Domestic Homicide Review

Alan/2011

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Commissioned by:
Kent Community Safety Partnership
Medway Community Safety Partnership

Overview Report

1 Introduction

1.1 On 12th September 2011 a man was stabbed to death by his son in their home in Kent. In accordance with Section 9 of the Domestic Violence, Crime and Victims Act 2004 the Kent Community Safety Partnership commissioned a Domestic Homicide Review. Greg Barry was appointed as the Independent Chair of the review panel and Author of the overview report. Greg is a retired Detective Chief Superintendent from Kent Police where he specialized in the investigation of abuse of vulnerable people, multi-agency working and reviewing investigations. He has been the Kent Police representative on various strategic groups in Kent and Medway dealing with safeguarding and domestic abuse. He holds a Diploma in Child Protection. On his retirement in 2009 he worked for the Kent Safeguarding Children Board (KSCB) for two years as the Development Officer with lead responsibility for Child Death Review. Greg did not have any involvement with this family whilst working for Kent Police or KSCB.

1.2 The full terms of reference for the review can be found in Appendix A. The main purpose of a Domestic Homicide Review (DHR) is to establish lessons to be learned by examining the way that individuals and organisations work to safeguard victims. The review was undertaken in accordance with the Home Office Guidance 'Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews' issued in April 2011 and the Kent and Medway Domestic Homicide Review Protocol published in September 2011.

1.3 There is a glossary in Appendix C which explains the terminology used in this report.

2 The Review Process

2.1 The review was carried out by a multi-agency panel that was independently chaired; the panel consisted of senior representatives from the key agencies involved in providing services to those involved in domestic abuse. The panel members had not been involved in this case. The panel considered Individual Management Reviews (IMRs) conducted by the various agencies who had been involved in providing services to the family. The completion of the IMRs was achieved by a combination of an examination of relevant records and interviews where appropriate with members of staff who had been involved with the family. The reports of the IMRs contained factual information and an analysis of the service provided, this was achieved by comparing what happened and what was expected in accordance with existing policy and good practice within that agency and on a cross agency basis. A list of the contributing agencies, the names of the authors of the IMRs and the panel membership is detailed in Appendix B. The GP surgery did not provide an IMR, however a report from the family's GP practice was provided by the GP who was involved in the Mental Health Assessment of the offender on the day of the homicide. The GP and the surgery where they work have not been named as to do so may lead to the identification of the family.

2.2 This review only examined the services provided in the main to the offender and where relevant to other members of the family. The focus of this review has been on the offender as the mental health services that have been involved with him for the majority of his life are in possession of the detailed history of this family. The incidents of domestic abuse all of which involved his father as the victim are linked to his mental ill health. The time period examined by this review was 1st April 1982 until 12th September 2011.

2.3 The decision to hold a review was made on 6th October 2011. The Crown Prosecution Service was consulted prior to the review commencing and they requested that the review should not be started until after the trial. The review commenced after the hearing at the crown court.

2.4 On completion of the hearing at crown court the victim's family were invited to contribute to the review and they provided additional information. This information has been included in the report and details of the liaison with the family and their comments regarding this report are detailed in Section 5.

2.5 The Kent and Medway NHS and Social Care Partnership Trust (KMPT) carried out an initial serious incident review in September 2011 and a further internal review took place in December 2011. The majority of the findings of these two reviews have been included in the IMR completed by the trust. A copy of the internal review has also been supplied to the author of this DHR report after he met with the family to share with them the draft final report, as they raised issues that were contained within the internal review report that were not included in the DHR report. Information and analysis from that review has been included in this report. As a consequence of considering this internal review and comments from the family after they had read the final draft the Independent Chair amended the final report and submitted it to KMPT for comment. As a consequence the Independent Chair requested further information from KMPT which was supplied. This has been included in the report along with an analysis of the additional information. The completion of the final report was delayed whilst the additional matters were resolved with KMPT. The DHR panel were then sent a copy of the amended final report for approval. KMPT then supplied additional information and comment; some of which has been included in the report. The details of the incident and the internal reviews were submitted to the South East Strategic Health Authority to enable them to make a decision regarding the holding of an independent investigation. A decision to hold an independent investigation will be made by the Kent and Medway Area Team of NHS England after they have considered the findings of this DHR as the Strategic Health Authority no longer exists. There are other reviews/investigations being carried out by agencies as a consequence of this homicide which are outside the remit of a DHR. This positive response by agencies is an indication of how seriously they are treating the issues identified after this death.

2.6 This report is anonymous and the following pseudonyms have been used:-
Father – Alan
Mother – Clare
Offender – Brian

2.7 Members of staff have not been identified; there were numerous Community Psychiatric Nurses involved in this case and therefore a number has been allocated to each of them from 2002 in order to differentiate them.

3 The Facts/Background

3.1 The Victim

Alan was seventy one years old when he died. He lived with his wife Clare (sixty eight years old) and their son Brian in the family home. They had lived there from at least 1982. He was still in employment when the homicide took place. The homicide took place at their home address where Brian fatally stabbed his father with a kitchen knife. Their daughter, who was two years older than Brian, lived in the same town; she had left home in 1981. Alan, his wife and daughter are all White British.

The family have described Alan as placid, dignified and generous. He also loved Brian very much. They state that Alan never provoked an argument with Brian and would go out of his way to avoid him, such as sitting in his van if Brian got up early and timing his bed time to avoid him. Even though the relationship was strained Alan would purchase tobacco for Brian every week. The family say that Alan did not support a prosecution when he was assaulted by Brian because he loved him. Alan was never aggressive or violent towards anyone.

3.2 The Offender

Brian was forty eight years old at the time of the offence. He suffered from mental ill health since 1982 and was formally diagnosed with paranoid schizophrenia in 1991. Brian had obtained qualifications to degree level in horticulture and in the early 1990s was employed as The Clerk of Works in a local authority in London. He lived at home with his parents other than when he was at college and for a short time he lived in London. Since 1993, when Brian was twenty seven years old, he has not been in employment after he assaulted a colleague where he worked. Brian is White British.

3.3 Accommodation

The house in Kent where they lived was purchased by Alan and Clare from the local authority in 1982. Around 1989 or 1990 when Alan had financial difficulties; Brian purchased the house for the full asking price. Alan also signed over the family business to Brian. Brian lived with his parents for the vast majority of his life and the household bills were paid between the three of them. Alan did move out for a short period to live with their daughter after one of the incidents of domestic abuse.

3.4 The Homicide

Brian's relationship with his father had deteriorated over the years and there had been many incidents when Brian was violent towards Alan, several of these incidents involved a knife taken from the kitchen. These incidents usually coincided with periods when Brian refused to take his medication. In August 2011 Brian

started to refuse his medication and despite an increased input from mental health professionals he continued to refuse to take it. As a result of concerns by his family and the mental health professionals involved in his care, a decision was made to assess Brian under the Mental Health Act 1983 to see if he should be admitted to hospital. The assessment took place on 12th September 2011 and it concluded that he was not detainable but a review of his treatment was required and increased visits by his Care Coordinator. Around 22:30 hours the same day, Brian took a knife from the kitchen and fatally stabbed his father several times. Brian was arrested by officers from Kent Police at the scene and was later charged with murder.

On 1st June 2012 Brian pleaded guilty to manslaughter on the grounds of diminished responsibility and was sentenced to a hospital order which had a condition to restrict his discharge indefinitely.
The coroner has decided to hold an inquest even though there has been a hearing at the crown court.

3.5 **Chronology**

Redacted

4 Summary of incidents and analysis of services

4.1 As Brian had been a patient at the same GP and of the same local mental health services, both in the community and as a patient in the psychiatric unit since 1982, the focus of this analysis is on the events since May 2007. The history prior to May 2007 has been summarised to assist the reader with the context. An explanation of how patient information was recorded by KMPT can be found in Appendix F.

4.2 When Brian was first treated by the mental health services details of his condition and treatment provided were held on paper files. There were separate inpatient and community files. Over time electronic systems were also used however the paper file was the 'primary' record and the electronic file was considered as a 'secondary' record.

4.3 During that time entries from the electronic system would be printed out and added to the paper record along with correspondence such as referral letters from GPs and prescription cards.

4.4 In 2011 the existing electronic system was used to create and store CPA documentations including Risk Assessments and Care Plans. Community, Crisis Team and rehabilitation services were using it to make their daily entries. Doctors on inpatient wards would also make entries into it. All departments and trained individuals across the Trust could access the system. Staff in the community teams were able to access the Risk Assessments, CPA documentation, entries by inpatient medical staff but would not have access to the day to day entries made in the inpatient notes by nurses and medical staff. However; on discharge from the ward the inpatient unit would send a detailed discharge summary drawing attention to the key information from that stay to both the community team and the GP.

Any team within the trust could make a request to medical records to have access to any paper record relating to a patient

4.5 Between April and September 2011 a new comprehensive electronic system was rolled out across KMPT and this system was to become the primary health record. During the six month roll out some staff did not have access to the new system until it was implemented in their department. The old electronic system was retained as a read only facility. It was not possible to transfer historic patient records from the old system to the new one. There was a manual transfer of basic demographics and information of clients currently being seen by the Trust, such as name, address, date of birth, GP details, admission (if a current inpatient), open referrals and CPA details. As there was no migration of clinical data, such as patient history and Risk Assessment; care co-ordinators were required to complete up to date Risk Assessments and Care Plans on the new system for each patient open to them at the time. As a consequence of the new system all new information regarding the patient is now held electronically and is available to all staff across KMPT.

4.6 When the new system was first implemented in 2011 there was still a need to have a paper file to hold correspondence and other documents. During the course of 2012 the ability to scan documents was phased in throughout the trust. There has been a reorganisation to the administrative teams so that part of their duties is to scan in documents such as GP letters, discharge summaries etc. When an individual is on an inpatient ward there is a need to have certain documents such as observation sheets and drug charts in paper form. When the patient is discharged from the ward or when the paper file is full it is sent to medical records so that any documents contained within this can be scanned and uploaded to the system.

4.7 Brian was first seen by the mental health services in April 1982 when he was admitted to a psychiatric unit for the first time having been referred by his GP. Brian was suffering from acute confusion with paranoia. Various tests were carried out as it was thought there may have been a physical cause for his confusion, however the tests were inconclusive. Once his confusion lifted he became depressed and he was treated with electro convulsive therapy (ECT). Brian remained in the psychiatric unit for several weeks and was discharged from the unit on 13th July 1982. Brian then attended outpatient appointments and as he remained well, he was discharged from the mental health services on 9th September 1983 to the care of his GP. At the time of discharge to the GP he was not prescribed any medication.

4.8 On 11th September 1991 Brian was admitted to the psychiatric unit after concerns were raised by his family about his behaviour which had come about because of various stressors in his life. One of the incidents involved Brian brandishing a knife in his parent's kitchen. This was the first recorded incident involving any violent behaviour by Brian towards his parents. Brian stated that he had suffered from auditory hallucinations (hearing voices) and feeling 'down in the dumps' but denied any suicidal thoughts or feelings of paranoia, although he said that the council had bugged the flat he had moved into. A medication regime was commenced and a diagnosis of schizophrenic psychosis – paranoid type was made prior to discharge which occurred on 9th October 1991. Brian did not comply with the medication regime and his behaviour became bizarre, including one occasion when he asked

his sister to 'stab him'. As a consequence he was readmitted after an outpatient appointment on 24th October 1991. After taking his medication improvements were seen very quickly and it was decided that a depot injection (slow release of medication) would be added to the regime in addition to the oral medication.

