Oxford Safer Communities Partnership
DHR Overview Report

Steve Appleton – Independent Chair

March 2014

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Section One

Introduction and background

1.1 Introduction

This Domestic Homicide Review (DHR) examines the circumstances surrounding the sudden unexpected death of Adult A in Oxford. It was commissioned by the Oxford Safer Communities Partnership. On the morning of Thursday 16th August 2012 Thames Valley Police received a phone call from Adult C (the mother of Adult A) saying she was concerned as she had not heard from Adult A.

The Police attended an address in Oxford where they found Adult A to be deceased. Adult B, Adult A's daughter was present, was arrested and subsequently charged with Adult A's murder on Saturday 18th August 2012.

On 22nd July 2013 Adult B was found guilty of manslaughter on the grounds of diminished responsibility. The Judge imposed a hospital order under the Mental Health Act and at the time of writing Adult B is detained in a secure mental health hospital.

Adult B courageously agreed to be interviewed to give her invaluable insight into the tragic events that led to her mother's untimely death.

It was the views from her and her brother that have enriched the Overview Report and influenced recommendations to help prevent further tragedies.

Sadly on 8th June 2014 Adult B passed away from natural causes. Our thoughts are with her family.

1.2 Purpose of the Domestic Homicide Review

Domestic Homicide Reviews (DHRs) came into force on 13th April 2011. They were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Adults 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 he was related or with whom he was or had been in an intimate personal relationship, or*

- *a member of the same household as himself, held with a view to identifying the lessons to be learnt from the death'*

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 violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

1.3 Process of the review

A DHR was recommended and commissioned by the Oxford Safer Communities Partnership on 28th August 2012 in line with the expectations of the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews 2011. This guidance is issued as statutory guidance under section 9(3) of the Domestic Violence, Crime and Adults Act 2004.

Given the associated issues relating to mental health, contact with NHS services and adult social care it was decided by the Oxfordshire Safeguarding Adults Board, the local NHS and adult social care that a separate Serious Case Review and Mental Health Homicide Review would not be conducted, but that the DHR would act as a means of addressing the issues that might otherwise have been raised by such reviews.

In that context, this DHR has also sought to satisfy the standards and requirements of an Adult Serious Case Review.

It has also sought to satisfy the standards and requirements of a Mental Health Homicide Review under Health Service Guidance (94) 27 which requires such a review when a homicide has been committed by a person who is or has been in receipt of mental health services and has been subject to the regular or enhanced Care Programme Approach of specialist mental health services in the six months prior to the event.

By drawing together these reviews within the DHR framework it has been possible to avoid unnecessary duplication of process, make more effective use of time and enable improved organisational engagement and learning.

Adult B, the perpetrator, had been arrested and charged, and a decision was made that, because of the potential delay in learning lessons from the review, the DHR

should be commissioned and not delayed by pending legal action. Agencies and interested parties were notified of the requirement to secure any records pertaining to the homicide to inform the subsequent Overview Report.

There were delays in the court process; these were due to complications in relation to legal advice of the fitness to stand trial of Adult B. The Home Office was written to on the 18th January 2013 to inform them of the delay and they have been updated throughout the process. The Crown Prosecution Service was informed that a DHR had been commissioned.

The Home Office was informed of the intention to conduct a DHR on 29th August 2012 and the first review panel was held on 25th October 2012. The process has been completed and the report submitted on 3rd March 2014

The membership of the DHR panel was:

Name	Title	Organisation
Steve Appleton	Independent Chair and author of the Overview Report	Contact Consulting (Oxford) Ltd
Richard Adams	Environmental Protection Service Manager	Oxford City Council
Jane Bell	Oxfordshire Designated Child Protection Nurse/Safeguarding Lead	Oxfordshire Clinical Commissioning Group
Lucy Butler	Deputy Director – Adult Social Care	Oxfordshire County Council
Karen Diver	Services Manager	A2Dominion Group
Paul Gration	Detective Supt.	Thames Valley Police
Peter Howe	Emergency Services Manager	Oxfordshire County Council
Elizabeth Jones	Domestic & Sexual Abuse Coordinator	Oxford City Council
Julie Kerry	Assistant Director of Nursing	Thames Valley Local Area Team (former Asst. Director – Mental Health, NHS South Central)
Dr James McIntyre	Consultant Psychiatrist	Southern Health NHS Foundation Trust

Jane Bell left Oxfordshire CCG during the review. Helen Ward joined the panel in her place in September 2013.

The Chair and author of the Domestic Homicide Review is Steve Appleton. Steve trained as a social worker and specialised in mental health, working as an Approved Social Worker. He has held operational and strategic development posts in local authorities and the NHS. Before working independently he was a senior manager for an English Strategic Health Authority with particular responsibility for mental health, learning disability, substance misuse and offender health.

Steve has had no previous involvement with the subjects of the review or the case. He has considerable experience in mental health, has worked with a wide range of NHS organisations, local authorities and third sector agencies. He is a managing director of his own limited company, a specialist health and social care consultancy. He is a Trustee of a local charity and is a Mental Health Act Commissioner with the Care Quality Commission.

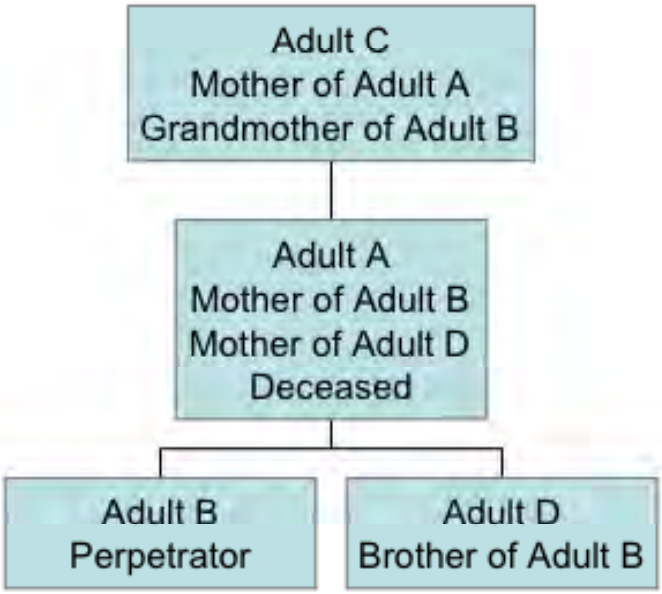
Steve has led reviews into a number of high profile serious untoward incidents particularly in relation to mental health homicide, safeguarding of vulnerable adults, investigations into professional misconduct by staff and has chaired a Serious Case Review into an infant homicide.

1.4 Subjects of the review

Adult A
Afro-Caribbean female
Date of Birth 27/07/1960
Date of Death 16/08/2012
Deceased was mother of the perpetrator

Adult B
Afro-Caribbean female
Date of Birth 04/04/1983
The perpetrator and daughter of the victim

1.5 Immediate Family Structure



1.6 Time Period

This review began on 25th October and was concluded on 3rd March 2014, when it was approved by the Oxford Safer Communities Partnership.

- The timeframe the DHR covers was decided upon because it related to the period when Adult B was most recently in contact with mental health services and then moved to Oxford. The primary focus of the review is therefore from May 2010 to 16th August 2012.

- Adult B was known to have resided in Birmingham before moving to Oxford in 2012. While in Birmingham Adult B had limited contact with local NHS primary care and with a mental health service. This review has therefore examined the immediate period prior to Adult B's move to Oxford and had contact with those professionals from Birmingham who could be identified and contacted.

The summary chronology contains some information about the period prior to 2010, which although not directly related to the antecedents of the incident under review, is helpful in building an historical picture and raising wider issues. Much of this information has been provided to the panel by Adult B and Adult D (brother of Adult B). We have taken account of this in our work and in reaching our conclusions and thank Adult B and Adult D for providing this information.

1.7 Terms of reference

This DHR had two central objectives. The first was to review and evaluate the care, input, context and circumstances leading up to the incident. The second was to identify any contributory factors to the homicide and learn appropriate lessons across organisations. The DHR's specific terms of reference, as agreed by the panel were:

1.	To review the care and treatment provided, including risk assessment and risk management
2.	To review the communication between agencies, services, friends and family including the transfer of relevant information to inform risk assessment and management
3.	To examine the events leading up to the incident, including a chronology of the events leading up to the incident
4.	Identify any care or service delivery issues, alongside factors that might have contributed to the incident
5.	To examine how organisations adhere to their own local policies and procedures and ensure adherence to national good practice

6. Review documentation and recording of key information, including assessments, risk assessments, care plans and management plans

7. Review communication, case management and care and service delivery of all the agencies involved

The review will make clear, implementable and measurable recommendations for agencies involved in the case.

1.8 Individual Management Reviews (IMRs)

IMRs were requested from a range of agencies that had been in contact with or providing services to both Adult A and Adult B. This included agencies in Oxford but also in Birmingham where Adult B had resided previously.

The objective of the IMRs which form the basis for the DHR was to provide as accurate as possible an account of what originally transpired in respect of the incident itself and the details of contact and service provision by agencies with both Adult A and Adult B.

The IMRs were to review and evaluate this thoroughly, and if necessary to identify any improvements for future practice. The IMRs have also assessed the changes that have taken place in service provision during the timescale of the review and considered if changes are required to better meet the needs of individuals at risk of or experiencing domestic abuse.

This Overview Report is based on IMRs commissioned from those agencies that had involvement with the victim and/or the alleged perpetrator. The IMRs have been signed off by a responsible officer in each organisation and have been quality assured and approved by the DHR panel.

The report's conclusions represent the collective view of the DHR Panel, which has the responsibility, through its representative agencies, for fully implementing the recommendations that arise from the review. There has been full and frank discussion of all the significant issues arising from the review.

The DHR Panel has received and considered the following Individual Management Review Reports (IMR):

Organisation	Author(s)	Title
Oxfordshire County Council	Wendy Paskell	Approved Mental Health Practitioner Service Manager
Oxford Health NHS Foundation Trust	Caroline Birch Dr Gail Critchlow Rebecca Kelly	Deputy Director of Nursing Deputy Medical Director Learning from Incidents Lead
Thames Valley Police	Tracey Thorne	Detective Constable Major Crime Investigation Review Team
Oxfordshire County Council – Safeguarding	Hugh Ellis	Safeguarding Adults Manager
Oxfordshire CCG	Dr. Judy Shakespeare	General Practitioner
Oxford City Council	Ann Phillips	Tenancy Manager

Scoping work was also undertaken on behalf of the panel by Elizabeth Jones to establish the need for IMRs from other organisations, particularly those in Birmingham where Adult B had previously resided. Although IMRs were not requested from the following organisations, helpful background information was supplied that has assisted the panel in its work:

- Reservoir Road GP Surgery – Erdington, Birmingham
- Birmingham City Council – Homeless and Pre-Tenancy Services
- Birmingham & Solihull Mental Health NHS Foundation Trust

1.9 The national context in relation to mental health

One in four people will experience a mental health problem at some point in their lifetime and one in six adults have a mental health problem at any one time[1]. Mental ill health represents up to 23% of the total burden of ill health in the UK – the largest single cause of disability[2].

Black and minority ethnic (BME) groups are four times more likely to experience psychosis than white people.[3] *The Aetiology and Ethnicity in Schizophrenia and Other Psychoses* (AESOP) study has indicated that the incidence of psychosis is significantly higher in Afro-Caribbean and Black African groups living in the UK than in the White British population. The study shows that people from BME groups were four times more likely to have psychosis than white people.[4]

Women account for over two-thirds of the growth in demand for NHS specialist mental health services. Representing 56% of service users, the report shows women are accessing mental health services in greater numbers than men. However, more men than women are hospitalised for their condition. The proportion of mental health service users who spent time in hospital was higher for some black and minority ethnic groups than for the white group. Some 9.7 per cent of those in the white group were hospitalised, compared to:

- 11.5 per cent of the Asian or Asian British group
- 14.3 per cent of the Mixed group
- 18.9 per cent of the Black or Black British group.[5]

Mental health and homicide

Between 1999-2009 the overall number of people with an abnormal mental state at the time of the homicide was 628, 10% of the total sample, an average of 57 per year.[6]

During the same period, 631 people convicted of homicide (10% of the total sample) were identified as patients, i.e. the person had been in contact with mental health services in the 12 months prior to the offence, an average of 57 homicides per year. The victims for male patients were most likely to be acquaintances whereas females most commonly killed family members or spouses/ partners.[7]

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[1] Adult Psychiatric Morbidity in England, 2007: Results of a household survey Leeds: NHS Information centre for health and social care. McManus S, Meltzer H, Brugha T et al. 2009
[2] WHO *The Global Burden of Disease: 2008*
[3] BME groups and mental health, National Mental Health Development Unit 2010
[4] *Perceptions of disadvantage, ethnicity and psychosis*' The British Journal of Psychiatry, 192, 185-190.Cooper *et al.* 2008
[5] The Mental Health Bulletin: Second report on experimental statistics from Mental Health Minimum Dataset annual returns 2003-2008, The Health & Social Care Information Centre, 24 March 2009 & News Release, NHS Information Centre, 224 March 2009
[6] The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness Annual Report July 2012
[7] ibid

38% of convicted adult family homicide perpetrators, in England & Wales, between 1997-2008 had symptoms of mental ill health at the time of the homicide.[8]

1.10 Diversity

The panel has been mindful of the need to consider and reflect upon the impact, or not, of the cultural background of Adult A and Adult B and if this played any part in how services responded to their needs.

"The Equality Act 2010 brings together the nine protected characteristics of age, disability, gender reassignment (with a wider definition) marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation."[9]

There are further considerations relating to income and pay gaps, the gender power gap in public sector leadership positions and politics, and the causes and consequences of violence against women and girls, under the Gender Equality Duty.[10]

This overview report specifically considers Adult A and Adult B's mental health history, Adult A's relationship with alcohol and Adult B's engagement with local mental health services and the response of local agencies.

1.11 Confidentiality

The Domestic Homicide Review was conducted in private. All documents and information used to inform the review are confidential. The findings of the review should remain confidential until the Overview Report, Executive Summary and Action Plan are accepted by Oxford Safer Communities Partnership. The Overview Report and Executive Summary have been anonymised.

1.12 Involvement with the family

The family of Adult A and Adult B have been kept advised of the work of the DHR panel throughout the process. This contact was via letters, emails, phone calls and third party support to advise them of progress. In early contact the review panel were mindful of the participation of family members in the legal process pertaining to Adult B. Initial contact was facilitated by Family Liaison Officers at Thames Valley Police.

[8] Mental Disorder & Domestic Homicide: A population based descriptive study. Journal of Psychiatric Services, S Oram & L Howard 2013.
[9] Paragraph taken from Home Office Domestic Homicide Review Training; Information Sheet 14. P47
[10] Gender Equality Duty 2007. www.equalityhumanrights.com/.../1_overview_of_the_gender_duty

Early attempts to engage members of the family with the DHR process were responded to by the family, who at that stage did not wish to meet or speak with panel members or the DHR chair.

Following the conclusion of the trial, the panel Chair, along with another member of the panel met separately with Adult A's mother and sister, Adult C and with Adult B herself.

Meetings have been held with Adult D who has been proactive in engaging with the process. The panel Chair has met with him as an individual and met with him and Adult B together. We have taken account of his wish to advise the panel of the family history and its relevance to the case. We have had further communication with him and his advocate via telephone and email.

Adults B, C, D and the sister of Adult A have had the opportunity to read and comment on the full draft of the Overview Report and their views have been taken into account.

During our conversations with both Adult B and Adult D they told us about a number of their concerns relating to their engagement with statutory services.

Adult B was particularly concerned about how she had been treated by the police when being retaken into hospital. *"When the Police were issued with a warrant they put me in handcuffs, leg cuffs and pulled my hat over my face. I couldn't breathe and they were very aggressive towards me. It was frightening."*

Adult B also stated that her state of anxiety and aggression was exacerbated by a lack of information about what was happening to her. *"No one sat down with me to discuss a care plan or what was happening. They didn't get a chance to do a proper assessment of me. They didn't explain the section and why I was there. I asked several times and they never answered"*

Adult B also told us that she felt frightened about being in hospital and the prospect of returning. Her fears may have been contributed to by her recollection of her experience: *"It was quite frightening when I went back to hospital. It took 8 staff to administer medication. They said they were giving me a pill and then they wanted to inject. It was very intimidating and frightening the way they were treating me."*

Adult B further described her lack of knowledge about her status as an informal patient, saying, *"They told me that I could leave the hospital after a few days when I was being moved back to Allen Ward. But I didn't know I was free to go when I wanted. They should have said so."*

Adult D told us that on a number of occasions he had tried to speak to staff at the hospital to enquire about his sister and to talk to her. He told us that he had not been able to talk to her and that the ward staff would not divulge any information to him as

he was not her next of kin, nor was he her nearest relative in relation to the Mental Health Act.

