

# **Bath and North East Somerset Community Safety Partnership**

**DOMESTIC VIOLENCE HOMICIDE REVIEW  
Into the death of Mary (pseudonym)**

## **OVERVIEW REPORT**

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Independent Domestic Homicide Review Chair**

**Report Completed: 28th April 2016**

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## **1. Preface**

1.1. Domestic Homicide Reviews (DHRs) came into force on the 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 person to whom she was related or with whom she was or had been in an intimate personal relationship or a member of the same household as herself; held with a view to identifying the lessons to be learnt from the death.

1.2. Throughout the report the term “domestic abuse” is used in preference to “domestic violence” (other than when quoting from official documents), as this term has been adopted by Bath and North East Somerset Responsible Authorities Group.

1.3. 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 identify what needs to change in order to reduce the risk of such tragedies happening in the future, to prevent domestic homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

1.4. This Review, which examines the circumstances surrounding the death of Mary (pseudonym) in June 2015 in Bath, was initiated by the Chair of the Bath and North East Somerset Responsible Authorities Group in compliance with legislation. The Review process follows the Home Office Statutory Guidance.

1.5. The Independent Chair and the DHR Panel members offer their deepest sympathy to all who have been affected by the death of Mary and thank them, together with the others who have contributed to the deliberations of the Review, for their time, patience and co-operation.

1.6. The Review Chair thanks the Panel for the professional manner in which they have conducted the Review and the Individual Management Review authors for their thoroughness, honesty and transparency in reviewing the conduct of their individual agencies.

1.7. The Chair is joined by the Review Panel in thanking Mark Hayward for the efficient administration of the DHR.

## **2. Review Panel**

David Warren	Accredited Independent Chair
Edward Yaxley	Avon and Somerset Constabulary
Claire Williamson	Avon and Wiltshire Partnership Mental Health NHS Trust
Val Janson	Bath and North East Somerset Clinical Commissioning Group
Lores Savine	Bath and North East Somerset Council
Helen Wakeling	Bath and North East Somerset Safeguarding Adults
Peter Brandt	BGSW Rehabilitation Service
Helen Dewbery	Knightstone Housing
John Trevains	NHS England South Central Team
Debra Harrison	Royal United Hospitals Bath NHS Foundation Trust
Geoff Watson	Sirona Care and Health
Debbie Sheppard	Southside

**Review Administrator:**

Mark Hayward                      Bath and North East Somerset Council

**3. Introduction**

3.1. This Overview Report of the Bath and North East Somerset Domestic Homicide Review examines agency responses and support given to the deceased, Mary and their contact with her son Zack (pseudonym) and with Mark (pseudonym), Mary’s ex-male friend, prior to Mary’s death.

3.2. Mary, who was white British, was aged 55 at the time of her death. She was divorced and had three children. At the time of her death, her 17 year old son Zack lived with her in a rented flat in Bath. From January 2014 until May 2015 Mary had been in a casual relationship with Mark, who was of mixed race (Black and White British) was 55 years of age. They never lived together.

3.3. Bath is 97 miles west of London and 11 miles (18 km) south-east of Bristol. Following local government reorganisation in 1996, Bath has been the principal centre of Bath and North East Somerset. In 2011 the population was 88,859. The City became a World Heritage Site in 1987 and is a major centre for tourism.

3.4. Incident Summary:

3.4.1. Mary had bi-polar disorder and during 2013 spent some time as an inpatient in a hospital mental health unit. Shortly after leaving the hospital in December 2013 she became friendly with Mark.

3.4.2. On 22nd May 2015 Mary contacted the Police to report that after ending her relationship with Mark, he found it difficult to accept and constantly made contact with her, which she found distressing and harassing. Although the police advised Mark not to contact Mary directly or indirectly, he continued to do so.

3.4.3. On a day in June 2015 the mental health service crisis team made a welfare visit to Mary’s home, but after she refused them entry, the police were contacted. On their arrival they found the front door was locked and whilst officers were talking to Mary through the door she collapsed and it was apparent she had stabbed herself in the chest. Officers forced

the door open and first aid was administered. Air ambulance and other services responded and once stabilised, Mary was taken to hospital. Four days later Mary's life support machine was switched off leading to her death.

3.4.4. The post mortem toxicology report revealed that the cause of death was hypoxic brain injury, secondary to the blood loss suffered as a consequence of the stab wound to Mary's heart.

3.5. On 24th November 2015 Bath and North East Somerset Responsible Authority Group after considering the background circumstances of Mary's death, took the decision to undertake a Domestic Homicide Review and the Home Office were informed on 2nd December 2015.

3.6. The key purpose for undertaking the DHR is to enable lessons to be learned from Mary's death, in order to reduce the risk of such a tragedy happening in the future.

3.7. The Review considers all contacts agencies had with Mary, her son Zack and Mark during the period from 1<sup>st</sup> January 2011 and the death of Mary in June 2015, as well as any contacts, relevant to stalking, harassment, domestic abuse, violence or health issues which occurred prior to that period.

3.8. The DHR Panel consisted of senior officers, from the statutory and non-statutory agencies listed in section two above, who are able to identify lessons learnt and to commit their organisations to setting and implementing action plans to address those lessons. None of the members of the Panel or any of the Independent Management Report (IMR) Authors have had any contact with Mary, Zack or Mark.

3.9. Expert advice regarding domestic abuse service delivery in Bath and North East Somerset (BANES) has been provided to the Panel by Southside, which provides the commissioned Independent Domestic Violence Adviser (IDVA) Service in BANES. Specialist independent advice relating to health issues has been provided by NHS England and Mind. Specialist advice regarding safeguarding adults and children has been provided by the BANES Safeguarding Boards.

3.10. The Chair of the Panel is an accredited Independent Domestic Homicide Review Chair. He has passed the Home Office approved Domestic Homicide Review Chair's courses and possesses the qualifications and experience required in section 5.10 of the Home Office Multi- Agency Statutory Guidance 2013. He is totally independent and has no association with any of the agencies involved in the Review nor has he had any dealings with Mary, Zack or Mark.

3.11. The agencies participating in this Domestic Homicide Review are:

- Avon and Somerset Constabulary
- Avon and Wiltshire Mental Health Partnership NHS Trust
- Avon Fire and Rescue Service
- Bath and North East Somerset Clinical Commissioning Group,
- Bath and North East Somerset Council
- Bath and North East Somerset Council Children's Social Care

- Bath and North East Somerset Safeguarding Adults
- Bath Citizens Advice Bureau
- Bath Mind Advocacy Service
- Bristol, Gloucestershire, Somerset, Wiltshire Rehabilitation Service
- Reach Housing/Developing Health and Independence (DHI)
- Great Western Hospital NHS Foundation Trust
- Knightstone Housing
- NHS England South Central Team
- North Bristol NHS Trust
- Reach Housing Options and Advice
- Royal United Hospitals Bath NHS Foundation Trust
- Sirona Care and Health
- Southside
- South Western Ambulance Service NHS Foundation Trust
- Women's Aid
- Zack's School

3.12. Mary's daughter was contacted at the commencement of the Review, the purpose of the Review was explained to her and after speaking with other members of the family, she agreed to be the family link with the DHR. She provided the Review with pseudonyms for her mother and younger brother, together with a consent form for access to her mother's medical records. She asked the Review to consider decisions made by the mental health trust in relation to her mother. She was provided with details of Header Right

Advocacy After Fatal Domestic Abuse (AAFDA) and it was explained what help the family could receive from the Charity.

3.13. A letter was sent to Mark informing him about the Review and asking him to contact the Review Chair. Mark later made contact, the result of which is at paragraph 14.22.

3.14. At the conclusion of the Review Mary's daughter and elder son read the Overview Report and Executive Summary prior to attending the Panel meeting on 28th April 2016. They stated there was mention in the Overview Report that their mother had on earlier occasions considered self-harming and taking her own life, they had never been made aware of these incidents. Whilst they acknowledged the need for patient confidentiality, as her carers, they strongly believe they should have been informed. It would have enabled them to introduce protective measures, including putting a key pad outside their mother's front door, so that emergency services could be given the code to gain entry of the flat if necessary. Panel members explained the difficulties that caring agencies are faced with in relation to balancing confidentiality against providing information to carers. Dr. [REDACTED] from

AWP informed the family that this was currently being reviewed by AWP and she will feed in their comments to inform the decision making process. The victim's son and daughter thanked her. They also thanked the Chair for the opportunity offered to write a tribute to their mother which they had declined as they felt it would be too difficult emotionally. They thanked the Panel for inviting them to the meeting, which they found extremely helpful, they had not realised how thorough the Review would be and they were reassured that changes for the better would come from their mother's death. Mary's daughter thanked the Chair for keeping the family informed throughout the Review process and for the detail and obvious care take in the Report.

## **4. Parallel Reviews**

4.1. The Coroner's Inquest was held in November 2015.

4.1.1. The Record of Inquest states:

"The deceased had bipolar disorder. From around 22nd May 2015 there had been a deterioration in her mental health owing to stressors in her life. On █ June 2015 Police Officers attended her home to conduct a welfare check. The officers spoke to the deceased, but then forced entry after seeing her unresponsive on the floor. Paramedics and doctors attended and emergency surgery was performed at the scene. She was taken to hospital but died on █ June 2015.

The conclusion of the Coroner was that the deceased died from a self-inflicted stab wound to the heart, at the time, the balance of her mind was disturbed, however her intentions were unknown".

4.2. There were no criminal proceedings initiated in relation to Mary's death

4.3. NHS England was satisfied that Mary's death does not fit the criteria for a Mental Health Homicide Review; nevertheless NHS England wished to be involved in this DHR.

## **5. Timescales**

5.1. Mary died in June 2015 and Avon and Somerset Constabulary notified the Bath and North East Somerset Adults Safeguarding Board on 10th July 2015. The Board later met and considered that Mary's death did not meet the criteria for a Safeguarding Adults Review but felt that it should be referred to the Bath and North East Somerset Responsible Authorities Group for consideration of a Domestic Homicide Review.

5.2. A decision to undertake a Domestic Homicide Review was taken by the Bath and North East Somerset Responsible Authorities Group on 24th November 2015 and the Home Office was informed on 2nd December 2015. The reason for the delayed referral to the Bath and North East Somerset Responsible Authorities Group was given to the Home Office by the Independent Chair.

5.3. The Home Office Statutory Guidance advises, where practically possible the DHR should be completed within 6 months of the decision made to proceed with the review. The Review was completed on 28th April 2016.

## **6. Confidentiality**

6.1. The findings of this Review are restricted to participating officers/professionals, their line managers and the family of the deceased until after the Review has been approved for publication by the Home Office Quality Assurance Panel.

6.2. As recommended by the Multi Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews, to protect the identity of the deceased and her family, the following pseudonyms have been used throughout this report.

6.3. The name Mary is used as a pseudonym for the deceased and Zack is used for her youngest son, they were chosen by her family. The Review Panel selected the pseudonym Mark for Mary's previous male friend; he later agreed for this pseudonym to be used.

6.4. This report and the Executive Summary have been carefully redacted in accordance with the statutory guidance.

6.5. The Review Panel has obtained the deceased's confidential information, (including police and medical records) after her daughter gave her written consent.

## **7. Dissemination**

7.1. Each of the Panel members (see list at beginning of report), the IMR authors, and Chair and members of the Bath and North East Somerset Responsible Authority Group have received copies of this report.

7.2. During the Review, Mary's daughter was provided with regular updates. She and her elder brother took the opportunity to read the Overview Report and Executive Summary prior to the final meeting of the Review which she attended.

7.3. A copy of the Reports have been sent to the Avon and Somerset Police and Crime Commissioner.

## **8. The Terms of Reference**

8.1. The decision for Bath and North East Somerset to undertake a DHR was taken by the Bath and North East Somerset Responsible Authorities Group on the 24th November 2015 and the Home Office informed on 2 December 2015.

8.2. The Home Office Statutory Guidance advises where practically possible the DHR should be completed within 6 months of the decision made to proceed with the review.

8.3. This Review, which is committed, within the spirit of the Equality Act 2010, to an ethos of fairness, equality, openness and transparency, will be conducted in a thorough, accurate and meticulous manner.

8.4. The Review will consider:

8.4.1. Each agency's involvement with Mary, 55 years of age at time of her death in June 2015, her son Zack who was 17 years of age at the time of her death or with Mark with whom she had previously been in a casual relationship. Agencies involvement should

include any contacts between 1st January 2011 and the date of Mary's death in June 2015; and any contacts relevant to stalking, harassment, domestic abuse, violence or mental health issues prior to that period.

8.4.2. Whether there was any previous history of abusive behaviour towards the deceased, her son or to any previous partner of Mark and whether these incidents were known to any agencies or multi agency forum?

8.4.3. Whether family, friends, work colleagues or neighbours want to participate in the review. If so, ascertain whether they were aware of any abusive behaviour to the deceased or health concerns prior to her death?

8.4.4. Whether, in relation to the family member's friends, neighbours or work colleagues; were there any barriers experienced in reporting domestic abuse?

8.4.5. Could improvement in any of the following have led to a different outcome for Mary?

- a) Communication and information sharing between services.
- b) Information sharing between services with regard to the safeguarding of adults and children.
- c) Communication within services.
- d) Communication to the general public and non-specialist services about available specialist services.