4.9 He was discharged on 6th November 1991 and then monitored through outpatient appointments, during this time Brian stated that he was feeling drowsy and forgetful at times and concerned about the dangers of using the machinery at work; as a consequence his oral medication was reduced. Brian was concerned about losing his job because of his mental illness and he admitted to hearing voices but they were 'outside of his head'.

4.10 On 24th March 1992 as a result of his worsening mental state and because he had assaulted his father in an unprovoked attack Brian was admitted to the psychiatric unit. He stated that his father was 'Count Dracula' and felt that his father was going to harm or kill him. He also said the voices had become increasingly troubling and was afraid of being in his own home. Brian responded quickly to the medication and his psychotic symptoms disappeared within forty eight hours and he started to sleep well. He was discharged in April 1992 and was monitored through outpatients, continuing with his medication, both oral and through the depot injection.

4.11 In November 1993 Brian was admitted to the psychiatric unit after a referral from his GP as his mental state had broken down and he had stabbed a colleague at work with a pair of scissors because he thought he was a snake and the voices told him to do so. The referral letter stated that Brian had for the last three to four weeks been feeling frightened and behaving oddly at times. Brian's medication was increased and he was discharged on 30th November 1993 and monitored through outpatients. Brian left his employment after the incident and never worked again. The assault was never reported to the police.

4.12 In April 1995 Brian was assessed in the local Accident and Emergency Department having been referred by his GP because of his deteriorating mental state. Brian's sister stated that he was suffering from sleep disturbance and was abrupt and irritable with those around him. She was of the opinion that one of the stressors was because their father had signed over the family business to Brian and that the parents had sold the house to Brian for the full asking price. Brian refused to enter the psychiatric unit but did agree to an increase in his medication. Brian did say he wanted to be more independent of his parents. He continued to be monitored through outpatients.

4.13 In October 1995 Brian was again admitted to the psychiatric unit following a breakdown in his mental state. He had stopped taking his oral medication although he continued with the depot injection. There had been another incident with Brian holding a knife over his father's head and calling him 'Dracula'. Brian stated that he thought his father was bad and was trying to harm him so he decided to stab him. It was believed that Brian was jealous of the time his father spent with his mother and the friction in the house appeared to increase if his father had been drinking. This was the first time that Alan's consumption of alcohol may have been an issue however this does not appear to have been explored by KMPT staff. A decision

was made by the consultant psychiatrist to refer Brian to the Forensic Psychiatry Team for assessment. Brian's name was also placed on the supervision register (see Appendix C) as it was considered Brian posed a serious risk of violence to others. It was an appropriate decision to refer Brian for a Forensic Assessment because of the continued violent events involving knives. The Forensic Team carried out the assessment on the ward and concluded that the risks increased when Brian did not take his medication; therefore it was recommended that the depot injection dosage should be increased with a view to removing the need for oral medication. The registrar from the Forensic Team noted that in his opinion when well; Brian presented little or no risk of violence, however when psychotic 'he obviously presents a significant danger of violence especially to members of his family'. The increased use of the depot injection would also enable additional monitoring, especially if Brian declined to accept the injection. The registrar agreed with the consultant psychiatrist's proposed rehabilitation plan which included the statement 'all staff involved in his care to be fully aware of his need to take medication and the necessity to alert health professionals should he show signs of becoming unwell or become non-compliant'. It was also agreed that structured daytime activities should be put in place to alleviate tensions in the home. This was the first time that the issue of family dynamics was raised. On 23rd January 1996 Brian was discharged from the psychiatric unit and his name was removed from the supervision register. The decision to remove his name after only four months is questionable, especially as he was returning to live with his mother; and his father who in the main was the victim of his violent outbursts.

4.14 Between 1996 and May 2000, Brian was monitored through outpatients and other than spells of reluctance to take his medication which were resolved; he remained well and had no admissions to the psychiatric unit.

4.15 In May 2000 Brian refused all medication other than anti-depressants which led to his mental health deteriorating and on 16th June 2000 he was admitted to the psychiatric unit. In 1999 the community consultant psychiatrist who had treated Brian since 1982 had handed over the case to another community consultant psychiatrist. Brian had not had a depot injection for seven weeks and had become hostile towards his father again; Brian admitted holding a knife to his father but stated 'I would not have hurt him'. It was recorded that Brian lacked insight and could see no reason for his admission and so he was admitted under Section 3 of the Mental Health Act 1983 (see Appendix C). He was discharged on 12th July 2000 after periods of home leave. Brian was then monitored through outpatients with no issues and on 9th October 2002 his depot injection was reduced as he was a little drowsy as a result of the injection.

4.16 On 16th December 2002 Brian was admitted to the psychiatric unit as he had refused the depot injection stating he 'felt well' although he acknowledged he suffered from schizophrenia. He did state that one of his problems was that 'he could not get on with his parents'. On 19th December Brian left the ward without agreement and this was reported to the police. He was located the following day by the police and returned to the unit. This was the first time that the Kent Police had any dealings with Brian. Brian then agreed to restart his depot injections and his condition improved, although he did try to leave the ward another four times. A decision was made that if he did make an attempt to leave the ward again the

Mental Health Act would be used to detain him, as the consultant psychiatrist stated that he was not well enough to be discharged. After some spells of home leave Brian was discharged on 9th March 2003.

4.17 Between 2003 and May 2007 Brian remained well and was monitored through outpatient appointments. On 21st May 2007 Brian was reported to the Kent Police as a missing person as he had gone out that morning in his car and not returned. The police commenced a missing person enquiry and on the 23rd May 2007 he returned home of his own accord; when he was spoken to by police he refused to say where he had been. As part of the missing person enquiry the police liaised with the mental health services. Then on 24th May 2007 the Crisis Home Treatment Team (CHTT) became involved as Brian had again refused his medication and his mother reported that he was becoming increasingly hostile. Brian agreed to return to the psychiatric unit on 31st May 2007 and commenced oral medication. Brian had been refusing his depot injection since February 2007. He was discharged on 10th June 2007.

4.18 A pattern was beginning to emerge of Brian being compliant with the medication regime for a period of years and then when he stopped taking the medication his mental health deteriorated necessitating admission to the psychiatric unit. The other significant issue was that Brian had a difficult relationship with his father, who was now in his early sixties and Brian had threatened him with knives and assaulted him in the past.

4.19 On 23rd June 2007 the police were called to the home address as Brian had refused to take his medication and an argument ensued with Brian assaulting his father. Brian was arrested, taken to the police station and was interviewed. During the interview he admitted pushing his father as he was confronting him and therefore it was self-defence. Brian was released without charge as Alan was unwilling to support a prosecution. The police informed the mental health services of the incident. The incident was recognised by the police as domestic abuse and a Risk Assessment using SPECSS+ (see Appendix C) was carried out and the risk was classified as medium. Brian's father was given safety advice by the police. There is no information if the mental health services took any action when they were informed about this assault by the police. As there was no prosecution and no further action by Kent Police or KMPT this was an opportunity missed to have referred the family to another agency to obtain assistance. The family could have been referred for floating support which is commissioned by Kent County Council or they could have been advised to seek support from the local mental health charity MIND. The author has been unable to identify any specialist services either locally or nationally that would have been available to assist a family where a mentally ill adult son has assaulted an ageing parent.

4.20 On 29th June 2007 Brian's niece contacted the police to report him missing. She explained his history of mental ill health; that he had not been taking his medication and that he had taken his car, dog and clothes. The police made a decision not to treat him as a missing person as they were of the view that he was free not to return home. This was a wrong decision bearing in mind his vulnerability and that the police knew he could be violent when he had not taken his medication. This

decision was also made in isolation without seeking any expert medical opinion from the mental health services.

4.21 On 10th August 2007 Brian did not keep his outpatient appointment but his parents did attend and spoke to the consultant psychiatrist. They informed the consultant that Brian had stopped taking his medication and was becoming aggressive, both physically and verbally towards them both. Brian was also laughing and talking inappropriately to himself. The consultant advised Alan and Clare that he planned to admit Brian to the psychiatric unit using the MHA if necessary. According to Brian's sister a doctor and an ambulance attended the home address with a view to detaining Brian, however he promised to take his medication which he did in their presence and so he was not sectioned. This was an example of Brian convincing the health professionals that he did not need to go to hospital with serious consequences the following day.

4.22 On 11th August 2007 police attended the home address as Brian had threatened his father with a knife and assaulted him. Brian was arrested and taken to the police station where it was decided that he was psychotic and unfit to be detained or interviewed. The assault was recognised by the police as being an incident of domestic abuse and a Risk Assessment using the SPECSS+ Risk Assessment tool was carried out. The risk was classified as being medium; safety advice was given to Brian's father by the police. When Brian's sister reported the assault to the police she stated 'if my Mum hadn't heard what was going on my Dad wouldn't be here'.

4.23 Brian was taken to the psychiatric unit for assessment where he was admitted for the tenth time in twenty five years. He was detained under Section 3 of the MHA. It was not until 20th August 2007 that the depot injections were re-commenced and they were dispensed against his wishes, therefore he had to be restrained whilst they were administered. During the stay in the unit Brian claimed his father drank heavily and also that his parents were trying to take the house from him. The house had been transferred to Brian's name along with the family business in about 1990 because Brian's father was declared bankrupt, although Brian's parents continued to live there and pay bills. During a ward round on 29th August 2007 it was agreed that family therapy should be offered to the family. This was never arranged and this was a missed opportunity by the mental health services to discover more information about the family dynamics, in particular regarding the house ownership, Brian's relationship with his parents and the comment about Alan drinking heavily. There is no evidence to say that the mental health services recognised this as an incident of domestic abuse. This assault occurred before the introduction of Multi Agency Risk Assessment Conferences (MARACs) in Kent. However, either the police or the mental health services could have called a professionals meeting to discuss the case as there were several issues that merited discussion on a multi-agency basis, such as increased violence, use of weapons and the vulnerability of Brian's parents. The holding of a professional's meeting is not usual practice although it is a recognised response to a case involving more than one agency.

4.24 On the 3rd September 2007 a Care Programme Approach (CPA) (see Appendix C) review was carried out and it was recorded that CPN 2 was to request a vulnerable adult safeguarding meeting to consider the allegations made by Brian regarding his parents trying to get him to sign the house back to them. It was also recorded that

Brian wanted to live with his parents as he would be lonely if he didn't. Brian also stated that his father had been drinking heavily for years. The benefits of family therapy were also explained to Brian. There was no record on the medical file of any follow up with adult social care regarding the safeguarding referral and no indication about arranging family therapy. There was also no attempt to confirm the issue about Alan drinking heavily even though this was the third time that Brian had commented about it. There is a record on the Kent County Council electronic system for an adult protection alert dated 25th September 2007 created by a KMPT practitioner that mentions issues regarding Brian and his parents. The entry however was of a poor standard and no actions or outcome was recorded and the entry was closed on 15th October 2009. This failure to record information accurately and then to follow it up, regarding both the adult protection allegation and the referral for family therapy was poor practice.

4.25 On 20th September 2007 Brian was discharged. At the review prior to his discharge, tension between Brian and his father was discussed and family therapy was again mentioned. It was recorded that there may be difficulties for Brian's father to get time off work to attend and they should wait to hear about his availability. This admission to the psychiatric unit was a significant missed opportunity by KMPT, as they had recognised that the family required some intervention and that there was an adult protection allegation, in addition to the risk that Brian posed, however they failed to follow up these issues.