Both Adult B and Adult D were unhappy that Adult A had been consulted during the assessment for detention under the Mental Health Act. Adult B told us that she had asked staff to contact her brother **not** her mother. The difference between next of kin and nearest relative status was not explained to either of them.

Many people confuse the term nearest relative with 'next of kin'. A person's next of kin is their closest relative and this is relevant when, for example, a person has died. Nearest relative is a specific legal term defined in Section 26 of the Mental Health Act. The Mental Health Act gives a patient's nearest relative some rights and powers in relation to detention, discharge and being informed or consulted when certain actions have been taken under the Mental Health Act or when these are being proposed. The role of a nearest relative is limited to these rights and powers under the Act.

It is only certain relations who are treated as relatives under the Mental Health Act and Section 26 lists these in groups or pairs: starting with husband, wife or civil partner, son or daughter, mother or father, brother or sister and so on. The nearest relative is identified by starting at the top of the list and working down. If the patient is living with or being cared for by any person on the list, this person is the nearest relative. For example, if the patient lives with an uncle or aunt, that person will be the nearest relative even if the patient has a mother or father. [11][12][13]

Adult B also shared their experiences of her early life: *"My relationship with my mum was not very good she was quite aggressive, especially if we were together too long. Aged 14 I moved to Birmingham then later to London so I did not live with her all the time. The problems were due to her mental health; she was aggressive and erratic. Also she was neglectful of herself and the condition of the house. Drinking was a problem too. I had to help myself. She could have given me more assistance. I felt abandoned by social care. Mum was aggressive but they didn't help. My school asked them for help but they didn't respond. I was left with my mother when I was 12. She needed counselling. The social workers should have done more and got support."*

Adult D requested a statement he has written in conjunction with Adult B be included in this report which we are happy to accommodate and this can be found at page 18. We have found his input to be helpful and informative.

The panel Chair, along another member of the panel met with Adult B at her current hospital. We were able to have an insightful and informative discussion with her

[11] Mind Legal Guide: Nearest Relatives under the Mental Health Act – accessed on line
[12] Code of Practice Mental Health Act 1983 HMSO 2010
[13] The Maze: A Practical Guide to the Mental Health Act Third Edition SLaM NHS Foundation Trust

which covered some of the areas raised by Adult D in connection with their early family life. Adult B was able to recount the series of events immediately leading up to and including Adult A's death and her relationship with Adult A. These were also taken into account in the preparation of the Overview Report.

Adult's B, C, D and the sister of Adult A saw a draft copy of this report and the final version will be shared at the appropriate time.

We are grateful to Adult B and Adult D for openly sharing their experiences.

Summary chronology

This summary chronology contains information relating to the period 2010 through to the incident in August 2012. As outlined in section 1.12, the panel received information from Adult B and Adult D about their childhood experiences and of contact with local services. Although not directly related to the incident itself, the panel agreed with Adult B and Adult D that this information should be summarised as part of the summary chronology in the main body of the report. This information is further augmented by the personal statement provided by Adult B and Adult D which is included below in this Overview Report.

A full chronology can be found at page 72

My sister and I have provided this statement, because restricting this review to only go back as far as 2010, will not provide a wide enough scope with regards to the many factors that we feel have lead up to this tragic event. And to give a first-hand account of what life has been like for us my mother, my sister and me.

It is hard to explain the impact that my mother's death has had on us, we feel that the last twenty years were leading up to this: my mother's lifestyle was unhealthy, she drank alcohol and chain smoked and had diabetes as well as poor mental health. She would wake up at 7am with only the thought for alcohol and she would drink alcohol until she passed out. She did this almost every day and for over ten year she hadn't gone more than two days without alcohol. The state of my mother's house as the police would have found it is how my mother lived. A few years ago I started taking pictures of my mother and what the house looked like, because on one occasion my sister had been blamed for the state of the house. Rather than the professionals who visited accepting that my mother needed more help than they were providing. A male friend refused to go to the house, because my mother did not keep the house clean. He would go there to get money from her and leave her with no money. She would then sit in the dark and drink alcohol.

She used to have an injection every two weeks for her mental illness. On more than one occasion appointments were missed or we expected the CPN to turn up but she

didn't. She would become extremely unstable and aggressive when she didn't have her medication. When we were younger my mother was sometimes physically and psychologically abusive towards us, but as we got older it was less physical and more psychological. She threw things, including bottles and cans of food at us. Once she threw a bottle that smashed over my sister's head. She had done things like this to me too when I was younger, but less so as we got older. She had said to me many times that she needed to say sorry to my sister for kicking her in the past. We always put this down to her mental illness, but I don't want people to think that she was a horrible person. She was mentally ill, but at the same time it seemed she didn't care about us. If we said anything to her about this she'd often say that it wasn't as bad as what she had experienced in her own childhood. She sometimes said that these experiences would make us stronger. She blamed her mental health and her addictions on her experiences with her family and things that had happened to her.

She was also neglectful; she would walk around the city centre and we would have to go looking for her, we would have to stand directly in front of her and shout until she snapped out of her daze, and she would continue walking, sometimes punching and kicking the air. We just got used to that being our mother, because most of our friends knew what we had to deal with. I remember this happening from the age of 6. My sister is older than me and often told me about things she remembered that were earlier than that. Her records show that her mental illness goes as far back as 1983.

Even though we were young I remember having a conversation with my sister about mum, we knew something was wrong with her and it got to the point that we knew we had to do something, but we didn't know what to do. Social services got involved when we started missing school, about a year or two altogether. We only made lives for ourselves because we both moved away. I went to a children's home and foster care, my sister went to foster care and then to Birmingham. We sacrificed years between us to come back to Oxford to look after her; it was the last place either of us wanted to be. People would say to us that we did so well to get on with our lives and go to university, but even then we had to keep coming back to look after our mother, because of situations created by our own family which made our lives harder. We both had to get away from her but we could never leave her alone for too long, because no one else would look after her. Our family never helped as they weren't there when we needed them. My mother's medication and treatment played a big part in her condition, along with her boyfriend and my grandmother; by this I mean her rapid physical and mental deterioration.

When my mother met a male friend about seven years ago he introduced her to gambling and strong spirits, and she came to care about only him and alcohol. The control that this male friend had over her was destroying our relationship with her and any help that we tried to give to her. It was known by certain relatives that this male friend had started a relationship with someone else but was still encouraged to stay with our mother.

People can't understand that we've been resigned to losing our mother for over 15 years, because of alcohol and her lifestyle. It was as if we had to watch her slowly committing suicide through alcoholism. If she were still alive we would still be have a

heavy weight on our shoulders and the rest of the family would be ignorant. Anyone who helped her drink was considered a friend, and anyone trying to get her to stop – like my sister and me – were considered an enemy as far as alcohol being involved. Her medication was changed and she gradually deteriorated: she became extremely forgetful, and she took less responsibility for her behaviour. She kept losing things like her purse, she stopped eating and got diabetes – with it her feet became swollen and it was hard for her to walk. She took medication not only for her mental illness, but also to help her body cope with the amount she was drinking. She used to have those booklets with her tablets spread out for the days of the week.

There was another occasion when I was about fifteen and living in foster care in oxford. I was at home on my own and she was banging on the door. When I answered she asked to come in. I didn't open the door, because I could see through the window that something about her didn't look right and I knew she had recently come out of the Warneford Hospital. There was a plate in the garden for the cat, and she picked it up and threw it at the window that I was standing behind and she then left the garden. I came outside, because I was worried about her. She lived in the city centre and I didn't know how she would get home in that state of mind. She was stood on the other side of the wooden gate; I could see her through the gaps in the gate. I thought she was going to come back through the gate, but then I saw her take a kitchen knife out of her handbag. And she stabbed the knife through a gap between the wooden panels of the gate. I stepped backwards, if I hadn't done so she would have stabbed me in the chest. I ran back into the house and called my foster carer, who called the police and my mother was later taken back to Warneford Hospital. When I spoke to my mum about this she said she had been given the wrong medication and from that day I have never forgotten the name Amitriptyline. After this happening my sister would say to me that her worst nightmare would be to end up like our mother and because of this I have almost seen history repeat itself. It is for reasons like this that my sister was scared of the treatment she would receive in the hospital and willing to do anything to get out. In the state of mind that she was in at the time she told me that she thought she would never get out.

When we were younger, my mother used to do things like waking us up in the middle of the night and taking us out to walk the streets; she had a knife in her bag and said someone was after us. She also took us to live in a women's refuge in reading for six months and another time when we were 7 and 8 she took us all the way to Amsterdam with no warning. We feel that if we hadn't of been left to grow up in this environment, then what happened would have seemed more out of the ordinary. We have had to deal with so much from such a young age that we almost became desensitised to things that most other people would not be able to deal with. Our anger is really directed at the professionals: social services and the mental health services. My mother was sectioned on numerous occasions, but never received the care she needed when she came out. No one would believe the life she was living unless they saw it; it was as if she had given up on life and that is why I started physically draining. I watched my mother's mental state go up and down as far back as I can remember. I feel the same way about how the hospital treated my sister too. They knew she had a brother, yet chose to correspond with my mother about my sister's care.

On more than one occasion my mother had been released into my sister's care and now they released my sister into my mother's care. On one occasion a family member tried to get my mother to marry a man who had assaulted my mother more than once and had put his hands around my sister's throat. This situation meant that I had to leave college and my sister had to come back from to stop this happening. We then had to get a letter signed by my mother's doctor at Warneford Hospital, stating that my mother was not fit to make this decision. My mother was a patient too and was still suffering with severe mental illness and drinking heavily. She couldn't even look after herself. My sister had asked for supported accommodation in 2008 for our mum but it never happened. Her CPN never knew the severity of the condition of my mother's home. She never walked past the front room to see the real condition in which she was living in. Our mother needed help mainly upstairs, because of the incontinence, alcoholism and diabetes.

I didn't see my sister for a while after the incident in August, even now when I see her in hospital, people have to be in the room with us. Strangers. It would be like trying to hold a private conversation while walking down the street, you just don't do it. I won't have a proper relationship with my sister until she comes out; any punishment to my sister almost feels like a punishment to me as well. I feel that I should be standing in the dock with my sister, because we are the only two people that know how hard things have been for us, it just became too much for her. We'd been through so much together, if I had been the one who got mental illness whilst trying to look after my mother and dealing with her behaviour I could have done what my sister did. My mother and I would get into confrontations and I would get annoyed, but my sister always had more empathy with my mother than I did; perhaps because she studied psychology, or perhaps because they were both female. For what happened my sister must have been ill. I know the two people involved better than anyone, so this affects me more than anyone else, but I have no control over the situation.

I was not aware that my sister had mental illness until I went to stay with her in Birmingham in September 2011. She had said that she had been under a lot of stress on more than one occasion over the last couple of years. She told me that she'd had two breakdowns and was on the verge of a third. I have seen no evidence of a nurse, CPN or medication. I wasn't sure how she would have gotten over a breakdown without going to hospital or maybe she had tried to deal with it herself. She was trying her best to stay on top of things whilst still working and decorating her new place.

I don't know what triggered the change in my sister, but I think she was attacked. My mum told me more than once that she had spoken to my sister about her having been attacked, but neither of them ever elaborated at all. I can't recall when we spoke about it, but it was in the last few years that my mother was alive. My paternal grandfather also told me that he had received a call from the police in relation to my sister being attacked and he had also been to talk to someone that had assaulted my sister on a previous occasion. West midlands police also contacted me about the same incident. As far as I know my sister was attacked and that had the biggest effect on her mental and physical health. My sister's outbursts used to be the same as my mum used to do, to the point that I could so many similarities in their behaviour.

We lived together in Birmingham between September and December 2011, during this time she told me a number of stories. But if I questioned her she would say that I didn't know what she had been through in the last couple of years and would get annoyed, frustrated or angry if I questioned her about these details. I can't remember the exact date, but whilst in Birmingham, she left the house and insisted that I didn't follow her, but I followed her anyway to see where she was going and what she was doing. I was worried about her because she was very vulnerable and had disappeared with a knife. Days later she said she was going to Oxford. So I followed her. We were kicked off the train in Banbury and walk 20 miles to Oxford at 10pm in the dark, not getting there until 8am. This just emphasised to me how vulnerable she really was. Although I could see similarities between her behaviour and my mother's behaviour, my sister didn't really drink and she still worked, it was as if she tried to fight against her mental illness and keep functioning. When I was living with her I could see that she was stressed out about something, but I didn't know what, she said I had to find somewhere else to live, which I did and moved my stuff out in December 2011.

We used to fight each other when we were younger and as we got older we would just argue. In December 2011 we argued at my maternal grandmother's house in Oxford. We argued and it lead to my sister smashing a glass and waving it at me, my grandmother thought this was really bad, but it wasn't the worst situation we had been in., given the environment that we had group up in. And within 10 seconds we were stood side by side talking outside my grandmother's house. That was the last time I saw my sister and the last time I saw my mother was in January 2012. I spoke to both of them on the phone many times between these dates. My mum said she had become scared of my sister, because she had kicked my mum in the chest at the top of the stairs, although my mum told me more than once that she had to apologise for kicking my sister when we were younger.

My sister moved back to oxford around Easter 2012, but it didn't strike me as unusual. We both sometimes went to visit and ended up staying much longer, trying to sort the house out, maybe redecorate and generally help and support our mother. I thought that was what my sister was doing in oxford. I said to my mother that when her nurse comes to the house she could ask my sister if she wants to talk to her. Then I was told by my grandmother that she was ringing the Warneford hospital. After the experiences that my sister and I had with my mother's treatment at the hospital, I had my reservations. I rang the hospital constantly day after day, but I found them to be very obstructive and contradictory of fellow staff members especially when I questioned the service being offered to my sister and to me as a distressed family member, I was told 'that is as good as it is going to get' and had the phone put down on me.

I was worried, because my sister had become fragile – she was ill. But after learning that she was AWOL from the hospital, I knew that her and my mother would argue, if she had gone back there. When my sister wasn't ill she would have walked away from a confrontation with my mother, but once she became ill, she had also become very irrational and confused. (Adult B and Adult D)

Adult A, her husband and Adult's B and D lived as a family unit in London until Adult D was 2 years old, when Adult A and her husband separated.

Adult A moved to Oxford with her two children, and when Adult D was approximately 9 years old he was moved to a children's home, as Adult A found him difficult to cope with. During their childhood, Adult A could be physically, mentally and emotionally abusive towards them, due to her mental health problems and her addiction to alcohol.

On one occasion, when Adult B and Adult D were approximately 8 or 9 years old Adult A woke them about 1am, as she was convinced that someone was going to coming to the house to harm them. Adult A took a knife with her. On returning to the house, Adult A behaved as if nothing had happened.

Social services became involved with the family when Adults B and D were quite small. Adult A would leave Adults B and D alone in the house.

Adult B remained living with her mother, Adult A, for a further two years before going to live with her father's parents in Birmingham.

Adult A would often allow different people to stay at her address.

Adult D moved to a foster family in Oxford and remained there until he was 17 or 18 years old.

Adult D would sometimes stay with his mother at aged 17/18 to assist her, as she had declining mental health.

Adult B would sometimes stay with Adult A after Adult A had been discharged from hospital, and Adult D would see her there. Adult D believes Adult A was often discharged from a psychiatric ward into Adult B's care.

Adult B lived alone in Birmingham until she went to stay with Adult A

1997 - 2001:

Concerns raised by Oxford City Council about the state of repair of Adult A's property. Adult B would often stay with Adult C for respite.

In 2000 period Adult A was sectioned under the Mental Health Act and was subsequently diagnosed with paranoid schizophrenia in 2001.

2010:

Concerns raised by GP over extent of Adult A's alcohol consumption, combined with diabetes and diagnosed paranoid schizophrenia.

2011:

Adult A attended a Care Programme Approach review. She communicated her stress at son staying and daughter planning to stay. She has a mobile phone debt of £850 incurred by nephew which was causing her distress. She was referred to SMART (Substance Misuse Service)
During GP Surgery visit she told the GP she wanted alcohol detoxification.

March- May 2012:

In March Adult A informs her psychiatrist and CPN that Adult B is staying with her and she is concerned about her daughter's mental health. Adult B has an appointment with the GP as she is feeling low but the GP records that she does not appear clinically depressed. The GP and CPN discuss making a safeguarding referral after Adult A says she has no money because her daughter takes it.

During April Adult A's drinking increases and she requests a detox. She also reports concern for Adult B's mental health.

