 2014, routed to a Contact Centre worker. The Review on the availability of professionally trained staff within the Adult Safeguarding Team access point and for referrers wishing to discuss their concerns with a Social Worker to be afforded that opportunity is equally relevant here.

8.49 The Adult Social Care response to this referral from C's GP was inadequate in a number of respects.

8.50 First, the GP wanted to raise an adult protection concern but beyond a request that a referral form be forwarded, this was not responded to as a safeguarding issue and Adult Protection Procedures were not initiated. The Adult Social Care report identifies that although it would have been good practice and in line with local procedures for the GP to have confirmed the referral in writing there is no reason why the Contact Centre worker could not have recorded an adult protection referral without such confirmation and they should have done so

8.51 Second, the Contact Centre worker was instructed to conduct enquiries into an adult protection case. Adult Social Care professionals undertake training to adequately equip them with information gathering and investigation skills for this, the Contact Centre staff do not and the worker should not have been asked to follow up the referral. More particularly neither the Contact Centre worker, nor any Adult Social Care staff should have been instructed to contact D, identified as the source of risk, for further information to inform a decision on the response to the referral.

8.52 Third, because of the approach taken there was no contact with other professionals to conduct lateral checks and neither D's GP nor the Community Mental Health Nurse was therefore involved or even aware of what was happening. As a consequence key information regarding recent contact by these professionals with D was not gathered and did not inform the decision on what action to take in respect of the referral.

8.53 This was a missed opportunity, attributable to poor individual decision making, to put in place a holistic multi-agency response to the situation of C and D. When interviewed, the Senior Social Worker who issued these instructions was not able to comment on her decision making or involvement in the case as she stated she had no recollection of it.

8.54 Finally, the absence of feedback from Adult Social Care to the referring GP obviated the possibility of the GP challenging that Adult Protection Procedures were not engaged and closure of the case without proper assessment of the situation and risks.

CONCLUSIONS

8.55 D has a long history of recurrent mental health problems which were treated by his GP and secondary mental health services as the episodes occurred. It is apparent that during the period under review the severity of D's mental health difficulties including delusions and paranoid beliefs increased while his earlier ability to minimise these when in contact with professionals diminished.

8.56 There are strong indications from the observations of D's GP and C's niece that the shared psychiatric phenomenon, commonly known as **Folie à deux**[13], in which delusional beliefs are transmitted from one individual to another was present in the relationship between D and his mother. While professionals recorded and C's niece noticed the adoption of D's delusions by C at the time it was not named as such.

8.57 The literature regarding this condition[14] differentiates between **Folie simultanée** where two people suffering independently from psychosis influence the content of each other's delusions or two people predisposed to delusional psychosis mutually trigger symptoms, and **Folie imposée** where a dominant person initially forms a delusional belief during a psychotic episode and imposes it on another, who might not have become deluded if left to his or her own devices. In the case of C and D the latter appears to have been the situation with D as the dominant party. This distinction is significant in that research suggests the delusions in the person with the induced beliefs usually resolve once the two parties are separated. This aspect was noticed by C's niece, along with recognition that the resolution was taking longer to achieve over time, suggesting that the phenomenon was becoming more firmly entrenched.

8.58 Professional recognition of this condition may have prompted more robust intervention to separate C and D in the interests of C.

8.59 The Review Panel was informed that while reference to the **Folie à deux** phenomenon in training provided to health professionals is widespread, the **Folie imposée** variant is not. The Review Panel considered that greater professional recognition of this would improve the identification of cases where a safeguarding response should be made in respect of the non-dominant individual. The Review Panel therefore recommend:

*That the Stoke-on-Trent Responsible Authorities Group includes within the dissemination of learning from this Review a strand which promotes nationally awareness by health professionals of **Folie imposée** and its safeguarding implications.*

8.60 C herself certainly recognised that D's behaviour was adversely affecting her mental health although there are no indications that she recognised herself taking on his psychosis. Even if she had done so it appears unlikely that she would have wished or been able to disengage herself from the relationship; with both her own care needs and her feelings of responsibility for the care of D acting as anchors to remaining with him.

8.61 It is claimed by D that C was complicit in him killing her and the note left by C tends to support this. However, while it may have been the expressed intention of D to commit suicide after killing C there is some doubt over whether he had a real intention to follow through on this. It is therefore unclear whether the death of C was within a failed suicide pact or a more cynical homicide in which D had convinced C that she should allow him to kill her.

---

[13] Arnone D, Patel A, Tan GM (2006). *"The nosological significance of Folie à Deux: a review of the literature"*. Annals of General Psychiatry **5**: 11.

[14] Dewhurst, Kenneth; Todd, John (1956). "The psychosis of association: Folie à deux.". Journal of Nervous and Mental Disease **124**: 451–459

8.62 There is not a solid evidence base in the literature on suicide pacts and murder-suicides although two studies have been identified which may have some, albeit limited, relevance to the situation of C and D.

8.63 Data on suicide pacts for the five year period 1988-92[15] identified a suicide pact rate of 0.6 per million population, (c0.6% of all suicides), with the method used in 95% being either car exhaust or medication poisoning. Of the 62 suicide pacts identified in the UK 26 were motivated by avoiding loss of the other party through ill health with a further 9 attributed to euthanasia. The research identified that Improved management of illness might avoid some pacts especially when partners in an enduring, affectionate relationship, with social isolation, are both ill.