4.26 On 26th September 2007 Brian's mother attended the GP surgery and requested a letter for the local housing department to support their application to be re-housed by the local authority. The GP sent a letter to the housing department on 1st October 2007 and they received a response on the 9th October 2007 outlining the assistance the council was providing to Brian's parents regarding re-housing. There is no record of the GP sharing this information with the mental health services or providing any additional support to Brian's parents.

4.27 On 2nd October 2007 at a CPA review, it was recorded that Brian's parents had moved out but no detail of where they had moved to. Brian was pleased about this as he said that it was the pressure they put him under that caused the aggressive outbursts. There was no record of any contact being made with Brian's parents by any of the health staff involved in this case to confirm the details of this and to offer them any support. This was poor practice by the mental health staff. At this stage Brian was still compliant with his medication. The issue of housing for the family was significant and bearing in mind the age and vulnerability of his parents, a professionals meeting for all of those agencies involved in this case would have been beneficial, to both the family and the professionals accepting that this is not usual practice.

4.28 On the 16th October 2007 Brian refused his depot injection and when he attended outpatients on 19th October his mental state was deteriorating, therefore it was decided to carry out an assessment under the MHA. On 26th October Brian was admitted to the psychiatric unit under Section 3 of the MHA. It is recorded that Brian had become abusive towards his parents, that he lacked insight and was disengaging from the medical staff that he had previously had a good relationship with. Brian displayed a great deal of anger and frustration towards his father. The

depot injections were restarted. On 3rd November staff overheard Brian on the telephone to his mother and accusing her of getting him admitted so she could have his house.

4.29 On the 7th November 2007 during a ward round, Brian again raised the issue of his parents exploiting him financially; however CPN 2 stated that Brian denied this whilst in the community. The matter of the house ownership and the financial situation was an on-going theme which the staff did not appear to take seriously and missed an opportunity to have a meeting, discuss it fully and to engage with all parties. This should have been considered as an adult protection matter.

4.30 As Brian was compliant with his medication and had a series of successful home visits; on 20th November 2007 his section was lifted and he agreed to remain in the unit informally. On 3rd December 2007 Brian's case was discussed at the ward round; it was reported that his mother had said that he was compliant with his medication. Brian reported that things had improved a little bit in regard to his relationship with his parents but they were still looking to move out. Comment was made that family therapy had not started and it was requested that the CPN should follow this up. A decision was made to discharge Brian and that the next depot injection would be administered on 7th December at the GP surgery. Brian did not attend his seven day post discharge appointment and there is no record of this being followed up. The family therapy was again not followed up and these missed opportunities are considered a failure to take action, as well as a lack of management oversight by the consultant psychiatrist and the service manager of the Recovery Team as this was now four months since family therapy had first been agreed.

4.31 The events of 2007 were very significant, with several hospital admissions after violent incidents and non-compliance with his medication. In addition there were tensions regarding the ownership of the house as well as the involvement of the police with Brian. All of these matters should have been identified as requiring a review of the extensive and complex history of Brian and his family to ensure that the response to Brian and his family was appropriate. The increased violence and emerging patterns of Brian's behaviour were not recognised and this was an opportunity missed by mental health professionals to reconsider the treatment plan and to consider formulating a plan for the future. The DHR panel concluded it was highly likely that Brian would not comply with his medication resulting in violent behaviour, probably towards his father at some stage in the years to come.

4.32 Brian then complied with his Care Plan; attending appointments and accepting his depot injections and on 12th August 2009 his case was discharged to the GP with the same plan of medication to continue.

4.33 On 21st June 2010 the records state that Brian had a depot injection, although it is recorded that the GP Practice Nurse contacted the Access Team on 24th June reporting that he was refusing his depot injection and that his mother was concerned he was relapsing. The information was passed to the Recovery Team. There is no record of any action being taken which is poor practice. Although the GP records stated that the Recovery Team informed the practice nurse that they had spoken to Brian and his mother and that he was refusing medication and

contact with the Recovery Team. The Recovery Team suggested that the surgery made contact with Brian in a weeks' time to see how he was getting on. On the 2nd July 2010 the practice nurse contacted Brian who said he would go and see the GP.

4.34 According to the KMPT IMR Brian refused his depot injection on 1st October 2010, however the GP report stated that the GP gave the injection successfully. When he attended the surgery with his mother she reported that Brian was gradually going downhill, he had a poor sleep pattern and was rude to his parents.

4.35 Brian was admitted on 5th October 2010 to a psychiatric unit in another town in Kent having been assessed at the local hospital. Brian was accompanied by his mother and it was reported that he had been verbally aggressive to his father and that he presented as paranoid with disordered thoughts. Brian described himself as having a 'dying condition' but did not expand on what this meant. On 12th October he was transferred to his local psychiatric unit. During his admission he refused his depot injection but agreed to oral anti-psychotic medication.

4.36 Brian was discharged on 3rd November 2010 even though he continued to refuse the depot injection and refused to work with the Crisis Home Treatment Team. Brian did say he would talk to his GP or the Access Team if he had any issues. This decision appears questionable taking into account his history of non-compliance and there is no record of any engagement with his family.

4.37 On 16th November 2010 Brian's sister telephoned the Crisis Team as she was concerned that Brian was not taking his medication as they had found tablets around the house, she made several other calls during this time because of her concerns. An appointment for the 22nd November 2010 was offered. The following day Brian's sister contacted the Access Team to say he had slept better and it was agreed that the Access Team would attend that day. When they attended Brian expressed some paranoid ideas around his parents but he did agree to take his oral medication until the review on the 22nd November 2010. On the 19th November 2010 Brian attended the GP surgery with his mother and Brian complained of side effects from the medication. The GP reduced the dose of his anti-psychotic medication from 600 mg to 300 mg without any liaison with the mental health team even though the dosage had been doubled during his recent admission. The details of his medication during his admission were included in the discharge summary sent to the GP on the 8th November 2010. KMPT relied upon the accepted practice of communicating with the GP by sending the GP copies of the discharge plan. It is not known if the GP read the discharge plan either on receipt or before making this decision.

4.38 On 22nd November 2010 Brian, accompanied by his mother and sister, saw the consultant psychiatrist from the Access Team. His mother and sister stated that he was being aggressive and not taking his medication regularly. Brian admitted spitting out his medication once since being discharged and complained that the tablets made him drowsy. It was agreed to continue him on oral medication.

4.39 On 26th November 2010 Brian's sister contacted the Access Team as she was concerned he was not taking his medication and as a consequence the Community psychiatric nurse (CPN 3) telephoned Brian who said he was taking his medication

and felt 'ok'. Brian refused to let the CPN speak to his mother stating 'he was a man in his forties and did not need his mother to intervene'. On the 2nd December 2010 Brian's sister contacted CPN 4 from the Access Team raising concerns again about Brian's mental state and that he was turning members of the family away when they tried to visit and he was not sleeping. The CPN spoke to Brian's mother who said although he was taking his medication it was not having the same effect the depot injections had. The CPN advised Clare to call the police if Brian became aggressive. The CPN did not advise the police they had given this advice which was poor practice, especially as the police had limited dealings with this family and the last being in 2007. The benefit of informing the police would have been that they could have recorded relevant information about Brian on their command and control system, such as his treatment plan and names of staff involved in his care. In the event of the police being called; this information would have been available to the officers attending. The CPN made a decision to discuss Brian's case at the next allocation meeting and to consider holding a home assessment.

4.40 On 6th December 2010 CPN 3 telephoned Brian's mother and informed her that Brian would be discussed at the next meeting. Brian's mother informed them that she had found Brian's tablets in the bin and that his behaviour was better when he was on the depot injections. She also said he was irritable and they tried not to upset him. She also commented that they had all been out to a restaurant the previous day and Brian had been fine. On the 7th December 2010 Brian's case was discussed at the allocation meeting and it was acknowledged that Brian did not want to engage with the service and he lacked insight. The case was allocated to a Social Worker to review and consider whether an assessment under the MHA was required.

4.41 On 21st December 2010 according to the KMPT IMR, although no mention is made in the GP report, the GP contacted the Access Team requesting that Brian was restarted on the depot injections. After a discussion with the team leader, the social worker and the GP this was agreed on the 23rd December 2010 and the case was allocated to CPN 5. The GP was requested to prescribe the medication due to the non-availability of medical staff from KMPT.

4.42 On the 7th January 2011 CPN 5 telephoned to introduce herself to Brian who stated that he was taking his oral medication but became angry when asked about starting the depot injections and said he was refusing to because of the side effects. Brian refused to have any more contact with the Access Team. CPN 5 then had a discussion with the team leader and it was suggested that Brian should be referred to the Assertive Outreach Team. At an interface meeting on 17th January 2011 it was decided that it was not appropriate to refer the case to the Assertive Outreach Team but the case should be allocated to the Recovery Team.

4.43 On 19th January 2011 Brian's sister contacted CPN 5 and stated she was concerned about Brian's care package and that he was being aggressive. CPN 5 and a colleague attended the home address and Brian admitted that he had now stopped taking the oral medication as well. It was recorded that Brian denied any homicidal or suicidal thoughts and he would start taking the oral medication. It was recorded that the family agreed to the plan, however it is not recorded who CPN 5

actually spoke to. It was also agreed that the medication would be reviewed the following week.

4.44 On 20th January 2011 Brian's case was discussed at the Access Team Allocation meeting and a decision was made to try and engage with Brian as most of the contact had mainly been by telephone. This was an appropriate decision. It was surprising, that taking into account the background to this case and the issues with his parents, professionals had not previously recognised that assessments could not be successfully carried out over the telephone.

4.45 On the 25th January 2011 CPN 5 attended the home address and after speaking to Brian they came to the conclusion that he should be admitted to the psychiatric unit because of his mood and behaviour. Brian agreed to an informal admission but he was advised that if he tried to leave then use of the MHA should be considered to detain him. Brian was anxious, disorientated and it was recorded that he had been tearful and paranoid; ruminating over past events. It was recorded that the family felt unsupported by the Access Team and that Brian had required admission for some time. At 15:00 hours on the 27th January, Brian was detained under Section 5(2) of the MHA as he was refusing to remain on the ward, he stated that he wanted to go to his flat but refused to be escorted. Brian was still living at home with his parents, therefore this mention of the flat was either a mistake in recording, or that Brian was confused or attempting to manipulate the professionals. A full assessment was carried out at 16:30 hours and the Section 5 detention was lifted as Brian agreed to remain voluntarily at the unit. Brian did agree to take his depot injection which was administered at 20:30 hours that day.

4.46 On 31st January 2011 at an interface meeting between the Access Team and the Recovery Team, it was decided that Brian would require long term support from the Recovery Team because of the recent admissions being in quick succession. On 3rd February 2011 the case was allocated to CPN 6 who was a senior nurse practitioner from the Recovery Team to act as the care co-ordinator.

4.47 On 14th February 2011 Brian's case was discussed at the ward round and it was recorded that Brian had been on home leave but had not taken his tablets as his mother had found them in the bin. Brian had also refused to take any further medication including that morning's dosage. Brian denied not taking his medication. Despite all of this it was agreed he could go on home leave from 18th February. The records state that during the weekend leave his behaviour and speech were bizarre. The KMPT IMR records that the signature of the person making this entry on the file was unreadable. This is one of many entries on the health files that have signatures which could not be identified. This is poor practice that staff did not print their name when signing records if their signature was not clear. This is contrary to accepted practice.