The CPN visits Adult A in May and the relationship between her and her daughter is not good. Adult A calls the Police as she believes Adult B is having a breakdown. Adult B has left the property when the Police arrive. They complete a domestic abuse risk assessment form with Adult A who is assessed as standard risk. Adult B returns home. The Police call Adult Safeguarding as concerned about Adult A. The duty social worker contacts the CPN who expresses concerns so a safeguarding alert is raised.

June 2012:

Police attended Adult A's address after receiving a report that Adult B had damaged property. This was thought to be because she was angry with the amount of alcohol Adult A was drinking, the state of the house which was a mess and then left the address.

Adult A's CPN was concerned about Adult A's alcohol consumption, and the poor state of her home. The CPN made arrangements for the property to be tidied. Adult A said she was worried about Adult B's mental health; stating that Adult B seemed to have a "different reality". The CPN and the GP advised Adult A that Adult B should move out.

July 2012:

A Money management plan completed with Adult A on 3rd July. Adult B was present at the time; the CPN observed that Adult B seemed to be laughing at unseen stimuli, but when asked refused to see a GP.

17th July

A police officer passing Adult A's address was nearly hit by a plant pot. On attending the premises, he was concerned that Adult B was behaving in an aggressive manner. Adult B was restrained in handcuffs and detained under Section 136 of the Mental Health Act. She was subsequently assessed and detained under the Mental Health Act, placed on a Section 2 and admitted to Allen Ward at The Warneford Hospital in Oxford.

18th July
Adult B is recorded as being uncooperative and refusing clinical assessment. (Adult B disputes that she was uncooperative)

20th July

Adult B is reported to the police as absent without leave two days after admission. The Police attended Adult A's address, but Adult B refused to return to the ward, and when the police call the ward, it transpires that there was no longer a bed for her.

21st -28th July

The following day, police phoned the ward and it was agreed that a warrant (under the Mental Health Act) needed to be obtained to secure Adult B's return to the ward. There was confusion regarding the required paperwork, resulting in a delay in getting a warrant. There is further confusion over whether Adult B should be an Oxford, or a Birmingham patient.

Three days later, Adult A phoned the ward to inform them that Adult B was no longer at her address. The following day, Adult A again called the ward saying that she doesn't think enough has been done to find Adult B.

A photograph of Adult B is issued to the police neighbourhood teams.

Adult A called the police to inform them that Adult B is back at her address. The police attend but no-one responds.

Adult C contacts the police and says both Adult A and Adult B were at the address, but had not answered the door because they don't want Adult B to return to the

ward. The police inform the staff at Allen Ward that it is their responsibility to secure Adult B's return to the ward, but the police will support if required. Allen Ward staff attend Adult A's address but do not feel comfortable approaching Adult B without police assistance, so they leave.

Allen Ward staff contact the police requesting assistance to execute the warrant for Adult B.

There are several calls between the police and Allen ward staff. The police advise Allen Ward staff that they will attend if Adult B becomes aggressive. Allen Ward staff leave the address without approaching Adult B to attend another incident.

During this period Adult B reported to the DHR chair that she went to London to stay with friends, but they were no longer there and she slept rough for a few nights.

29th July

After 10 days, Adult B is returned to the ward by hospital staff and police officers. During the process Adult B is placed in arm and leg restraints. Adult B also reports that her hat was pulled over her face so that she couldn't breathe.

Adult A is not in agreement with Adult B's return to hospital.

30th July

Attempts to assess Adult B are unsuccessful. Adult B is reported to have spat at staff, refused oral medication, and to have assaulted staff. She is physically restrained and transferred to the Psychiatric Intensive Care Unit (a locked ward with higher levels of staffing) at Littlemore Hospital. Adult D tries to speak to ward staff about his sister but they are uncooperative to the extent that he wanted to make a complaint.

31st July

Adult B is given medication. She is reported as being hostile. Her medication is increased. She is reviewed again later in the day and her medication is reduced.

August 2012:

1st August

Adult B is reviewed in her room. She reportedly refuses to engage in conversation. Her risk is recorded as low for self-harm, suicide, non-compliance to treatment and

absconding; moderate for self- neglect. The plan is to continue with her current medication.

It is recorded that the Doctor tried unsuccessfully to contact Adult B's brother, Adult D. Adult D disputes that the Doctor tried to call him as there was no missed call on his phone because if there was he would have called back.

2nd August

Adult B continues to refuse medication, denies that she has a mental health problem and says that someone has "set her up".

3rd August

Adult B receives a visit from Adult A and Adult C, which she cuts short. She is informed her Section 2 will be reviewed on the 14th August 2012. .

4th August

Adult B becomes agitated when asked to finish her meal, and throws the plate. She is taken to the de-escalation area in 'holds'. She asks for and is given her rights and section papers.

5th August

Adult B smashes a towel dispenser and TV remote in a communal area, and shouts that she should not be in hospital, and will continue to be aggressive until she is discharged. She is taken to the de-escalation area in 'holds'.
10th August

Adult B refuses to come out of her room, so the Doctor and nursing staff go to her. There have been no further aggressive incidents. Adult B is reported as being initially uncooperative, but engages once the Doctor explains that they cannot discharge her unless she engages with them.

Adult B has applied for a Mental Health Managers Hearing, and gives an outline of her personal history, her aspirations, and her reasons for behaving in an aggressive manner. The ward staff agree that she does not meet the necessary criteria to continue to be detained under the Mental Health Act. Adult B agrees to be discharged from the PICU into an open acute ward as an informal patient. She refuses evening medication.

11th August

Adult B leaves from the ward through her bedroom window. AWOL policy is instigated. Police are informed and requested to attend Adult A's address, which they do. Adult B says she will return to the ward. Risk assessments are "low".

Ward staff contact the police in the evening as Adult B has not returned to the ward, and state that they are concerned, both for the potential wellbeing of Adult A, and for their staff who may be assaulted if they approach Adult B.

Police cannot return Adult B to the ward as she is an informal patient; they spoke to her earlier in the day, and Adult A was present and did not express any concerns. Police advise they will attend if ward staff are threatened by Adult B.

16th August

At 7.47 Adult C contacts the police stating that she has not been able to contact Adult A "since Sunday". Adult C called the house every day but Adult B only answered once and said that Adult A cannot speak because she could not come to the phone.

At 09:28 Police gain entry to Adult A's address and find Adult A and Adult B present. There are no signs of life from Adult A.

At 09:28 Adult B is arrested on suspicion of murder.

Section Two

Domestic Homicide Review Panel Report

2.1 Introduction

This overview report is an anthology of information and facts from agencies that had contact with, had provided or were providing support for Adult A and Adult B. The report examines agency responses to and support given to Adult A and Adult B prior to the incident on 16th August 2012.

Six agencies had records of contact with Adult A and Adult B within the time period covered by the DHR. They were:

- NHS Oxfordshire – General Practitioner
- Oxfordshire County Council - Safeguarding Team
- Oxford City Council
- Oxfordshire County Council – Approved Mental Health Professional Service
- Oxford Health NHS Foundation Trust
- Thames Valley Police

None of Adult B's contacts with the agencies prior to the incident were associated with a referral or subsequent assessment and case management associated with domestic violence.

Police contact

Adult B was known to Thames Valley Police (TVP) prior to the time period covered by this DHR.

The deceased, Adult A was also known to TVP prior to the time period covered by this DHR.

Domestic Abuse Contact

Neither Adult A nor Adult B were known to the services of the Oxfordshire Domestic Abuse Service, the Reducing the Risk Independent Domestic Violence Advisory (IDVA) Service or Oxford Sexual Assault and Rape Crisis Centre.

2.1.1 Summary of the facts of the case

Adult A

The victim in this case, Adult A, was a 51 year old Afro-Caribbean female. Adult A lived in a rented local authority flat in central Oxford and was registered with a local GP. She is known to have had a chronic alcohol dependency and had also been

treated for schizophrenia. Adult A had been detained under the Mental Health Act (MHA) on three occasions during her life but it is known that her mental health had been stable since 2008 when she was last sectioned under the MHA. She was receiving medication for her schizophrenia by depot injection[14] every fortnight. Adult A also had a number of physical health issues arising from diabetes, including foot pain and ankle swelling. She was a regular attendee at her GP practice.

Adult B

Adult B is a 30 year old Afro-Caribbean female. She was 29 at the time of the homicide. Adult B is the daughter of Adult A. Adult B spent some time living away from Adult A in Birmingham as a child. In 2003 she had contact with secondary healthcare services in Birmingham but no mention is made of mental illness at that time; she moved away from Birmingham that year. She moved back to Birmingham in 2009. In 2011 she was assessed by the Healthy Minds service, provided by Birmingham & Solihull NHS Foundation Trust. This revealed some issues with obsessive compulsive disorder, low mood and possible suicidal ideation.

Adult B moved to Oxford in February 2012 and was living with her mother Adult A. On 17th July 2012 Adult B was detained under Section 136 of the Mental Health Act. The police were alerted to her 'disturbed behaviour' after a flower pot was thrown from the balcony of Adult A's flat when the police were walking past below. She was assessed at the Section 136 suite at Littlemore Hospital in Oxford and detained under Section 2 of the Mental Health Act. She was admitted to Allen Ward at the Warneford Hospital.

On 19th July Adult B was reported as Absent Without Leave (AWOL). On 29th July Adult B was returned to the Warneford Hospital by police and was referred to the Psychiatric Intensive Care Unit (PICU), Ashurst Ward. On 31st July Adult B was transferred to the PICU.

Following review, Adult B was discharged from Section 2 of the Mental Health Act on 10th August 2012. She was not deemed to have a mental illness and was not judged to be psychotic. She was transferred back to Allen Ward as an informal patient.

On 11th August Adult B left hospital through a window. She was not classed as AWOL as she was no longer detained under the Mental Health Act. Nursing staff contacted the police to report her as a missing person at 06.51. Adult B was sighted by police on 11th August, it is believed, at her mother's address. They had no legal power to return her to a mental health facility.

[14] "*Depot injection is a special preparation of medication, which is given by injection. The medication is slowly released into the body over a number of weeks. It is usually administered into a large muscle, often the buttocks, as the medication is often thick, this reduces swelling and pain*." Royal College of Psychiatrists – Treatments & wellbeing. www.rcpsych.ac.uk

At 07.47 on Thursday 16th August 2012 Thames Valley Police received a phone call from Adult A's mother, Adult C saying she was concerned as she had not been able to speak with her daughter. This was unusual and she was worried.

The Police attended the address of Adult A in central Oxford where they found Adult B and her mother, Adult A, who was deceased as a consequence of stabbing. Adult B was arrested and on Saturday 18th August 2012 was charged with her mother's murder.

2.2 Analysis of individual management reviews

This section of the report analyses the IMRs and other relevant information received by the panel. In doing so it examines how and why the events occurred and analyses the response of services involved with Adult A and Adult B, including information shared between agencies, why decisions were made and actions taken or not taken. Any issues or concerns identified are a reflection of the evidence made available.

In doing so the panel have been mindful of the guidance relating to the application of hindsight in DHRs and have attempted to reduce it where possible. This is in accordance with the Pemberton Homicide Review conducted in 2008: "*We have attempted to view the case and its circumstances as it would have been seen by the individuals at the time. It would be foolhardy not to recognise that a review of this type will undoubtedly lend itself to the application of hindsight and also that looking back to learn lessons often benefits from that very practice*."[15]

The panel has also borne in mind the helpful statements contained in the Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, led by Robert Francis QC:

"It is of course inappropriate to criticise individuals or organisations for failing to apply fully the lessons to be learned from the knowledge that is now available, and accepting in the light of that knowledge, not possessed at the relevant time, that more or earlier intervention should have occurred. It must be accepted that it is easier to recognise what should have been done at the time… There is, however, a difference between a judgment which is hindered by understandable ignorance of particular information and a judgment clouded or hindered by a failure to accord an appropriate weight to facts which were known."[16]

It is important that the findings of the review are set in the context of any internal and external factors that were impacting on delivery of services and professional practice during the period covered by the review.

[15] A domestic homicide review into the deaths of Julia and William Pemberton. Walker,M. McGlade, M Gamble, J. November 2008

[16] Report of the Mid-Staffordshire NHS Foundation Trust Public Inquiry Executive Summary pp23 Francis QC, Robert February 2013.

In order to properly manage a clear account of agencies' involvement the report describes and reviews the separate involvement of each agency. The accounts of involvement of services with Adult A and Adult B cover different periods of time prior to the homicide and as would be expected some of the accounts have more significance than others. All the agencies that responded with information indicating some level of involvement with Adult A and Adult B had varying levels of knowledge of both parties prior to the death of Adult A in August 2012.

Adult B and Adult D: 'We strongly deny that we took our mother's money, in fact she was being taken advantage of by a male friend. That was where most of her money would go; towards alcohol and gambling. We also want to make it clear that we were not responsible for the state of her home. It was always in a mess due to her mental health and alcohol dependency.'

2.2.1 NHS Oxfordshire – General Practice

The General Practitioner (GP) service is a universal service that provides primary medical care to families 24 hours a day both at the local practice where a family is registered and through the Out of Hours service. It provides holistic medical care (to include physical and psychological health care) for families from birth to death.[17]

It is important to remember that GPs are not directly employed by the NHS. Rather, they are independent contractors commissioned by the Local Area Team of NHS England. Prior to the changes in organisational structures brought about by the implementation of the *Health and Social Care Act 2012*, their Primary Care Trust, under the terms of a national contract.

A retired General Practitioner who was independent of the case and its management conducted the IMR of the primary care (GP) services provided to Adult A and Adult B on behalf of NHS Oxfordshire.

Adult A was registered with the Jericho Health Centre. A named GP was allocated. Adult A was seen on a regular basis at the Jericho Health Centre for routine general practice care as would be expected, given the fact that Adult A had a long term condition, (diabetes) as well as chronic mental health and substance misuse problems (alcohol dependency).

Adult B had been registered with a different GP practice in Oxford in the past, and with Jericho Health Centre between 2007 and 2009. She was registered with Reservoir Road Surgery in Birmingham in May 2010 and then with Jericho Health Centre as a temporary patient between March and July 2012.

[17] Sheffield DHR Overview Report, Cantrill, Prof. Pat December 2011

Adult B was seen by the Reservoir Road Surgery between May 2010 and March 2011 for depression. She had been referred for assessment with Birmingham and Solihull NHS Foundation Trust Healthy Minds service. She took part in a telephone assessment on 12th April 2011 and a face-to-face appointment with a mental health work on 3rd May 2011. She did not attend a follow-up appointment on 24th May 2011.

Review of the detailed records in the IMR has identified that the following particular contacts may be relevant to this review:

- In May 2011 the GP received a letter from Adult A's psychiatrist expressing concern that her son and daughter (Adult B) "*take advantage of her, often ask for money*". A further such letter was received by the GP from Adult A's psychiatrist in March 2012 noting that Adult B was staying with Adult A and that Adult A reported she had no money "*as daughter takes it off her*".

- In March 2012 Adult B had a consultation with the GP during which she confirmed she was staying with Adult A and had experienced low mood. Adult B had a score of 12/21 for depression and 16/21 for anxiety but the GP reported she did not appear depressed. The GP advised Adult B to leave Adult A's house as it may not be best environment for either of them. It is also noted that Adult A was drinking too much. It is important to restate that Adult A had a known alcohol addiction. Her levels of drinking were significantly higher than those of Adult B who reported drinking 28 units per week to the GP. Adult B and Adult D both reported to the Chair of the panel that Adult A was regularly consuming several bottles of spirits and/or wine every day.

- On 28th March, the GP records that the Adult A's Community Psychiatric Nurse is planning to refer to adult safeguarding procedure because of financial abuse of Adult A by Adult B. This allegation was made to the CPN by Adult A. Both Adult B and Adult D told the Chair of the panel that in fact a male friend of Adult A was taking money from her.

- In April 2012, Adult A expressed concern about Adult B during a routine appointment with the GP.

- On June 2012 Adult A had a joint consultation with the GP and her Community Psychiatric Nurse (CPN). Adult A told them that Adult B's presence in her house was not good.

- The GP advised it would be better if Adult B moved out. Adult A, although reluctant to accept this, felt there could be some advantage.

- The GP wrote to Adult B inviting her to come for an appointment.

- In July 2012 the Community Psychiatric Nurse (CPN) phoned the GP about Adult A. The CPN confirmed she would continue to monitor Adult A and discuss issues related to Adult B with the psychiatrist. The CPN confirmed a home visit for assessment was being considered.

- Later the same month the GP received a letter from the psychiatrist following a home visit to Adult A that mentioned concern about Adult B and her mental health, although she was not in the house during the visit. The letter also stated that Adult B was borrowing money from Adult A and that she had none left. Again Adult B and Adult D have told the panel Chair that this money was being taken from Adult A by a male friend of hers.