8.4.6. Whether the work undertaken by services in this case are consistent with each organisation's:

- a) Professional standards
- b) Domestic Abuse policy, procedures and protocols
- c) Policies for the safeguarding of adults and children

8.4.7. The response of the relevant agencies to any referrals relating to Mary, her son or Mark concerning stalking, harassment, domestic abuse, violence or mental health issues. It will seek to understand what decisions were taken and what actions were carried out, or not, and establish the reasons. In particular, the following areas will be explored:

- a) Identification of the key opportunities for assessment, decision making and effective intervention in this case from the point of any first contact onwards with the deceased, her son or Mark.
- b) Whether any actions taken were in accordance with assessments and decisions made and whether those interventions were timely and effective.
- c) Whether appropriate services were offered/provided and/or relevant enquiries made in the light of any assessments made.

- d) The quality of any risk assessments undertaken by each agency in respect of Mary, her son or Mark.

8.4.8. Whether organisational thresholds for levels of intervention were set appropriately and/or applied correctly in this case.

8.4.9. Whether practices by all agencies were sensitive to the ethnic, cultural, linguistic and religious identity of the respective family members and whether any specialist needs on the part of the subjects were explored, shared appropriately and recorded.

8.4.10. Whether issues were escalated to senior management or other organisations and professionals, if appropriate, and completed in a timely manner.

8.4.11. Whether, any training or awareness raising requirements are identified to ensure a greater knowledge and understanding of domestic abuse processes and/or services.

8.4.12. The review will consider any other information that is found to be relevant.

## **9. The schedule of the Domestic Homicide Review**

9.1. Mary died in June 2015.

9.2. On 10th July 2015 Police referred the death to Bath & North East Somerset Safeguarding Team for consideration of a Serious Case Review. Further information was sought.

9.3. On 28th August 2015 information was returned by key agencies and a report was compiled for the Safeguarding Adults Board.

9.4. On 23rd September 2015 Consideration given at the Safeguarding Adults Board and a decision was taken not to proceed as a Serious Case Review but to recommend it be considered for a DHR by the Responsible Authorities Group.

9.5. On 18th November 2015 the BANES Multi-Agency Homicide Review Advisory Group met and agreed to recommend that the Responsible Authority Group establish a DHR.

9.6. On 24th November 2015 the BANES Responsible Authorities Group met and agreed that a DHR should be established.

9.7. On 2nd December 2015 the Home Office was informed of this decision.

9.8. On 14th December 2015 the Independent Chair was appointed.

9.9. On 25th January 2016 The DHR Panel had its opening meeting at BANES Council Building, Keynsham.

9.10. On 1st February 2016 the Independent Chair wrote to the Home Office to explain the initial delay in establishing a DHR. Later the same day, the Home Office responded that they were content with the reasons for the delay and noted that the explanation would be included in the Overview report. That is, that the circumstance of Mary's death was initially referred to the Bath and North East Somerset Safeguarding Adults Board for consideration to hold a

Safeguarding Adults Review. It was decided that it did not fit the criteria for a Safeguarding Adults Review but did for a Domestic homicide Review and it was referred to the Responsible Authorities Group which acts as the BANES Community Safety Partnership. The times of these meetings are set out above.

9.11. On 11th March 2016 the DHR Panel met, at the British Legion Premises in Keynsham to consider the presentations of the Individual Management Review Reports.

9.12. On 28th April 2016 The Review Panel met at BANES Council Building Keynsham to consider the Overview Report and Executive Summary. The deceased's daughter and elder son attended this meeting.

## **10. Methodology**

10.1. This report is an anthology of information and facts gathered from:

- The Individual Management Reviews (IMRs) and reports of participating agencies;
- The Pathologist
- The Coroner's Inquest papers and statements
- Mary's family
- Interviews with Zack's teachers
- Mark
- Discussions during Review Panel meetings.

## **11. Contributors to the Review**

11.1 Whilst there is a statutory duty that bodies including, the police, local authority, probation trusts and health bodies must participate in a DHR; in this case twenty-two organisations have contributed to the Review (listed in Para. 3.11). Twelve have completed Individual Management Reviews (IMRs).

11.2. The deceased's daughter who lives in a different part of the country, has kept in regular telephone and email contact with the DHR Chair and has provided information to the DHR. When asked for details of her mother's friends she said because of the nature of her mother's illness, Mary had become very suspicious of other people and had not kept in contact with any of her friends. Her only regular contacts were her family, her mental health service carers and Mark.

11.3. Individual Management Report Authors:

Lisa Finch, Avon and Somerset Constabulary

Philip Rhodes, Avon and Wiltshire Mental Health NHS Partnership

Dr. Leach, Bath and North East Somerset Clinical Commissioning Group

Trina Shane, Bath and North East Somerset Council Children's Social Care

Karyn Yee-King: Bath and North East Somerset Safeguarding Adults

Gill Whitehead, Bath Citizens Advice Bureau

Helen Dewbery, Knightstone Housing

Sean Collins, North Bristol NHS Trust

Sarah Shatwell, Reach Housing Options

Debra Harrison, Royal United Hospitals Bath NHS Foundation Trust

Geoff Watson, Sirona Care and Health

Suzi Ingram and Brian Mc Gee, Zack's School

## **12. The Chronology**

12.1. The facts obtained from the agencies IMRs and chronologies, Mary's family and Mark are summarised as follows:

12.2. Mary was born in London and spent her early years with her grandmother, a time in her life she remembered fondly.

12.3. Mary moved to Maidenhead with her parents, at the time of starting school. She experienced trauma in the form of abuse from her father during her subsequent childhood years, social services became involved and she was in their care until the age of 16.

12.4. She left school with no qualifications and at the age of 17 engaged in a relationship with her first husband, having her first son two years later. She was subjected to emotional and physical abuse during this marriage. Her husband, a drug user, introduced her to intravenous opiate use and as a consequence she later became infected with Hepatitis C.

12.5. Mary left her husband in 1988. During this time she obtained work in modelling and re-engaged with education, attending the ■■■ School of Ballet and later in 1989 attending ■■■ College to read English Literature, graduating with a Bachelor of Arts degree.

12.6. She married her second husband in 1991, with whom she had a daughter in 1991 and a son in 1997. The family moved several times to different parts of the country prior to settling in Bath in 2006. After most moves Mary found employment as a medical secretary.

12.7. Mary's second marriage became difficult and they separated during 2011 and were divorced in 2014. She found this time particularly stressful, she lost her employment, moved into rented accommodation and found herself in financial difficulties.

12.8. Mary had mental ill health for approximately fifteen years and in 2013 she was diagnosed with bi-polar disorder. On 1st January 2011 she was admitted to hospital under section 2 of the Mental Health Act 1983 for a short period and was then treated on an outpatient basis by the Avon and Wiltshire Mental Health Partnership NHS Trust (AWP)

Recovery Team. She was discharged from services in May 2011, with a rapid access plan in place if her mental health deteriorated and she required further input from services.

12.9. Mark has a long history of criminal convictions from 1978 for offences including drugs and offences against the person, two of which were assaults on women (not domestic abuse).

12.10. On 10th October 2011 AWP recorded a medical consultant's notes of Mary: "Mental health: (*Mary*) Feels under "stress" because of background problems but no current early warning signs of relapse, no insomnia, preoccupation or feeling overwhelmed."

12.11. In March 2012 Mary made contact with the Avon and Wiltshire Mental Health Trust (AWP) Rapid Access Team reporting that she was feeling stressed because the relationship with her husband was really bad at that time. He has become distant and had requested a divorce. Mary went to her GP and he suggested that she spoke to Women's Aid.

12.12. On 30th November 2012 Mary telephoned AWP's Intensive Service and said she was suicidal, wanting to throw herself in the river. No one was available in the Intensive Service to call and assess her, so the Primary Care liaison team made contact with her. Mary spoke about the difficulties she was experiencing, she had lost her job and disclosed that she had been abused by her father in the 1960's and 1970's, but she did not wish to make a complaint to the police. After talking for some time, Mary reflected she did not feel suicidal and wanted to cope. She said she had resources and would be able to find another job.

12.13. On 6th June 2013 the police and Bath Children's Services had received a call from Mary, who was anxious and distressed. She claimed paedophiles were abusing Zack, her 15 year old son. She informed the police that she had severe mental health issues, depression and psychotic tendencies. Mary herself believed she needed a psychiatric assessment and she felt unable to look after her son adequately. She said she left Zack home alone a lot and she needs support. She had no information to support her concerns that Zack was being sexually abused; nevertheless the police contacted Zack to check on his welfare. He confirmed he was fine and that there was no substance to his mother's worries. The police then contacted the AWP Crisis Team (Intensive Service) and called for an ambulance. Mary was taken to hospital and later was discharged home with support from the AWP Intensive Service. A few days later she again contacted the police to inform them that Zack was being groomed by paedophiles. Again there was no evidence to support this and Bath Children's Social Care (CSC) was informed of the incident. CSC checked on Zack's welfare with his school. The school made discrete enquiries and confirmed there were no problems.

12.14. On 8th July 2013 Mary's daughter contacted the GP out of hours service with concerns over her mother's vulnerability as she was leaving the house in the middle of the night and "going and trying to help homeless people". She was spending money on them that she did not have, putting one homeless man into a hotel for the night and buying one over £100's worth of designer clothing. The next day she agreed to speak to a member of the AWP Intensive Service. However Mary's erratic behaviour continued and on 12th July 2013 Mary's daughter contacted the police as she thought her mother needed to be detained under the Mental Health Act. She explained Mary had been trying to get money for homeless people; she had run off that evening and her daughter and son were out looking for her. Mary's daughter later called back to say they had found her. She was advised by police to contact the AWP Crisis Team.

12.15. On 14th July 2013 Mary's daughter again reported her mother as missing for over 24 hours, having gone off with a strange man. Mary later returned of her own accord. This was new behaviour for Mary and her elder son contacted AWP with fears that his Mother's erratic and changeable behaviour made her vulnerable to harm from others. He was advised to contact the police which he agreed to do. On 15th July 2013 Mary was taken to hospital and was referred for admission for further assessment of her mental health needs. Mary's daughter raised her concerns that when her mother was due to be discharged, there should be a robust discharge plan, as she said her mother often rapidly deteriorated post-discharge. After Mary was discharged, she went missing and when she later returned she had lost 2 stones in weight.

12.16. On 8th August 2013 the Mental Health Intensive Care team contacted the police to report Mary missing. The police were informed that Mary had been recently sending her parents and daughter increasingly bizarre texts and was very agitated. Mary had recently been discharged from the mental health unit at the RUH; she was vulnerable and easily befriended strangers. Police officers attended at Mary's home address. Mary was not at home but all her windows and doors were unlocked. Mary was later found and taken back to her home address.

12.17. On 13th August 2013 she was again taken to hospital and after assessment was detained under Section 2 of the Mental Health Act. The Psychiatric notes stated: "In brief, Mary seen on Observation Ward at *the hospital* for a mental health assessment - brought in by ambulance after concerns that she had spent the last 2 nights in the woods. Recent admission to ■ Lodge - discharged after 2 weeks - then under care of Intensive Team. She has not engaged with them. Recently she has been self-neglecting, felt to be vulnerable as disinhibited".

12.18. During the period she was an inpatient, there were several incidents<sup>1</sup>, including setting fire to a waste bin, going missing and being taken to A&E with self-inflicted lacerations to both wrists.

12.19. On 8th December 2013 the police received a complaint from a woman dog walker that she was being subjected to regular harassment by Mark, who was verbally abusive and regularly tried to block her way. He was given a harassment warning.

12.20. On 10th December 2013 Mary was discharged from hospital but continued to receive outpatient support. The psychiatrist noted that she was in the process of divorce proceedings and was living in temporary accommodation. She engaged well with her care coordinator and asked that her medication be reduced which was agreed.

12.21. On the evening of 31st December 2013, New Year's Eve, Mary met Mark for the first time. A few months later she started to meet him socially and by August 2014 it had developed into a casual relationship. Mary would not stay over at his flat as her son, Zack, was living with her. Mary's daughter has told the Review that her mother would not let Mark into her home as she was always protective of who she let in while Zack was with her. Mark did not work, but told Mary if he could buy a van he would then be able to obtain employment. Mary's daughter said her mother felt pressured into offering him some money for a second

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<sup>1</sup> The detail of what Mary believed happened to her on the occasions she disappeared from the hospital have been discussed with Mary's daughter and a decision has been made to leave her comments out of this report as they are not relevant to the focus of the Review

hand van when her divorce settlement came through. This was on the basis it would be a few hundred pounds, however Mark wished to purchase a much more expensive vehicle and wanted Mary to pay for it. Mary told him she could not do so as the divorce had not been finalised. Further details of Mary and Mark's relationship are set out in the notes taken by Mary's Recovery Coordinator in paragraph 12.30. below.

12.22. On 19th September 2014 Mary was referred to the Sirona Mental Health Reablement Team and her assessment started. Five days later Mary met with a Sirona worker to complete the assessment, her notes stated: "She talked for 2 hours [about] her life story and how she ended up in [REDACTED] Lodge (mental health unit). She complained that her wealthy husband is not offering enough money to keep herself and son. Mary did not want information shared with children's services. Zack is 17 years old and living on the floor in the flat's small lounge. No assessment signed or support plan agreed, however Mary happy to meet with me at the CAB next week".

12.23. Mary had regular positive meetings with the Sirona worker during October and November 2014. On 18th November 2014 the worker's records stated "She filled me in on her plans. She has signed a tenancy agreement and plans to move to a flat on 2nd December. Mary remains supported through Reach for social housing. She has support of CAB (Citizens Advice Bureau) for financial issues. Mary is active in community groups. She is aware of stressors that affect her mental health. Closed service today as needs met. Mary advised to contact her GP if relapse signs appear." The case was then closed by Sirona Mental Health Reablement Team.

