MANCHESTER COMMUNITY SAFETY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW IN THE CASE OF KAREN

FINAL REPORT

CONTENTS

1 INTRODUCTION

The review panel offer sincere condolences to Karen's family on their tragic loss.

1.1 Key People

Karen (deceased)

John (brother of Karen) – Convicted of Karen's murder

Joe (Karen's oldest child, an adult at the time of the incident)

Nat (Karen's youngest child, an adult at the time of the incident)

1.2 Incident Leading to the DHR

In early March 2016 North West Ambulance Service (NWAS) were called to Karen's home via a 999 emergency call made by Nat. Nat said that her mother was on fire in the street outside the family home.

When the emergency services arrived they found Karen to be in a serious condition, with her clothes and body extensively burned. Paramedics treated Karen at the scene and transported her to hospital by Helimed.

Karen's injuries were catastrophic. She had suffered 90% burns and was put into an induced coma.

Two days after being admitted to hospital Karen tragically died as a result of her injuries.

1.3 Police Investigation

Following the incident, police immediately secured Karen's home as a crime scene and began an investigation. It was known that John had been at Karen's home and had fled at some time during the incident.

An extensive search for John was undertaken and he was found in another part of Greater Manchester a few days later. He was arrested in relation to the incident and was subsequently charged with Karen's murder.

When questioned John told police that there had been a dispute with Karen and that he had poured petrol on her. He said that he had intended only to maim her, not to kill her. *Note: John maintained throughout the criminal proceedings that Karen had been holding a lighted cigarette and lighter. He said he had thrown petrol at her in an argument and the cigarette had caused the petrol to ignite.*

Police established, through witness statements made by family members, that John had visited Karen at home on the day of the murder. Nat was upstairs at the time and heard them speaking to each other, although she could not clearly hear what they were saying. She recalls

hearing Karen say something like 'let's sort this out'. Nat said that John did not appear agitated and she had no concerns about leaving them together.

The criminal investigation learned that Karen and John's father had died six weeks prior to the incident. He had been residing in a nursing care home for a number of months *Note: there were no suspicious circumstances surrounding his death.*

Police learned that, following their father's death, John had sent text messages to Karen accusing her and their sister of killing their father. It transpired from the police investigation that, during the weeks leading up to father's death, John had become increasingly fixated with the idea that Karen and her sister were attempting to poison their father. John believed that their motive was to secure money from their father's estate and to exclude him (John) from any inheritance. John contacted police on 29th February 2016 regarding his father's death, saying that the Care Home had been keeping him away from his father. He did not make a formal complaint and no investigation was made in relation to his allegation.

Note: A series of emails and letters between John and the nursing home was provided to the review and as police evidence. None of this information was known to police or any other agency prior to father's death.

A criminal trial was scheduled to take place in September 2016, however the defence said that they wished to explore new technical evidence in relation to immolation (burning). The judge adjourned the trial and set a new trial date of March 2017.

John continued to maintain his innocence and in March 2017 the trial was re-opened with John entering a plea of not guilty to murder. In March 2017 John was found guilty of the murder of Karen and was sentenced to life imprisonment, to serve a minimum of 27 years.

1.4 Time Period under Review

The panel agreed that events that took place between the beginning of January 2013 and the date of Karen's death were most relevant to the terms of reference of the review, and that this period of scrutiny would offer learning that could influence current practice. As Karen and John were sister and brother there was a long history between them which the DHR panel took into consideration in the review.

Note: Following the initial panel meeting it was clear that both Karen and John had a history of contact with mental health services. The panel agreed that additional information in relation to both Karen and John's mental health would provide important context to the review. The panel therefore requested information from mental health services from 2001. A summary of this information is provided at sections 3 and 4 of this report. The panel also discussed whether John's mental health background warranted a Mental Health Homicide Review. The panel reviewed the criteria and established that, because there had been no recent contact with mental health services, the case did not meet the criteria for MHHR, a recommendation is made in this regard.

1.5 Background to Karen

Witness statements from Karen's family describe her as a loving mother and as someone who cared a great deal about her family. She is described as an attentive sister who was considerate towards her brother John who was described as being a 'difficult' person with a long history of mental health problems. The witness statements indicate that Karen remained in contact with John and did not ostracise him despite his unusual and sometimes challenging behaviour.

Karen has three children, two of whom are referred to in this report as Joe and Nat. All three children were adults at the time of the incident leading to this review. It appears that Karen's relationship with the children's father had broken down several years ago and the couple had separated. The children continued to live with their mother.

Witness statements indicate that Karen had an ongoing relationship following her separation from her husband and that her partner lived in another part of the country.