4.48 On 21st February 2011 a CPA review was held which Brian's parents and sister attended. They reported that Brian's behaviour was bizarre including 'standing naked' in his parent's kitchen and he said he 'had taken off his dressing gown to stop it getting wet'. It was also recorded that he had been making racist comments. On 28th February Brian's case was discussed on the ward round. It was mentioned that Brian had been grumpy during a spell of home leave according to his mother

and that his sleep had been erratic. The medication was altered to try and secure a more restful night.

4.49 On 2nd March 2011 a decision was made to discharge Brian and as part of the Care Plan he would be visited twice daily by the Crisis Team. His next depot injection was due to be given on 10th March and then at fortnightly intervals. The Crisis Team CPNs 7, 8, 9 and 10 then visited Brian over the next three days; although he was compliant with his medication his sleep pattern was erratic and this was affecting his parents. On one occasion medication was posted through the letter box which appears to be inappropriate practice. During the visit on the 6th March 2011, Brian and his mother were arguing about Brian telling his mother where he was going and the issue of the parents moving out was again raised by Brian. A decision was made by the Crisis Team to add night sedation to his regime.

4.50 On the 7th March 2011 Brian's mother telephoned and spoke to CPN 7 and reported Brian was irritable and had not been sleeping. CPN 7 advised that the depot injection, which was due in three days, might help if his behaviour was due to his illness. CPN 7 also stated that the level of high expressed emotions in the house could also be contributing to Brian's behaviour. This comment appears to be extraordinary bearing in mind Brian's parents had been coping with his mental ill health for thirty years and CPN 7's first contact with the family had been five days previously. At 14:30 hours that same day the Team Doctor attended with CPN 11; the doctor felt Brian showed little insight and although he was not refusing outright he did appear reluctant to have his depot injection. The records stated that night sedation for two weeks was added but it is not clear if this was in addition to the sedation added the day before. The standard of record keeping by health staff on several occasions was poor. At 18:00 hours the same day Brian's sister telephoned CPN 9 of the Crisis Team and stated that Brian was irritable, she felt Brian had been discharged too early and that staff only saw one side of Brian. CPN 9 agreed to raise the matter with the team leader.

4.51 On 8th March CPN 12 and CPN 13 carried out a home visit and recorded that Brian's sleep pattern had not changed and he was compliant with the medication. It was also recorded that Brian was exercising by walking the dog and he planned to attend a local art group. After a discussion with the hospital consultant psychiatrist it was decided to add another medication to Brian's oral dosage to try and treat his irritability. The review panel could not understand the decision to add another drug to the oral medication as it was already known that Brian had previously refused to take his oral medication.

4.52 On 9th March 2011 the records stated that an associate specialist (doctor) spoke with Brian on the telephone to remind him that if he took the anti-anxiety medication it may make him drowsy and so he should not attempt to drive, this is the first occasion that an issue regarding his driving was recorded. The notes also recorded that family dynamics were contributing to Brian's behaviour and the team were going to speak to the consultant about this. Later that day Brian's sister telephoned and spoke to CPN 12 and told them that once Brian had come off the telephone from speaking to the associate specialist he became very hostile to the family. Brian was upset about not being able to take the anti-anxiety medication and drive. Brian's sister also stated she felt he had been discharged too early.

4.53 The review panel were concerned that the mental health services did not recognise the pattern was again developing and they did not identify that the police could have been informed of the situation, as it was likely the family may need to call them if Brian's behaviour deteriorated. The benefits of multi-agency information sharing and planning an agreed response are recognised as being good practice.

4.54 At 21:13 hours on 9th March 2011, Brian's mother called the ambulance service and the police as Brian had threatened to kill his father with a knife. Uniformed police officers attended and ascertained from Brian's parents what had happened that evening; the history and that the Crisis Team was visiting twice daily. After the incident Brian's father contacted the Crisis Team who said they could not become involved until the police had made a decision whether Brian was to be arrested. A decision was made by the police to contact the psychiatric unit who agreed to admit Brian informally and he was taken there voluntarily by the police. There is some confusion about how this matter was resolved as some of the KMPT records stated that the police detained Brian using their powers under Section 136 of the MHA, however, it has been confirmed that Brian attended the unit voluntarily.

4.55 Brian was taken to the psychiatric unit where the Crisis Team assessed him. When he was assessed he was calm but appeared confused and disorientated; he commented that his 'family winds him up'. Brian agreed to be admitted informally. When Brian was admitted he stated that it was not all his fault and the family had ganged up on him, although he did admit holding the knife to his father but he had done this because his father was drunk and had been abusive towards him. The police report makes no mention of the father being drunk. Family therapy was again suggested but again this was not followed up. This was the fourth time that Brian had alleged that his father had an alcohol problem however again the matter was not clarified with the family. When Brian's father was spoken to by the police he made it clear that he did not want to support a prosecution regarding the incident. The police officer that dealt with this incident, having spoken to the psychiatric unit and taken advice from his supervisor, made the decision to take Brian to the unit. The officer did consider arresting him and taking him to the police station, however he made a pragmatic decision based on all of the information available to him. The incident was recorded by the police as a non-crime incident rather than a crime which is a questionable decision as there was evidence of a criminal offence having occurred. It could be argued that Brian's mental state prevented him from having the required mental capacity to commit a crime; however it is not usually the case for patrol officers to make that decision. The officer did recognise the matter as being a domestic abuse incident and carried out a DASH-RIC Risk Assessment (see Appendix C). The Risk Assessment concluded that the risk was medium.

4.56 The family state that after Brian was taken to the unit they received a telephone call from a member of staff requesting that Brian was collected and taken home. The reason given to Brian's sister was that they could not be involved in domestic disputes. Brian's sister refused to collect Brian. Brian's sister has been told by a mental health professional that a record of this telephone call is in the notes however this review has been told that there is no record in the notes of this conversation. Brian remained in the hospital. Details of other telephone

conversations between KMPT staff and the family are recorded in the notes. If this was said by the member of staff it displayed a lack of understanding of their responsibility in dealing with domestic abuse, mental ill health and adult protection both to Brian and his parents. In a telephone conversation on 10th March between one of the Doctors, Clare and Brian's sister, they spoke of their concerns which included:-

- Problems with Brian since his discharge and described him as having a 'Jekyll and Hyde ' character, and that as soon as he was home he appeared paranoid and was aggressive towards his parents and sister, particularly towards his father.
- That they had requested an assessment on two occasions and that they had asked the associate specialist the previous day to admit him but the doctor recommended sedation.
- That he had not been sleeping; was paranoid and described the incident involving the knife and his father. They described the incident as being unprovoked.
- They were concerned for Alan's safety as a frail 71 year old if Brian's aggression continued.
- Brian's sister asked 'who would be responsible if he ended up killing Alan on one of these occasions'.

The doctor advised the family of the treatment plan.

4.57 On 10th March 2011 a note in the health file records that the police made contact with CPN 6 to say that Brian had been detained under Section 136 the previous night when he had allegedly been threatening his father with a knife. When the domestic abuse report and Risk Assessment was considered by the Public Protection Unit (PPU) Supervisor it was downgraded to standard risk as Brian was in hospital. This decision is questionable as Brian was only there as a voluntary patient and could leave at any time unless the staff used the MHA to detain him. An officer in the PPU, who specialised in adult protection and mental health matters, spoke to CPN 6 by telephone and requested that health arrange a professionals meeting before Brian was discharged in order for the police and other agencies to discuss plans to reduce the risks that he posed. There is no record of this request in the health file. This request by the police is significant as there is no policy or guidance regarding the calling of such a meeting; however it does display initiative by the police officer who had recognised the risk that Brian posed and correctly took positive action to reduce that risk. The officer should be recognised for this positive action. It will be seen later on in this report that the meeting never took place. As the assault was dealt with by Kent Police and KMPT primarily as an incident of mental ill health and no prosecution or further action was taken this was an opportunity missed for a referral for additional support for Alan and Clare. As mentioned at paragraph 4.19 the family could have been referred for floating support or advised to contact MIND for assistance.

4.58 On 14th March 2011 a care manager assistant attended the home address as Brian's mother had requested a Carers Assessment as she was worried about the housing situation. During the visit Brian's mother was advised to contact the Citizens Advice Bureau about the house ownership issue. The same day on the

ward round, it was decided that the care co-ordinator (CPN 6) should explore a referral for family therapy; this never happened which was a continued failure by the unit staff and the CPN to follow through with agreed actions. The significance of the family situation cannot be under estimated in this case and it is disappointing that the mental health professionals involved did not respond accordingly. The lack of review and supervision with regards to this action was a failure.

4.59 On 21st March 2011 during the ward round, a discussion regarding Brian's home leave the previous day took place, it was reported that it had not gone well and Brian's mother had indicated she was unable to cope with any more home leave. Brian stated he felt bad but did not elaborate and when staff tried to discuss the knife incident with Brian he left the room and there is no record of this lack of engagement being challenged by staff.

4.60 On 23rd March 2011 a CPA discharge meeting was held involving the same consultant psychiatrist and doctors that had been on the ward round on 21st March, and CPN 6 as well as the ward manager. The incident resulting in Brian's admission and the issue of Brian getting legal advice before making any decision about signing over the house to his parents were discussed. A decision was made to discharge Brian who accepted his depot injection prior to discharge. There is no record of any discussions with Brian's parents or the police about this decision and the possible impact on the family. The comment from Brian's mother about not being able to cope appears to have been ignored as does its significance, as Brian had usually related well to his mother and they have been described by the family as being very close. The decision to discharge him may have been a sound medical decision; however the lack of engagement with the family and the police was a significant failure by the mental health team not recognising their duty in protecting Brian's father and mother who both could be considered vulnerable due to their age and that Alan had been assaulted by Brian in the past. The concerns of the family were very explicit in the telephone calls from the family to KMPT on 9th and 10th March 2011 and appeared to have been ignored. The team also did not recognise the need to alert the police that a man who has a significant mental health history, coupled with a predilection for using sharp instruments was being released into the community and back to a difficult family situation. There appeared to be a lack of acknowledgement of the risk of harm that Brian posed. The meeting that had been requested by the police prior to Brian's discharge never took place and there is no record of the police being told by health that he was to be released.

4.61 At 09:15 hours on 24th March 2011, Brian's sister telephoned CPN 2 and raised concerns that Brian had been discharged too early and that he had made threats towards his mother saying if he became ill again 'she was dead'. The CPN spoke to Brian on the telephone and he admitted that he had said if he became ill again his parents were to blame. The issue of the house ownership was also raised by Brian saying that his mother wanted the house so that if he threatened them again they could throw him out. The CPN advised the mother to call the police if Brian continued to threaten them again. The CPN did not contact the police, which was again evidence of the continued failure of the mental health services to work with the police to reduce the risk that Brian posed to his parents. By dealing with this matter over the telephone and not visiting the home to carry out an assessment was also a failure to take any positive action themselves.

4.62 On 24th March 2011 the care manager assistant updated Brian's mother to say she had completed the Carers Assessment. The care manager assistant had already referred Brian's mother to the local MIND for support. Brian's mother again raised the issue of having the house signed over to her and her husband so they could get Brian to leave if he threatened them again. The care manager assistant discussed this issue with CPN 6 who stated, that as Brian had capacity, Brian could decide what he wanted to do with his property and CPN 6 said they would monitor the situation. The house ownership situation was never subject to any formal discussion between professionals and all of the family members, which is surprising as this had been an issue that had caused tension for several years.