12.24. On 2nd March 2015 Mary was seen by her consultant psychiatrist who recorded: "I am pleased to report that *Mary's* mental health has remained stable with no signs of recurrence of mental illness. She has been stabilising her situation at home and appropriately protecting herself from undue stress. She is proceeding further with her divorce which should be finalised over the summer despite some very difficult compromises on her part in terms of financial settlements. Her son *Zack* is currently living with her and after completion of his A-levels, should he be successful, is planning to study medicine. She continues to live in private rented accommodation at great expense, however has increased priority for re-housing and continues to bid for properties.

She is working on a part-time basis and is again seeking secretarial work.

We talked at length about the various aspects leading to *Mary's* mental health problems including early and continued experience of abuse, the effect of which has added to her vulnerability to mental health problems. She is increasingly accepting of the need to continuously manage her risk of worsening mental health in the future. I shared my opinion that given her excellent level of insight and active work in stabilising her life, her prognosis is very favourable. She has experienced significant side-effects in the form of dry mouth and sedation which I feel is most likely caused by Quetiapine, although this remains at a low dose. I have advised a phased withdrawal of this".

12.25. On 20th May 2015 Mary complained to the police that she had ended her relationship with Mark. She said he was unhappy with this and has been texting and making phone calls, which she found distressing. Mary would not make a statement but wanted officers to speak to Mark. Officers visited him and gave him advice not to contact Mary. His reaction was that he was shocked that Mary did not want anything to do with him, he did not realise the relationship was over. Mary's phone was not in her possession when she was seen by officers. Consequently, police officers did not view the text messages.

12.26 On 22nd May 2015 Mary contacted the AWP Intensive Service early in the morning, anxious and concerned for the safety of her son, following receipt of threats from Mark. This information was shared with the Recovery Team. Mary's sister was present with her at the time of the call and planned to remain with her until speaking with the Recovery Team. This was the first time AWP was aware that Mary was having difficulties with Mark. Later the same day, the Recovery Team completed an assessment of Mary and arranged for additional support to be provided by the Intensive Service over the coming days. Later the same day, Mary accompanied by her daughter attended her GP practice. It was noted that there was an escalation of Mary's symptoms i.e. "Pressure of speech and tangential thought, recent house move and financial issues. A man she has been spending time with, was now after money as he knew her divorce settlement was coming through. She felt threatened by his aggressive texts". Her GP ascertained the AWP recovery team had been in contact with her.

12.27. On 23rd May 2015 the AWP Intensive Service made attempts to contact Mary by both telephone and a visit but there was no response. Police assistance was requested to conduct a welfare check. Police confirmed they had already been in contact with Mary in relation to reported threats made by her ex-partner. Mary had moved to a new property and had a new mobile phone number. Mary was later seen at her new home by an intensive service practitioner. Her daughter was also present and contributed to the interaction.

12.28. On 24th May 2015 Mary's sister contacted the police, stating she had Mary's phone as Mark had been calling it all morning. Mary had claimed she had deleted offensive text messages Mark had been sending her. Mary's sister had not answered any calls but was concerned that Mark may go to Mary's address since he could not contact her by phone. The Police visited Mary and she told them that Mark had not harassed her as he had been unable to get hold of her and he had not been to her home address.

12.29. On 26th May 2015 the AWP Care Coordinator met with Mary and completed a detailed review of her mental health and current circumstances. A comprehensive plan was documented on RiO (AWP data record system), which included a safety plan in the event of Mark making contact with her. A potential safeguarding referral was discussed on account of her concerns for her son's safety.

12.30. Below are the RiO notes of the Care Coordinator's visit, which also included a timeline around Mary's relationship with Mark. (Names have been changed to the pseudonyms)

*"Seen at home as planned.*

*Due to not seeing Mary for a number of weeks as Mary has cancelled several meetings and the circumstances occurring last week, spend a long period of time collecting information. Mary reflects that her recent move has been stressful, however she is pleased she is now in a "life time assured tenancy" and this will hopefully reduce worries for her and make her feel settled in time.*

*Timeline of information regarding ex-Partner, Mark*

- Met Mark on New Year's Eve 2013*
- Following that Mary had little contact with Mark for several months*
- Later into 2014: Began meeting Mark occasionally for coffee etc. Mary reflected wanting company at this time, not a relationship.*
- Summer 2014: Mary reflects feeling "better" in herself and due to working; she started to get out more and at this time increased seeing Mark. They went out to do things or spent time at each other's homes but Mary wasn't "staying over."*

- *Aug/Sept 2014: Mary's son Zack moved in with her and their relationship was good. Mary felt better having Zack home and she started offering Zack increased support regarding studies and applying for university. At this point "pressure" increased from both her son and Mark for attention and time.*
- *Late 2014: Before Christmas Zack began going out more or wanting Mary out of the property, so at this time Mary began spending more time with Mark and staying over.*
- *Through late 2014 & into 2015 Mary shared more things with Mark and he was aware Mary was awaiting a divorce settlement. Mark spoke about a new job and Mary reflected she had offered in time when her settlement came through, she would buy him a secondhand van for his new job idea.*
- *2015 - Mark began wanting to see Mary "more and more" but Zack began to want more of her time too. Mary found going to Mark's an option to relax and have some company.*
- *April 2014 - Mark's mother passed away and at this point, Mary reports Mark wanted to see her "24/7" and he was ringing Mary several times a day. Around this time Mary reports that she started thinking Mark was seeing someone else, due to calls he was receiving and a female turned up at Mark's property whilst Mary was there, "He said go away Mary is here."*
- *Mary reports in the last few months, she had been trying to end the relationship due to feeling unable to trust Mark anymore. Mark wasn't accepting of her attempts to break up.*
- *24th April 2015 Mary disclosed that Mark was physical violent towards her for the "first" time. Mary reports that he "roughed me up," "pushed me around" and "head-butted me." This was following an attempt to end the relationship whilst at his home. Following this first act of violence, Mary reports that Mark physically harmed her again a possible "four or five times more."*
- *17th May 2015: Mary spoke with Mark's brother to inform him of the violence. Following this Mary informed me that he stopped harming her.*
- *Sunday 17th - Tuesday 19th May 2015: Mary went away with Mark for her birthday. Mary reports a female was texting Mark whilst they were away together and he kept disappearing to answer calls.*
- *Tuesday 19th May: When Mary had returned home from her break, she made contact with Mark to explain "I cannot see you anymore and it's finished." After sending this message Mary reflects that Mark began to send lots of "abusive" and "threatening" texts:*

*"I'm going to fuck your son"*

*"I will get him (Zack) if I see him"*

*Mark expressed he would get his family to "hurt" Zack.*

*Mark also made threats to come to Mary's flat and "smash" all her windows.*

*Mark made threats to "hit" Zack.*

*Mary informed Mark that her family would be visiting soon and if this carried on they would "contact the authorities."*

*At this point Mary felt she went "completely bi-polar" or maybe "terror" due to feeling worried for her son. Mary couldn't describe what she meant by "completely Bi-Polar."*

*(We explored that her reactions were rational and appropriate to the current stressors and concerns. Mary reflects she was trying to "calm" Mark and at the same time "thoughts" in her head around how to keep Zack safe. In the past when mental health was unstable, Mary experience thoughts of fear about her children, i.e. such as there might be a fire at home and Zack would be harmed. We discussed that in this instant, her thoughts about her son's safety and fear he could be harmed were rational, considering the threats that were being made and these thoughts weren't like the ones she had when unwell).*

- *Wednesday 20th May: Attempting to keep Mark calm & suggesting they could be friends.*

- *Thursday 21st May: Mary's sister came to stay. Mary continued to receive contact from Mark she was trying to keep him "calm" still responding to all his texts and calls. Eventually Mary shared with her sister the texts that Mark had been sending and at this point her "instinct" was to contact the "authorities" and speak with the Intensive Service. Mary had support from Intensive Service and advised to liaise with CC/Recovery Service the next day.*
- *Friday 22nd: Mary reports she initially contacted the Recovery Service as she wanted to request if I could be with her when she met with the police, however due to me being off sick, her sister stayed with her. The police attended Mary's home to collect a statement and see any evidence. Mary reported that sadly due to the "high volume" of messages that Mark was sending, a lot of the "threats" that Mark had made had now been deleted so she couldn't show them to the police. Police informed Mary that they "knew" Mark and they would attend Mark's property to issue a "warning" and they took Mary's mobile number to access phone records if needed. Mary felt unsure of what the police were going to do. Mary confirmed that the police have put a marker on her mobile and landline to treat calls as urgent if she dials 999.*
- *22nd May 2015: Following the police attending (21st May 2015), Mary has changed her mobile and phone number. Mary reports that her sister has kept her old phone so Mary can't become distressed by any further messages and that phone contract has now been cancelled.*
- *Mary reports at points recently she had suggested or thought about giving Mark her divorce settlement thinking this would make him leave or avoid him harming Zack. Mary reports that she doesn't have access to her divorce settlement at present and won't for a while. Mary confirms she doesn't want to give any money to Mark and won't pass on any money but at the time when she was worried; she thought this would be a good idea so Mark would leave, "To calm the situation."*

*Mary confirmed that Mark has made no attempts to come to her property since the threats began (19th April 2015) or following her mobile number changing or police giving Mark a warning on 22nd May 2015.*

*Mary confirmed that Mark has made no attempt or followed through with any threats he has made at this present time, i.e. smashing her flat windows or harming her son.*

*Mary confirmed that she has not made any contact with Mark since 21st May 2015 Mary last saw Mark Tuesday 19th May 2015 following a short break for her birthday.*

*Mary confirmed she doesn't remember Mark's mobile number.*

*Mary did have a set of Mark's keys however she has now re-turned them. Mary went to Mark's brother's place of work and left the keys there.*

*Mary reflects that she doesn't feel "scared" herself but remains worried about the threats Mark made towards her son. Mary confirmed that Mark knows what Zack looks like and Zack's place of work. Mary reflected that Mark has a large family and knows some "nasty" people. Mary informed me that Mark had told her something's recently, "That I wish I didn't know" but she didn't open up further on this.*

*Mary has been open with her son, explaining that someone has made threats towards him and that that Zack has been advised by the police to stay in later at night but Mary reports Zack "doesn't listen" and feels Mary is "being over the top."*

*Mary doesn't feel that Mark will make any further attempts to contact her.*

#### **Safety Plan:**

- *Mobile phone number has been changed & ex-partner doesn't have this number*
- *Mary doesn't have ex-partner's number, so she is unable to make contact with him*
- *Treat as Urgent markers have been placed on her mobile & home phone*
- *Mary has made a police report regarding threats from ex-partner Mark & previous violence from Mark*

- *Mary has returned Mark's keys to Mark's brother so has no access to the property & has reduced reasons for Mark to come to her flat*
- *To always use intercom properly to enter person's in her flat building, i.e. check identity of person before buzzing into the flat*
- *To dial 999 if feeling under threat or worried about her or son's safety*
- *To answer her front door with latch left on, if someone has been able to reach her flat without contact via the intercom*
- *Advised to consider an additional lock on her front door or smaller chain, as she feels it isn't secured well enough at pre-sent.*
- *Whilst at work (Mark knows her place of work & has turned up there in the past) to ensure her mobile is always on her person, as she does work alone in the shop majority of the time*
- *Mary and her daughter have shared with Zack that threats have been made against him and they have advised him not to stay out late or be alone as suggested by the police*
- *Will contact for support also via BANES Recovery or Intensive Service*
- *Good rapport with GP so can access support there & review medication to support wellbeing*
- *Some distance between her home & Mark's.*
- *When out alone, will ensure she keeps to busy public areas (has seen Mark's brother & cousin locally since the incident, they made no contact with her)*

*Other areas of discussion:*

*Work/Employment:*

*Mary informed me that following events last week, she saw her GP who did a short prescription of Diazepam but also advised Mary to take some time off work over the weekend and then return this Wednesday for normal shift pattern.*

*Smoking:*

*Mary noticed that she had started to smoke more often recently, which she recognises as a reaction to worry or stress.*

*Intensive Service Input:*

*Mary has agreed that at this time she doesn't feel any further support is needed from the Intensive Service, "Now you are back, I'm fine." Mary reflected that she was due to see a worker yesterday from Intensive Service but didn't hear anything, "They must have been busy." Mary feels, "It's good really they didn't come as I didn't really need it." I have agreed that at this time there doesn't appear a need to continue with additional support from The Intensive Service as mental state appears stable and changes in presentation recently have been reactive to current stressors i.e.: moving, threats from ex-partner and employment. I have agreed with Mary that I will liaise with the Intensive Service on my return this afternoon and that they will most likely contact her in due course to arrange a final discharge appointment. Mary confirmed she has the BANES Intensive Service number and will contact if needing support out of hours.*

*Agreed plan with Mary:*

*Mary is aware & agrees that a Safeguarding Alert may need to be raised, especially in light of the threats made towards a child (Zack) via an Adult (Mark) however some areas of advice that may come from a Safeguarding meeting has already been covered, i.e. statement made to the police, treat as urgent markers placed on contact numbers, safety plan development, not hold keys to Mark's property any longer, mobile number changed. Agreed with Mary that*

*I will keep her involved in the process and plans that maybe developed following my discussion with my Senior Practitioner.*

*We have also agreed that I will contact the Work Development Team to review their input, if a new referral needs completing in relation to current work stressors, i.e. risk of unemployment & management being unsupportive ( Mary has had previous support).*

*Mary is aware as agreed above, that I will liaise with the Intensive Service to agreed discharge of their additional input at this time.*

- *Next appointment with Care Coordinator, Friday 5th June 10.30am at home*
- *Mary to contact BANES Recovery or Intensive Service for additional support if felt needed*
- *Mary to follow identified safety plans regarding ex-partner Mark*
- *Mary will dial 999 if feeling under threat or worried about her safety*
- *Mary to attend medication review with (named psychiatrist), Monday 1st June 2pm at NHS House”*

The Care Coordinator discussed the review of Mary with the Recovery Team Manager on return to the team base. They agreed that the manager would contact AWP’s safeguarding team to discuss the situation and seek advice. The Care Coordinator and Recovery Team Manager jointly agreed that additional support from the Intensive Service was no longer required.”