Information from a witness statement made by Karen and John's sister confirms that, in their childhoods, both Karen and John spent some time in a children's home due to behavioural issues. John returned to the family home before Karen, with Karen remaining in care for a longer period of time.

Karen experienced mental ill health as an adult. She was referred to and treated by mental health services and was diagnosed with paranoid schizophrenia. Between October 2000 and March 2009 Karen's care was managed by the local Community Mental Health Team (CMHT), this was in an area outside Manchester. She was treated with anti-psychotic medication to which she responded well. She was discharged to the care of her GP in 2009 and remained on anti-psychotic medication until her tragic death.

Karen appears to have responded well to treatment. There is no record of her having been admitted to any hospital either voluntarily or under the Mental Health Act. She did however experience side effects to the prescribed medication and alternatives were tried. This resulted in a return of her psychotic symptoms and she was returned to the original medication.

During her early treatment, risk assessments were undertaken which showed no indications of any risk to self or others. When she was acutely unwell she reported to clinicians that she heard voices telling her to kill her youngest child. This was known to clinical services who recorded that Karen had good insight into her condition. The review found no evidence of any concerns being raised by clinicians at this time in relation to the safety of Karen's children. Subsequent guidance indicates the need for continuing review of the impact of paranoid schizophrenia on the individual and family members which would now be expected practice.

Karen's medical records show that concerns were raised with her regarding alcohol use, it was recorded that she was drinking a bottle of vodka a week. There is no record of any referral to a specialist service or outcome relating to these concerns at any point during the period under review.

In 2012 Karen moved home and was referred to a local hospital to continue treatment.

Karen lived in rented accommodation and held her own tenancy. During the period under review Karen moved home on one occasion. Karen had lived at her most recent address from 2013 until the incident leading to this DHR took place in February 2016. Nat lived with her.

The review learned that Karen had a long term partner who lived in another part of the country. Witness statements indicate that they saw each other regularly (NB Karen's partner did not provide a witness statement to police and it was not possible to find a contact address for him). There are no records relating to Karen's relationship although on one occasion Karen presented to her GP saying that she was 'trying for a baby'.

As Karen's family did not participate in the review it is not possible for the review to comment with certainty on the relationship between Karen and John. The review learned that there were no police call outs to any incidents involving altercations, violence or domestic abuse between them. The police investigation however revealed that, following the death of their father, the relationship between Karen and John became tense, with John accusing Karen and her sister of conspiring to kill their father. John reported concerns to police on 29th February 2016 but did not make a formal complaint.

1.6 Background to John

Information provided to the DHR showed that John had a long history of mental ill health. The review asked for agency information dating back to 2001 and this is summarised in section 3, but is not analysed in detail due to its historic nature.

Between 2001 and 2006 John had contact with mental health services and was diagnosed with paranoid schizophrenia. He was sectioned under the Mental Health Act in 2001 and spent a period of time in hospital. John absconded from treatment. He then had sporadic contact with mental health services until 2006 when his contact with mental health services ceased.

During the period under review John changed his GP on one occasion, although he had previously been registered with two GPs (not simultaneously). In total between 2001 and the date of Karen's death John was registered with four separate general practitioners. During the period under review John had many contacts with general practice which are summarised in section 3 of this report.

Historically John was known to the police in relation to complaints regarding activity of a sexual nature in relation to children. Police spoke to John following reports of concerns by members of the public, however there was no evidence of a crime and matters were not pursued. John was also questioned in relation to an incident of stalking a female, again no charges were brought in relation to this incident.

John appears to have had periods of transience where he lived in remote areas in tents and outbuildings. He also spent some time living with his mother who was recorded as his next of kin by mental health services and general practice.

During the period under review John held tenancies in two separate properties with different social landlords.

It is apparent from primary care records that John experienced on-going mental health problems during the period under review. He had frequent contacts with general practice, often reporting symptoms of medical conditions for which no cause could be established. The nature and pattern of John's presentations was noted by general practitioners however there is little evidence that John's mental health was viewed as a cause for further investigation or referral by general practice with John receiving only one referral to mental services in 2011, which he did not attend. His GP was notified and no further action was taken.

1.7 Parallel Processes

1.7.1. Coronial Matters

The Coroner was informed by e-mail of the commencement of the DHR. An inquest was pended until the police had finished their investigations. No inquest has taken place.

1.8 Involvement of Family in the Review

At the commencement of the review Karen's family were notified that a review was taking place. The family were at that time receiving support from a Police Family Liaison Officer (FLO) who facilitated contact between the DHR Chair and family members. The family were provided with information about the DHR process and given information regarding the support available from independent agencies for families and friends who have experienced a domestic homicide.