- It is known that Adult B was admitted to the Warneford Hospital (Oxford Health NHS Foundation Trust) in July 2012 but this admission was not communicated to the GP.

- 17th August 2012 –the GP was informed by her practice manager of reports in the local press of the murder of Adult A.

- 20th August – Adult A's psychiatrist contacted the GP and informed her of the murder of Adult A.

Analysis of General Practice involvement

The IMR author identifies that Adult A was well known to the GP, as well as other members of the practice team, including the reception staff. Adult A had multi-factorial long-term conditions, not least schizophrenia and diabetes. Adult A was a frequent attendee at the practice, the staff of which appear to have been able, in the view of the IMR author, to manage her chaotic lifestyle and behaviour. They had offered an "open-door policy" for her to ensure ease and rapidity of access for support. The GP made regular attempts to engage with and support Adult A, including providing assertive advice about her relationship and living arrangements with Adult B. The IMR author concludes that the quality of care was "*well above average*".

The GP had kept detailed and accurate notes of her consultations and input with Adult A, these have assisted in building a clear picture of her involvement.

The IMR notes that a formal, written Care Programme Approach (CPA) appeared to cease in 2010. This would accord with the changes to the implementation of CPA that year following revised guidance from the Department of Health.

However, although Adult A had a chronic mental illness that appeared well managed and stable the DHR panel believes it is reasonable to question why the change in CPA status occurred when Adult A also had other complex issues, most notably her alcohol dependency. Multiple referrals had been made by the GP to alcohol and podiatry services, but Adult A failed to engage with these. The IMR notes that such services can remove people from waiting lists if they do not attend, but that GPs must re-refer.

Communication with the GP from secondary care mental health services appears to have been limited to specific letters as described in the IMR. Such services are not obliged to communicate with temporary GPs and as such information relating to involvement with Adult B was, if it occurred, limited.

The GP did not know about Adult B's admission to the Warneford Hospital under the Mental Health Act. The fact that she did not is unlikely to have had any impact on the case itself, but had she known, the GP would have had a wider view of both Adult A and Adult B's current circumstances and could have responded to support needs accordingly.

Adult A was clearly vulnerable and there are at least two references to concern about potential financial abuse. The GP could have raised a safeguarding concern in respect of Adult A. Although the IMR notes that the CPN was to raise this with Adult A's psychiatrist, the GP could also have undertaken this process. The GP had been informed by the CPN that a safeguarding referral would be made. The reasons for the CPN not doing this are not clear. The IMR suggests that safeguarding processes and procedures are not widely or well understood by GPs, this was not an issue in this case. A safeguarding concern was raised in May 2012 by the police.

No assessment of Adult A's mental capacity was undertaken. Given the provisions of the Mental Capacity Act 2005, the DHR panel considers this to have been a missed opportunity.

Lessons learned

The GP was aware, to a limited extent, of the complex and difficult relationship between Adult A and Adult B and did her best to advise and support Adult A. The knowledge of the input, referrals and subsequent engagement of secondary care mental health services in Birmingham with Adult B was not adequately communicated to the GP. This highlights the need for appropriate exchange of information when individuals move from one area to another.

The practicality of the advice offered to Adult A, specifically advising her to ask Adult B to leave the flat is questionable. It is not clear how Adult A would have addressed

this issue, nor what alternative accommodation Adult B would have been able to move to.

Communication between secondary and primary care in relation to their respective roles and issues arising in their care and support of Adult A and Adult B was not as regular or robust as it might have been. The changes in CPA implementation may have contributed to this which highlights the need for appropriate communication of current issues and care plans, even if not part of a formal CPA process.

The GP did not raise a safeguarding alert in respect of possible financial abuse of Adult A either by Adult B or Adult A's male friend. The GP had been informed, and it is documented in the notes that the CPN would make the safeguarding referral. There is a need for continued awareness raising and education of safeguarding responsibilities.

The linkages between mental and physical health and the opportunities for joint working between primary and secondary care were not fully explored. The NHS Mandate provides a clear lever for organisations to improve this.

Communication to the GP about the incident itself and its outcome to the GP was not adequate. Local organisations must develop plans to ensure that those involved with individuals who find themselves in such circumstances properly advise each other of such events appropriately and in a timely way.

The use of the Mental Capacity Act was not considered and as such, health professionals must be made aware of the importance of assessment under the Act in situations where abuse or exploitation is disclosed or suspected.

Conclusions

The contact between the GP and Adult A and Adult B was not directly due to issues of domestic abuse. However, concerns were raised and discussed about the vulnerability of Adult A, in particular in relation to her alleged financial abuse by Adult B which had been reported to the GP by Adult A.

Information about their respective mental and physical health issues was not communicated effectively between primary and secondary care.

The GP was aware of the need for a safeguarding alert to be raised and had been informed that the CPN would do this. There is no mechanism in place to inform GPs of safeguarding alerts and therefore the GP was not aware that the alert had not been made.

2.2.2 Oxfordshire County Council Social & Community Services – involvement with Adult B (AMHP service)

The Social & Community Services Directorate of Oxfordshire County Council provides a range of services to adults across the county. This includes the provision of mental health services in partnership with Oxford Health NHS Foundation Trust, the secondary care Trust that provides both community and mental health services across Oxfordshire and Buckinghamshire.

The Directorate had two types of involvement with Adult B that are relevant to this DHR. Firstly, the Directorate provided an Approved Mental Health Professional (AMHP) service on the occasions when Adult B was assessed under the Mental Health Act. The Directorate also provided an Appropriate Adult Service for Adult B, arranged through the AMHP service and via the Emergency Duty Team (EDT) under the provisions of the Police and Criminal Evidence Act 1984. Only one of these, the Mental Health Act Assessment, preceded the death of Adult B, on 17th July 2012. The subsequent Mental Health Act assessment and Appropriate Adult engagement took place after the homicide when Adult B was in police custody on 16th and 17th August 2012.

Analysis of AMHP involvement

The IMR was conducted by the AMHP Service Manager. It sets out the chronology of contact with Adult B, including both the Mental Health Act Assessment on 17th July prior to the homicide and the Mental Health Act Assessment and Appropriate Adult input on 16th & 17th August. For the purposes of this DHR, this overview report concentrates solely on the information in relation to the Mental Health Act assessment on 17th July 2012 prior to the homicide.

- The AMHP service is managed by Oxfordshire County Council Social & Community Services Directorate. The role of the AMHP is to co-ordinate the process of assessment for the patients they assess for possible detention under the Mental Health Act.[18] The AMHP is part of the assessment team, with one, but usually two doctors. When a compulsory admission is recommended and the AMHP is satisfied the application for admission should be made, the AMHP is responsible for making that application to the relevant hospital and for arranging the admission.[19]

- The IMR describes that Adult B was referred for an assessment under the Mental Health Act on 17th July 2012. This was to be conducted in the

[18] Mental Health Act Code of Practice para 4.40 TSO 2007
[19] Mental Health Act 2007 New Roles: Guidance for approving authorities and employers on Approved Mental Health Professionals and Approved Clinicians. NMHDU 2007

prescribed place of safety at Littlemore Hospital. This followed her detention by the Police under Section 136 of the Mental Health Act.

- This was Adult B's first contact with Adult Social & Community Services in Oxfordshire.

- The detention of Adult B under Section 136 occurred when the police were attending another incident, when a flower pot was thrown from a balcony, narrowly missing the officers below. The police then attended the home of Adult A and Adult B and found it to be 'trashed' and Adult B to be 'incomprehensible'. She was observed to be swearing, shouting and running around the flat.

- A formal Mental Health Act assessment took place at the Section 136 suite at Littlemore Hospital. One of the doctors present during the assessment was from the Warneford Hospital and provided the AMHP with useful background information about Adult B. This was because she had seen Adult B during a joint visit with a CPN to see Adult A. The IMR notes that it was not possible to establish when that visit took place, but records suggest it was 11th July 2012.

- The doctor indicated that Adult B's behaviour had been worrying and that she could be threatening towards Adult A.

- Adult B was described by the doctor as not wanting to engage with Adult A's care team, intimidating Adult A at times and using Adult A's money, thus leaving Adult A without money.

- Those present at the assessment concluded that Adult B was thought disordered, highly vulnerable and that there were high risks associated with her unpredictable behaviour and social isolation.

- The AMHP made the application for admission under Section 2 of the Mental Health Act, during which process the AMHP identified Adult A as Adult B's nearest relative under the terms of the Act and consulted her. Although her consent was not required for a Section 2, Adult A raised no objection to the admission.

- Adult B was admitted to Allen Ward at the Warneford Hospital.

Lessons learned

The IMR describes the process of assessment clearly. This appears to have been a routine Mental Health Act assessment of the type an AMHP would undertake on a

regular basis. As such, the DHR panel agreed with the findings of the IMR that there were no specific lessons to be learned.

Conclusions

The assessment took place in a timely manner. It started 2 ½ hours after the initial referral and Adult B was admitted to hospital just under two hours later, well within the timescales set out in the Mental Health Act Code of Practice.

The professionals involved in the assessment were able to share relevant information in their possession to inform the process. It does appear that there were reasons to suspect domestic violence within the home but that, quite appropriately, the detention of Adult B was not predicated solely on the incident that led to the police initially detaining Adult B under Section 136.

Given Adult B's presentation during the assessment the decision to admit Adult B to hospital under Section 2 of the Mental Health Act was entirely appropriate.

2.2.3 Oxfordshire County Council Social & Community Services - involvement with Adult A.

As described in Section 2.2.2, the Social & Community Services Directorate of Oxfordshire County Council provides a range of services to adults across the county. This includes the provision of mental health services in partnership with Oxford Health NHS Foundation Trust.

It also has statutory responsibilities, in common with the NHS, in relation to safeguarding adults. Safeguarding is about preventing abuse and neglect as well as promoting good practice for responding to concerns on a multi-agency basis.

Presently, there is no legislation that places a statutory duty to co-operate on any agencies involved in safeguarding adults. However the NHS assurance and accountability framework, *Safeguarding Vulnerable People in the Reformed NHS* updates and replaces *Arrangements to secure children's and adult safeguarding in the future NHS.* It describes how the new NHS system works and sets out the responsibilities of each of the key players for safeguarding in the future NHS, including arrangements for partnership working.[20]

Health services have a duty to safeguard all patients and to provide additional measures for patients who are less able to protect themselves from harm or abuse.[21]

[20] Arrangements to secure children's and adult safeguarding in the future NHS. The new accountability and assurance framework – interim advice NHS England March 2013
[21] Safeguarding Adults - The Role of Health Service Practitioners Dept of Health March 2011

Social & Community Services had one involvement with Adult A during the time period covered by this DHR and this related to safeguarding.

Analysis of the Social & Community Services involvement

The Safeguarding Adults Manager conducted the IMR. It sets out the chronology of contact with Adult A. He has no line management responsibility for the service that received and processed the referral.

The contacts that are relevant to this DHR are as follows:

- On 28th May 2012 the duty social worker received a referral from a police constable about their concerns in relation to Adult A but this did not constitute the raising of a safeguarding concern. (This is dealt with in the Thames Valley Police IMR).

- On the same day the duty social worker contacted the Community Mental Health team covering Oxford City and established that Adult A was known to them, and that one of their Community Psychiatric Nurses (CPN) was her care co-ordinator under the Care Programme Approach.

- On 29th May 2012 the duty social worker spoke to the CPN on the telephone, it was during this conversation that the CPN raised safeguarding concerns. These related to her poor living conditions, on-going alcohol dependence, her vulnerability and concerns that Adult A might be the subject of financial abuse. In addition there were concerns expressed about Adult A's mental health and questions about her compliance with medication for her physical and mental health problems. There were also issues in relation to a long-standing mobile telephone bill that remained in dispute with the service provider.

- A safeguarding alert was raised with the Oxfordshire County Council Social & Community Services Directorate as a result of the care co-ordinator's concerns.

- On 30th May 2012 a safeguarding manager was appointed. This manager was a Oxfordshire County Council Social & Community Services Directorate employee, working in mental health services and seconded to Oxford Health NHS Foundation Trust.

- The safeguarding alert form records that the safeguarding manager met with the care coordinator and decided that an initial assessment/investigation should be undertaken and an action plan was set out.

- On 31st May 2012 a joint visit was conducted by the safeguarding manager and the care co-ordinator to Adult A. The IMR reports that the meeting

focused on getting help for Adult A to clean and tidy her flat and the concerns about financial abuse, including whether a money management service might be of help. The IMR also notes that during the visits Adult A appeared to be someone who had mental capacity (although no formal assessment under the provision of the Mental Capacity Act 2005 took place) and who was not intoxicated during the visit.

- Throughout June 2012 the care co-ordinator made contact with the City Council in an attempt to secure improvements to Adult A's flat.

- The CPN made efforts to engage Adult A in money management support and carried out some cleaning of the flat, a service that was further declined by Adult A later in the month. Paperwork to procure domiciliary care services to maintain the flat was completed.

- The safeguarding manager remained in touch with the case and monitored the work of the case co-ordinator from 1st June 2012.

- The safeguarding alert was still active at the time of Adult A's death on 16th August 2012.

Lessons learned

There was effective communication between the Social & Community Services and the care coordinator following the referral on 28th May 2012. However, this communication only took place after the police first raised the issue.

A safeguarding alert was raised within 24 hours and within a further 24 hours a safeguarding manager had been appointed and there had been discussion between the safeguarding manager and the CPN.

Follow up to the alert was appropriate and swift and the IMR notes that these responses were timely and in accordance with the Oxfordshire County Council Safeguarding Adults Policy.

There was no evidence available to the safeguarding manager at the time of the alert that Adult A was subject to domestic violence or physical abuse.

The IMR states that the fact that the safeguarding alert was still active at the time of Adult A's death suggests that the process was not systematically reviewed following the initial assessment.

There are also issues raised about problems experienced by the safeguarding manager in accessing the County Council information systems.

Conclusions

The raising of safeguarding concerns was appropriate and the safeguarding alert was raised swiftly.

There were problems with access to recording systems between agencies. The recording systems of the County Council and Oxford Health NHS Foundation Trust are not compatible and this may have contributed to these difficulties. There is currently no locally agreed minimum standard for recording in adult protection cases and improved access to recording and IT systems between agencies remains a deficit.

The outcomes from the initial safeguarding investigation were not properly recorded and as the IMR notes, the case was allowed to remain open without a clear resolution plan in place. The local policy requires that a decision be made within one week of the alert as to whether the case should be retained under adult protection procedures. However, there is no evidence that this had any impact or influence on the subsequent events.

A more proactive approach to the management of the case would have assisted in the decision making process in relation to retaining the case under adult protection procedures.

2.2.4 Oxford City Council

Adult A lived in a property rented from Oxford City Council. An IMR was requested from the City Council. It draws upon records held by the housing department, Crime & Nuisance Action Team, Housing Benefit Finance and Direct Services. Files relating to Adult A, Adult B and Adult C were reviewed. The IMR focuses on the time period defined for the DHR. It also includes some relevant information from an earlier period.

Analysis of Oxford City Council involvement

- Adult A applied to the City Council for housing, citing homelessness in 1989 and was first housed in temporary accommodation. She subsequently moved to the central Oxford address in February 1990. The homicide subsequently took place at that property.

- In 1991/92 allegations of racial harassment towards Adult B were investigated by the Senior Estates Manager, following that investigation, warnings were issues to other tenants.

- In July 1993 Adult A spent a time at a women's refuge in Reading, after what is described as a breakdown in her relationship with her mother, Adult C. Adult A returned to the rented property in Oxford in October 1993.

- In July 1997 the Estate Management Officer raised concerns regarding the condition of the property. It is reported that there were clothes and rubbish scattered around the flat. It is also reported that Adult B had smashed the glass in the balcony door and pulled the lounge door from its frame. It is also stated that Adult B often spent time with her grandmother, Adult C due to problems in her relationship with her mother Adult A.

- In 2007 a Tenancy Update visit was conducted. Adult A advised that Adult B was no longer resident at the property. The note of the visit by the officer on her notepad states "*past history of problems involving a relative staying at the property. If any reports from the tenant speak to EB [the officer] or PC P. [police officer].*"

- In April 2009 Adult A advised the Estate Manager that Adult B was again resident at the property and that she should be added to the household on the City Council records.

- On 18th June 2010 a Tenancy Update visit was conducted. The property was found to be in good order. Adult A provided details of those other professionals with whom she was in contact, specifically her GP and CPN.

- Between 21st March 2012 and 16th April 2012 Adult A contacted the City Council on five occasions relating to repairs to the heating and hot water system at the property.