12.31. On 27th May 2015 following Mary’s agreement with her Care Coordinator she was discharged from the extra support of the AWP Intensive Support and the Work Development Team were updated with Mary’s new address, contact number and her current situation. There was a plan in place for the Consultant Psychiatrist to review Mary on 1st June and to meet with the Care Coordinator on 5th June, with additional telephone support.

12.32. On 29th May 2015 the AWP Care Coordinator telephoned Mary for a further review and to plan future appointments. Later the same day, Mary had an unplanned contact with Mark. She reported to her Care Coordinator that the conversation was an amicable one about their breakup and money and raised no matters of concern. A progress note was entered on the RiO data base by the Recovery Team Manager stating that a safeguarding referral had been made. The safeguarding concern/alert form was later uploaded to RiO.

12.33. On 31st May 2015 the police made a follow-up visit to Mary. She told the officer that she had seen Mark in the park near her home address. She had approached Mark and had a conversation with him. Mark was upset that she had not told him she wanted to end the relationship. Mary told him she had explained but that he would not listen. According to Mary they had an amicable conversation during which she made it clear she wanted no further contact from him. Mark seemed to accept this and Mary felt there was no longer any need for police involvement as she did not feel he would contact her again. If he did try to contact her, she would report it as harassment to the police. The police investigation was then finalised by a Supervisor, recording it had been dealt with by way of words of advice based on the victim’s wishes not to support any action.

12.34. On 1st June 2015 Mary contacted her Care Coordinator via telephone and reported that Mark had attended her building earlier that morning. She did not allow him entry to the building but spoke with him from her window (her flat was not on the ground level). He asked Mary for money for a van. She refused and asked him to leave which he did. Mary contacted the police, who attended her property a short time later. The officers recommended that Mary obtain an injunction preventing Mark from contacting her. They also arranged for a police and fire safety check to be conducted the next day as her door appeared to require

more suitable security. A police officer later spoke with Mark and advised him to have no further contact. A “treat as urgent” marker was considered and found to be still in place from an earlier incident. Mary’s beat manager was notified. Mary informed her Care Coordinator that she planned to speak with a solicitor about obtaining an injunction. That afternoon Mary attended a planned appointment with her Consultant Psychiatrist and the Care Coordinator. They discussed her current circumstances, mental health presentation and prescribed medication. The Consultant Psychiatrist noted that she appeared appropriately upset by recent events, but displayed no evidence of active mental illness.

12.35. During the early hours ■ June 2015 Mary telephoned her daughter, who had arranged to travel from Manchester later that day to visit her. Mary sounded extremely upset, telling her not to come as she was afraid Mark would harm her. Her daughter was so concerned about her mother’s state that she telephoned AWP. An AWP Work Development Support Worker visited Mary at home that morning. The worker became concerned about Mary’s behaviour and the content of their conversation and tried to contact the Recovery Team to provide a handover. As they were on another call, she left a letter detailing her concerns for the Care Coordinator. (This letter is only seen and read by the Care Coordinator at 5.20pm).

12.36. The same day Mary telephoned the AWP Recovery Team and spoke with the Duty Practitioner, who reported that she sounded distressed and was pressured in her communication. Mary informed him that she had attended the police station earlier to discuss her guilt at not reporting her abusive ex-partner sooner and commented on how this may impact on her son. The Duty Practitioner contacted the Care Coordinator to give an update and she contacted Mary by telephone. Mary was encouraged to focus on the support available to her (daughter visiting and staying with her later that evening) and the Care Coordinator agreed to visit her in person later that day.

12.37. During the afternoon, the Care Coordinator and the Duty Practitioner attended at Mary’s home to complete a review and were met by Mary and a Fire and Rescue worker who was completing a check of her property, as previously planned through the police. Mary presented as preoccupied and fixed on the idea that her children would come to harm because of her mistakes in relation to Mark. Despite this, she was able to focus on the task of contacting her solicitor to discuss pursuing an injunction. While the duty practitioner remained with her, the Care Coordinator made a telephone contact with the Consultant Psychiatrist and agreed an updated medication regime as Mary had become confused as to the doses she was meant to take. The duty practitioner spent time organising the medication and writing down clear instructions for her to follow. She was encouraged several times to take Diazepam, while they were with her but refused. The staff noted that there was a quantity of unused medication at the property, which they subsequently removed.

12.38. At 3.30pm that day upon returning to the team base, the Care Coordinator discussed the situation with the team manager and agreed to contact Mary’s daughter to involve her in planning support and to make a referral to the Intensive Service for additional support. Both parts of this plan were immediately followed up. The Care Coordinator contacted Mary by telephone to confirm the plan of support for the evening and proceeding days, which was to include home visits by the intensive service and support from her daughter who was travelling down from Manchester to stay with her later that evening. Following this the Intensive Service arranged with Mary to visit her at 5.30pm.

12.39. The Intensive Service Support Worker and Intensive Service Practitioner arrived at Mary’s property as planned, but she did not respond to the door buzzer. They called her phone, which she answered and asked them to wait a minute. After approximately five

minutes, the staff entered the building with a help of a housing contractor who had arrived at the building. The staff went to Mary's property door and knocked but she did not respond. They again called her telephone which could be heard ringing inside her property but heard no other sounds of movement. The staff were concerned and decided to contact the police and request their assistance in the form of a welfare check. They returned to their office (a short distance away) on the understanding that the police would notify them once they arrive at the property.

12.40. At 7pm the police notified the Intensive Service that they were en-route to Mary's property and two Intensive Support Workers went to meet them. They were let into the building by the police, who informed them they had initially had some communication with Mary through the door of her property, but she was no longer communicating. The police officers decided to force entry into her property and found Mary with a wound to her chest. Other emergency services were called and on arrival begun emergency treatment before conveying Mary to hospital.

12.41. It was during the afternoon of June 2015 that the Safeguarding Adults Duty Chair first received a safeguarding concern/alert form detailing concerns for Mary around her ex-partner Mark. The Duty Chair wrote an observation note stating the following: "... to Recovery Team to find out more information in order to decide on SG (*Safeguarding*) response Team not available, in meeting. They will ring back into duty today".

As yet, there is no information on consent from client.

It is unclear if they have reported concerns into children's services.

It is unclear if they have referred to any DV (*domestic violence*) services. Police were called to Mary's home address following contact from the Hospital, concerned for the welfare of Mary. On arrival, whilst the officers were talking to Mary through the door, she collapsed and was apparent she had stabbed herself in the chest hitting her heart. A Strategy meeting was booked for Friday 12th June 2015 at 11am at NHS House,"

### **13. Key issues arising from the review**

13.1. The Review Panel, having had the opportunity to analyse the information obtained from agencies, from Mary's family, Mark and from the Coroner's Inquest, consider the key issues in this Review to be;

- **Mary's long term mental health.**
- **Mary's fears relating to the safety of her children.**
- **The level of support Mary's children received.**
- **The rapid deterioration in Mary's mental health on 2nd June 2015.**

#### **13.2. Mary's long term mental health.**

13.2.1. Mary first received treatment for mood-related problems in 1999, when she required treatment as an inpatient under the Mental Health Act (MHA) for an episode of psychotic depression. However it is not clear how long she had suffered from mental illness although is noted that she had been abused as a child and childhood abuse has been associated with a plethora of psychological and somatic symptoms, as well as psychiatric and medical diagnoses including depression, anxiety disorders.<sup>2</sup>

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<sup>2</sup> Childhood family violence and adult recurrent depression. Kessler RC, Magee WJ Health Soc Behav. 1994 Mar; 35(1):13-27. and Childhood sexual abuse as a risk factor for

13.2.2. Mary was discharged in 1999 on an antipsychotic medication and an antidepressant which she continued to take and was followed up intermittently as an out-patient until 2011. She was again admitted under the MHA in February 2011 following a further similar episode which resolved rapidly and she was discharged with similar medication and with outpatient follow up.

13.2.3. Mary was admitted informally for several weeks in July 2013 and diagnosed as having had an episode of hypomania. Following discharge her mental health again deteriorated, becoming increasingly erratic, she was expressing paranoid beliefs and was detained under the MHA from August to December 2013. While in hospital she suffered self-inflicted lacerations to both wrists. During this admission her diagnosis was confirmed as that of bi-polar disorder. Antidepressants were discontinued and she was established on mood stabiliser drugs.

13.2.4. Mary had no other reported incidents of self-inflicted injuries although on one occasion in 2012, after she lost her job, she did telephone the mental health service to say she was thinking about ending her life, however after talking through her problems she changed her mind.

13.2.5. Mary knew that her mental health could very quickly deteriorate but she was aware of the stress factors that could cause this and when she recognised them she or her children sought help. Her divorce, financial situation, subsequent housing and work issues along with concerns for the welfare of her children were examples of stressors which triggered her bipolar disorder.

13.2.6. The Panel noted that 90% of suicides in the UK are related to forms of mental health problems<sup>3</sup> and that a history of sexual or physical abuse or a history of child neglect can increase an individual's vulnerability to suicidal behaviour. In addition a perceived stressful situation may push a person "over the edge" leading to suicidal thinking and action<sup>4</sup>.

### **13.3. Mary's fear relating to the safety of her children.**

13.3.1. There were several occasions when Mary's mental illness manifested itself in her having unfounded concerns about her children's safety. In 2012 she believed that her two younger children were at home and the house was on fire, this was not the case. In 2013 there were instances, recounted in section 12 of this report, where she worried that Zack was being targeted by paedophiles; she contacted Children's Social Care to inform them her son was at risk from herself due to her illness and she contacted AWP with worries about her daughter coming home from holiday late at night. On 16th July 2013 she contacted her elder son and a friend stating her younger son and daughter were being abused, again this was not true. She told them she was leaving for Dubai to save her children from the Devil.

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depression in women: psychosocial and neurobiological correlates. Weiss EL, Longhurst JG, Mazure CM

*Am J Psychiatry.* 1999 Jun; 156(6):816-28

<sup>3</sup>Mortality statistics in England and Wales by sex and age range (ONS) Dec 2015

<sup>4</sup>NHS - Choices <https://www.google.co.uk/url?>

13.3.2. Mary's daughter has told the Review that her mother would not let people into the house because of her phobia about the safety of her children.

13.3.3. Mary recounted to her Care Coordinator that she would not let Mark into her home because of her fears for Zack. Mark knew of Mary's anxieties about Zack and whilst he has denied making threats regarding Zack or sending threatening text messages, Mary believed that he had and she told both the police and her Care coordinator that she felt she had put her children at risk because of Mark. Her text replies to Mark which were recovered by the police from her phone, confirm the depth of her fears. (See para 14.7.4).

13.3.4. Since the conclusion of the Review Avon and Somerset Constabulary have been able to recover all of the deleted text messages from Mary's mobile phone. Most were outgoing messages to Mark's phone. At least five of those outgoing messages imply or state directly that Mark was threatening either her or Zack. Those text messages did not outline the nature of the threatening behaviour, other than saying Mark intends to "hurt" Zack in a non-specific manner. Although there were text messages from Mark, only one could be construed to be possibly threatening; this was a message in which he offers the view that he "should have a word in [Zack's] ear to show his mother some respect".

#### **13.4. The level of support Mary's children received.**

13.4.1. After Mary separated from her second husband in 2011, Zack, her youngest son initially stayed with his father but later moved in with Mary for a short period in 2013 before moving to live with his 19 year old sister who was at University in Bath. In 2014, after his sister moved away from Bath with work, Zack went to live with Mary. Until the time of her death, her children often found themselves having to look out for her. As she became ill she would become fixated on particular issues. In 2013 this preoccupation was on homeless people. She would go out in the middle of the night, leaving Zack alone at home. She became vulnerable, giving homeless people money she could not afford. Too frequently her daughter and sons had to comb the streets of Bath looking for her. On more than one occasion they had to report her missing to the police and went as far as asking for her to be detained under the Mental Health Act for her own safety. Due to the age of the elder son and daughter at that time, no consideration was given to child welfare issues.

13.4.2. Agencies including the Police, AWP, GP, School and Sirona were aware that Zack was living with his mother and of her concerns in respect of him. Bath and North East Somerset Council (BaNES) Children's Social Care (CSC) never received any formal referral relating to Zack although they did receive information regarding him. Mary herself contacted CSC on two occasions, when she spoke of her fears that, she was abusing her son Zack. Enquiries were made with Zack's school and it was confirmed "he was a bright boy who does not present with any concerns about his home situation" no further action was taken. On 17th July 2013 a police intelligence report to CSC indicated that Mary's mental health was deteriorating. CSC again made contact with the school, where there were no concerns and no further action was taken. In October 2013 further contact was made with CSC by the school, confirming that Zack had moved in with his sister and they were receiving support from the School swimming instructor, who would make a referral if necessary. CSC had no further information until 26th May 2015 when Mary again contacted them to state she was upset by contacts from Mark. CSC thought there was no role for them to play.