Due to on-going criminal investigations and an impending trial the family were consulted with regard to timing of their involvement. At this time Joe indicated that the family had agreed that he would act as their representative.

The Chair of the DHR contacted the FLO to ensure that the family were happy with the arrangement that Joe would represent them and asked specifically whether Karen's mother would wish to be involved in the review. The FLO informed the Chair that Karen and John's mother did not want to participate due to the trauma of events; similarly Karen and John's sister had the same view. Nat had been deeply affected by the trauma of witnessing her mother's injuries and said that she wanted Joe to speak on behalf of the family.

Over the period of adjournment the Chair liaised with the FLO to ensure that the family were kept appraised of progress. The Chair shared the terms of reference for the review and asked if the family had any other questions they wished the review to explore, no further questions were proposed by the family.

When the trial was adjourned because of potential new evidence, the Chair informed the family that their input to the review would be welcome once the criminal proceedings had concluded. The review learned that Nat had responded to a request to become involved in a

television documentary about the activities of Greater Manchester Police and asked if the DHR could be included in this documentary. The panel agreed that it would not be in the interests of the process and declined this invitation.

Following the conclusion of the criminal trial, the Chair contacted the FLO to arrange a meeting with Joe. The panel had expressed the view that it would be useful to talk to other family members as well as Joe and asked the FLO to speak to Joe to explore the possibility of other family members participating (it was requested that a direct request be made rather than through Joe). Unfortunately no member of the family responded to this request. The FLO attempted to contact Joe on a number of occasions without any success.

2. CONDUCT OF THE DHR

Domestic Homicide Reviews (DHRs) were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004)[1]. This provision came into force on the 13th of April 2011. This Act makes it a statutory responsibility for Community Safety Partnerships (CSPs) to complete a Domestic Homicide Review (DHR) when a case meets the criteria set in the guidance.

This Domestic Homicide Review was commissioned by Manchester's Community Safety Partnership in May 2016. The Review has been completed in accordance with the regulations set out by the Act and with the revised guidance issued by the Home Office to support the implementation of the Act. The Home Office definition of domestic abuse and homicide is employed in this case.

Following the publication of the Home Office Action Plan in March 2012 (particularly Action 74, which gave a commitment to "review the effectiveness of the statutory guidance on Domestic Homicide Review"), guidance on the conduct and completion of DHRs has been updated.[2]

The panel noted the revised definition of domestic abuse to ensure that all aspects of domestic abuse were addressed in the terms of reference and in the reports provided by agencies.

Revised guidance was produced by Home Office in November 2016. Although the review was partially completed at the time of publication, this report has incorporated this guidance into the process and final report.

2.1 Terms of Reference and key lines of enquiry

The over-arching purpose of a Domestic Homicide Review (DHR) is to:

- Establish what lessons are to be learned from a domestic homicide, particularly regarding the way in which professionals and organisations work individually and together to safeguard victims;

[1]https://www.gov.uk/government/publications/the-domestic-violence-crime-and-victims-act-2004

[2] https://www.gov.uk/government/publications/revised-statutory-guidance-for-the-conduct-of-domestic-homicide-reviews

- Identify clearly what those lessons are, both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;

- Apply these lessons to service responses including changes to policies and procedures as appropriate; and

- Prevent domestic violence, abuse and homicide and improve service responses for all domestic violence and abuse victims and their children through a co-ordinated multi-agency approach which ensures that domestic abuse is identified and responded to effectively at the earliest opportunity.

2.2 Rationale for the Review and Terms of Reference

The rationale for the DHR is to ensure that the review process derives learning about the way agencies responded to the needs of the victim. It is the responsibility of the panel to ensure that the daily lived experience of the victim is reflected in its considerations and conclusions and, wherever possible and practicable, family and friends of the victim should participate in reviews to enable the panel to gain a deeper understanding of the victim's wishes and feelings.

The review aims to understand how agencies respond to domestic abuse by offering and putting in place appropriate support mechanisms, procedures, resources and interventions with an aim to avoid future incidents of domestic homicide and violence.

Learning from the review will help to improve services to victims of domestic abuse and a multi-agency action plan is appended clearly setting out the actions that agency should undertake to improve service delivery.

TOR 1:

To establish the circumstances surrounding the alleged homicide.