- On 10th August 2012 a recharge was raised for a window to be re-glazed. A City Council maintenance worker attended to measure up the window which was in Adult B's bedroom. The worker reported that Adult A told him that a relative had thrown something through it and smashed it. Adult B was only present as the maintenance worker was leaving the property and he did not report any conflict between them in his presence.

Lessons learned

Contact with Adult A appears to have been routine, focusing on issues to do with the condition and residency of the property.

Tenancy Services staff at Oxford City Council had responded to contact requests initiated by Adult B but she was very often not available to participate in home visits. It is not clear how proactive the Tenancy Services staff were in following up those

requests, although it should be stated that most of those requests from Adult A do not appear to have been related to any issues other than routine housing related matters.

Tenancy Services staff have received training in respect of policies and procedures relating to domestic abuse. Had such issues been explicitly raised by Adult A then those staff would have had the knowledge to be able to respond appropriately.

In 2007 when Adult A raised the difficulties that she experienced with Adult B these were recorded only on the worker's notepad and not in the file. This highlights the need for accurate and timely recording.

Conclusions

Oxford City Council had sporadic contact with Adult A over a lengthy period. Most of these contacts concerned routine matters in relation to the condition of the property. However, given some of the issues in relation to damage that were recorded and the fact that Tenancy Services also recorded the history of sometimes difficult relationships between Adult A and Adult B, more regular visits might have been expected.

There was no file note that provides further detail of a note on the notepad of the Tenancy Services Officer where past problems between Adult A and Adult B are mentioned. These constitute a deficit that highlights the need for accurate and timely recording of contact between agencies and clients.

On the information available it does not appear that had any additional visits taken place it would have had any influence on the eventual incident.

2.2.5 Thames Valley Police

Throughout the period covered by the DHR and the IMR, Thames Valley Police (TVP) had contact with both Adult A and Adult B. There was also contact with Oxford Health NHS Foundation Trust in relation to Adult B.

TVP set up an Investigation Review Team (IRT) in April 2010 to deal with all requests for IMRs. A group of officers, all of whom are accredited detectives with a background or knowledge of at least one element of the Protecting Vulnerable People disciplines are part of this team. The IRT are independent of any investigation or police action for which IMRs are requested.

Analysis of TVP involvement

The TVP IMR covers the period of the DHR, but also contains some brief information about contact with Adult A and Adult B prior to that time. The following contacts have

been reviewed and are set out in some detail for this analysis, given their complexity and relevance:

Both Adult A and Adult B had contacts with the Police prior to the time period covered by the DHR. In Adult B's case this was in 1996 following a shop lifting incident when she was aged 13. Adult A had contact in 1997, 2002 and 2010. These contacts related to incidents of theft, assault (against Adult A by a boyfriend) and criminal damage. In May 2011 a report of theft of a purse was made by Adult A.

Relevant contacts within the timeframe of the DHR:

- On 11th May 2012 at 20.30 Adult A telephoned TVP to report that Adult B had been staying with her and that she was concerned that Adult B might be experiencing a mental health breakdown. The call appears to have been triggered by Adult A returning home to find a glass table top had been smashed and although not witnessed, Adult A believed Adult B to be responsible.

  Adult A reported to TVP that Adult B appeared agitated and had argued with her. Adult A has been so concerned that she had locked the door of the flat, but Adult B left the property by climbing out of a window.

  Sgt1 requested the officers return to the address and treat the incident as a fear for welfare. In addition a DOM5 DASH was completed with Adult A and awarded a standard risk. Standard risk is awarded when current evidence does not indicate likelihood of causing serious harm[22].

  TVP officer completed a Missing Persons Report, grading Adult B as a medium risk missing person. At 09.45 on 12th May TVP received a call from Adult A to say that Adult B had returned home. A TVP officer attended Adult A's address later that day and spoke with Adult B who stated that she had had an argument with Adult A on 10th May which resulted in her then smashing the table and leaving the flat to visit a friend in London. The TVP officer found Adult B reluctant to speak initially, but she did subsequently state that she experienced difficulties in her relationship with Adult A, in part due to Adult A's mental health problems.

  Adult A confirmed that she did not wish to make a complaint about the damage to the table and the missing person report was closed, with an endorsement that a referral would be made by TVP to Social Services. By cross referencing the IMRs it appears this referral was made on 28th May 2012.

[22] Domestic Abuse, Stalking and Harassment and Honour Based Violence (DASH 2009) Risk Identification and Assessment Checklist for Police Staff

- On 11th June 2012 TVP responded to a call from the Ambulance Service regarding Adult B, who was reported to have been unwell and had caused damage to Adult A's flat. When TVP arrived at the flat Adult B had left. Adult A informed TVP that Adult B had told her that she was "*fed up with Adult A's drinking so had walked out*". TVP officers located Adult B in central Oxford later that day and an intelligence report was filed, following TVP officers search of Adult B.

- On 17th July 20012 a TVP officer was passing Adult A's flat when a flower pot was thrown from the balcony, narrowly missing the officer and a member of the public. TVP officers attended Adult A's flat and found blood on the floor and food on the walls. Adult B was reported to be aggressive towards the officers and they thought she might be mentally unwell. The officers were concerned for Adult B's safety and that of the pubic and so detained her under Section 136 of the Mental Health Act. It was this detention that resulted in an assessment under the Mental Health Act by the Oxfordshire County Council Social and Community Services AMHP service.

- A 08.17 on 19th July TVP received a telephone call from staff at the Warneford Hospital stating that Adult B had left the hospital and explained that she was detained under Section 2 of the Mental Health Act. The Warneford staff reported that Adult B was "*very unwell*" and "*was at risk of committing violence*" towards Adult A. The nursing staff reported that a search of the hospital grounds had been conducted.

- A TVP Sergeant spoke with ward staff who informed the Sergeant that Adult B did not need medication but had been showing signs of psychosis and needed to be returned to hospital. An entry was made of the Missing Person Database (MPDB); this entry noted that Adult B was "*not deemed to pose a significant risk to herself or others*".

- At 22.20 TVP officers attended Adult A's flat and found Adult B to be present. Adult B informed the officers that she was not intending to return to hospital. The officers contacted the hospital and were advised that there was no bed for Adult B. The TVP officers noted on the MPDB that they did not have a legal power to physically restrain Adult B or return her to hospital by force.

- During the following two days efforts were made to secure a warrant under Section 135(2) of the Mental Health Act. This section allows police officers "*to enter…premises and remove the patient so that they can be taken or returned to where they ought to be. Such a warrant may be used…to help return a*

patient who has absconded."[23] A warrant was secured on 23rd July 2012. However, when staff from the Warneford Hospital contacted Adult A to advise that they planned to execute the warrant, Adult A informed them that Adult B was no longer at the flat and her whereabouts were unknown.

- On 28th July 2012 staff from the Warneford Hospital contacted TVP again to request assistance with the execution of a Section 135(2) warrant.

- The IMR states that TVP were willing to provide assistance if needed but that if Adult B was '*OK*' Warneford staff would take Adult B back to hospital themselves, however at 18.02 the TVP Command and Control log states that Warneford staff were again requesting TVP attendance and that they did not feel safe to approach Adult B without Police assistance and were waiting at Adult A's property.

  At 18.14 the Warneford staff contacted TVP again to advise they had to leave their position outside Adult A's flat to attend to another patient back at the hospital, due to staffing shortages and would "*have to deal with this matter another day*".

- At 10.35 on 29th July 2012 the Missing Persons coordinator at TVP telephoned Adult A to enquire about the whereabouts of Adult B. Adult A confirmed that Adult B had returned to the flat and did not wish her to be returned to the Warneford Hospital. The Missing Persons co-ordinator passed this information to the Duty Sergeant. At 14.53 a TVP officer attended Adult A's flat with staff from the Warneford Hospital to assist in the execution of the Section 135(2) warrant. Adult B was detained and returned to the Warneford Hospital.

- Adult B had been absent without leave from the Warneford Hospital for 10 days.

- At 06.51 on 11th August staff reported Adult B as a missing person and that although no longer detained under Section Two of the Mental Health Act, she had not been granted permission to leave. They advised TVP that Adult B was a low level risk and requested TVP to attend Adult A's flat as they believed this was where Adult B was most likely to be.

- A telephone discussion took place between TVP and staff at the Warneford Hospital. The content of this discussion is detailed in the TVP IMR. The conversation focused on the legalities of locating and returning Adult B to hospital and demonstrates misconceptions and misunderstandings about that

[23] Mental Health Act Code of Practice Chapter 10.5 TSO 2008

process between the TVP staff and staff at the Warneford Hospital. They also include references to roles, responsibilities and staffing shortages on both sides.

- The view of TVP was that it was the responsibility of the Warneford staff to "*conduct their own enquiries*" into the whereabouts of Adult B was "*AWOL and not a missing person*."

- The IMR states that "*although it was against police protocol, the address (of Adult A) was only a short distance from the police station so they would attend*". TVP officers located Adult B at Adult A's flat at 08.55. Adult B informed the officers that she had returned to the flat to collect some property and intended to return to the hospital later that day. The MPDB records that the missing person report was not to be closed until Adult B had returned to the Warneford Hospital.

- Later that evening, further telephone conversations took place between TVP and Warneford Hospital staff. The TVP view was the Adult B had been sighted earlier in the day; they had received no concerns from Adult A that she was a voluntary patient and as such the police had no power to compel her to return to hospital. The log was closed by TVP at 20.16 on 11th August 2012.

- At 07.47 on 16th August TVP received a telephone call from Adult C, stating that she was concerned as she had not been able to contact her daughter, Adult A. Adult C advised TVP that Adult B would answer the phone at the flat but that Adult A could not speak with Adult C as she was sleeping.

- At 09.28 TVP officers gained entry to Adult A's flat and found Adult A deceased. Adult B, who was present at the flat, was arrested on suspicion of murder and taken into custody at St. Aldates Police station.

Lessons learned

There was confusion about the correct process for raising concerns about adult protection in relation to both Adult A and Adult B. This has highlighted the need for greater clarity about the systems and processes that TVP officers should follow. This matter is already being addressed by TVP.

The fact that the initial contact with TVP related to criminal damage at Adult A's flat should not have precluded a report of a domestic incident. The IMR highlights this as a missed opportunity to deal with Adult B as an offender within the context of domestic abuse and to appropriately refer Adult A as a vulnerable adult.

The criminal behaviour of Adult B was viewed in the context of her perceived mental health problems. This behaviour was not recorded as criminal, continued to escalate and was not being actively investigated. This was a breach of TVP recording standards and viewed as a missed opportunity to deal with the offending behaviour of Adult B.

Misunderstandings by TVP and Oxford Health NHS Foundation Trust about the legal position in respect of Adult B as a person detained under Section Two of the Mental Health Act resulted in opportunities for Adult B to be returned to hospital not being taken. Even if that understanding had been greater, the fact that there was lack of bed capacity at the Warneford Hospital might have frustrated attempts to return Adult B to hospital satisfactorily.

There was further confusion in relation to the legal status of Adult B when she was reported as missing in August 2012. The identification of concern for the welfare of Adult A in this situation was an oversight. No welfare check was conducted in relation to Adult A and the IMR concludes that this was a missed opportunity brought about by focusing only on Adult B rather than the connection between the issues and relationship between both Adult A and Adult B.

Conclusions

A key feature of the TVP IMR is the lack of multi-agency working. There were opportunities for Adult A to have been referred to Social & Community Services but these did not take place appropriately and in some cases did not take place at all.

There was misunderstanding in relation to the application of the powers in the Mental Health Act, in particular to the execution of Section 135(2) powers. In addition there was misunderstanding of the legal status of Adult B when she left hospital when an informal patient. This was further compounded by confusion about the execution of the Section 135(2) warrant and later the status of Adult B as a missing person.

TVP officers misunderstood and were incorrect in their understanding of their responsibilities in relation to the Mental Health Act.

TVP did not regard Adult B as an offender in relation to the incidents of criminal damage at Adult A's flat. The criminal behaviour was too firmly viewed in the context of Adult B's perceived mental health problems and as a result, the effect was to legitimise this behaviour which allowed it to escalate and distorted the perception of risk both to Adult A and to Adult B herself.

The assessment of risk by TVP did not align with that of the staff at the Warneford hospital which led to differing views about risk and dangerousness. This caused

confusion between agencies and their staff and may have unduly influenced decision making.

TVP and Oxford Health NHS Foundation Trust staff routinely disagreed about decisions made and taken. This included TVP not conducting a welfare check on Adult A.

There is no evidence that any of the issues related to misunderstanding of the legal position were referred to the TVP mental health lead. If this had happened, the lead may have been able to provide accurate advice directly to officers, or assisted in the conversations with Warneford Hospital staff.

Opportunities to raise adult protection concerns, to return Adult B to hospital and to check the welfare of Adult A were missed.

2.2.6 Oxford Health NHS Foundation Trust

Oxford Health NHS Foundation Trust (OHFT) provides specialist mental health care services. It does this through both inpatient and community based services, some of which are delivered in partnership with Oxfordshire County Council Social and Community Services Directorate.

The Trust had contact with both Adult A and Adult B and consequently were asked to conduct an IMR. The authors were independent of the care of both Adult A and Adult B.

Analysis of the involvement of the Trust:

- Adult A was first diagnosed with paranoid schizophrenia at the age of 40 and had been in the care of the OHFT since 2000. Adult A had been admitted to the Warneford Hospital on two occasions, in 2000 and 2001. Following the second admission, for which she was subject to Section Two of the Mental Health Act, Adult A was prescribed depot medication and took this regularly until 2007 under the care of the Oxford City Central Community Mental Health Team (CMHT).

- In 2007 Adult A ceased depot medication at her request and was transferred to an oral medication. Adult A's mental health deteriorated after this and a further, third admission to hospital took place. Depot medication was then reinstated. Adult A also continued to drink alcohol heavily as has been identified earlier in this Overview Report.

- Adult A was visited on a fortnightly basis by a CPN for the administration of the depot medication and for mental state monitoring. Adult A was seen by a

Consultant Psychiatrist every six months, the last time being at home on 12th July 2012. The IMR reports that at that visit Adult A's mental health was stable and that she was making efforts to reduce her alcohol intake.

- The CPN had been concerned about the home situation and had engaged with the safeguarding manager as previously described in Section 2.2.3. At the time of her death, the focus of the OHFT's involvement with Adult A was on the monitoring and management of her mental state, assisting with the management of her living conditions and the state of her flat and her financial affairs.

- The IMR also notes that the CPN made attempts to see Adult A on 6th, 7th, 8th, 13th and 15th August to administer depot medication but these were unsuccessful.

- Adult B had her first contact with OHFT on 17th July 2012 during a Mental Health Act assessment and her subsequent detention under Section 2 of the Mental Health Act. Adult B was transferred from the Section 136 Place of Safety to Allen Ward at the Warneford Hospital on 18th July 2012, where she was assessed by the duty doctor later that evening.

- A risk assessment was completed on 19th July 2012. This risk assessment indicated that Adult B had attempted to climb out of one of the ward windows the day before, but there was no further detail about the circumstances. Adult B was placed on level two nursing observations of 15 minute intervals. This means that a member of the nursing staff should check on the patient every 15 minutes and observe their behaviour. The observation should be recorded in the patient's notes. This is standard practice within OHFT for newly admitted patients and is a means of monitoring mental state, including suicidal ideation, risk behaviour and inform staff of any changes or concerns.

- At 07.55 on 19th July 2012 Adult B was found to be Absent Without Leave (AWOL). The IMR states that Adult B had requested to go outside into the fenced garden area for some fresh air and when the staff member opened the door, Adult B ran out and managed to jump over the fence. A search of the grounds was conducted and as Adult B was not located, ward staff contacted TVP.

- TVP contacted Allen Ward on 20th July 2012 to advise that Adult B was at Adult A's flat. It was agreed that the process of applying for a warrant under Section 135(2) should commence. The IMR states that this first attempt was unsuccessful as the ward staff completed the wrong forms.

- On 23rd July 2012 the ward spoke with Adult A, who advised that Adult B was no longer at her flat. The ward advised TVP of this and that as a result the Section 135(2) warrant they had subsequently secured could not be executed.

- On 27th July 2012 TVP contacted Allen Ward to advise that they had located Adult B and requesting that ward staff attend Adult A's flat to collect Adult B. Staff did attend but did not enter the flat as they did not feel confident to do so without police support due to concerns about Adult B's potential for violent behaviour.

- During 28th July 2012 there was confusion about arrangements made with TVP to attend the flat of Adult A. As outlined in Section 2.2.5, the ward staff that went to the flat returned to the ward as the police had not attended.

- On 29th July 2012 TVP attended Adult A's flat with staff from Allen Ward to assist in the execution of the Section 135(2) warrant. Adult B was detained and returned to the Warneford Hospital. Adult B had been AWOL for 10 days.