4.63 On 7th April 2011 Brian's case was discussed at the local Clinical Risk Management Forum for the Recovery Team. The risk forum had been established in 2009 and their purpose was to provide a Multi Professional Clinical Review Forum for high risk cases to contribute towards community safety and local risk management. The meetings are held every month and are usually chaired by the consultant psychiatrist or the service manager. The Risk Forum is not a formal process; it is a meeting that allows clinicians to voluntarily bring difficult cases to discuss which may assist with new ideas to input into the Care Plan. The meeting was attended by the consultant psychiatrist from the Recovery Team and CPN 6. CPN 6 had referred the case to the meeting and he presented the case. The minutes stated that Brian had a history of schizophrenia and he was living with his parents, there was a very fraught home situation, particularly with his father who abused alcohol. The discussion included the issue of the house ownership; his recent admissions, poor sleep pattern and non-compliance with medication. Details of the incident leading to his admissions were discussed including the incident with the knife. It was recorded that Brian had said afterwards that he and his father had both been threatening during an argument. The risk discussed was that Brian's parents had alluded to ward staff that if Brian signed the house over to them he could get re-housed by the council and this would be better for family members. It was noted that this has cropped up in the past. It was also stated that there were frequent arguments in the family, with lots of tension. The only concern was about exploitation. It was stated that there was no forensic history which was incorrect as there had been a Forensic Assessment in December 1995. Brian had never received any services from the Forensic Team nor had he been charged with any criminal offences; therefore in strict clinical terms he had no formal forensic history.

4.64 This forum failed to consider all of the aspects of this case. The paper file which held important historic risk information was not examined. The focus of the risk appeared to consider current risk factors and diluted those that would have supported the historic perspective of threats to Alan, even though the last episode of violence against Alan had occurred less than a month previously and that Brian had recently made threats to both of his parents which were recorded on the KMPT file. No evidence of Alan abusing alcohol has been presented to this review and the family have stated that he did not have a problem with alcohol misuse. The source of this information is not documented and it appears to have been information obtained from Brian; however the minutes infer it is fact rather than a comment from the patient. This matter should have been clarified by a member of staff to enable the team and the forum to give due weight to the information and respond

accordingly. One option open to the forum was to refer the case to the Directorate Community Safety Group to enable effective managerial and corporate risk management. It is possible that if all of Brian's history and the concerns of the police, as well as those of the family had been shared then the case may have warranted referral to this group. Learning from this case has been fed back into the working practice of the risk forum.

4.65 Brian's mental state was monitored by CPN 6 over the next two weeks and when he began to deteriorate Brian reluctantly accepted his depot injections. His sleep pattern was also erratic. The Crisis Team also became involved and eventually he was admitted on 12th April 2011 as the previous day he stated he had thoughts of hurting others which he later denied. His behaviour at home and then on the ward was described as bizarre. The hospital consultant psychiatrist requested a review of all admission records held on Brian, paying particular attention to the medication prescribed. This was conducted by CPN 6 the allocated care co-ordinator for Brian. This reflected good practice and for an individual who had been subject of so many admissions; a chronology of events is a good method of reviewing the history and identifying any reoccurring themes. It was through this action that on 20th April 2011 Brian was put back on his original depot medication that he had started when he was first diagnosed with schizophrenia which had been so effective in the past. He then made good progress and his mental state improved considerably.

4.66 On 5th May 2011 Brian's case was discussed at the local Clinical Risk Management Forum for the Recovery Team. CPN 6 attended the meeting; the consultant psychiatrist gave their apologies. A discussion took place regarding the ownership of the house and the incident on 9th March 2011. The minutes also stated 'there is a huge difference from what the parents perceive as risks around Brian living with them and other agencies'. CPN 6 was given an action to establish if Brian held the mortgage on the house or if it was in joint names with his mother. The minutes do not record who made the statement about perception of risk and there is no explanation of which other agencies had a differing view from the parents. The Kent Police were certainly concerned as they had requested a meeting to discuss the risk that Brian posed. CPN 6 was given an action to comprehensively update the Risk Assessment to reflect the frequent arguments in the family and lots of tension. This is another example of KMPT staff not really understanding the issues within this family even though the family had made their views clear and KMPT failed to establish exactly what the home situation was, including the allegation that Alan had a problem with alcohol.

4.67 On the 7th May 2011 Brian started a period of home leave stays and these were reported to have gone well. He did still complain of memory problems but continued to refuse a CT scan. During this period the Crisis Team visited him whilst on home leave. On 25th May 2011 a decision was made to discharge Brian from the unit.

4.68 On 6th June 2011 Brian and his mother did not attend a CPA meeting as they had forgotten about it. The community consultant psychiatrist and CPN 6 agreed an outline Care Plan which CPN 6 would share with Brian at a home visit. The Forensic Assessment of Brian which had taken place in 1995 was discussed. The Care Plan was shared with Brian on 8th June 2011. The Care Plan recognised that non-compliance with medication was a prevalent theme, however it was not expressly listed under the relapse indicators even though it is good practice to do

so. This was an example of poor record keeping. On 14th June 2011 Clare telephoned the Recovery Team as she was concerned that Brian had been aggressive. A message was taken for CPN 6 who cannot recall receiving that message. This is a further example of CPN 6 not responding to telephone calls. On 11th July 2011 Alan telephoned the Crisis Team as he was concerned the medication was not working and he was advised to contact CPN 6. There is no record of Alan contacting CPN 6.

4.69 On 18th July 2011 when the final Risk Assessment before the homicide was entered onto the electronic records system it stated that there had not been an incident of someone being injured. This was untrue as Brian had stabbed a work colleague in 1993 and that Brian had assaulted his father in June 2007 and in August 2007 causing minor injuries. This was another example of poor record keeping which may have contributed to the dilution of Risk Assessment. This may have been exacerbated by the transferring of paper records and information from the old electronic system onto the new system. These Risk Assessments are required to be updated regularly and as a minimum every six months. There is a requirement to update them within seventy two hours of a CPA review and they are usually updated after a significant event such as admission, discharge, change of medication, social circumstances or transfer to another health care provider. Risk Assessments on Brian were regularly updated.

4.70 During this time Brian had several appointments with the vocational advisor and no concerns regarding his mental health were noted other than on the 1st August 2011 when he mentioned some of his issues about hearing voices and the family dynamics.

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4.71 On 3rd August 2011 Brian refused his depot injection and he continued to refuse the injection each week when CPN 6 visited. There was no evidence of any relapse although his sleep pattern was still erratic and he was smoking heavily because he was bored. On the 6th September he was irritable when KMPT refused payment for a French course and he was offered a computer course instead, which he did not accept as being vocational.

4.72 At 10:55 hours on Friday 9th September 2011, CPN 6 attended the home address unannounced as Brian's mother had telephoned the previous day to say Brian was irritable. Clare asked CPN 6 not to tell Brian that she had contacted him. On attendance Brian expressed paranoid ideas about his father, CPN 6 and a previous consultant psychiatrist. Brian also threatened to sue the mental health services and demanded the CPN to leave the house. The CPN discussed the matter with the consultant psychiatrist in charge of Brian's care and they agreed that the Crisis Team should become involved and if that was refused then an assessment under the MHA would need to be carried out. Brian refused an input from the Crisis Team and the duty Approved Mental Health Professional (AMHP) was informed.

4.73 As part of the planning for the assessment the AMHP discussed the case with CPN 6 and obtained details of his current presentation as well as a history of waving a knife in front of his father. The AMHP also read the risk profile document. The AMHP also spoke to the community consultant psychiatrist who made it clear to the AMHP that they expected Brian to be admitted for a period of

treatment/assessment. The AMHP was also aware that the consultant psychiatrist had briefed the staff grade psychiatrist who was assisting with the assessment. The staff grade psychiatrist had not met Brian but was aware of his case as a result of attendance at team meetings. The preparation for the assessment appeared to be thorough and in line with the Code of Practice.

4.74 At 15:30 hours on 9th September 2011, the AMHP accompanied by a support worker, staff grade psychiatrist and independent section 12 doctor (see Appendix C) all attended the home address but Brian was not there. None of the professionals within the team knew Brian. The section 12 doctor was employed by the Strategic Health Authority and therefore did not have access to KMPT files and relies on information shared with them by KMPT staff. Prior to entering the house the AMHP provided information on Brian to the section 12 doctor; they waited about half an hour and then left the house. The AMHP remained outside of the house for a while to see if Brian would return with the intention of speaking to him and then making a decision on how best to proceed. Brian's mother told the team that Brian had stopped engaging with his treatment plan, had been abusive towards his nurse, she was worried and she 'wanted something done about his condition'. Clare also told the team that Brian was spending a lot of the night in the garden and was sleeping very little. When Clare was asked if she was afraid of Brian she said she was not but Brian did not have such a good relationship with his father and had threatened him with a knife in the past. Brian's mother was told to call the police if Brian became agitated or threatening over the weekend.

4.75 When the AMHP is carrying out a MHA Assessment they are doing so on behalf of the Local Social Services Authority (in this case Kent County Council). The conduct of assessments is outlined in the Code of Practice. At least one of the two doctors involved in an assessment should have previous acquaintance with the patient. Preferably, this should be a doctor who has personally treated the patient. However, it is sufficient for the doctor to have had some previous knowledge of the patient's case. It is the responsibility of the AMHP to arrange for the most appropriate doctor to carry out the assessment.

4.76 The police were not informed of the situation which was a further failure by the mental health services to work together with agencies and took no action to protect Brian's mother, and more importantly his father. It is significant that this was a Friday as the assessing team took no further action, other than advising the Crisis Team of the outcome and that the family may contact them over the weekend. The AMHP did not discuss the outcome with the consultant psychiatrist however the staff grade psychiatrist updated the consultant at 16:30 hours. The lack of urgency regarding this matter, taking into account the history of this case, is quite remarkable; leaving two vulnerable people to care for a mentally ill individual without any support. The judgement of risk was effectively passed to Brian's parents to make any decision as the mental health service had not seen Brian. The decision to wait until the following week before trying to carry out the assessment again was discussed and endorsed by the duty senior. This assessment should have been passed to the Out of Hour's Team in accordance with the Code of Practice. The question of which individual was actually in charge of Brian's care was discussed by the DHR panel and the response from KMPT was that it is a team approach. This process with no apparent defined accountability is questionable as it appears that

the consultant had an expectation that Brian would be detained that day, however, the AMHP team who did not know Brian were able to decide that the assessment could wait until Monday. It was surprising that the consultant did not intervene and instruct that the assessment would be carried out over the weekend when they were told of the outcome although it is not clear exactly what they were told by the staff grade psychiatrist. The lack of communication was poor practice.