8.64 During the same period 144 incidents of homicide-suicide, in which homicide was followed by the perpetrators killing themselves, were identified[16]. In these the victims of male suspects were predominantly their female partners, past or present, and their children. Compared with the suicide pacts the method used, perhaps unsurprisingly given the absence of victim acquiescence, tended to involve greater aggression.

8.65 D only disclosed thoughts of suicide to a professional on one occasion (on 27 January 2015) and even then made light of it. On other occasions when asked about suicide ideation by professionals he denied it. C never mentioned suicide to her GP or to any other professional.

8.66 D was more open with C's niece and both he and to a lesser extent C referred to their intention to commit suicide in December 2014 and January 2015. These remarks were not however taken seriously and were not referred to any professional. C's niece did take seriously the impact that D's mental health issues were having on C and advised both to engage with professional help. It is however also clear that D's behaviour was adversely affecting the wellbeing of C's niece and therefore unsurprising that on being satisfied that D was engaging with the CMHT she took the opportunity to step back from her involvement with D.

8.67 The Review Panel also identified that there is little known regarding the impact that carer's responsibilities and associated strain on older people with mental health difficulties (factors which affected D) may have on the potential for them to commit homicide . The Review Panel therefore recommend:

> *That the Stoke-on-Trent responsible Authorities Group refer carer strain in older people to the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness[17] as a suggested topic for examination within their research programme.*

8.68 Overall, on the basis of the information available to professionals there is no basis on which the death of C could reasonably have been predicted by them.

8.69 That the manifestation of D's mental health condition was likely to harm C should however have been both recognised and led to intervention. Any intervention, to be effective, would have required a holistic approach across agencies and disciplines to address D's mental health issues, C's care and support needs and understand the impact on her mental

[15] Brown, M, Barraclough, B. Partners in life and in death: the suicide pact in England and Wales 1988-1992. Psychological medicine, Nov 1999, vol. 29, no. 6, p. 1299-1306, 0033-2917 (November 1999)
[16] Barraclough, Brian, Harris, E Clare. Suicide preceded by murder: the epidemiology of homicide-suicide in England and Wales 1988-92. Psychological medicine, May 2002, vol. 32, no. 4, p. 577-584, 0033-2917 (May 2002)
[17] http://www.bbmh.manchester.ac.uk/cmhs/research/centreforsuicideprevention/nci/

wellbeing of D's mental health. This was never delivered, although there were opportunities to do so, the main issues leading to which were.

8.70 First, not engaging Adult Protection procedures, which would have provided a framework for such communication and coordination, in response to referrals from D's acquaintance in November 2014 and from C's GP in March 2015. This is attributable to:

- Routing of Adult Safeguarding referrals through a Contact Centre with insufficient professional oversight and support
- Dealing with incidents in isolation within a system that did not promote consideration of previous events and contacts
- Poor individual decision making and management direction of staff.

8.71 Second, poor recognition of the family context in which D and C were living, which contributed to and manifested as:

- Not all relevant agencies and professionals being engaged in the Care Programme Approach response to D's mental ill health
- Silo working by and an absence of direct communication between GPs where the situation of a patient is likely to impact on the health and wellbeing of a patient at another practice.

8.72 Third, inappropriate signposting by professionals to other services when direct referrals should have been made:

- D's acquaintance by Adult Social Care to C's GP in November 2014
- D by his GP to Adult Social Care in January 2015
- D by C's GP to Adult Social Care in January 2015.

RECOMMENDATIONS

8.73 The Review Panel make the following recommendations:

8.74 *That Stoke-on-Trent City Council review and monitor the effectiveness of their arrangements for professional oversight of the Adult Social Care access point and for referrers wishing to discuss their concerns with a Social Worker to be afforded that opportunity.*

8.75 *That the Stoke-on-Trent Responsible Authorities Group includes within the dissemination of learning from this Review a strand which promotes health professional awareness of* ***Folie imposée*** *and its safeguarding implications.*

8.76 *That the Stoke-on-Trent responsible Authorities Group refer carer strain in older people to the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness*[18] *as a suggested topic for examination within their research programme.*

8.77 Recommendations for action to improve their services were also made by agencies which contributed to this Review. These recommendations, along with the associated Action Plans are provided at Appendix B.

8.78 Implementation of action plans arising from recommendations of the Review Panel and the contributing agencies will be monitored under arrangements agreed by the Stoke-on-Trent Responsible Authorities Group. The Responsible Authorities Group will also implement a communications plan which ensures that learning from the Review is effectively disseminated.

[18] http://www.bbmh.manchester.ac.uk/cmhs/research/centreforsuicideprevention/nci/

APPENDIX B

Single Agency Recommendations

NHS England

- All correspondence from GPs when requested to be sent by fax to Adult Social Care/Safeguarding be scanned into records and confirmation received by Social services.
- Advise the GP surgery to review the criteria used to determine when to make a Safeguarding referral when there are concerns about a patient whose health and or vulnerability is impacting upon another vulnerable person with care and support needs
- Advise that Safeguarding Training undertaken in primary care includes information on how a vulnerable adult looking after another vulnerable adult has the potential to increase risks and need for care and support.
- Advise GP primary care practice meetings to discuss the theme of safeguarding when reflecting on the needs of patients who are a cause of concern.

Stoke-on-Trent City Council

- As a result of this review discussions will be held between the Strategic Manager responsible for Adult Safeguarding and more senior management within the local authority. There has been a change in practice which should have an immediate effect on the issues raised within this review.

South Staffordshire and Shropshire Healthcare NHS Foundation Trust

- Develop a field for “address for communication” on the Rio (electronic patient record) system.