13.4.3. Mary's daughter and elder son have stressed to the DHR that they and Zack tried to ensure that Zack's education was not affected by their mother's illness and that Zack would not discuss family issues at school. If asked specific questions he would play down the gravity of the situation and as he was doing well academically, at sport and socially there would have been no reason for the school or CSC to challenge him.

### **13.5. The rapid deterioration in Mary's mental health prior to her death.**

13.5.1. The day before her death, Mary contacted the police after Mark had turned up at her home asking for money, Although he left when she told him she had no money to give him, the police attended and agreed a positive course of action with her. This included the placing of a "treat as Urgent marker" on the police computer, to ensure immediate responses to any further calls to her address; arranging for an urgent security survey of her address and for her to obtain an injunction to stop Mark contacting her. Later the same day she met with her Consultant Psychiatrist, who noted that she was reacting normally to the stresses she was faced with and that her mental health remained stable at that point.

13.5.2. However it appears that during the night Mary became increasingly anxious, becoming convinced that she had put her children at risk because of her relationship with Mark. In the early hours of the morning she made a number of telephone calls to her daughter, telling her not to come to visit her as Mark would harm her. Her daughter contacted AWP with her concerns and mental health workers visited Mary and spoke to her on the telephone several times during the day. Arrangements were also made for her to have visits from the AWP Intensive Support Team during the evening until her daughter arrived from Manchester.

13.5.3. Whilst the mental health workers who visited her, were concerned about her deterioration from the previous day, it was not thought that she was at such risk as to warrant initiating the process to consider her being detained under the Mental Health Act. During the early afternoon she had been able to rationally discuss contacting a solicitor about obtaining an injunction in relation to Mark. It was also known that she would be receiving extra support that evening from the Intensive Team until her daughter arrived later that night. The care coordinator left Mary 3.30pm and the Intensive Team spoke to her on the telephone at 4.32pm to confirm they would be with her at 5.30pm. When they arrived at her address at 5.30pm, her condition had declined to the extent that she was unable to or would not open the door to them.

13.5.4. Mary's mood swings from normality on █ June 2015 when she saw her Consultant Psychiatrist, tone of intense depression, feeling uniquely guilty (in her case of believing she had introduced her children to danger from Mark) during the night and morning of █ June 2015, to normality in the afternoon when she was able to rationally discuss security improvements with the Fire and Rescue Officer to telling the Care coordinator she was about to see her solicitor for an injunction, back into an intense depressive episode in the evening, is recognised behaviour for someone who suffered from Bipolar Disorder.<sup>5</sup>

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<sup>5</sup>Goodwin, G.M. (2009) Evidence-based guidelines for treating Bipolar Disorder: revised second edition - recommendations from The British Association for Psychopharmacology. *Journal of Psychopharmacology*, 23(4); 346-388.

Geddes, J. (2003) *Bipolar disorder*. *Evidence Based Mental Health*, 6 (4): 101-2.

13.5.5. As the Police have now accessed the messages Mary had deleted from her mobile phone it is apparent that Mark had not made threatening text messages to her. Mary nevertheless perceived his messages as threatening towards her son and she became increasingly anxious, thinking she had put her son at risk. This possible delusional mood (the pervasive sense of foreboding that something bad is about to happen) was real to her.<sup>6</sup> Research evidence shows a direct link between women's experiences of domestic abuse and fear of violence with heightened rates of depression, trauma symptoms, and self-harm.<sup>7</sup>

## 14. Analysis

14.1. Agencies completing IMR's were asked to provide chronological accounts of their contact with Mary, Mark and Zack prior to Mary's death. Where there was no involvement or insignificant involvement, agencies advised accordingly.

14.2. The Review Panel has checked that the key agencies taking part in this Review have domestic abuse policies and is satisfied that those of the statutory and specialist domestic abuse organisations are fit for purpose. The need for other organisations to introduce domestic abuse policies is addressed in the action plans.

### 14.3. Equality and Diversity

14.3.1. The Panel and IMR authors have been committed, within the spirit of the Equality Act 2010, to an ethos of eliminating discrimination, fairness, equality, openness, and transparency, and have ensured that the Review has been conducted in line with the Terms of Reference.

14.3.2. The practices of agencies were carefully considered to ascertain if they were sensitive to the nine protected characteristics of the Equality Act 2010, i.e. age, disability, gender reassignment, marriage and civil partnerships, pregnancy and maternity, race, religion and belief, sex or sexual orientation. In line with the Terms of Reference, the IMR authors detailed how these were considered.

14.3.3. Mark's mixed race heritage was not found to be a relevant factor either in relation to the circumstances of Mary's death or to the way he was treated by any of the agencies with whom he had contact.

14.3.4. The abuse Mary suffered as a child from her father in 1960/70s was clearly because she was female and would therefore now be considered an Equality issue although at the time that was not the case. Social Services became involved and Mary was taken into care until she was 16 years of age. Due to the confidentiality of child protection proceedings and the length of time since the events occurred, the detail of the events are not known. However

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Morriss, R. (2004). *The early warning symptom intervention for patients with bipolar affective disorder*. *Advances in Psychiatric Treatment*, 10: 18 - 26.

*NICE CG185: Bipolar Disorder: the assessment and management of bipolar disorder in adults, children and adolescents, in primary and secondary care* (2014)

<sup>6</sup> Geddes, J. (2003) *Bipolar disorder*. Evidence Based Mental Health,

<sup>7</sup> Mental Health and Domestic Violence: 'I Call it Symptoms of Abuse'

Cathy Humphreys Ravi Thiara Br J Soc Work (2003)

It is accepted by the Review Panel that positive action was taken in removing Mary from her abusive home environment. Mary never told her children what had happened to her and it was not until she was having suicidal thoughts in November 2012 that she disclosed the abuse by her father to the Primary Care Mental Health Liaison Team. Although encouraged to do so, she refused to report this historic abuse to the police.

14.3.5. Mary's mental health issues were considered to be a disability within the meaning of the equality and diversity legislation.

- Avon and Somerset Constabulary were able to evidence that officers were aware of Mary's mental health disabilities and took appropriate care when responding to requests from the mental health service for welfare checks and generally when attending calls from Mary for police assistance. Whilst information was shared with other agencies the police have recognised that whilst officers routinely submitted reports identifying Mary as a vulnerable adult there were issues on how this information was later retained on the police data systems and shared with other agencies. This has been identified as a lesson learnt (see para 15.3.2) and a recommendation has been actioned to address it.
- Avon and Wiltshire Mental Health Partnership NHS Trust generally provided care and treatment to a good standard, but there are information sharing issues to be addressed. No consideration was given to the help Mary could have received from a domestic abuse support service; procedures relating to requests for welfare checks were unclear and whilst Mary was identified as a vulnerable adult and a Safeguarding Alert was initiated, in the view of the Bath and North East Somerset Safeguarding Officer the process was too slow.
- Bath Citizens Advice Bureau (CAB) was aware of Mary's mental health and provided her with satisfactory help in addressing her employment problems. A rapport was built up and Mary felt able to confide about her marital problems. She was sign-posted to the local domestic abuse support service but on reviewing this, a policy of making direct referrals has been agreed.
- Bath and North East Somerset Clinical Commissioning Group conducted an individual Management Review in relation to Mary's GP Practice. It was identified that on 22nd May there was an opportunity to conduct a safeguarding assessment but as she had been given an urgent appointment with the mental health team, there was an assumption that the mental health team would conduct the assessment. This has been identified as a lesson learnt by the Practice.

Knightstone Housing was not notified about the severity of Mary's mental health illness, at the initial letting stage interview she was assessed as low on the risk assessment matrix as she was managing well on her medication and already had support in place. The Association has recognised the need for more comprehensive interviews the future to ensure that tenants are properly flagged for any vulnerability.

Sirona Mental Health Service's Reablement Team workers were involved in Mary's life for eight weeks during 2014. The team provided Mary with support on housing and financial issues, as well as emotional support. She was coping well with her mental health issues and as there were no obvious concerns the case was closed in November 2014.

Bath and North East Somerset Adult Safeguarding highlighted the delays in receiving a safeguarding alert from AWP and that the police notification on the "Carefirst" system, appeared to be for information only, rather than constituting a safeguarding referral. The

DHR Panel accepts that the agencies have made recommendations to address these issues.

14.4. Twenty-two agencies were contacted about this review. Ten have responded as having had no relevant contact with Mary, Zack or Mark.

They are:

- Avon Fire and Rescue Service
- Bath and North East Somerset Council
- Bath Mind Advocacy Service
- Bristol, Gloucestershire, Somerset, Wiltshire Rehabilitation Service
- Great Western Hospital
- Developing Health and Independence (DHI)
- NHS England
- Southside
- South Western Ambulance Service NHS Foundation Trust
- Women's Aid

14.5. Twelve organisations have provided Individual Management Reviews and Reports. The Review Panel has considered them carefully from the view point of Mary and Zack to ascertain if each of the agencies' interventions were appropriate and whether they acted in accordance with their set procedures and guidelines. Where they have not done so, the Panel has deliberated if all possible lessons have been identified and are being properly addressed.

14.6. The Panel is satisfied that the authors of the IMR's have followed the Review's Terms of Reference carefully and addressed the points within it where relevant to their organisations. The Panel is also generally satisfied that each author has been honest, thorough and transparent in completing their reviews and reports. The following are the analysis of each report together with in the Review Panel's opinion on the appropriateness of the agency's interventions.

#### **14.7. Avon and Somerset Constabulary**

14.7.1. The IMR author carefully reviewed each of the contacts the police had with Mary, Zack and Mark. Overall she was assured that positive action was taken in each incident. Nevertheless she has highlighted contacts with Mary where further action may have been considered.

14.7.2. In relation to the incident on 6th June 2013 when Mary called police saying that she was very concerned that her son was being abused by paedophiles. The IMR author commented "It is evident from this information that Mary felt in crisis and needed help due to mental health difficulties; concerns for her son should have been referred to Children's

Social Care. Although the log was tagged for the Every Child Matters officer, it is not documented whether they then received this and what action was taken. The information regarding Zack should have been referred to Children's Social Care and a strategy discussion considered.

14.7.3. When Mary again contacted the Police on 10th June 2013 with similar concerns about Zack's welfare, although it appeared the information was shared with Children's Social Care, there was no record of this discussion or what decisions were proposed.

14.7.4. Mary had deleted from her mobile phone, all of the text messages she had received from Mark, and as she did not have the phone with her when the police attended (her sister who lives in Cornwall had taken it) they were not able to take the phone to try and retrieve the deleted messages. Later attempts were made by Avon and Somerset Constabulary to recover the data but initially they were only able to recover some text-messages sent from Mary's phone to Mark, in effect presenting half of a two-sided conversation. The time and date information is missing from the recovered messages and could not be obtained. The messages read:

1. *I've never threatened anyone u chose to call live with u decision u abuse is a waste of credit it won't make me ill*
2. *Ok u won't stop these threats im not beggin u again*
3. *What ?*
4. *U threatened my son im not waitin to get him protection if u family dont deal with u mine will up to u cos my family will go to the authorities in a heartbeat and my sons safety is all i care 4*
5. *Someone threatens u child u gona do nothing to protect them if u wont let u family deal with it up to u but im not goin to b afraid 4 [Zack - my edit] all mornin cant talk to stu later im workin later and not livin in fear or guilt if i do nothin so i will have to deal with this*
6. *U already involved my son too late i don't trust u u hit me i would believe stu not u im getting help so go away*
7. *I been to his office hope he deals with this threaten in a child is v serious u lucky i havnt been anywhere else yet I hope he calls asap*

(After the conclusion of this Review the police made a further attempt to retrieve the calls from Mark to Mary. They were successful in doing so, but found that only one of his text messages could be considered to be possibly threatening; this was a message in which he offers the view that he "should have a word in [Zack's] ear to show his mother some respect").

14.7.5. Mark was contacted by the police for comment during the preparation of the report for the Coroner. The report notes that "He denied that they were threatening but did agree that they had "fallen out" as people do." No further action was taken; the original crime report (for harassment) had been filed and this new data did not in the view of the officer who reported to the Coroner necessitate it being re-opened.

14.7.6. The IMR author confirmed that the police officers had informed Mary about the help she could receive from Southside the Bath Domestic Abuse Support Service and that this was followed up by letter.

14.7.7. The Panel acknowledges that the data base issues highlighted as lessons learnt have already been addressed by the introduction of the Niche database system. The Panel accepts that the Police action plan will address the lessons learnt from the Review.

#### **14.8. Avon and Wiltshire Mental Health Partnership NHS Trust**

14.8.1. The IMR author expressed his satisfaction that services responded quickly and appropriately to the concerns of Mary and the family. "Communication between Intensive Service and Recovery Service was clear, effective and professional. There is comprehensive documentation detailing plans, treatment and risks at different points of the chronology". He did not identify any evidence to indicate that "the treatment and management decisions made by the team at the time, lacked detail, rationale or compassion".

14.8.2. When considering whether services could have acted to intervene in relation to domestic abuse, information about the incidents involving Mark only became apparent on 22nd May 2015. That information was followed up actively by the Intensive Service and Recovery teams over the next few days including liaison with the police. A comprehensive review was carried out on 26th May 2015. This included a review of a detailed safety plan, discussion of a safeguarding alert and review of her mental health. A Safeguarding Alert was raised on 29th May 2015. The IMR author felt it would have been helpful to have known about the perceived threats Mary was experiencing earlier. Given her history of trauma and previous abusive relationships it is possible that further assertive probing about her relationships may have encouraged her to disclose earlier, although this is speculative. If Mary had disclosed information at an earlier stage this could have enabled the input of specialist domestic abuse services at a much earlier point in the relationship to provide support and advice.