TOR 2:

To establish whether the victim was known as being at risk of domestic abuse by any statutory agency, non-government organisation (including the third sector) or any other individuals

TOR 3:

To establish what actions were taken to safeguard the victim and whether these were robust and effective

TOR 4:

To establish whether the alleged perpetrator was known as a perpetrator of domestic abuse and what actions were taken to reduce the risks presented to the victim and/or others

TOR 5:

To establish whether risk factors such as drug or alcohol misuse, mental health issues, offending or any other indicators of abuse were known by agencies and what actions were taken to address them

TOR 6:

To establish whether organisations have appropriate policies and procedures in place to identify, refer and escalate concerns to appropriate safeguarding pathways

TOR 7:

To establish whether there are any lessons to be learned from the case about the way in which professionals and organisations carried out their duties and responsibilities and worked together to safeguard victim and manage risks posed by the perpetrator both at practice and strategic levels

TOR 8:

To identify clearly what those lessons are, how (and within what timescales) they will be acted upon and what is expected to change as a result through the production of a multi-agency action plan

TOR 9:

To recommend to organisations any appropriate changes to such policies and procedures as may be considered appropriate in the light of this review.

2.3 Specific Key Lines of Enquiry

(i) Did any agency know that Karen was subject to domestic abuse by John at any time during in the period under review?

(ii) If so, what actions were taken to safeguard the victim and were these actions robust and effective?

(iii) Was John known to any agency as a perpetrator of domestic abuse and if so what actions were taken to reduce the risks presented to the victim and/or others?

(iv) Did any agency have knowledge that Karen or John were experiencing difficulties in relation to drugs, alcohol, mental health or other vulnerabilities/risk factors?

(v) Did Karen disclose domestic abuse to family and/or friends, if so what action did they take?

(vi) Did John make any disclosures regarding domestic abuse to family or friends, if so what action did they take?

(vii) Are there any matters relating to safeguarding vulnerable adults and/or children that the review should take account of?

(viii) Were issues of race, culture, religion and any other diversity issues considered by agencies when dealing with the victim and alleged perpetrator?

2.4 The DHR Panel

A DHR Review Panel was established by the CSP and met on seven occasions to oversee the review. The Panel received reports from agencies and dealt with all associated matters such as family engagement, media management and liaison with the Coroner's Office. In addition the panel liaised with local police in relation to the criminal investigation.

The Community Safety Partnership appointed Maureen Noble as independent Chair and Author to oversee and direct the Review and to write the overview report. Maureen Noble was previously employed by Manchester City Council as Head of Crime and Disorder. Maureen left this role in September 2012.

The Chair/Author has extensive experience in the field of public protection and community safety and significant experience in conducting Domestic Homicide Reviews and Serious Case Reviews. The Chair/Author has extensive experience in the field of domestic abuse having been the strategic lead for domestic abuse whilst employed as Head of Crime and Disorder reduction for a large metropolitan council. The Chair/Author has also served as a member of the NICE national programme management group on domestic abuse which produced the current NICE guidance and has worked on the production of domestic abuse service standards with NICE.

The Chair had no contact with the victim or perpetrator in this case and had no professional or personal contact with any of the agencies involved in the Review prior to the incident occurring.

In line with Home Office guidance a panel of senior officers was appointed to conduct the Review. Panel members were selected based on their seniority within relevant agencies and ability to direct resources to the review and to oversee implementation of review findings. The names and roles of DHR panel members are included.

A representative from the independent sector organisation MIND served as a panel member to advise on mental health issues. The CSP domestic abuse co-ordinator also served as a panel member.

In line with Home Office guidance the panel discussed the potential for hindsight bias influencing written reports and panel discussions. Care was taken to ensure that reports reflected what agencies knew and how they responded at the time the events took place. Agencies were asked to extract records as they were written, with interpretation of events and actions taking place in the context of services, policies and procedures in place at that time.

In summarising information and drawing conclusions the author reviewed information based on how services were delivered, and what was known, at the time of events recorded.

2.5 Panel Membership

Name	Agency
Maureen Noble	Independent Chair and Author
Michelle Hulme	Manchester City Council
Louise Honour	NHS and Clinical Commissioning Group
Teresa Lam	Greater Manchester Police
Claire Tyrell	Registered Housing Provider
Lisa Henson	Registered Housing Provider
Delia Edwards	Manchester City Council
Tracey Hurst	Tameside and Glossop Clinical Commissioning Group
Paul Starling	Greater Manchester Fire and Rescue Service
Mary McDonagh	National Probation Service
Elizabeth Simpson	Manchester Mind

2.6 Sources of Information to the Review

Following initial scoping for the review the following agencies were identified as having had contact with the victim and/or the perpetrator.