- Following an incident of physical violence towards members of staff on 30th July 2012 Adult B was referred to the Psychiatric Intensive Care Unit (PICU). Adult B was admitted to the female high dependency unit.

- On 1st August Adult B was reviewed by a Speciality Doctor (Doctor 5 in the IMR), a nurse and pharmacist during the ward round. Her risks were assessed as low for self-harm, suicide and non-compliance with treatment and moderate for self-neglect as she would only eat in certain circumstances. The IMR states that efforts had been made by Doctor 5 to contact Adult B's brother to glean more information and history but this was not successful.

- On 2nd August 2012 Adult B reluctantly agreed to be seen by 'Doctor 5'. During this interaction Adult B denied having any mental health problems and that she suspected that Adult A had "*set her up for arrest*" although she did retract this allegation swiftly.

- On 10th August 2012 a ward round took place. The IMR shows that there were various ward staff, including the Consultant Psychiatrist, who were absent due to annual leave. Another doctor had been asked to attend the ward round because Adult B's Section 2 was due to expire in two days and a decision was needed in relation to this. The IMR notes differences of opinion in relation to Adult B within the clinical team. These were also present in respect of the process of discharging the Section 2.

- The IMR states that the records from the ward round on 10th August 2012 indicate that Adult B had been stable, with no recent episodes of violence or

aggression and that she had accepted oral medication. Adult B refused to attend the ward round but was seen in her room by the team.

- During this conversation Adult B told the team she was upset that Adult A had told her CPN that Adult B was not well and needed admission to hospital. Adult B acknowledged that she did not get on with Adult A but also said her mother had given her money.

- The staff at the ward round and present for the conversation with Adult B formed the opinion that Adult B no longer met the criteria for detention under Section Two of the Mental Health Act. There had been no evidence of auditory hallucinations, risks of self-harm or harm to others was deemed to be low as was the risk of absconding.

- It was agreed that Adult B would be discharged from Section Two of the Mental Health Act later that day (this occurred at 14.00 on 10th August 2012), that she would move back to Allen Ward as an informal patient while plans were made for community based follow-up on eventual discharge from hospital.

- The doctor who discharged Adult B from Section Two of the Mental Health Act recorded in the clinical notes that he did not believe Adult B had a mental illness and was "certainly not psychotic". The discharge plan was felt to need to include help for Adult B in securing housing and dealing with financial issues and welfare benefit. Urgent allocation of a care co-ordinator was sought and a CPN was assigned by the CMHT that day (10th August 2012).

- Adult B moved to Allen Ward and is reported to have gone to bed at 23.20 on 10th August 2012. At 06.30 on 11th August 2012, nursing checks revealed Adult B to be missing from Allen Ward; it appears by climbing through the window in her room. Ward staff put the AWOL policy in place and contacted TVP as outlined in Section 2.2.5.

Lessons learned

The IMR provided by OHFT highlights issues in relation to Adult A regarding the level and frequency of communication with primary care as outlined in Section 2.2.1.

The IMR reveals that there were shortcoming in the way in which Adult B's care and support was organised. Although the IMR attempts to place these in the context of Adult B's lack of willingness to engage, the DHR panel does not believe this to be a wholly mitigating factor.

Annual leave arrangements for medical and nursing staff were not well coordinated and contributed to confusion about roles and responsibilities in relation to Adult B.

Deficits in case recording and communication contributed to a lack of clarity about care planning and delivery.

Conclusions

The IMR reveals a level of confusion about the identification of the responsible Consultant Psychiatrist for Adult B. The IMR suggests this was in part due to confusion among the team about where Adult B was resident and whether she had an Oxford or Birmingham GP. The DHR panel believes that this information was available but that the lack of communication with primary care meant that the OHFT did not establish the fact that Adult B was temporarily registered with Jericho Health Centre. The decision by one doctor not to take over Adult B's care even though that doctor would have been the responsible clinician was not recorded.

There is no evidence to suggest that Adult B was ever assigned a named nurse whilst an inpatient and that she was not allocated a care coordinator until re-graded as an informal patient. This is a significant deficit of care planning and co-ordination.

The AWOL procedure and process was poorly coordinated and the interagency working with TVP was not effective as previously described in Section 2.2.5.

There was confusion among ward staff about Adult B's legal status and the execution of the Section 135(2) warrant as previously described in Section 2.2.5. The poor communication and roles of teams led to a warrant not being executed because the police would not attend and that between the 23rd July and 27th July the agencies relied up the assertion of Adult A to conclude that Adult B was not in the house.

These factors taken together suggest a lack of adequate clinical leadership in Adult B's care and treatment.

The adequacy of the assessment of Adult B's mental health is also open to debate. This is in part due to the amount of time available to conduct such an assessment given that Adult B was AWOL for 10 days. Section Two of the Mental Health Act allows for up to 28 days of assessment. Adult B was absent for a significant portion of this time and the Section was discharged four days before its expiry date. In addition she was on two different wards during her time in hospital; three days of her time in hospital were taken up with such transfers, this meant only 11 full days were available for assessment.

On the date of discharge of the Section 2 over reliance appeared to be placed on the assessment of the covering Consultant, with a lack of clear communication of the views of the multi-disciplinary team treating Adult B. It is important to note that the assessment recorded in the IMR by Dr. 5 prior to discharging the Section 2 was suggestive of someone who was coherent and gave a rational explanation for previously expressed anger towards staff and Adult A. However, the IMR also notes that 18 entries were made by the nursing staff on Allen Ward that record Adult B responding to external stimuli.

Although recognising that Adult B was reluctant to engage with the clinical team(s), which in itself is not particularly unusual, it does not appear that sufficient effort was made, nor note taken of relevant background information, history, previous contacts with other services or agencies.

Communication about Adult B's care was not adequate. There were a number of communication breakdowns, not least in relation to who the responsible Consultant was and how this was recorded or details for the management of the case during periods of annual leave by medical and other ward staff. There was limited communication (or attempts at communication) with the wider family of Adult B. Details of conversations with Adult B or other members of the team were not relayed to the wider nursing team on the ward. Emails regarding Adult B's care were not logged on the electronic recording system (RiO) and the contents were thus only known to the email recipient(s) and not the wider care team on the ward.

The transfer of Adult B from the PICU to Allen Ward was not properly planned. The transfer was instigated as a result of the discharge from Section Two of the Mental Health Act. An earlier review of the position would have aided transfer planning.

The triangulation of information in relation to Adult A and Adult B was not adequate. The Safeguarding issues relating to Adult A were not communicated across the teams in contact with both Adult A and B resulting in a lack of knowledge of the issues and concerns in respect of their relationship.

Issues of domestic violence in the relationship between Adult A and Adult B were not explored or considered by the Trust in their contact with Adult B despite knowledge of the criminal damage caused to Adult A's flat and the circumstances of Adult B's detention under Section 136 of the Mental Health Act. The CPN did ask Adult A if she felt threatened by Adult B, but Adult A said that she did not and enjoyed the company.

The CPN did discuss strategies should she feel threatened, however Adult A did not see herself as a victim. Adult A was concerned about her daughter's mental health but there is no evidence that she saw herself at risk of violence.

Section Three

Conclusions

3.1 Conclusions

This section sets out the conclusions of the DHR panel, having analysed and considered the information contained in the IMRs within the framework of the Terms of Reference for the review. The independent chair of the DHR is satisfied that the review has:

- Been conducted according to best practice, with effective analysis and conclusions of the information related to the case.
- Established what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and support vulnerable people and victims of domestic violence.
- Identified 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.
- Reached conclusions that will inform recommendations that will enable the application of these lessons to service responses including changes to policies and procedures as appropriate; and
- Will assist in preventing domestic violence homicide and improve service responses for all vulnerable people and domestic violence victims through improved intra and inter-agency working.

In line with the terms of reference the DHR has covered in detail the period from 1st May 2010 until 16th August 2012. Agencies have provided a history and context, where appropriate, for periods that occurred prior to May 2010. Where appropriate the DHR has drawn upon this information to assist in developing a broader knowledge of the background and history of both Adult A and Adult B. The panel has also taken account of information received via Adult D and Adult B about issues relating to the period prior to that covered by the DHR, in particular those relating to their respective childhoods and the engagement of local services.

The conclusions presented in this section are based on the evidence and information contained in the IMRs and draw them together to present an overall set of conclusions that can be drawn about the case.

3.1.1 Care and treatment, including risk assessment, care planning, transfer and discharge

The DHR panel has considered the care and treatment provided to both Adult A and Adult B. For clarity, the conclusions in respect of this area of review are therefore presented separately for Adult A and Adult B.

The care and treatment provided to Adult A

- Adult A was a regular attendee at her GP practice. The majority of these contacts were in relation to routine and long standing health issues and not about domestic violence.

- It appears that the GP had a largely positive relationship with Adult A and made regular efforts to assist Adult A in addressing her difficulties in relation to alcohol dependency, her mental health and her living conditions.

- The GP was aware of the difficulties in the relationship between Adult A and Adult B and attempted to advise Adult A about how to remedy this, but not always appropriately.

- OHFT was engaged in regular monitoring of Adult A's mental state and the regular administration of medication. However, the details of the care plan being followed by the Trust with Adult A were not adequately communicated to the GP.

- The CPN was aware of the difficult relationship between Adult A and Adult B. Although the CPN raised a Safeguarding concern with Social & Community Services in relation to Adult A's vulnerability, with a particular focus on concerns about financial abuse, this only occurred after contact from a social worker who had been called by the Police.

- Offering money management to someone who was believed to be the subject of financial abuse was not appropriate, as it infers that the abused has control of the abuse, which is evidently not the case.

- There is no evidence to suggest that the standard of clinical care provided to Adult A was inadequate or that it fell below professional standards that would be expected. However, there were deficiencies in communication that precluded the GP from having a deeper knowledge of Adult A's potential and actual vulnerability.

The care and treatment provided to Adult B

- Adult B was not known to OHFT prior to her admission to hospital in July 2012.

- During the admission there was confusion about Adult B's registration with primary care. OHFT staff believed Adult B was registered in Birmingham, but she was in fact both temporarily registered at Jericho Health Centre and also permanently registered in Birmingham. This demonstrates the need for clarity and communication with both GPs.

- The assessment of Adult B whilst in hospital was inadequate. The OHFT IMR similarly makes this conclusion. In part this was due to the length of time that Adult B was AWOL during the period of her Section 2, ten days in total. Given that the Section 2 was discharged four days before its legal expiry date, and three days were concerned with ward transfers, this allowed only 11 days when assessment of Adult B's mental health could take place.

- The DHR panel recognises that Adult B presented challenges in both management and engagement, but it concurs with the view of the OHFT IMR that the assessment process was not robust.

- The panel further concludes that insufficient effort was made, and note taken, of relevant background information, history and previous contacts with other services or agencies. Opportunities were also missed to talk with other family members or to gather information from Adult A's CPN.

- There was confusion about the appointment of a responsible clinician. This was further compounded by periods of annual leave by medical and other ward staff, resulting in a lack of clarity about who was responsible for taking clinical and management decisions about Adult B's care and treatment.

- There is no evidence to indicate that Adult B was ever assigned a named nurse whilst an inpatient. In addition, Adult B was not allocated a care co-ordinator until she was re-graded as an informal patient. This is a significant deficit of care planning and co-ordination.

- The behavioural and management challenges that Adult B presented, coupled with her recent history of violence, probably in the context of her mental health difficulties, specifically assault and criminal damage and her difficult relationship with Adult A were not given due weight in the risk assessment process.

- Adult B's classification of low risk appears to the DHR panel to be at odds with her presentation and history. It is reasonable to conclude that there was a potential risk of violence, which could have been inferred from Adult B's history and her hostility, she did not present with a long history of physical violence in adult life and there was no history of the use of weapons. Therefore the panel acknowledges that violence with a knife was not predictable.

- The assessment of risk by TVP did not align with that of the staff at OHFT. This led to differing views about risk and dangerousness. This caused confusion between agencies and their staff and may have unduly influenced decision making.

- There was an inappropriate weight placed on Adult B's mental health by TVP officers and as such she was not regarded as an offender. There was reluctance by TVP officers to treat Adult B's offending behaviour as just that, offending behaviour and this effectively gave legitimacy to that behaviour by placing it in the context of her mental health. This meant that opportunities to address that offending behaviour were not taken.

- The transfer of Adult B from the PICU to Allen Ward was not properly planned. The transfer was instigated as a result of the discharge from Section 2 of the Mental Health Act. As a result there was not sufficient planning and liaison between the wards.

- Care planning and preparation for discharge in August 2012 did not commence until the transfer from the PICU back to Allen Ward. Although the DHR panel recognises that urgent allocation of a care co-ordinator was sought, this process was not properly planned. Engagement with family members in care planning was not adequate.

- The triangulation of information in relation to Adult B and Adult A was not adequate. The safeguarding issues relating to Adult A were not communicated across the teams in contact with both Adult A and B. Issues of domestic violence in the relationship between Adult A and Adult B were not explored or considered by the Trust in their contact with Adult B despite knowledge of the criminal damage caused within Adult A's flat and the circumstances of Adult B's detention under Section 136 of the Mental Health Act. This resulted in a lack of knowledge of the issues and concerns in respect of the relationship between Adult A and Adult B.

The DHR panel concludes that there was a lack of adequate clinical leadership in Adult B's care and treatment. A more coordinated approach to Adult B whilst in hospital under the Section Two may have delayed her discharge and placed more

effective care and risk management around her. This may have prevented the outcome.

3.1.2 Communication between agencies

The communication between agencies was not adequate. The DHR panel concludes that there were opportunities to share information about history, background and current circumstances that were not taken.

- The Mental Health Act Assessment conducted by the AMHP service was undertaken swiftly, appropriately and in accordance with legislation, policy and procedure.

- There was a lack of communication from OHFT to primary care about the on-going care and support being delivered to Adult A. This resulted in the GP not being aware of the Trust's involvement and the shared concern about Adult A's vulnerability and difficult relationship with Adult B.

- Given that secondary care services are not obliged to communicate with temporary GPs, it is perhaps not unsurprising that there is no evidence of contact between the Trust and the GP in respect of Adult B. This is further compounded by the confusion within the Trust about Adult B's primary care registration and this is more likely to be the reason for this lack of communication.

- There was effective communication between Adult A's CPN and Social & Community Services following the safeguarding alert.

- Communication between OHFT and TVP was confused, with misunderstanding and misconception about legal frameworks, duties and responsibilities being a clear feature. This will be addressed in subsequent conclusions.

- Communication by OHFT with the family of Adult B, including Adult A, Adult C and Adult D was lacking.

The DHR panel concludes that there were deficits in communication that contributed to a lack of understanding, knowledge and actions in respect of both Adult A and Adult B.

3.1.3 Recording

- The recording of the Mental Health Act Assessment by the AMHP service was appropriate and complied with legal duties and responsibilities.

- The GP made accurate notes of her interactions with Adult A, which provide a fuller picture of the circumstances and issues that affected Adult A.

- There were problems with access to recording systems between agencies. The recording systems of the local authorities and OHFT are not compatible and this may have contributed to these difficulties. The outcomes from the initial safeguarding investigation were not properly recorded. The case was allowed to remain open without a clear resolution plan in place. This is a deficit of both recording and practice.

- There were no details recorded of conversations between Adult A and the Oxford City Council customer services team. In addition there was no file note that provides further detail of a note on the notepad of the Tenancy Services Officer where past problems between Adult A and Adult B are mentioned. The consequence being that this information was not available to other members of the team or other agencies.

- The DHR panel concludes that there deficits in recording that contributed to knowledge about both Adult A and Adult B not being detailed, shared or appropriately known by the agencies working with them.

3.1.4 Multi-agency working

A range of agencies were in contact with both Adult A and Adult B. Their ability to work together was impacted by the lack of effective communication and recording that the DHR has already outlined.

In particular there was confusion about the correct process for raising concerns about adult protection in relation to both Adult A and Adult B. There were opportunities for TVP to have referred Adult A to Social & Community Services but these did not take appropriately and in some cases did not take place at all. This delayed the raising of a Safeguarding alert in relation to Adult A.

There are specific issues in respect of the interactions between TVP and the Trust in relation to Adult B that the DHR panel concludes had a negative impact on this case:

- Misunderstandings between OHFT and TVP about the legal position in respect of Adult B as a person detained under Section Two of the Mental Health Act resulted in opportunities for Adult B to be returned to hospital not being taken. In addition, there was confusion among Trust and TVP staff about Adult B in relation to the execution of the Section 135(2) warrant.

- TVP and OHFT staff routinely disagreed about decisions made and taken. This included TVP not conducting a welfare check on Adult A when Adult B was missing.