4.77 About 09:30 hours on Monday 12th September 2011 a different AMHP was informed of the need to assess Brian. The AMHP liaised with CPN 6 who provided information about his history and the current situation. The AMHP stated that CPN 6 said there was no apparent forensic history (see comment at paragraph 4.63) which was incorrect and CPN 6 was aware of the Forensic Assessment as they had discussed it with the consultant psychiatrist in June 2011. This was an example of poor preparation and communication. CPN 6 did advise the AMHP that there was high potential for conflict in the family and that Brian's parents had wanted him to leave the home even though he owned the house. The AMHP was also informed that the police had been called to the house on two occasions as Brian had brandished a knife at his father. The AMHP then discussed the failed assessment with the AMHP who had attended on the Friday. The AMHP then liaised with the GP surgery to see if a GP was available to assist, they also spoke to the AMHP backup worker who stated they knew Brian. The AMHP then spoke to the section 12 doctor (different from the one on Friday) and provided a brief history and details of Brian's case. The section 12 doctor was unaware of the failed assessment on the Friday and they cannot recall being given any information about the use of a knife in previous incidents. The AMHP also requested a bed in the psychiatric unit and reserved an ambulance; both of these actions are standard practice as part of preparation in the event an individual being assessed and being admitted. As part of the preparation the AMHP printed the Care Assessment, Risk Assessment and Care Plan; they also viewed two previous Risk Assessments. The relapse indicators on the Care Plan were; bizarre speech, glassy eyed, increased smoking and poor sleep, it did not mention non-compliance with medication which was a failure to record all relevant information. The AMHP was aware of this issue from the discussion with CPN 6. The AMHP when spoken to as part of the KMPT internal review stated they did not go 'massively far back' as they thought they had sufficient information.

4.78 About 13:30 hours on Monday 12th September 2011, the AMHP and the back up worker went to the home address to carry out the assessment under the MHA. En route to the house the AMHP and the back up worker discussed the history and previous assessments of Brian. After they arrived the GP attended and went straight into the house. The AMHP gave the backup worker some print outs from Brian's file. There is a difference of opinion whether any written information was shared with the section 12 doctor on their arrival at the house. Prior to attending, the GP reviewed the computer record of Brian's medical records to update himself on the recent hospital admissions, contact with the surgery and letters from the hospital. The GP had a good relationship with Clare and was familiar with the family although he had never treated Brian personally. Neither the AMHP nor the section 12 doctor knew Brian and therefore the selection of the section 12 doctor by the AMHP was contrary to the Mental Health Act Code of Practice which states that

'local arrangements should, as far as possible, ensure that assessments are carried out by the most appropriate AMHP and doctors in the particular circumstances. This coupled with the fact that neither of them attempted to liaise with the community consultant psychiatrist before the assessment took place was poor practice. If the AMHP had contacted the consultant psychiatrist there would have been the opportunity for the consultant to have attended or arranged for a doctor within their team to have been present. There was no valid reason for the AMHP not to have spoken to the consultant psychiatrist; although the AMHP stated that they had spoken to CPN 6 as they were the person with the most knowledge of the case. It is also surprising that the consultant psychiatrist had not made any contact with the AMHP Duty Team to discuss the assessment. Consequently the staff involved did not have a thorough understanding of all the long and complex history of Brian and his family. The history in this case contained vital information that should have been considered as a key part of the MHA Assessment.

4.79 During the assessment the GP spoke to Brian's mother who informed him that Brian was becoming irritable; he was 'hoovering at 4 a.m.' and that he was not sleeping well, she also asked for Brian to be restarted on the medication that had worked previously. Brian's niece was also present. Brian was described as casually dressed, clean shaven, placid, pleasant, co-operative and relaxed with good eye contact and concentration. The AMHP, GP and section 12 doctor all asked Brian questions and Brian stated that he had refused the depot injections because of the physical side effects. There is no record of the team exploring the paranoid ideas about his father that he had expressed to the CPN on the 9th September. At one point he did make derogatory remarks about his father because his mother was making a shepherds pie for his father however this issue was not picked up on. He agreed that his sleep pattern was poor but this had been an on-going problem. He did admit to swearing more but denied hearing any voices or feeling aggressive. The team suggested that his mental state had improved when taking the anti-psychotic medication, however he still refused to resume the injections. At some stage during the assessment Brian left the house and went into the garden where he was observed to be mumbling to himself. During the assessment Clare frequently answered some of the questions from the team; however there was no negative interchange between Brian and his mother. The GP was unaware that the other doctor was not a member of KMPT.

4.80 Having spoken to Brian and his mother; the team had a discussion; at no time was the history of violence or the safety of Alan mentioned. The AMHP backup worker stated that when they had seen Brian previously he had been more friendly and engaging. The backup worker has stated that they were never asked their opinion regarding detention under the MHA and did not offer a view. Neither the section 12 doctor nor the GP appeared to consider the question of *'The deteriorating patient' under Section 3 of the MHA and consideration of the judgement under Popplewell J. in R v The Mental Health Review Tribunal for the South East Thames Region ex parte Smith in respect of 'nature'. ' One of the objectives of the examination and interview of such a patient (one who is failing to continue with medication) would be to identify whether there is any evidence (apart from the cessation of medication) to suggest that it is likely that history will repeat itself in that the symptoms of the patient's medical disorder will reappear. If there is such evidence, the 'nature' of the patients mental disorder could lead professionals to conclude that detention in*

hospital is either 'appropriate' or 'warranted' even though there is no current manifestation of the disorder ('the degree') or if the symptoms of the mental disorder are not yet acute '. The section 12 doctor knowing that he did not have previous knowledge of Brian and had not spoken to the consultant psychiatrist he was unaware of the 'nature' of Brian's mental illness and therefore could not apply this test. The admission of a well known asymptomatic patient who had ceased to take medication and who has a history of significant deterioration has been further commented on by *Hale LJ in Smirek v Williams (2000) Mental Health Law Reports 38 at paragraph 19 ' …. There are, of course, mental illnesses which come and go, but where there is a chronic condition, where there is evidence that it will soon deteriorate if medication is not taken, I find it impossible to accept that it is not a mental illness of a nature or degree which makes it appropriate for the patient to be liable to be detained in hospital for medical treatment if the evidence is that without being detained in hospital the patient will not take that treatment.…However, although it might be lawful to make an application in these circumstances, whether it will be clinically and ethically right to do so is a separate question. It is submitted that the crucial factor in determining whether an application should be made in respect of an asymptomatic patient is the assessment of risk to the patient and/or others following the cessation of medication'*. The assessment failed to probe Brian on his relationship with his father or to focus attention on the risk factors regarding the recent incident when Brian threatened Alan with a knife, an incident necessitating police involvement. In addition the Forensic Assessment of 1995 was not considered within the context of the evidence to support probability. The Code of Practice states that a medical examination must involve *'….consideration of all available relevant clinical information, including that in possession of others, professional and none professional'.*

4.81 The team decided that there were insufficient grounds to detain Brian under the MHA; they concluded that he was not psychotic; he was relaxed, pleasant with no altered thought processes, delusions or hallucinations and had only been irritable for a few days. He was not demonstrating any aggressiveness to either of his parents and it was agreed that he did not pose any risk of suicide, self harm or significant risk to others at that time. The team did agree that his condition could deteriorate and then he could become a risk to others. The AMHP recorded in their report 'we recognise there is a degree of risk but we are encouraged by his agreement of increased monitoring and early care review'. As part of an assessment the Code of Practice states the following:-
As well as the criteria for detention the following must also be considered:

- *The patient's views and wishes of their needs*
- *The patient's age and physical health*
- *Any past wishes or feelings expressed by the patient*
- *The patient's cultural background*
- *The patient's social and family circumstances*
- *The impact that any future deterioration or lack of improvement in the patient's condition would have on their children, other relatives or carers, especially those living with the patient, including an assessment of those peoples ability and willingness to cope; and*
- *The effect on the patient, and those close to the patient, of a decision to admit or not to admit under the Act.*

4.82 The AMHP did not think there were reasons to admit Brian in terms of health, safety and protection of others even though they had not liaised with Alan who was the nearest relative and the subject of Brian's previous violent outbursts, including being assaulted and threatened with a knife. The AMHP was of the view that as Brian was at home with his mother it was more important to have contact with her and if there had been an admission, to make contact with the nearest relative then. This lack of action by the AMHP was a serious failure to consider Alan's safety. Also the Code of Practice states that the AMHP should, when informing the nearest relative that they do not intend to make an application, advise them of their right to do so instead. If the nearest relative wishes to pursue this, the AMHP should suggest that they consult with the doctors involved in the assessment to see if they would be prepared to provide recommendations anyway. This was a failure to comply with the Code of Practice.

4.83 Having come to that conclusion, the GP attempted to get Brian to restart the depot injections but on a lower dosage. Brian still refused. Brian also refused an informal admission. The team did agree that Brian needed to be closely monitored by his care co-ordinator and CPN 6 and that an urgent review by the consultant psychiatrist should be arranged. When Brian was asked if he would agree to see the consultant psychiatrist he stated that he would not see an 'Indian' doctor, and when told the doctor was 'African' he initially refused but after a discussion he did agree. Brian's mother was informed of the outcome which she accepted and Brian was told of the plan for monitoring and the review by the consultant psychiatrist and Brian agreed to the plan. The team spent about an hour and a half at the house. Neither the consultant psychiatrist nor CPN 6 (Brian's care co-ordinator) was informed of the outcome of the assessment. Brian's mother was advised to contact the police or the duty team of the mental health services if there was a problem. Brian's mother was also told that she should in future discuss appointments with Brian as he felt unhappy that she had contacted CPN 6 without speaking to him. This advice given to Clare fails to recognise the vulnerability of someone caring for an individual with a mental illness and reinforces that the focus of their work was on Brian rather than considering the family as a whole. There is no process for the independent section 12 doctor or the GP to record their decisions on the KMPT electronic records system when they do not make a medical recommendation to the AMHP after an assessment. This matter is being addressed by KMPT.

4.84 As the MHA Assessment did not take into account all of the extensive history of Brian, the patterns of behaviour within that history and none of them knew Brian that well it is not possible to say that the decision not to detain Brian was correct, especially as there were several breaches of the MHA Code of Practice. Had full consideration been given to all of the information available to the team then the least restrictive intervention could have been under Section 2 of the MHA; admission for assessment. The appreciation of past risk to inform present risk and manage it accordingly was not evident in this assessment. There also seemed to be some naivety regarding the conclusion about Brian's willingness to engage; a close examination of the notes would have indicated that there had rarely been any problem with Brian engaging. However, there was a history of non-compliance and that medication, usually whilst in hospital, was the only method of improving his mental state and establishing some stability. There had never been any meeting

between the mental health services, the GP and the police to understand the incidents and to work out any form of risk reduction plan for Brian's parents, in particular his father. The GP by his own admission had not received any training since his initial training in Mental Health Assessment. In addition, the team did not hold any pre-assessment meeting/discussion or conduct a debrief to confirm agreed actions. There was no record of the team trying to arrange for another worker who knew Brian to try to engage with him. There is no record of any professional involved in Brian's care considering referring his case back to the Clinical Risk Management Forum even though there was evidence of him relapsing and concerns from his family.

4.85 Throughout this review there have been numerous occasions when the rule of optimism has been evident and it appears that no one seriously considered the potential risk that Brian posed in particular to his father. The approach on several occasions has been 'if he gets too difficult then call the police'.