14.8.3. After Mary's death, AWP conducted a Root Cause Analysis (RCA) under an independent chair to identify the root causes of any faults or problems in the treatment of Mary, this included a review of the quality of the psychiatrist's meetings with Mary. The findings of the RCA forms the basis of the AWP IMR.

14.8.4. The IMR Author has investigated issues raised by the family. The concerns and responses are included in paragraph 14.21 below.

**14.8.5. The Review Panel carefully considered the IMR and accepts the appropriateness of the identified lessons learnt and recommendations to address them. The Panel also welcomes the willingness of AWP senior management to meet with the family to discuss the issues raised and to unreservedly apologise for inconsiderate comments made.**

#### **14.9. Bath and North East Somerset Adult Safeguarding**

14.9.1. The IMR Author highlighted that the AWP Care Coordinator identified on 26th May 2015 that a Safeguarding Alert was indicated following contact with Mary on that day. However, from considering the RiO (data base) entry it would seem that Mary had first raised concerns about her "abusive relationship" with Mark on 22nd May 2015. It would appear

that rather than completing the safeguarding concern paperwork on the 22<sup>nd</sup> May 2015 and forwarding it on to the Safeguarding Team as per the Operating Protocol between Avon and Wiltshire Mental Health Partnership Trust and Bath and North East Somerset Council, the information was passed to the Senior Practitioner within Recovery Team and she undertook to complete it on behalf of the Recovery Coordinator. The Care Coordinator had been the first responder in relation to the allegations made by Mary and so it would have seemed more appropriate and timely if she had raised the concerns and merely informed her supervisor that she was doing so.

14.9.2. There was subsequently a delay from 22<sup>nd</sup> May 2015 when the need for a Safeguarding response was potentially indicated until 2<sup>nd</sup> June 2015 when the alert was received by the Bath and North East Somerset Adult Safeguarding Team, a delay of 7 working days.

14.9.3. As per the Operating Protocol between Bath and North East Somerset and AWP, the Duty Chair should have expected to have seen the alert within 2 working days of the concern being raised with the Senior Practitioner by the Recovery Coordinator. The latest for this would have been 26<sup>th</sup> May 2015, as 25<sup>th</sup> May 2015 was a Bank Holiday.

14.9.4. The Safeguarding Alert/Concern form contained very detailed information obtained from Mary in the form of a timeline. This is considerably more information than is usually received and the Care Coordinator should be commended on the level of detail obtained from Mary.

14.9.5. The Police Report, dated 22<sup>nd</sup> May 2015 on the "Carefirst" system, detailing that Mary had reported her concerns to the police following her ending of the relationship with Mark was not received by Sirona Adult Duty Team until 26<sup>th</sup> May 2015. This report appears to be 'for information only' and there was nothing to indicate that it constitutes a Safeguarding referral. The report was faxed to the Recovery Team on 26<sup>th</sup> May 2015, for the attention of Mary's Care Coordinator. This indicates evidence of different organisations appearing to hold different information in regard to the deceased.

14.9.6. There was a clear indication that an earlier strategy meeting could have taken place. The purpose of an earlier Safeguarding Strategy Meeting would have been to enable the relevant organisations to share the information they had and to enable a more coordinated approach. Additionally, an interim protection plan could have been implemented. However, there is insufficient information to suggest that holding a strategy meeting a week earlier would have prevented the incident which led to Mary's death.

14.9.7. The Safeguarding IMR Author concluded:

- The delay of eight working days for Safeguarding Alert/Concern to be made resulting in missed opportunity for a more timely Safeguarding Strategy Meeting.
- A DASH risk assessment did not appear to have been completed either by police or by Recovery Team which may have clarified the risks posed to Mary and indicated whether MARAC referral was required.

**14.9.8. The Panel endorses the conclusions in this IMR and has ensured that they are addressed by the relevant agencies in their lessons learnt and recommendations.**

**14.10. Bath and North East Somerset Clinical Commissioning Group**

14.10.1. The IMR author has noted that on 26th February 2012 when visiting her GP about another health matter, Mary disclosed abusive behaviour by her husband. The GP advised her to contact the Police and Women's Aid, but made no safeguarding assessment.

14.10.2. During surgery visits in 2013 Mary told her GP about her stress and anxieties which had resulted in her forgetting to collect her son from school as she had stayed all night at work at hospital. On another occasion she told her GP that her son had moved in to help due to her bi-polar disorder and was having to sleep in the lounge. But there is no mention of child safeguarding/young carer support being considered.

14.10.3. On 22 May 2015 when Mary first told her GP about the threats she was receiving from Mark, there was no Safeguarding assessment made, although the IMR author believes this may have been because of an assumption that as Mary was to be seen urgently by the mental health team, the safeguarding assessments would be made by them.

14.10.4. The Panel notes that the IMR Author has given feedback to the Practice, and the Panel is satisfied that the recommendations made by the IMR Author will address the lessons identified.

#### **14.11. Bath and North East Somerset Council Children's Social Care (CSC)**

14.11.1. The IMR Author highlighted that the whilst it is known that Mary contacted CSC on 28th May 2013 no details about this call were found. Zack's school however had a record to show they were contacted by CSC as his mother was concerned he was being targeted by paedophiles. The school was able to confirm that enquiries were made and this was not the case and that Zack had told his teacher for the first time that his mother had mental health problems. The IMR author identified the lack of accessible records as a lesson learnt.

14.11.2. CSC's first record of Mary and Zack was a notification in June 2013 by the local hospital about Mary's mental health problems and that she had a fifteen year old son living with her. Mary was contacted and she spoke of her fears of abusing her son, but was lucid and insightful agreeing that her medication had not yet had the desired impact but she had recently had new prescription. Contact made to Zack's school who described him as a bright boy who does not present with any concerns about his home situation. The school accepted CSC's decision that no further action would be taken and the case was closed. A month later CSC received a police intelligence report indicating that Mary's mental had been deteriorating. CSC again contacted the school who again had no concerns for Zack.

14.11.3. In October 2013. CSC were informed by Zack's school that he would be staying with his 19 year old sister and that both would be receiving support from a swimming instructor linked to the school. It was agreed that if there were any issues he would formally notify the department.

14.11.4. CSC were notified of Mary's suicide and arrangements were immediately made regarding Zack. It was confirmed that the school had taken him in a boarder. He was seen by a social worker who confirmed he remained calm and focussed on his A levels. No concerns were identified regarding his care. Later the arrangements were confirmed with Zack's father and sister and the case was closed.

14.11.5. The IMR author highlighted that although information was provided by agencies to CSC, no agency made a formal referral that they were aware of any risks to Zack or regarding any alleged threats made towards him by Mark.

**14.11.3. The Review Panel accepts that CSC reacted appropriately to the information they received in 2013 and that the record keeping in relation to the call from Mary on 26th May 2015 needs to be addressed. The Panel is however concerned that no formal referral was made to CSC by any of the agencies that were aware of the conditions Zack was living in or of the alleged threats made towards him by Mark.**

#### **14.12. Bath Citizens Advice Bureau**

14.12.1. The Citizens Advice Bureau (CAB) first assisted Mary with an employment related grievance in December 2012. During her meeting, she mentioned that her marriage was ending after 21 years and that her husband had been controlling and abusive to her. She was given advice about refuge provision, but she decided not to consider that as an option. She was also told about the help she could obtain from Southside, a domestic abuse specialist support service. Since that time CAB has amended its policy from one of signposting victims of domestic abuse to specialist support agencies to one of directly referring them to such an agency.

14.12.2. Mary again sought assistance from the CAB in October 2014 when she attended with her Reablement worker seeking advice regarding benefits. She was given other appointments in relation to this, but always cancelled them.

**14.12.3. The Panel is satisfied that Mary received the advice and support appropriate to existing policy and practice but notes the changes in the current policy to that of direct referral to specialist support services.**

#### **14.13. Knightstone Housing**

14.13.1. Knightstone Housing involvement was restricted to that of being Mary's landlord. They had no contact or knowledge of Mark.

14.13.2. Mary, on her pre-tenancy application and interview form, made no reference to domestic abuse or violence (as part of the risk assessment) or during further discussions with the Housing Officer. It was recorded that Mary did have mental health problems with mention of her having been "sectioned" for a prior severe relapse. The severity of her mental health illness did not seem to transcend to her interview with the Housing Officer so Knightstone Housing were not aware of the severity of her current mental health illness and had subsequently not flagged the tenancy for any vulnerability. Mary was assessed as low on the risk assessment matrix as she was managing well on her medication and already had support in place.

**14.13.3. The Review Panel is satisfied with the lesson identified by the IMR Author and that it will be appropriately addressed by the recommendation made.**

#### **14.14. North Bristol NHS Trust**

14.14.1. The Trust has only one contact with Mary when she received treatment at [REDACTED] Hospital after she stabbed herself in June 2015. The IMR author was satisfied that her treatment was carried out in accordance with best practice. The Hospital was never made aware of any domestic abuse issues. The Trust therefore has no lessons to learn or recommendations to make in respect of this contact.

**14.14.2. The Review panel is satisfied that the North Bristol NHS Trust has no lessons to learn in this case.**

#### **14.15. Reach Housing Options and Advice**

14.15.1. The IMR author identified that Reach had 81 records relating to Mary primarily in relation to support given regarding accommodation, employment and benefit issues. Mary did inform her advisor about other issues including her anxieties about her children's safety but her major concerns with Reach appeared to be regarding housing and finances. There was no mention of domestic abuse. When asked if information could be shared with other agencies Mary refused.

**14.15.2. The Panel is satisfied with the identified lessons learnt and the recommendations to address them.**

#### **14.16. Royal United Hospitals Bath NHS Foundation Trust**

14.16.1. Between 2011 and 2014 Mary was seen nine times. Three of her out-patient appointments were regarding non-relevant medical issues. The others related to her mental health and after being seen in the Emergency Department she was discharged in to the mental health ward.

14.16.2. The IMR Author was of the opinion that all of the hospital contacts with Mary were in line with accepted policy and procedures and that there were no lessons to learn or recommendations to make.

**14.16.3. The Panel accepts that there are no lessons for the hospital to learn from their contacts with Mary.**

#### **14.17. Sirona Mental Health**

14.17.1. The Sirona Mental Health Reablement Team workers were involved in Mary's life for 8 weeks in total. During that time the team provided Mary with support on housing and financial issues, as well as emotional support. The case was closed in November 2014 as her presenting needs at that time had been met.

14.17.2. The IMR Author highlighted that it was recorded in the notes of the 24th September 2014 that "Mary is not wanting information shared with children's services" and no referral was made to Children Social Care relating to her son Zack having to sleep on the floor in her living room. It was felt there were not sufficient concerns about Zack to raise a referral, bearing in mind his age (16 years) and the fact that he did not appear to be at significant risk.

14.17.3. No mention of Mary's relationship with Mark was made in the notes so it is assumed that he was either not on the scene at that time or that Mary chose not to share this information. There was no record of concerns about domestic abuse or violence from any quarter. The IMR Author was assured that if the worker had known of an abusive relationship she would have made an appropriate referral either to the police or to the MARAC.

**14.17.4. The Panel is satisfied that Mary was provided with appropriate support from Sirona Mental Health, in line with policy and practice and have no lessons to learn from the Review.**

#### 14.18. Zack's School

14.18.1. The Report Author informed the Review that Zack is a very private individual who never discussed home issues with other pupils or his teachers. He told no one at the school about Mark or of any threats made towards him. His Head of Year was aware of the divorce of Zack's parents and later that Mary had some type of mental health problems.

14.18.2. In 2013 Children's Social Care contacted the School after receiving a telephone call from Mary that she was worried of abusing Zack. The school was able to check with Zack and was satisfied he was not presenting with any problems. Later the school contacted CSC to inform them that Zack had moved in with his elder sister and was receiving support from the school swimming instructor. It was agreed that if there were any concerns a referral would be made to Children Social Care.

14.18.3. Zack was an outstanding pupil who focused totally on his school work and swimming. He did particularly well in his A levels, gaining a place at University to study medicine. After Mary's death, which occurred when Zack was the week before his A Level exams, the school took him in as a boarder. The Report Author was confident that if the school had been fully cognisant of the environment in which Zack was living they would have made a formal referral to Children's Social Care.

**14.18.4. The Panel accepts that the school, which provided Zack with extra support after Mary's death has no lessons to learn from this review.**

#### 14.19. Pathologist's Report

14.19.1. The Pathologist stated: "This lady had known mental health issues. There was cause for concern and police were called to her home address on █ June 2015. Initially talking through the letter box then when they had immediate concern, made a forced entry. She was found inside with a stab wound to her chest and was bleeding profusely. Police confirm she was in the house on her own and had used a knife to stab herself in the heart. Medics were called. She was operated upon at the scene. Three days later after the surgery a CT scan showed unsurvivable hypoxic injury.

At post mortem there was a thoracotomy wound with an incised wound in the left ventricle of the heart, which was sutured. This is in keeping with the history provided. The cause of death was likely hypoxic brain injury secondary to the blood loss she suffered as a consequence of the stab wound to her heart."

#### 14.20. Mark

14.20.1. Mark was interviewed by the Panel Chair. He had no questions himself for the Review. He was asked about the nature of his relationship with Mary and in particular about abuse and the text messages. He said they sometimes argued about her son, but he denied ever physically abusing or assaulting her. When asked about the text messages it was not disclosed to him that the messages had been deleted. Nevertheless, he denied that the texts he had sent her were threatening or abusive.