- There were disagreements between TVP and OHFT staff about responsibilities. These took place in the broader context of staffing shortages in both agencies.

- These misunderstandings of the legal position and disagreements were not referred to the TVP mental health lead, or to a more senior member of OHFT staff. If this had happened, the lead may have been able to provide accurate advice directly to officers, or assisted in the conversations with staff at the Trust.

The DHR panel concludes that TVP officers and OHFT staff misunderstood and were incorrect in their understanding of their responsibilities in relation to the Mental Health Act. This was compounded by confusion by OHFT staff about whether Adult B was AWOL or a missing person on the second occasion that she left the hospital.

The DHR panel further concludes that the multi-agency working between TVP and OHFT fell short of what was expected, that existing joint protocols were not observed and that issues were not appropriately referred to the TVP lead or to more senior OHFT staff for advice and guidance. This lack of appropriate escalation by both agencies represents a missed opportunity to seek advice and guidance that would have assisted in a more swift resolution of the issues.

This set of circumstances has highlighted poor working practices at practitioner level between TVP and OHFT (particularly outside normal working hours). It is the view of the DHR panel that these difficulties in multi-agency working and mutual understanding of legal frameworks and responsibilities led to Adult B not being returned hospital in a timely way in July 2012 when subject to a Section 2, and impacted on the determination of her whereabouts in August 2012.

3.1.5 Leadership

The DHR panel concludes that as evidenced in 3.1.1 there was a lack of clinical leadership in relation to the management and care planning for Adult B. This contributed to confusion about clinical responsibility for Adult B and her case management.

Although Joint Protocols for multi-agency working are in place these were not adhered to. More senior staff did not deal with the disagreements and misunderstandings between TVP and OHFT. Indeed, it appears on the basis of the information available that their advice was not sought. This demonstrates a lack of

leadership by staff within both organisations who could and should have taken the initiative to seek advice and guidance.

The failure to address the inconsistent recording of information suggests that more senior staff in OHFT and Oxford City Council (See 3.1.3) did not fulfill their function of staff oversight and supervision effectively.

3.1.6 Predictability and preventability

This DHR has been conducted with the aim of identifying the lessons that can be learned from the incident. In doing so it has been conducted in way that will also satisfy the standards and requirements of a Serious Case Review and a Mental Health Homicide Review. In all three forms of review the question of predictability and preventability must be considered.

In reaching a view about predictability and preventability the DHR panel has carefully considered the information presented in the IMRs and spoken with IMR authors. The DHR panel has also discussed this in detail at formal meetings of the panel.

Predictability

The DHR panel concludes that the homicide was not predictable. Although there were previous examples of violence by Adult B towards people, these were twelve years ago. The incidents within the timeframe of this review took place in the home of Adult A and were incidents of criminal damage to property. The difficulties in the relationship between Adult A and Adult B were of long standing, but in the timeframe of this review, they largely centred on money, or the lack of it, rather than incidences of domestic violence between Adult A and Adult B.

Preventability

This overview report has highlighted a number of missed opportunities to address Safeguarding concerns in relation to Adult A. It has also described the lack of communication, deficits in recording and disagreements and misunderstandings between agencies. In particular the issues relating the period when Adult B was AWOL from the Warneford Hospital contributed to the lack of an appropriately comprehensive assessment of her mental health. The decision making process in relation to Adult B's discharge from Section Two of the Mental Health Act, transfer from PICU to Allen Ward, her subsequent leaving of the hospital, all conspired to allow Adult B to return to Adult A's flat.

The information about the difficulties in the relationship between Adult A and Adult B were not properly communicated between agencies. The Safeguarding process,

although in place, had not been closed, but its operation and status was not known to all agencies.

Although the incidences of violent behaviour by Adult B were directed at property, her history of assaultive behaviour provided some clues to her risk level. The differing assessment of Adult B's risk led to confusion about the urgency with which her initial AWOL period and then her leaving of hospital while an informal patient should have been dealt with.

The issues related to the initial AWOL period meant that Adult B's mental health had not been properly assessed and understood. If a more effective assessment, care planning and transfer process had taken place then the need to discharge Adult B from Section Two would not have appeared so urgent.

When taking these factors into account, the DHR panel concludes that opportunities to communicate and act were missed. On this basis we conclude that the homicide was preventable.

Section Four

Recommendations

4.1 Recommendations

4.1.1 Recommendations made in the individual IMRs

NHS Oxfordshire

1. Commend the care given by the GP

2. Secondary care to communicate significant events, such as deaths of Mental Health Act Section patients to temporary registered GPs if they have had substantial input with patients

3. GPs need education about Adult Safeguarding procedures

4. GPs and mental health professionals need to be explicit about roles, responsibilities and boundaries in patients with complex physical problems and serious mental illness

5. Each health professional should be aware of the importance of explicit assessment of mental capacity in a vulnerable adult patient when abuse/exploitation is disclosed or suspected

6. Mental Health to send full CPA review reports to GPs every time an assessment is completed.

Oxfordshire County Council Social & Community Services (AMHP)

No recommendations made

Oxfordshire County Council Social & Community Services

1. There should be a proactive approach to the management, coordination and review of all cases open to the adult protection procedures which includes clear decision making based upon risk.

2. Minimum recording standards should be introduced in relation to adult protection cases

3. CMHT safeguarding managers should be afforded better more reliable access to OCC systems for reporting and recording adult protection concerns and outcomes

Oxford City Council

1. There was little contact made by Adult A to the Tenancy Services team. In these circumstances where the team is aware of problems within the family more regular visits should be carried out to the property.

2. When Adult A did contact the council there were no details recorded by Customer Services of the conversation. It is important that the Customer Relationship Management system is fully updated in order that information is available to other Service Areas.

3. Communication between the Service Areas should be improved to ensure that where there is multiple repair orders raised involving damage to the property this is passed to the Tenancy Management team for further investigation.

Thames Valley Police

1. The review recommends that further work is completed within the Protecting Vulnerable Persons Strategy Unit to highlight the importance of correctly identifying and appropriately referring vulnerable adults.

2. The review recommends consultation between Control Room & Enquiries Department CRED training and the Force Mental Health Lead to assess the need for further training.

3. The review recommends that further work is conducted by the TVP Mental Health lead to reinforce the importance of managing mental health assessment alongside a criminal investigation.

4. The review recommends a reminder be sent to officers concerning the importance of appropriate use of warning markers within PNC and of the importance of creating a record within the Command and Control of any attempts to execute a warrant.

5. The review recommends that consideration be given to the development of a generic risk assessment specifically for patients who have either unexpectedly discharged themselves or who have left when under a legal duty to remain.

6. The review recommends reviewing the standardised approach for dealing with warrants secured under the Mental Health Act. Such an approach would include documentary notification of the warrant to the TVP Control room, including a copy of the warrant and a risk assessment completed by the agency securing the warrant with a caveat that this would not be required in cases of urgency where it was not practicable to send documentary notification.

7. The review recommends that the Oxfordshire Safeguarding Adult Board consider replicating the OSCB escalation protocol to promote better inter-agency working when responding to vulnerable persons reported missing from mental health care settings.

8. The review recommends that consideration be given to mandatory refresher training for operational officers regarding police response to mental illness.

9. The review recommends that the Oxfordshire Safeguarding Adult Board consider producing a joint protocol concerning the management of vulnerable adults who become missing persons that could be applied across the TVP area.

Oxford Health NHS Foundation Trust

1. The mental health division to agree a consistent pattern of practice in relation to adequate assessment of patients detained on Section 2 of the Mental Health Act, including good practice in engaging with patients; exploring background information including collateral history, all old notes and third party risk information and consider any implications for further training.

2. The relevant responsible community team and named care co-ordinator should be established early on in an admission (within 7 days) to allow adequate links to be established. By default inpatients are subject to CPA and rapid allocation is good practice.

3. CMHTs to have clear clinical and operational leadership, working collaboratively to ensure all appropriate systems and processes are in place to ensure timely allocation of responsibilities, delivery of care and communication.

4. That the mental health division provides assurance that the CMHT responsible for care of Adult A and Adult B is operating effectively in respect

of the management of referrals, handover of patient care between clinicians and allocation of responsible practitioners.

5. All professionally registered clinical staff need to be able to open a new case of RiO to enable them to make contemporaneous records. This is subject to any information governance restrictions.

6. The “Patients who are absent without leave or who are missing from hospital” policy (CP17) needs reviewing following clarification between the police and the Trust and the crisis service and the inpatient wards on the respective responsibilities for returning patients to hospital.

7. Medical leave to be better co-ordinated and a standardised system of handover of care during these periods to be developed in the CMHT, with consultants making better use of the leave folder in the shared drive.

8. The Management of Unregistered Patients protocol to be reviewed and amended with further guidance included where required. This protocol should include a method for ensuring registered GP, any temporary registrations and the name of the last GP seen are sought from patients and or their relatives.

9. Communications via email must always be copied to progress notes on RiO.

10. Learning from the serious incident to be shared with the relevant clinical teams in this case.

4.1.2 DHR recommendations

The issues that have arisen from this DHR have significant consequences for the agencies that were engaged in the delivery of services or had contact with both Adult A and Adult B. The Panel expects the organisations to address the issues raised in their own reviews and that they should have in place a process where they monitor their own progress against the actions they raised. The panel acknowledges the work the organisations have done since the incident.

The DHR panel makes a number of recommendations, some of which apply to particular organisations and a number of more general recommendations that apply across the local agencies.

1. We recommend that TVP, OHFT and Oxfordshire County Council Social & Community Services work together, through the adult safeguarding board to ensure a co-ordinated and mutually agreed approach to the identification and appropriate referral of vulnerable adults.

2. We recommend that OHFT put in place systems to ensure the appointment of a care co-ordinator in the community as early as possible after a person is admitted to hospital. The failure to do so in this case has been highlighted as an omission in the care planning process. The Trust should also put in place a process to monitor and assure senior management that this is taking place and that their current policy is being applied.

3. We recommend that OHFT put in place a process that ensures a consistent pattern of practice that enables appropriate and adequate assessment of patients' mental health whether or not they are detained under the Mental Health Act. This should include a clear process for determining the responsible clinician and for making any necessary changes to that responsible clinician.

4. We recommend that a robust and clear process for communicating with GPs should be devised, in consultation with primary care colleagues and implemented as swiftly as possible so that the management of patients who are temporarily registered with a GP or do not have a GP can be improved.

5. We recommend that TVP, OHFT, Oxfordshire County Council Social and Community Services and Oxfordshire CGG review their current recording processes and practices and put in place measures to assure themselves that recording is of a sufficient standard and takes place in a timely manner.

   This should focus in particular on recording of safeguarding and risk assessment, whether this is through established case management systems, file notes or other databases.

6. We recommend that the OHFT and Oxfordshire County Council Social & Community Services Directorate work together to put in place information technology systems that are accessible to the staff of both organisations.

7. We recommend that OHFT review its policy and guidance in respect of patients who are AWOL or missing from hospital. We further recommend that this policy and guidance be developed with partner agencies including TVP. OHFT and TVP should agree how expert advice should be sought and how concerns should be escalated from the front line.

8. We recommend that TVP, OHFT, Oxfordshire County Council Social and Community Services and Oxfordshire CGG work together with the adult safeguarding board to identify and address training needs and necessary organisational culture change in respect of mental health legislation and its application. In doing so the organisations should develop a mechanism for better networking and relationship building of frontline police, Trust and other health and social care staff.

9. We recommend that the content of mandatory safeguarding training for all health and social care staff should include material and information about domestic abuse/violence. It should highlight examples of incidents that might trigger a safeguarding alert. More specialist training should be available in relation to domestic abuse

10. We recommend that OHFT, TVP and Oxfordshire County Council Social & Community Services Directorate work together to develop an appropriate forum where practitioners and clinicians can meet to discuss issues of practice and develop solutions to local operational challenges.

11. We recommend that in light of the information provided to us, a further internal review into the care and protection of Adult B and Adult D be undertaken by Children's social care in conjunction with local mental health services, given that the account of their childhood raises a number of potential child protection issues, which may necessitate further investigation but fall outside the scope and Terms of Reference of the DHR.

Chronology

July 1997	Adult A	Adult B
	Oxford City Council: concerns were raised due to condition of property. Social services were aware of problems in the relationship.	Adult B often stayed at Adult C's address for respite.
May-November 2010	Concerns about alcohol consumption raised by GP and CPN.	
May 2011	CPN records son & daughter take advantage of Adult A and often ask for money. Money management suggested	
August 2011	Adult A attends a Mental Health review. Records stress at son staying and daughter planning to stay. Mobile phone debt of £850 incurred by nephew causing distress. Referred to SMART. Surgery visit debt seeing CAB, wants alcohol detox	
March 2012	Adult A states her concerns to a Mental Health worker, says daughter is living with her. Adult A is worried about Adult B's mental health. Adult B kicked the stairs after argument. CPN & Dr discuss referral to Social Care. 16th March - Psychiatrist and CPN visit Adult A, she is drinking too much but no psychotic symptoms. Psychiatrist concerned about Adult B's mental health and suggests she sees the GP	29th March Adult B visits GP, explains she is living with her mother, has a low mood, is not working and is drinking 28 unit of alcohol per week. She requests a certificate for two weeks for her Job Seekers Allowance. The GP records that Adult B does not appear clinically depressed and that she scored 12/21 for depression and 16/21 for anxiety
April 2012 26.04.2012	Adult A sees her GP requesting detox due to her chronic alcoholism. She says that Adult B is causing her	

	concern	
06.05.12	Adult A is taken to hospital as she has low sugar levels and is talking to herself. She has hypoglycaemia but not psychotic. A referral to the Crisis Team is made. Crisis team visit Adult A later that day, she says Adult B is headstrong and borrows money.	Adult B shouts from upstairs.
09.05.2012	The CPN visits Adult A who says that her relationship with Adult B is tense as she is moody	
10.05.2012	The GP receives a call from the CPN saying Adult A is vulnerable and a psychiatric and physical review is needed. A joint appointment is made.	
11.05.12	Adult A calls police concerned Adult B is having a breakdown.	Adult B left through window.
12.05.12	DASH completed - Standard risk. Adult A calls police to report that Adult B has returned. Intelligence report saying house a mess, contacted Warneford who know Adult A, referral to Social Care should be made.	Missing Person Report – Medium risk
24.05.12	CPN visits Adult A. Adult A says no problems with Adult B.	Adult B refuses to speak to CPN
28.05.12	Duty social worker gets referral from police relating to Adult A.	
29.05.12	The Social Worker calls CMHT and finds out that Adult A has a CPN who is also the care coordinator. Safeguarding alert raised after Social Worker speaks to the CPN. The Social Worker tells the CPN that the police found the house in a state of disarray when they attended. Safeguarding manager appointed and arrange a visit	

	to Adult A	
31.05.12	CPN & Social Care manager visit Adult A, who agrees to money management. Agreed no immediate need for action, but emerging picture of gradual deterioration particularly in areas of finance, home environment and physical health.	
June 2012 11.06.12	Police arrive. Adult B has left. Adult A says Adult B smashed own property because she was fed up with Adult A's drinking. Adult A concerned by the manner in which she left.	Police receive a call from the Ambulance Service as female "freaking out". Adult B spotted in central Oxford. Stopped & searched for drugs as she matched the description of another female. Nothing found. Adult B said she was going back to Adult A.
12.06.12	CPN takes Adult A to GP, Adult A had drunk alcohol. Reports Adult B had broken items in the home in a temper and then left. Adult A had called police. CPN notes the state of flat. Adult A says she is worried about Adult B's health and the last few weeks had been very difficult. Adult A says Adult B is depressed and with a 'different reality'. CPN reinforces the need for medical help and agrees to clean Adult A's home. Adult A advised Adult B should move out. Adult A reluctant to accept this advice.	
July 2012 3.07.12	CPN completes money management with Adult A.	CPN records that Adult B was in the kitchen during the visit, talking to her-self, laughing but didn't want to join them. CPN spoke to Adult B, who said she was going to leave Adult A's address soon and refused to

		see a GP.
6.07.12	CPN and a colleague clean Adult A's home. CPN asks Oxford City Council for help with the property but none available. CPN discusses Adult A in CMHT meeting and appointment with Dr (Psych) agreed for 11/07/12	Adult B upstairs.
11.07.12	CPN & Dr visit Adult A. Adult A says Adult B has a mental health problem and had taken her money. Adult A said she would ask for it back. Adult A's alcohol intake discussed.	Adult B not present.
17.07.12	Adult A is consulted and does not object to Adult B's detention.	A Police Constable is passing Adult A's home when a flower pot is thrown out of the window. On entering the property, blood is found on the walls and floor. Adult B is very aggressive and appeared mentally unwell. Adult B will not engage, and she leaves the property. There is concern for Adult B's safety; Adult B is restrained in handcuffs and detained under Section 136 of the Mental Health Act. She is taken to the Runis Ward at Littlemore Hospital. An assessment is completed by 2 Drs and an Approved Mental Health Professional. Adult B is detained under the Mental Health Act and placed on a Section 2. She is admitted to the Allen Ward. Adult B is irritable at times, giggling at others, and avoids eye contact but is deemed aware of her legal status. She is assessed as highly vulnerable, unpredictable with a risk of