4.86 The detail of an individual's psychiatric history in assessing risk is crucial to how the risks are managed and the Care Plan that is subsequently put in place. This is clear in the Mental Health Act 1983 and is documented in KMPT's own Clinical Risk Assessment and management of service users' policy. The most knowledgeable individual in this case was CPN 6 and although he handed over the information to those trying to assess Brian he was not present at either assessment. If CPN 6 had been there it may have allowed the opportunity for Brian to be probed further on his thought processes. However, it is the duty of those carrying out the Mental Health Act Assessment to ensure they have all the information they need before conducting such an assessment. CPN 6 himself felt it may have been detrimental to the assessment process had he been present, as Brian had been so angry and hostile on the last home visit. When a patient has been in the service as long as Brian, there is a great deal of information held on him. There is also the ability to identify themes over a period of time. If those carrying out the assessment of Brian had completed their own chronology it would have been evident that this pattern of relapse was very much in keeping with what had happened over the years. The circumstances of this assessment and the subsequent homicide are very similar to the events of 10th and 11th August 2007.

4.87 Once again there was no safeguarding measure in place to protect the family or indeed an increasingly vulnerable patient. Brian had now been without medication for six weeks. If staff had fully understood his history and the risks he posed they may not have so readily accepted an informal agreement with him. It is also documented that those suffering from schizophrenia are more likely to relapse if the environment is stressful and they are not taking the prescribed anti-psychotics (Keltener et al 1999).

4.88 The consultant psychiatrist from the Recovery Team that took over the treatment of Brian in May 2011 after his discharge from the psychiatric unit had never seen him and relied on information from CPN 6 to agree his Care Plan. The consultant had also been in charge of Brian's case for a time in 2009 and again had never met him. Taking into account the serious threat that Brian posed to his father it was poor practice not to have seen him in a period of over three months.

4.89 At 22:56 hours the same day Brian's mother telephoned the police to inform them that Brian had stabbed his father and he was unresponsive. The police attended the house and Brian was arrested. A murder enquiry was commenced and Brian was subsequently charged with murder. At a hearing in the crown court he pleaded guilty to manslaughter on the grounds of diminished responsibility.

4.90 As a consequence of this case, KMPT and Kent County Council are carrying out a review of the role of the Approved Mental Health Professional. The purpose of the review is to identify the learning from this case and to consider how Mental Health Act Assessments are carried out in Kent and Medway with the intention of developing improved practice.

4.91 It was surprising that there was no reference to Brian in his father's GP file, especially as he was seventy one years old and had suffered significant health issues in 2009. He was a vulnerable adult who was carrying out some caring responsibilities of his son who had significant mental health issues. There was no indication from the GP report that all of the family was ever considered as a whole and appropriate care or advice provided. In the GP file of Brian's mother there were two references to Brian's mental ill health. The first being on 26th September 2007 when she requested a letter to support an application for re-housing by the local authority which the GP supplied, the second entry was on 19th January 2011 when she discussed Brian with the practice nurse and raised concerns about his condition worsening because he was not taking his medication. The practice nurse correctly advised Brian's mother to contact the Crisis Team.

5 Information from the family

5.1 The Independent Chair and Author of this report has met the daughter of the victim in this homicide on four occasions. She has been supported by a Homicide Case Worker from Victim Support since the homicide occurred although there has been a change of staff from Victim Support. The daughter has discussed the review and its findings with the victim's brother and sister. The Independent Chair initially met the daughter after the hearing at the crown court and before the final report was drafted. When the Independent Chair delivered a draft copy of the report to the victim's daughter to enable her to read it and make comment she offered a copy of the KMPT internal review report to the Independent Chair. This was declined as the Independent Chair had previously requested a copy of the report from KMPT which had been refused as the KMPT representative gave assurances that the IMR had used information from that review. At the meeting; the daughter raised some issues from the internal review which were not in the KMPT IMR and consequently were not in the DHR report. As a consequence of communication with KMPT the Independent Chair was provided with a copy of the internal review.

In response to comments from the daughter and information obtained from the internal review report the final report was amended and it was passed to KMPT for comment. A representative from KMPT's legal department who had not been involved in either compiling the IMR or the internal review considered the report and requested some changes. As a result of these requests and provision of new additional information the final report was further amended.

The daughter shared a great deal of information and provided an insight into the family life and she echoed much of what was in the report, however there was other information that she has provided which added to the history of this case including:-

- Alan never provoked Brian, he would go out of his way to avoid contact with him such as going and sitting in his van if Brian woke up early and going to bed early.
- Alan did enjoy a drink however he did not drink excessively and Brian used this as an excuse for his actions.
- Brian was violent and verbally abusive towards his sister.
- Brian, on at least one occasion, caused damage at his sister's house.
- Brian drove his car whilst on medication contrary to advice from the doctors.
- Brian's mother struggled to accept Brian was mentally ill.
- Brian usually had a very good relationship with his mother and only verbally abused her occasionally.
- Brian's condition deteriorated over the years with more bizarre behaviour.
- When Brian was stable he would go shopping with his mother, do the garden, took his niece and nephew swimming and do the housework.
- Brian had no interests or hobbies and was not capable of living by himself.
- Brian never did any voluntary work.
- Brian was good at telling health professionals what they wanted to hear and get them to believe all was well when the opposite was true.
- Alan had stopped going to meetings with KMPT or having contact with them as they did not listen to him and he believed that they would only take any real action regarding Brian once he had committed a serious assault on him.

5.2 Brian's sister feels let down by the mental health services and included the following matters as being of concern:-

- The family were not consulted enough by the mental health professionals; they would carry out a visit and then leave the family to manage Brian.
- Advice and support for the management of schizophrenia was never provided.
- There was too much reliance on telephone assessments and not enough visits and if they were coming to visit Brian he would go out to avoid them.
- They did not take any real action to stop him from driving.
- Communication between the family and the mental health services was poor, for example one professional said Brian would get worse as he got older and another said he would mellow.
- When they did visit Brian; he would be spoken to and on occasions the family excluded.
- They did not return telephone calls.
- There were too many changes of staff.
- There was no liaison between KMPT and the police.
- Health professionals were too ready to expect that Alan and Clare, despite their increased age, take on the responsibility as principal carers.

- Why did it take so long to put Brian back on the original depot injection in 2011 when it was clear that the change of medication in January did not work.
- The focus was on Brian and not the vulnerability of her father. Brian's human rights were being respected by not forcing him to have medication. However, the human rights of Brian's father were sacrificed because of the respect for Brian's. Now Brian is detained he can be forced to have medication which appears to be illogical to the sister.

5.3 The issue of the family being excluded from meetings with Brian was not covered in any of the KMPT reports as it only became an issue at a later stage. The sister has highlighted this to KMPT; this criticism was particularly regarding CPN 6 who often asked the family to leave rather than ask Brian if he wanted the family to remain which is in accordance with the Code of Practice.

5.4 Brian's sister has read a copy of the draft final report and has requested a number of amendments to the report which in the main have been accepted. She agrees with the overall majority of the report however she feels that because in her view the family were not listened to and on occasions actively discouraged from working with KMPT the report has not reflected the level of concern that they had regarding Brian when he was unwell. In addition she feels that too much emphasis was placed on issues such as Alan's drinking which were only made by Brian when he was unwell. She is also unhappy that reasons have not been provided by KMPT for the failure to deliver family therapy as well as the overall response by KMPT to the many issues she has raised with them directly.

5.5 Brian's sister has seen the amended final report which contained the changes after the Chair considered the report of the KMPT internal review and the additional information subsequently obtained from KMPT. She is content with the history and findings of the DHR final report.

6 Conclusion

6.1 This review has confirmed that there is a link between domestic abuse and mental ill health.

6.2 Brian had a thirty year period of treatment by the local mental health services starting in 1982. His diagnosis in 1991 was one of paranoid schizophrenia. A well defined pattern of periods of compliance and co-operation would deteriorate into periods of non-compliance and eventual break down of his mental state warranting his return to the psychiatric unit. The pattern of aggression and paranoia towards his father was also a constant feature prior to his admissions. There was only one occasion recorded where he physically attacked another individual other than his father. Brian had a total of fifteen admissions to the same psychiatric unit and at least four of them were formal detentions under the Mental Health Act.

6.3 Brian appeared unable to live alone yet whilst living with his parents there were obvious tensions. Although there were regular contacts with Brian and his family by the mental health services the family dynamics were never explored in any depth. The issue of the family dynamics was first recorded in 1995 and was highlighted in

the Forensic Assessment. It was suggested on four occasions in 2007 and 2011, that the family should have family therapy as it was becoming more evident with each admission that the tensions at home were a contributory factor in Brian's wellbeing. Such therapy or other work with the whole family may have gone some way to increase an understanding and self awareness within the household. There was no evidence that this ever took place and it has been suggested that this may have been because of a lack of therapy availability in the area, however this is not accepted by the review panel as justification especially as there is no record of even a referral taking place. The lack of follow through regarding actions from meetings and the provision of management oversight by the consultant psychiatrist and service manager on several occasions in 2007 and 2011 was substandard and the family were let down by KMPT.

6.4 In between admissions and outpatient appointments Brian had reviews of his Care Plan in accordance with national guidance under the Care Programme Approach (1999), with the multi-disciplinary team and with both parents attending some of these meetings. In the last two years before the homicide, it was noticeable that it was Brian's mother and sister who attended these meetings, the family have said that Alan had given up trying to get KMPT to care for Brian properly. Overall Brian kept his appointments in the outpatient clinics with the medical team and had a very high rate of attendance.

6.5 Brian received treatment from a combination of staff from the same psychiatric unit and various community teams all from the same service throughout. The community consultant psychiatrist that had overall charge of his case when he was not in hospital was the same between 1982 and 1999, the next consultant psychiatrist cared for him between 1999 and 2007 and then there were further changes in 2010 and 2011. A number of nurses and junior doctors both in the community and on the wards had contact with Brian over the years. The only person who may have had a real understanding of the whole history of this case was CPN 6, who in April 2011 at the request of the hospital consultant psychiatrist compiled a chronology of Brian's admissions.

6.6 In 1995 Brian was referred to the Forensic Psychiatric Team for assessment as there were concerns about the incident involving Brian threatening his father with a knife. This was the only time that a specialist team outside of the local services was involved with Brian. Taking into account the increased violence and continued use of sharp instruments, as well as the vulnerability of his family, there would have been benefit in having a further assessment by the Forensic Team in 2007 and in 2011.

6.7 Adult protection was only considered once although there were several occasions when an alert should have been considered, especially as the parents got older. This was a family that consisted of a man suffering from significant mental ill health; being cared for by two parents who at the time of the homicide were aged seventy one years and sixty eight years old and therefore both of them could have been classed as vulnerable. The issues that should have been identified as adult protection included:-

- The alleged attempts by the parents to take back control of the house.
- The allegations by Brian that his father drank heavily and verbally abused him.
- When Brian made threats to his father in 2007.
- In March 2011 when Brian threatened his parents that 'they were dead if he fell ill again'.

6.8 The only time that adult protection was raised was in 2007. However, the entry on the alert system makes no sense and no outcome was recorded. This was a failure by the various mental health professionals involved in this case not to recognise these matters as adult protection and refer them for consideration for investigation.

6.9 The officers from Kent Police who attended the three allegations of assault by Brian on his father recognised the incidents as domestic abuse and recorded them accordingly; carrying out risk assessments in line with national and local guidance. The police provided safety advice to Brian's father and liaised with the mental health services. There was no recognition by the health professionals involved with this family that this was domestic abuse and that they had a responsibility to both the victim and the offender who was their patient. The mental health service focus was on the mental health.