#### 14.21. Mary's Family

14.21.1. The family decided that they wanted Mary's daughter to be the link with the DHR. Consequently she has been the member of the family the DHR Chair has regularly contacted with updates and questions. All of Mary's children have read the Overview Report, Executive Summary and Chronology. Mary's daughter and elder son attended the final Panel meeting of the Review.

14.21.2. The following comments are from an email sent to the DHR Chair and is included here with the consent of Mary's daughter:

14.21.3. "There have been a number of instances that I have had first-hand experience of looking after my mother specifically during the times she became unwell. Three instances that stand out to me, the most are also what I feel are not best practice from the services in supporting both, most importantly my mother who is unwell, but also the level of service received on my behalf is appalling.

14.21.4. Services available are not explained well and there is little guidance of what to do/who to contact when you believe someone is unwell or having a manic episode. Also on occasions that I have called the BANES Crisis Team, there has been no answer on the phone and even the Recovery Team who work alongside the Crisis Team have been unable to get through at times. To me this seems ludicrous as the name Crisis to me seems as though someone should be available to answer the call 24/7.

14.21.5. My first example, is very recently – two weeks prior to my mother's death, both my mother and I made an appointment to see the GP as my mother was feeling anxious. The GP then referred my mother to the recovery team over the road from the GP Surgery in Bath. As soon as we sat down with xxx and another lady, the first thing xxx said to my mother and I, was not how are you, or how can I help, she told my mother that she finishes at 17:00pm so we haven't got much time so we will have to be quick. This is not something you want to hear when you attend an appointment, for the patient but especially as a family member. I was disgusted by this and quite frankly if xxx wanted a 09:00-17:00 job then maybe she should look at another career. I am happy to escalate this to the appropriate channels if necessary.

14.21.6. The second example was approximately in 20th December 2013 – when my mother experienced a highly manic episode. After numerous phone calls to the: recovery team, crisis team, Psychiatrist and the Police, the crisis team eventually came out to our family home to assess my mother. My mother was unwell, screaming that there was a fire in the house (when there clearly wasn't) and refused to allow both myself and my younger brother into the house. The crisis team assessed my mother and concluded there was nothing wrong with her, even though she was clearly frantic and had not been taking her medication for numerous days. The only reason the mental health team took my mother into the hospital was that we threatened we would sue them if they did not take my mother who was clearly unwell into hospital. And low and behold they took my mother into hospital just like that. This is a defining reason why I would urge individuals who were to find themselves in a similar situation to what I have experience not to bother with the mental health team and their services as they are clueless, I have done more for my mother than any professional in this industry which is despicable and dis-heartening to myself and my family.

14.21.7. Also another large contribution to my mother's poor health and more than likely played a key part in her passing, was the facilities and safety at [REDACTED] in Bath (mental health hospital). When my mother was in [REDACTED] they prevented me from seeing my mother for a long period of time, giving me no reasons as to why I could not see her. My mother became

addicted to cigarettes, smoking which clearly is not part of her rehabilitation programme set to make her better to be released from hospital in the community. The facility was not guarded or sectioned off for males and females, it was not clean and there was only one occupational therapist that worked for the hospital so there were many days where the patients would be unable to leave the premises. The one main factor with the facilities which may I add were never investigated, which to me can only be deemed as covering something up – was that whilst my mother was a patient at [REDACTED]

14.21.8. I hope this has provided you with an overview of the below average support my mother and her family received from the mental health team. There are many instances off this, however I would rather not re-live this experience and allow my mother to rest.”

14.21.9. The AWP Panel member arranged for the points raised by Mary’s daughter to be investigated by the AWP IMR Author. She has also offered to meet with Mary’s daughter to discuss the issues she has raised.

14.21.10. From AWP IMR in response to the above family concerns.

14.21.11. “Two concerns were raised during the IMR process by the family in relation to their mother’s care:

*‘Two weeks prior to my mother’s death, both my mother and I made an appointment to see the GP as my mother was feeling anxious. The GP then referred my mother to the recovery team over the road from the Surgery in Bath. As soon as we sat down with ( Senior Practitioner) and another lady, the first thing (Senior Practitioner) said to my mother and I was not how are you, or how can I help, she told my mother that she finishes at 17:00pm so we haven’t got much time so we will have to be quick’.*

With regard to this event AWP would like to apologise to Mary’s daughter and would recommend contacting the PALS department if she would like the matter to be further investigated. The RiO (data base) record for this meeting (entered at 5.29pm) has a comprehensive plan that was developed with information from Mary around the difficulties she was presenting with at that time, to help support her and her family. Looking at the plan, this would have taken a reasonable amount of time to have discussed and would suggest that the meeting was not rushed, but that time was taken to enable this to be developed.

14.21.12. *‘The one main factor with the facilities which may I add were never investigated, which to me can only be deemed as covering something up was that whilst my mother was a patient at [REDACTED]*

[REDACTED]

14.21.13. The Review Chair gave Mary’s daughter the feedback from AWP on 8th March 2016. She thanked the AWP Panel member for the offer to meet to apologise in person for the reported comments of the member of staff (see above). The daughter asked that her thanks be passed on to Dr. Williamson and said she would speak to her on 28th April 2016. when she would attend the final meeting of the Review. She added that she was grateful that she was being told everything relating to her mother and the sensitivity being shown as to what would be related prior to publication. It was agreed that due to the nature of the incident referred to para 14.21.7. and the response from AWP that it should be redacted

from this report as is not relevant to the circumstance of Mary's death.

14.21.14. AWP later recognised that Mary's daughter's point regarding the Crisis Team's 24/7 availability had not been addressed in the above response. The AWP Panel member asked the Chair to explain that the Crisis Team is available 24/7 however the team is comparatively small and on occasions when more than one call for urgent help comes in at the same time, there may be no one immediately available to answer the call.

14.21.15. At the DHR Panel meeting of the 28th April 2016 the Panel Chair asked the family if they knew why their mother had not made any contact with Southside, the Domestic Abuse Support Service. The family explained their mother was terrified of Mark and had thought carefully about even involving the police. They knew she was very reluctant to contact anyone else in case it made matters worse. The Southside Panel member explained to the family, the many facets of confidential services they are able to supply including working with the police and in hospitals. Mary's son said they now recognised this was a missed opportunity by their Mum, as she would have found the one to one help very helpful.

**14.21.9 The Review Panel wish to take the opportunity to commend Mary's daughter for the caring support she gave her mother over the years Mary was mentally ill and to thank her and her brothers for their engagement with the Review.**

## **15. Effective Practice/Lessons to be learnt**

15.1. The following agencies that had contacts with Mary, Zack or Mark have identified effective practice or lessons they have learnt during the Review.

### **15.2. Avon and Somerset Constabulary**

#### **15.2.1. Identified good practice**

- Evidence of steps taken to protect Mary, such as the use of Treat as Urgent markers
- Good liaison between two new teams: the Lighthouse and the Safeguarding Coordination Units

#### **15.2.2. Issues of concern**

- Officers did not routinely submit reports regarding vulnerable adult web storm logs, or routinely share this information with Adult Social Care. The information remained on a separate database (Storm) and was not linked to Mary's intelligence record held on the Constabulary's crime intelligence and incident management system Guardian. In order to overcome this gap, vulnerable adult information should require submission of an intelligence report documenting the details of the victim and circumstances. This information will then be recorded on the intelligence and incident management system database. This will be accessible to the Safeguarding Coordination Units or other relevant Police department should any future public protection or welfare concerns arise.
- On occasions, police officers did not recognise the risk to children living with a parent with deteriorating mental health.

- In view of Mary's fears further efforts could have been made to obtain the deleted text messages from Mary's phone as they would either have provided evidence of harassment or have reassured Mary that her fears were groundless.

### **15.3. Avon and Wiltshire Mental Health Partnership NHS Trust**

15.3.1. It was identified that the care and treatment was of a satisfactory to good standard, all core aspects of treatment and care were addressed, including risk assessment and management plans.

15.3.2. Following the information being shared by Mary that she had experienced domestic abuse it may have been appropriate to work with her on a referral to a local domestic abuse support service such as Southside, to help provide more specialist support and work on any issues that arose from this although given the short timescale between her disclosure and her death this may not have been practical.

15.4.3. There was no operating procedures or guidance within AWP for mental health staff to consider when requesting for the police to conduct a welfare check on a service user and what is required from AWP staff once a request has been made.

### **15.4. Bath and North East Somerset Adult Safeguarding**

15.4.1. Mary's Care Coordinator should be commended on the relationship she appeared to have forged with Mary which enabled her to disclose the level of information that she did. Also of note is the degree of recording completed by the Coordinator on 22nd May 2015 outlining the risks and stating the safety plan that she had worked through with Mary.

15.4.2. Conversely, in considering the level of detail presented by the Care Coordinator there is an opportunity to question whether the Safeguarding Alert/Concern that was sent to the Adult Safeguarding Team required consolidating in order to focus on the relevant and most pressing issues, in this case the level of domestic abuse and the effects on Mary.

15.4.3. Consideration should be given to the level of support or training an individual worker requires following a disclosure of abuse being made to them.

15.4.4. Similarly, consideration needs to be given to how individuals both with mental health needs and without are supported through the process of disclosure of abuse.

15.4.5. The Care Coordinator clearly identified the need to progress to Safeguarding and as per the above protocol discussed with her supervisor. However, this assurance measure, the rationale for which is appropriate, led to a delay in the alert/concern being made and forwarded. The protocol needs to consider whether a degree of flexibility is required to enable professionals to act on their concerns as the need arises.

### **15.5. Bath and North East Somerset Clinical Commissioning Group**

15.5.1. Blood results were not always actioned by Doctor viewing and filing results.

15.5.2. There is a need understand when and how to consider referrals to adult and child safeguarding.

15.5.3. All patients on a mental health register should have a documented assessment of any adult or child safeguarding issues.

15.6.4. Child safeguarding should be re-assessed if any mental health admissions or episodes of deliberate self-harm are apparent.

15.5.5. There is a need for increased awareness of domestic abuse.

## **15.6. Bath and North East Somerset Council Children's Social Care**

15.6.1. The record of the telephone call from Mary on 26th May 2015 had insufficient detail to explain why the decision was made that there was no role for CSC and that there was to be no further action. There is a need to ensure that all Duty workers and Duty Managers record decisions in a detailed, clear manner which sets out succinctly the rationale for the decision/agreed actions .

15.6.2. There is a need to ensure that agencies are aware of the process of making a safeguarding referral.

## **15.7. Knightstone Housing**

15.7.1. Letting interview questions and recommendation was not as comprehensive as it needed to be.

## **15.8. Reach Housing Options and Advice**

15.8.1. The lack of a risk assessment was apparent.

15.8.2. There needs to be more clarity about information sharing.

## **16. Conclusions**

16.1 In reaching their conclusions the Review Panel has focused on the questions:

- Have the agencies involved in the Review used the opportunity to review their contacts with Mary and Mark in line with the Terms of Reference (ToR) of the Review and to openly identify and address lessons learnt?
- Will the actions they take improve the safety of domestic abuse victims and individuals suffering from mental health issues in Bath and North East Somerset in the future?
- Was Mary's death predictable?
- Could Mary's death have been prevented?

**16.2. Have the agencies involved in the joint Review used the opportunity to review their contacts with Mary, Zack and Mark in line with the Terms of Reference (ToR) of the Review and to openly identify and address lessons learnt?**

16.2.1. The Review Panel acknowledges that the Individual Management Reviews and other reports have been thorough, open and questioning from the view point of Mary. The Panel is satisfied with the evidence provided by those organisations, that have shown that their

contacts with Mary, Zack or Mark were in accordance with their established policies and practice, have no lessons to learn. Other organisations have used their participation in the Review to properly identify and address lessons learnt from their contacts with Mary, Zack or Mark in line with the Terms of Reference.

### **16.3. Will the actions they take improve the safety of domestic abuse victims and individuals suffering from mental health issues in Bath and North East Somerset in the future?**

16.3.1. The Panel, while satisfied that the implementation of the recommendations made within the Review will address the needs identified from the lessons learnt and make life safer for victims of domestic abuse who are also suffering mental health disorders, wishes to emphasise the need for more timely referrals to appropriate Safeguarding bodies.

### **16.4. Was Mary's death predictable?**

16.4.1. Although in 2012 there was one occasion when Mary was known to have spoken about being suicidal, and there were incidents in 2013, when on one occasion she had cut both her wrists and on a second put a plastic bag over her head, there had been no indication since that time that she intended to self-harm or take her own life.

16.4.2. On █ June 2015 she was seen by her Consultant Psychiatrist who noted that: "Despite recent occurrences (*Mark calling at her house that morning*), she appeared appropriately upset by recent events, but displayed no evidence of active mental illness. She spoke in detail about events of the previous weeks and described how she had felt panicked. She reflected upon her abusive relationships and appeared determined to remain in control of her stresses and was clear in her intention to continue treatment. She stated that she had appreciated the support given to her and was clear that she was relieved that services had supported her at home rather than in hospital. We agreed that she would continue to receive frequent support as per her care plan and we made an appointment to meet again for review of her treatment in August 2015."

16.4.3. Mary's panic attacks during that night and following morning, which were followed by the episode of normality when she was able to rationally discuss home security and obtaining an injunction, before sinking into the later intense episode of depression were typical of bipolar disease mood swings as was the fact that she was unwilling or unable to accept the help on hand.<sup>8</sup> The DHR Panel is therefore of the opinion that Mary's mood swings could have been predicted, but concluded that there were no grounds to foresee that Mary would inflict a fatal wound on herself.