		social isolation and of further behaviour which may affect the safety of others. There are concerns about Adult B's behaviour 'thought to be worrying and could be threatening towards mother'.
18.07.12		Adult B is seen by a Dr. She is uncooperative and refuses clinical assessment. Adult B reports a neck injury following a domestic violence incident, but does not give details. Adult B attempts to climb out of a window.
19.07.12		Adult B is reported as Absent Without Leave from the hospital. She had requested to go out for fresh air, and when staff opened the door Adult B jumped the fence. Police are informed and the hospital's AWOL policy is executed. Police receive the call from the Warneford explaining that Adult B is a Section 2 patient still being assessed. Ward Staff report that Adult B is very unwell and in midst of 'psychotic episode', and she may be at risk of committing violence towards her mother. Police transfer Adult B to the Missing Persons Database. MPDB noted that 'based on risk assessment she is not deemed to pose a significant risk to herself or others.' Police ask ward staff what they are doing to secure Adult B's return to the hospital. Ward staff respond that they are too short staffed to find her. Police state it is the Ward's duty to

		find Adult B but to call the police if Adult B became violent. 22.20 Police attend Adult A's address and locate Adult B. Adult B refuses to return to the Warneford. Police call the Warneford and inform them of Adult B's whereabouts. The Warneford no longer have a bed for Adult B. Adult B leaves Adult A's address.
20.07.12		The Warneford is informed by police that Adult B is at Adult A's address but is refusing to return. It is agreed that a warrant needs to be requested from Magistrate's Court to secure Adult B's return to the ward. Incorrect paperwork is submitted to the court so no warrant is issued. The Warneford seeks to locate a mental health bed in Birmingham without success. The Warneford informs the police that they will make attempts to recover Adult B, and will contact the police if required. Police reduce missing person grade to low.
22.07.12		Warneford staff speak to the Police Missing Persons Unit to inform them of the unsuccessful attempt to obtain a warrant. Adult B is still AWOL. Adult B informed the DHR chair that she went to London during this date and 28th July, to stay with friends but as they were no longer

		there slept rough for a few nights.
23.07.12	Adult A calls the Warneford and says that Adult B is no longer at her address.	Warneford staff inform the Police that they now have a warrant but do not know Adult B's whereabouts, and she should be a Birmingham patient.
24.07.12	Adult A calls the Warneford 3 times asking what they are doing to find Adult B. Adult A does not think the hospital are doing enough to find Adult B. Warneford staff respond that the Police are aware and there is a plan in place to find Adult B. Adult A calls Police wanting to speak to Adult B, stating that she had not seen Adult B since 19th July.	Police speak to Warneford staff who confirm that a warrant had been obtained on the 20th July and Adult B is an out of sector patient. Warneford staff give the police a possible alternative address for Adult B. Adult B is not at the alternative address.
25.07.12		A photo of Adult B is given to police neighbourhood teams.
26.07.12		Adult C calls the Police to say that Adult B is back with Adult A. Police attend the address but no one is in.
27.07.12		Adult C calls the Police to say Adult A and Adult B were asleep when they called. The police attend the address again but there is no response. The Police then call Adult C for an update; Adult C reports that Adult A and Adult B were at the address but did not answer because they do not want Adult B to go back to hospital. The police Operator notes that Adult C is concerned that Adult A is not OK The police note that the Warneford has responsibility

		to collect Adult B and police will give assistance if needed. The police call the Warneford to inform them that Adult B is at Adult A's address. They request for ward staff to go and collect Adult B to and call for police assistance if needed. Staff attend the address, but do not feel confident to attempt to approach Adult B without police assistance.
28.07.12	Warneford staff call Adult A who says Adult B is not there. The Police are updated and they suggest ward staff still attend the address and call for police assistance if needed.	13.25 Warneford staff call the police to inform them that ward staff are executing the Section 135 warrant and to request police. 15.57 There is a second call to the police; Ward staff asked for police officers to attend Adult A's address to collect Adult B and return her to the ward. Police responded that ward staff needed to attend and call police if assistance is required. 16.31 Ward staff call the police en- route to Adult A's address to request for police officers to meet them there. 17.17 Ward staff call the police to inform them that they had sighted Adult B walking to Adult A's house. The police reiterate that ward staff need to collect Adult B and if she gets violent the Police will assist.

		18.02 Ward staff chase assistance from the police. 18:14 Ward staff call the police to say they had left the address to deal with another patient.
29.07.12	10:35 The police call Adult A to ask the whereabouts of Adult B. Adult A confirms that Adult B has been with her for a couple of days. Adult A had not wanted Adult B to return to the Warneford. 14:53 Police attend Adult A's house with Staff from Warneford to assist in the execution of the warrant. Adult A calls stating that she does not agree with Adult B's referral to PICU.	After 10 days AWOL Adult B is returned to the ward by staff and police. Adult B had refused to return, had become agitated, and had required handcuffs and leg restraints. The police had to call for assistance. Adult A had attempted to intervene. Adult B is referred to the Ashurst PICU due to the high risk of her absconding and her volatile behaviour. Adult B seems more settled in the evening, though her behaviour suggests she may be responding to unseen stimuli.
30.07.12		01:30 duty Dr attempts to assess Adult B, who refuses and throws a cup of tea at his foot. Adult B appears tired and annoyed. She is seen later in the day by the clinical team. Adult B becomes increasingly agitated and spits at staff, is speaking incomprehensively, giggling at times and appears to respond to external stimuli. The content of her thoughts remains inaccessible.

		Adult B's brother calls the ward. Dr tries to return the call without success. 18:00 staff attempt to give Adult B oral medication, and she physically objects. Adult B is restrained after spitting and hitting out at staff. She escapes the restraints, punches one member of staff and kicks another. She is restrained again, calms down but remains hostile and aggressive. 23:55 Adult B is transferred to PICU.
31.07.12		Adult B arrives at PICU at 00:30. She is agitated and given further medication. A reviewed and physical examination is undertaken by a Dr. Later in the day Adult B is seen by a Dr. She seems angry but not hostile, and reports someone 'outside' has engineered her admission and she is not mentally ill. Adult B appears distracted, repeatedly looking at the ceiling & refuses to engage. Her medication is increased. Dr notes Adult B's history of anxiety with depression in Birmingham GP notes. Adult B is reviewed again later in the day. The Dr is unable to see signs of psychotic or manic/hypomanic features. Adult B is neither hostile nor angry. Her medication is reduced.
August 2012 01.08.12		Adult B is reviewed in her room. She refuses to engage in conversation. Her risk is recorded as low for

		self-harm, suicide, non-compliance to treatment and absconding; moderate for self- neglect. The plan is to continue with her current medication. Dr. tries unsuccessfully to contact Adult B's brother.
02.08.12		Adult B reluctantly agrees to see Dr. Adult B is very argumentative, denies she has mental health problems and says a family member has "set her up for arrest" and she suspects it was her mother, but quickly retracts this. Adult B refuses medication.
03.08.12		Adult B is seen in her room again. It is not possible to carry out a mental state examination. Adult B has shown some improvement in her motivation for food and using the garden, although she remains socially isolated. Some staff note that Adult B behaves in a way that suggests she is responding to auditory hallucinations. Adult B's Section will be reviewed on 14/08/12. Adult B receives a visit from Adult A and Adult C who bring her clean clothes. Adult B takes half of the clothes. She is reported to be hostile and terminates the visit after a couple of minutes.
04.08.12		Adult B becomes angry when asked to finish her meal, and throws it on the floor. She is taken to the de-escalation area in escort holds. Adult B requests and is given her rights and section

		papers. She calms down on the ward.
05.08.12		01:45 Adult B leaves her bedroom for the high dependency room and smashes the TV remote control, shatters the paper towel dispenser and tips a bin onto the floor. Adult B is shouting that she should not be in here and will continue to be destructive and aggressive until she is discharged. Adult B is taken to the de-escalation area in escort holds until calm.
10.08.12		Dr and staff see Adult B in her room as she will not come out. Dr records that Adult B seems stable; that there have been no recent episodes of aggression or violence and Adult B is taking oral medication. Adult B has applied for a managers hearing. Initially Adult B is initially uncooperative but Dr explains that without engagement she cannot be assessed or reviewed for discharge. Adult B starts to engage and makes eye contact. She gives a brief history of her-self, including not getting on with her mother. She wants to return to London, but has no money. Adult B says she is angry with her mother for speaking to the CPN about her and suggesting she needed admission to hospital. Adult B further explains that she had been violent to staff out of protest and she took her oral medication not because she

		accepts she needs it, but to avoid injections. Adult B is not distracted, although initially guarded and angry. Staff agree Adult B does not meet the criteria for detention and there is no evidence through formal assessment that she is responding to external stimuli. Risk of self- harm, suicide, harm to others, self- neglect and absconding are assessed as low. Adult B agrees the plan that she will be discharged from PICU into the Allen Ward as an informal patient. Adult B's medication will be stopped and her mental health will be monitored for a drug free period. A care coordinator will be identified to facilitate Adult B to visit Adult A to collect her belongings. Dr notes that Adult B is not mentally ill and certainly not psychotic. Adult B is transferred to the Allen ward, where she refuses her medication, and retires to bed at 23:30. Nursing observations suggest Adult B absconded between 05:30 and 06:30 through the bedroom window. AWOL policy instigated.
11.08.12		Nursing observations suggest Adult B absconds between 05:30 and 06:30 through the bedroom window. AWOL policy instigated. 06.51 Warneford staff call the police to report Adult B as a missing person, stating

		that she is an informal patient and has probably gone to Adult A's house. Staff explain that Adult B had to be restrained last time she was returned to the Warneford. Adult B is assessed by the Warneford as low risk. A police unit is requested to attend Adult A's address to locate Adult B. There is a discussion between the police and ward staff about whose responsibility is to locate Adult B. Police state it is the Warneford's responsibility, however they undertake a welfare check at Adult A's address at 8.55 am. Adult B is there and says she will be returning to the hospital later. Police inform the Warneford. Risk assessment indicates Adult B is low risk. 19:49 Warneford staff contact the police, expressing concern due to not being able to contact Adult A. Adult B has not returned to hospital, and Adult B was hostile and aggressive when she had previously been coerced into returning to hospital. The police will not be taking Adult B back to hospital, as she was sighted by Officers earlier in the day and all was in order. Adult A had not expressed any concerns. Warneford staff express their concern in relation to Adult B's aggressive behaviour. The police reiterate that ward staff should retrieve

		Adult B, and contact police if there is a breach of the peace. The Missing Persons report remained open.
16.08.12	07:47 Adult C contacts the police. She has not been able to speak to Adult A since Sunday. Adult C says it is unusual not to be able to contact Adult A and she is worried. Adult C reports that Adult B answers the phone at Adult A's address, and maintains that Adult A cannot come to the phone because she is asleep. 09:28 Police gain entry to Adult A's address and find Adult A and Adult B present. There are no signs of life from Adult A. 09:28 Adult B is arrested on suspicion of murder.	

Definitions and glossary

The Mental Health Act:

The provisions of the Mental Health Act have effect with respect to the reception, care and treatment of mentally disordered patients, the management of their property and other related matters.[24]

Section 2:

Section 2 of the Mental Health Act allows compulsory admission for assessment, or for assessment followed by medical treatment, for a period of up to 28 days.

An application under Section 2 can be made by a relative or an Approved Mental Health Professional (AMHP) and must be supported by two medical recommendations one of which must be from an approved doctor under Section 12 of the Act i.e. having special experience in the diagnosis or treatment of mental disorder - generally a consultant or senior registrar psychiatrist.

The medical recommendations must agree that the detention is in the interests of the patient's own safety, or the safety of others, or the patient is suffering from mental disorder of a nature or degree which warrants detention for assessment, or assessment followed by treatment, at least for a limited period.

Appeal to the Mental Health Review Tribunal is allowed within 14 days of admission. The Mental Health Act 2007 has earlier automatic referral to a Mental Health Review Tribunal (Tribunal) where patients don't apply themselves and new Tribunal system structure.

Each medical recommendation shall include a statement that the grounds of the application are complied with and must be signed on or before the date of the application. One medical recommendation may be given by a doctor on the staff of the hospital admitting the patient; this does not extend to nursing homes. It is often most appropriate for this to be the consultant who will subsequently treat the patient.

[24] Mental Health Act 1083 amended 2007 HMSO 2007

Section 136

Section 136 of the Mental Health Act 1983 allows a police officer to remove a person they think is mentally disordered and 'in immediate need of care or control' from a public place to a place of safety, in the interest of that person or for the protection of others.

The person may be detained for up to 72 hours so that they can be examined by a registered medial practitioner and interviewed by an approved mental health professional (AMHP), and to make any necessary arrangements for their treatment or care.[25]

Care Programme Approach:

The Care Programme Approach (CPA) was introduced in England in the joint Health and Social Services Circular HC (90)23/LASSL (90)11 - '*The Care Programme Approach for people with a mental illness, referred to specialist psychiatric services*'. It was published by the Department of Health in 1990, effective from 1 April 1991. It required Health Authorities, in collaboration with Social Services Departments, to put in place specified arrangements for the care and treatment of mentally ill people in the community.

The original aims and objectives of CPA remain as relevant to practice today as they were when first introduced, the principle one being to provide a framework for effective mental health care. Within this there are four central components that underpin that key principle:

- Systematic arrangement for assessing the health and social care needs of people using specialist mental health services

- The development of a care plan which identifies those health and social care needs and how they will be met through a range of providers in the statutory and non-statutory sector

- The allocation of a care co-ordinator (originally termed the key worker) to keep in close touch with the service user and to monitor and co-ordinate their care

- To undertake regular review and where necessary, agree changes to the care plan

[25] Guidance for commissioners: service provision for Section 136 of the Mental Health Act 1983 Position Statement PS2/2013 Royal Collage of Psychiatrists April 2013

In 2008 changes were made to the operation of CPA in England. *Reviewing the Care Programme Approach* (2006) had set out the reasons and aims of the review of the CPA which was published in March 2008. It made clear that the ultimate aim was to ensure that there was a renewed focus on delivering a service with the individual using the services at its heart. Most importantly, *Refocusing the CPA* (2008) described a revised position in respect of the use of CPA. From 2008 it would only apply to those service users with complex needs or characteristics. These might include:

- Severe mental disorder – with a high degree of clinical complexity
- Current or potential risks including:
    - Suicide, self-harm, harm to others (including offending history)
    - Relapse history requiring urgent response
    - Self-neglect
- Vulnerable adult
- A need for multiple service provision
- Currently or recently detained under the Mental Health Act

Those people who use services who have less complex needs or who do not present within the categories outlined above would not now be expected to have a CPA. Rather their needs and the plans to meet them will be set out in the clinical and medical notes. No formal review meeting is required.

Clinical leadership

Where the report refers to clinical leadership in the context of the care and treatment of Adult B, this term relates to Doctors or medical leaders and the actions of the Responsible Clinician within the terms of the Mental Health Act.

SO2087 form

An SO2087 form is the official paperwork used by the AMHP in Oxfordshire to record the details of an assessment under the Mental Health Act.

Mental Capacity Act

The Mental Capacity Act 2005 (MCA) was enacted on 1st April 2007 and was implemented on 1st October 2007. The MCA applies to everyone who works in health and social care and is involved in the care, treatment or support of people over 16 years living in England and Wales, who are unable or may be thought to be unable to make all or some decisions for themselves.

The MCA established an obligation for professionals to consult people who are involved in caring for the person who lacks capacity and anyone interested in their welfare (for example family members, friends, partners and carers) about decisions affecting that person.

Clinical Commissioning Group

The commissioning of local health services transferred from Primary Care Trusts to Clinical Commissioning Groups (CCGs) in April 2013. They hold the local budget for health care and are responsible for deciding what services should be delivered and by whom. They are accountable to NHS England who support and regulate CCGs.

Miscellaneous acronyms

Absent without Leave	AWOL
Adult Mental Health Professional	AMHP
Community Psychiatric Nurse	CPN
Community Mental Health Team	CMHT
Domestic Homicide Review	DHR
Oxford Health NHS Foundation Trust	OHFT
Thames Valley Police	TVP