6.10 The police recognised the risk that Brian posed and this is evidenced by them asking Brian's care co-ordinator CPN 6 for a professionals meeting if Brian was to be discharged after he was admitted in March 2011. The police officer that made this request acted on their own initiative as there is no protocol or guidance that recommends such action. However, it was a sound judgement and the most appropriate method for agencies to share information and agree an action plan to protect Brian's parents and any others who may be at risk, as well as agreeing a plan to manage Brian in the community. There was no record of the request within any of the health files; therefore this was either a failure to record the request, or a failure to arrange the meeting.

6.11 There is an underestimation of the difficulties in caring for someone with a severe mental illness. In this case there was heavy reliance on the parents to seek support for Brian if they needed to, particularly once the assessment for formal detention had failed. Yet his father, the most affected family member when Brian's mental health was deteriorating, in September 2011 was the only relative not consulted on whether that was acceptable or not. A Carers Assessment was completed with Brian's mother in 2011 by a care manager assistant (CMA) who then referred Clare for further support from the local MIND. However, Brian's mother was reluctant for any outside support and her main concern was ownership of the house, the fact that Brian owned it and his threats to 'throw them out when he was unwell'. It is unclear what support MIND would have offered. Brian's father was not present for any part of the Carers Assessment process although it was offered to both parents. This may have enabled Brian's father to share his thoughts and concerns in dealing with Brian and the impact it was having on his own physical and mental wellbeing. Brian's sister was present at the first meeting the CMA had with her mother. As the mental health services had not involved the police in any planning or joint working, the opportunity for the family to be aware of the police's role in dealing with

incidents was never explored. The family relied on calling the mental health teams and only called the police when Brian was very violent or had gone missing.

6.12 Information sharing by the health service was limited to the mental health team and the family GP, which in the main was by sending copies of discharge summaries. On the one occasion that Brian absconded from hospital information was shared with the police in order to aid his safe return to the ward. There is no written evidence that information was shared on the grounds of domestic abuse or any other vulnerability of either Brian or his parents. There were no other agencies that the police could have shared information with as no other agency were or should have been involved.

6.13 The issue of records is relevant; Brian having had contact with the mental health service for several years meant there was a variety of files and over the past thirty years KMPT created both paper files and recorded information on electronic systems. Information regarding historic risk factors, the Forensic Assessment and a psychology report had not been transferred onto the current electronic file therefore the full extent of static and dynamic risk factors were not readily available to be considered within the context of a deteriorating mental state and regarding the protection of others. This was a failure by KMPT and could have been overcome by the creation of a chronology at an early stage which was reviewed and updated each time there was an admission or other significant event. There were other examples of both poor record keeping and members of staff not responding to telephone calls. The failure not to read all the available relevant information by staff carrying out the MHA Assessments influenced the decision making as all of the available information was not considered.

6.14 It is not the role of the panel of this review to conclude whether Brian should have been detained on the afternoon of 12th September 2011 using the Mental Health Act 1983: that is a matter that may be considered if the Kent and Medway Area Team of NHS England establish an independent investigation. The KMPT internal review has highlighted numerous failings in the way the assessment was carried out and failure to adhere to the Code of Practice. Comment has been made above on how that assessment could have been improved. The panel has concluded, based on all of the information presented to them that KMPT could have done more to reduce the risk that Brian presented, especially to his father. The panel did conclude that it was likely there would have been further incidents of domestic abuse and probably involving a sharp instrument; the factors that they identified to support that conclusion were:-

- There were at least seven incidents recorded involving a sharp instrument.
- The first time a sharp instrument was recorded as being used was 1991.
- The nature of Brian's enduring serious mental ill health.
- Brian's frequent refusal to take medication which stabilised his behaviour.
- The increasing vulnerability of Brian's parents.
- The tensions caused by the issue of the ownership of the house.
- The pattern of non-compliance followed by violence.

6.15 On the day of the homicide the team carrying out the MHA Assessment did not appear to consider the escalation of risk of harm and were too optimistic that Brian would comply. The importance of the principle that previous behaviour being an indicator of future behaviour was not applied sufficiently and this may have been a consequence of the team not reading all of the long history with the patterns of behaviour and responses to treatment.

6.16 The panel also concluded that the Kent Police acted in accordance with all existing local and national guidance when they dealt with the incidents involving Brian, recognising them as domestic abuse and responding accordingly. They did attempt to work with the mental health services when they identified the risk that Brian posed if released from the psychiatric unit, however the mental health services did not arrange a professionals meeting when Brian was released in May 2011 despite the police having requested a meeting.

6.17 The panel concluded that the GP surgery involved in treating Brian and his family did not have a major role in the care of Brian, as in the main they only saw him when he was compliant and attending the practice for his medication or regarding a physical ailment. The panel did feel that consideration should be given to encouraging GPs to attend update training in carrying out Mental Health Assessments, domestic abuse and adult safeguarding as there are links between all three areas. The issue of GPs providing reports as opposed to IMRs conducted by an independent GP requires consideration by the Kent and Medway Community Safety Partnership.

6.18 The panel came to the conclusion that the mental health services, both in regard to the psychiatric unit and the community mental health services did not identify all of the risk issues and respond accordingly. There were times when the mental health services worked effectively with Brian and his behaviour was quickly modified. There was more that could have been done in terms of risk identification and then putting strategies into place to manage that risk, as well as some of their responses to specific events. KMPT operated often in isolation when there would have been benefits for Brian and his family, as well as the staff involved, if they had worked more closely with the police. The main issues the panel identified that require improvement are:-

- Identification of the assaults and threats as domestic abuse.
- Recognition that there were allegations of adult abuse.
- Exploration of the family dynamics by arranging family therapy or other form of engagement.
- Establishing the truth of comments made by patients regarding family members/carers to enable accurate information recording and appropriate responses, for example the allegation of Brian's father abusing alcohol.
- Working with the police in managing Brian in the community by informing them that Brian's behaviour was worsening and the family may call if he threatened or assaulted them.
- Standard of record keeping.
- Failure to transfer relevant historic information from paper files onto new electronic system.

- Identification of the patterns of non-compliance by Brian followed by violence.
- Improvement of communication between teams.
- Unrealistic expectation of Brian's parents to manage his behaviour, especially as their own vulnerability increased.
- Increased involvement of families when they are caring for a member who is mentally ill.
- Improved Risk Assessments and contingency planning including the role of the Clinical Risk Management Forums.
- Following through agreed actions and standards of supervision.
- Improvement in preparation when carrying out MHA Assessments, for example reading the whole record and having a team meeting prior to attendance and agree an approach.
- A lack of urgency by not pursuing the MHA Assessment over the weekend of 10th and 11th September 2011, and not informing the community consultant psychiatrist and the care co-ordinator of the outcome of the assessment held on the 12th September 2011.
- Deployment of staff that know the patient and their history when carrying out MHA Assessments.
- Non-compliance with the MHA Code of Practice.

6.19 Since this homicide the KMPT have amended their practice in several areas including:-

- Non-compliance with medication is a standard agenda item on all CPA reviews.
- The Recovery Team are looking at accessing training on family dynamics via the Early Intervention Psychosis Service to better equip themselves for future work with families where appropriate.
- A domestic abuse lead was established in January 2012 which gives additional support to frontline staff and work with the Kent and Medway Domestic Abuse Strategy Group has taken place to help plan training. This will be made available to all frontline staff. This position has also given KMPT a presence at all the MARACs which is an additional source of support for members of staff that have high risk cases of domestic abuse.
- There is a review underway around the AMHP service and the model they work to. This involves both KCC and KMPT.
- KMPT have raised the issue of governance of independent section 12 doctors with NHS England.

6.20 The panel considered whether there were any issues regarding ethnic, cultural, linguistic and religious identity of the victim, their family and the offender regarding the service they received and the panel concluded that there were no such issues. The report has highlighted the issues of vulnerability for both Brian and his parents.

6.21 This review has identified the difficulties some agencies have in providing relevant information to a DHR in particular when other internal reviews with different terms of reference have been established. As a consequence KMPT should review their

process of conducting IMRs when an internal review has taken place to ensure all relevant information is provided to the DHR panel.

7. Lessons Learnt

7.1 This review has highlighted issues of good and poor practice that have been identified previously in other reviews of domestic abuse prior to the inception of DHRs as well as serious case reviews of child and adult protection cases. Rather than turn those items of poor practice into recommendations which are reminders to staff to apply current procedures and act in accordance with good practice, the issues are listed below and agencies should encourage all staff that may come into contact with families involved in domestic abuse to read this report. In addition, all agencies in Kent and Medway should ensure that the findings of this review are incorporated into their existing and any new training in the response to domestic abuse. These matters should also be considered when any policy, guidance or process is being reviewed. The main issues are:

- The benefit of the creation and maintenance of a chronology which is reviewed at six monthly intervals and always considered before the decision to close a case is made, or when making significant decisions such as the discharge of a patient from a psychiatric unit and when care is being transferred between teams.
- When members of staff take over complex and/or longstanding cases they should take the time to read the whole file to ensure a good understanding of the case and identify patterns.
- The importance of considering past behaviour as an indicator of future behaviour and the benefit of reading files prior to undertaking assessments, in particular when staff do not know the individual.
- Referrals to MARAC should be considered using professional judgement for complex cases such as those involving mental ill health and coupled with abuse that has endured for a long time and the violence is escalating.
- To liaise with other agencies that are providing services to an individual to ensure treatment is complimentary.
- To consider the family as a whole especially when others within the family are vulnerable.
- To have current domestic abuse policies.
- To have an awareness of chronic co-dependent relationships (the ‘cannot live together but cannot live apart’ relationships).
- All staff who may come into contact with those affected by domestic abuse to have undergone basic domestic abuse awareness training.
- The importance of sharing information in all domestic abuse and adult safeguarding cases.

7.2 Any DHR in Kent and Medway that has an element of either child or adult safeguarding is passed to the relevant safeguarding board for them to consider the issues which they are responsible for and are outside of the remit for the Kent and Medway Community Safety Partnerships, therefore the issues regarding adult protection have not been made subject to any specific recommendations. The

issues regarding recognition of adult protection by mental health staff have been included in the KMPT action plan.

7.3 As a consequence of completing their IMR Kent Police have identified some issues regarding their response to mental ill health which have not been subject to any comment in this review. The panel welcomes any initiatives by agencies to improve their practice.

8. Recommendations

In addition to the lessons learnt identified by this review outlined in Section 7 the panel have recommended the following actions

- There should be an identified clear communication protocol outside of the Kent Police custody environment for police to refer and be able to seek advice regarding mental health issues in the community.
- Consideration of the creation of a multi-agency information sharing and assessment process to identify and manage people with mental health issues that present a potential safety risk to the public. (Individuals outside of existing protocols such as MARAC, MAPPA etc).
- The issue of GPs providing reports as opposed to IMRs conducted by an independent GP requires consideration by the Kent and Medway Community Safety Partnership with a view to raising it with the Home Office to consider including GPs in the DHR process.
- The MHA Assessment process could be improved.
- KMPT should review their IMR process when internal reviews have already been completed to ensure all relevant matters are included in the IMR.

An action plan detailing the recommendations resulting from this review and how they should be achieved with target dates and the agencies responsible can be found at Appendix E.

The Kent and Medway NHS and Social Care Partnership Trust have implemented a series of recommendations arising from this review which apply to the assessment and treatment of patients suffering from mental ill health and not just those where domestic abuse is an issue. The panel welcomes the response by KMPT and a copy of those recommendations and action plan can be found in Appendix D