### **16.5. Could Mary's death have been prevented?**

16.5.1. After Mary separated from her husband, she had been subjected to a number of stressors including financial, accommodation and employment issues. However it was apparent to those people who spoke to her on █ June 2015, particularly her daughter and her care coordinator, that on that day, the one issue which triggered her intense and rapid depression, was the fixation that she had put her children at risk of harm from Mark. The Panel therefore has focused on the following questions when considering if Mary's death could have been prevented:

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<sup>8</sup> Improving Lives of people with mental illness: Bipolar Disorder: Royal College of Psychiatrists April 2015

- Could more have been done to allay Mary’s fears that Mark would harm her son?
- Did the care offered by the mental health service appropriately address Mary’s needs at that time?

### **16.5.2. Could more have been done to allay Mary’s fear that Mark would harm her son?**

Both the police and Mary’s Care Coordinator spent time with Mary, reassuring her and organising detailed safety plans which included advice about how to obtain an injunction, Officers warning Mark not to contact Mary, a “treat as urgent” marker was in place, her beat manager was notified and her home was visited on █ June 2015 for a security and fire risk assessment. The Police response was nevertheless limited as Mary never told them that Mark had been physically violent to her and she had deleted his text messages prior to contacting the police. If the police had been able to view Mark’s messages at that time they would have been able to reassure Mary that the messages were not threatening. During the Care Coordinator’s and Duty Officer’s visit to Mary on █ June it was apparent that the stressor she was most anxious about was what she believed were threats by Mark to her children; yet she explained her fears and spoke rationally regarding the process of seeing a solicitor about obtaining an injunction to prevent Mark from having contact with her and her family.

### **16.5.3. Did the care offered by the mental health service appropriately address Mary’s needs at that time?**

16.5.3.1. Whilst the Mental Health National Service Framework 1999 sets out service models for treating people with mental ill health, it is clear from the notes of Mary’s consultant psychiatrist on █ June 2015, that Mary’s community based treatment was not as a result national policy<sup>9</sup> but rather was based on Mary’s wishes and what was considered to be the most appropriate treatment for her at that time. It was recorded in her Consultant Psychiatrist’s notes that she preferred to be treated at home by her Care Coordinator supported by the Intensive Team when needed.

16.5.3.2. On █ June 2015, Mary received an intense level of support from the mental health service. There were visits from the AWP Work Development Support Worker, followed by telephone support during the morning, visits from the Care Coordinator and Duty worker during the afternoon, her condition was discussed with a supervisor and her psychiatrist, her medication was sorted (although she refused to take her diazepam while the AWP staff were with her) and visits by the Intensive Team arranged for that evening.

16.5.3.3. While, during the morning of the █ June 2015 there were visible warning signs: lack of eye contact, speech patterns and her failure to take her medication, which should

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<sup>9</sup> In 1999, the Mental Health National Service Framework set out the service models that mental health services should provide. The intention was that inpatient care should be used only when necessary and that intensive treatment in the community should be offered in its place. The Cochrane Review (which analyses existing research on a given subject) suggests that this service model provides equal or better outcomes for service users than inpatient treatment alone and results in higher service user satisfaction. Consequently, current guidance is that services should seek to provide people in mental health crisis with the ‘least restrictive’, appropriate treatment option. Essentially this means that home treatment, with input from an Intensive Team, is routinely considered as an alternative to admission to hospital. Hospital admission remains an option, but will normally only be considered if the assessment process indicates that treatment cannot be provided safely at home and/or if the service user does not agree to engage in home treatment.

have triggered a decision to having her detained under the Mental Health Act, this was discounted, when treatment options were being considered, due to her mood swing during the afternoon when she was positive and able to hold rational discussions. Once it was decided that there was insufficient grounds for Mary to be detained under the Mental Health Act the mental health service appeared to take action to maintain regular contact with Mary. Her Care Co-ordinator stayed with her until 3.30pm when Mary was going to contact her solicitor, She knew that support had been arranged for the Intensive Support Team to visit her and they telephoned her at 4.3pm to tell her they would be with her at 5.30pm. they arrived on time and spoke to her from the front door but although she told them she would open it in a moment she never did so. When they could not gain entry they contacted the police for a welfare visit and the police had arrived and were speaking to her through her locked flat door when she stabbed herself.

16.5.3.4. Mary's family has raised concerns that when the Intensive Team contacted the police on the evening of the ■ June 2015 requesting a welfare visit to Mary, it was not made sufficiently clear that Mary was very mentally ill and that the Police should attend with door opening equipment. The family believes that the time it took for the police to send for the equipment after they saw through the letter box that Mary had stabbed herself, resulted in Mary losing too much blood to be saved.

16.5.3.5. The Review Panel accepts that it is not police practice to carry door opening equipment to every welfare call.<sup>10</sup> Emergency medical services were on hand to render assistance to Mary as soon as the door was opened and there is no medical evidence to indicate that if the police had been able to open the door more quickly, the medical assistance at the scene would have been more successful.

**16.6.4. The Review Panel therefore believes that on the evidence available it is not possible to conclude that Mary's death was preventable.**

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<sup>10</sup> Avon and Somerset Constabulary does not equip every patrol car with a door-ram because of the weight and bulk. The list of equipment that a frontline police officer may require, far exceeds the capacity of a typical car so some choices have to be made about the numerous items such as rams, fire extinguishers, shields, road signs, bollards, first aid equipment, tools, evidence bags etc., balancing the risk of not having the equipment with the likely frequency of its use. Rather than a national stance on how to approach this issue, Avon and Somerset Constabulary devolves the decision on how best to equip a police vehicle to local area commanders, as the typical requirements of a rural area are potentially very different from those in a city. Rams are always available to frontline staff but they may have to be brought by a colleague.

## 17. Recommendations and Action Plans

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Date of completion and Outcome
Avon and Somerset Constabulary to ensure that all operational staff-members are reminded of the importance of intelligence submissions for any relevant incident they attend.	Local	To form part of training and raising awareness which will, in turn, increase knowledge and understanding of our Domestic Abuse processes	Avon and Somerset Constabulary	A dip sample of intelligence system to be taken and remedial measures implemented as necessary.	To be conducted before the finalisation of the IMR report.	31/03/16
All operational staff to be reminded of the importance of recognising the risk to children living within a parent declining mental health. To be measured by an increase in referrals from the Safeguarding Coordination Units to Children's social care.	Local	Implement through briefings	Avon and Somerset Constabulary		completed	31/03/16

AWP to organise training to increase awareness of how vulnerability to domestic abuse can be linked to history of trauma and agencies available to support	Local-organisational wide	Training session to be organised by Recovery Team Manager	AWP		31/07/16	31/07/16
The Operating Protocol in relation to Safeguarding decisions between AWP and Bath and North East Somerset Council needs to be reviewed particularly in relation to alerts having to be made by Team Managers or Senior Practitioners	Local to Bath and North East Somerset	To review protocols	AWP and Bath and North East Somerset Council Safeguarding Team	Protocol reviewed and agreed	1/05/16	completed on target.

Awareness raising to be undertaken amongst AWP on CAADA DASH/Safe Lives tool and MARAC referrals, particularly the availability of option to refer to MARAC on professional judgement basis.	Local to Bath and North East Somerset		AWP and the Avon and Somerset Constabulary	training programme agreed delivery ongoing	31//16	training delivery ongoing
Explore IT solutions to reduce potential admin delays in reporting Safeguarding concerns	Local	Continue to implement Liquid Logic project	BANES Local Authority and AWP		30/09/16	30/09/16
During the Review it was identified that B&NES does not appear to have a clear multi-agency policy / procedure on Domestic Abuse and Violence or a multi-agency training programme.	Local to B&NES agencies	B&NES Council to publish a clear multi-agency policy / procedure on Domestic Abuse and Violence, along with a multi-agency training programme.	B&NES Responsible Authorities Group (Community Safety Partnership)		complete d	31/11/2016

Review procedure on passing messages to advisers	Local	Quality Manager to review system and report to Director	Citizens advice B&NES		29/04/16	completed on target
Continue to implement the“ASK RE” information policy which highlights the need not just to signpost to services but t where appropriate to directly refer.	National Citizens Advice policy	Continued training for new advisers	Citizens advice B&NES		ongoing for new staff	All existing advisers trained continuous training for new advisers/volunteers
Referrals to Children's Social Care to ensure clarity on what constitutes a referral to CSC	Local	The issue about what constitutes a referral is clearly documented on CSC website. A C.2 is The form used for all agencies to request a service from CSC. This was not progressed by any agency and CSC saw no need to undertake an assessment. If an agency is not happy with the response from CSC they should refer to the LSCB escalation policy	Bath & NES Council Children's Social Care	All local agencies will be reminded by BATHNES RAG of referral routes into CSC		

Case notes Reminders to be given to Duty Team to ensure clarity and consistency in record keeping	Local	Duty Team manager will ensure records are recorded directly by the person who receives the information	Bath & NES Council Children's Social Care	This issue will be referred to at the duty workshop	05/05/16	Completed by 31/03/2016
That the Local Safeguarding Adults Board reviews the quality of referrals being made into safeguarding, particularly those made by statutory partners.	Local to Bath and North East Somerset	To review current referrals, identifying key issues/learning. Working across agencies, particularly statutory partners to agree a minimum set of data that should be provided by organisations when making safeguarding referrals. Consideration also to be given to how referrals for alternative forms of support such as social care assessments should be identified separately from safeguarding concerns, or where information only is being shared that there is an agreed process for how these should be actioned by the receiving agencies.	BANES Safeguarding Adults Board			31/12/16

DHI risk assessment for clients entering casework services to be reviewed and re-issued to all staff	Local (Reach service specific) and regional (all DHI services)	Review and revise service and organisational risk assessment processes	DHI	A revised and agreed risk assessment will be the measure of success	30/09/16	Reach risk assessment completed, organisational actions on track for target date
Relevant DHI policies and procedures to be reviewed to consider appropriateness of current thresholds for action	Regional (all DHI services)	Review and revise organisational policies and procedures (if appropriate)	DHI	DHI Board sign off of policy & procedure review will be the measure of success	30/09/16	Adult safeguarding policy & procedure currently under review, other actions on track for target date
Lettings procedures to be clear about specifically asking about DV and what support is or could be in place.	Local to Knightstone	To review lettings procedures	Knightstone	Procedures reviewed	01/04/16	29/03/16 Procedures amended to include DV

Audit of thyroid function test management as proxy for management of blood results	Local	Perform a search on all patients prescribed thyroxine within the past 12 months to ensure all have a TFT result within the past 12 months. Any who do not will be recalled for a TFT blood test. For all patients where TFT result is outside the normal range, a clinician will review the notes to ensure that the result has been actioned and any dose amendment or repeat test arranged	GP Practice	Completed	30/04/16	31/12/16
Baseline assessment of documentation of consideration of child and adult safeguarding issues for all patients on mental register	Local	Review of records	GP Practice	Completed	30/04/16	31/12/16
All patients on mental health register to have documentation of consideration of child and adult safeguarding issues	Local	Any not documented to have documentation of consideration of safeguarding issues	GP Practice	Completed	31/08/16	31/12/16
Staff are up to date with mandatory child and adult safeguarding training	Local	Training records to be checked	GP Practice	records checked by 15.3.16	30/05/16	31/12/16

IRIS training and advocacy package completed	Local	All staff to have the training	GP Practice	Admin staff have already been trained and clinicians training booked for 21.3.16 and 27.4.16	30/05/16	31/12/16
Specific DVA policy developed	local	Develop policy	GP Practice	Completed	30/05/16	31/12/16

## Appendix A: Glossary of Terms

### Avon and Somerset Police:

- **PNC (Police National Computer)** – Contains information of convictions, remand history and court appearances of identified individuals.
  
- **PND (Police National Database, previously Impact Nominal Index)** – a national Police computer system which allows officers to establish, in seconds, whether any Police force anywhere else in the country holds relevant information on someone they are investigating. Previously, this information would not have been visible outside the force holding the record. PND was implemented following the Soham enquiry.
  
- **ASSIST** – a ‘data warehouse’ search tool used within Avon and Somerset Constabulary that scans all other Avon and Somerset systems for information on individuals in relation to road traffic collisions, alcohol licensing, firearms, calls for service from the public and details of crimes reported to the Police.
  
- **STORM or WEBSTORM** – the command and control system used by Avon and Somerset Constabulary to manage calls for service. When contact is received from a member of public which requires police action a log is created at the first point of telephone contact with the Police and attendance is managed by control room staff based in Police Headquarters. If the call results in the police recording details of a criminal offence or a crime related incident the STORM log will be concluded with a Niche reference number for the incident.
  
- **GUARDIAN (GDN)** – a criminal intelligence database introduced in 2007 and active until September 2015. All criminal offences and crime related incidents were recorded here. Avon and Somerset Constabulary replaced this system following the implementation and utilisation of an alternative database, Niche (detailed below).
  
- **NICHE** – a criminal intelligence database introduced in September 2015. All criminal offences and crime related incidents will be recorded here, including all domestic abuse cases regardless of whether a crime or verbal argument is reported. The system enables information relating to domestic abuse, child abuse and missing persons to be linked to a nominal record. Information which is not reporting a specific incident will be recorded as ‘intelligence’, including information obtained from a third party, via Crimestoppers or shared by another agency. Risk assessments are collated using a relevant template (in line with the nature of the risk posed) and are linked to the individuals involved. These are available at all times to all staff and ensure a complete history can be viewed in one place.

- **NSPIS** – a record of every person arrested by Avon and Somerset Constabulary. This not only records the facts of their arrest but also records every aspect of their treatment and detention whilst in police custody. This is a legal requirement under the Police and Criminal Evidence Act 1984.

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