Agencies that had significant, relevant and/or prolonged contact with Karen and/or John were asked to provide Individual Management Reports. Other agencies were asked to provide short reports.

There were no conflicts of interest recorded during the Review. Authors of Individual Management Reports and short reports were not directly connected to the parties. Two of the panel representatives were IMR authors and declared this interest at the commencement of the process. The panel agreed that any potential conflicts arising should be dealt with as they arose in meetings. None were identified.

IMRs and short reports were received from the following agencies:

Agency	Role
Eastlands Homes	Housing Provider
Northwards Housing	Housing Provider
Moss Bank Homes	Housing Provider
Clinical Commissioning Group	General Practitioners
Pennine Care	Mental Health Services Provider
Greater Manchester Police	Police services
Greater Manchester Fire and Rescue Service	Attended the incident leading to the DHR
North West Ambulance Service	Attended the incident leading to the DHR

Each agency was asked to make single agency recommendations based on learning from the review. Each agency contributed to the compilation of the multi-agency action plan.

2.7 Additional Information Sought by the Review Panel

2.7.1. Mental Health Services

Due to John's long standing and complex mental health history the panel invited a senior manager with extensive experience in mental health to a panel meeting. The purpose was to assist the panel in understanding the diagnosis of paranoid schizophrenia received by John and the pattern of service delivery that might be expected at the time of John's engagement with services. The panel also discussed the impact that John's diagnosis may have had on his relationships and whether such a diagnosis may carry inherent risks to others.

The information provided at this meeting has been used in formulating the analysis and conclusions regarding agency involvement in the management of John's mental health.

Following the submission of information from mental health services in relation to John's treatment and care, further information was requested to clarify aspects of John's involvement with services during the period 2001-2006. Further information was provided

which assisted the panel in understanding John's contact with services and decisions regarding his treatment and care during this period.

2.7.2. College Safeguarding Services in respect of Nat

The review identified a potential safeguarding issue in relation to Nat regarding incidents that took place in November 2015 and February 2016. These incidents, which are outlined in section three of this report, involved disclosures made by Nat to a member of staff at the college at which Nat was a student. The disclosures in November related to Karen threatening to harm Nat. The second disclosure in February 2016 was made to Karen's GP by Nat and concerned Karen's mental health, this incident is also outlined and analysed in section three of this report.

The Safeguarding Lead for Education attended a meeting of the DHR panel to provide further information with regarding to safeguarding policies and procedures within further education establishments. The college also held a separate meeting with a panel member and provided further detailed information in writing and by telephone on the incident relating to Nat. *Note: As Nat was not a child at the time of these events she was not subject to the guidance set out in Working Together to Safeguarding Children.*

2.7.3. Witness Statements provided to police during the criminal investigation

The Chair viewed statements made by Karen's family as part of the criminal investigation. This report makes some reference to material used in witness statements due to the family's wishes not to be involved in the review. Their statements have assisted the review panel in building a picture of Karen's daily lived experience.

Note: The panel is mindful that witness statements may be subjective and are not taken for the purpose of reviews such as this. This has been taken into account when citing them as a source of information to the review.

2.7.4. Prison Services

The panel made enquiries with the prison where John was remanded pending trial to ascertain whether John's previous psychiatric history was known to them, and whether they had commissioned psychiatric reports. The prison responded that they were unable to share previous records with the DHR and that they could not report on whether psychiatric reports had been commissioned.

As this material was outside of the scope of the DHR review period the acquisition of any current reports was not pursued.

NB: As far as the review could ascertain no psychiatric reports were requested or produced in relation to the criminal trial.

2.7.5. Care Home

The review received brief information regarding the care home's contact with Karen and John in relation to their father's illness. The review also saw copies of emails sent by John to the care home.

2.8 Other Reviews

No other reviews have been conducted in relation to the case.

The DHR made enquiries regarding the conduct of a Mental Health Homicide Review (MHHR) and were informed by NHS England that the case did not meet the criteria for the conduct of a MHHR as neither Karen nor John was engaged with mental health services under a Care Programme Approach during the 6 months prior to Karen's death.

2.9 Disclosure

With regard to disclosure of relevant material, the panel liaised with the Senior Investigating Officer in the case to ensure that any new or additional material was made available that may be relevant in the criminal proceedings.

2.10 Delays in the DHR process

The DHR commenced in May 2016, at which time a trial date was set for September 2016. Following representation from John's legal advisor regarding new evidence, the trial date was pended until March 2017. During this period the DHR continued to gather information.

In March 2017 John was tried and convicted of Karen's murder. Following conviction the DHR contacted Karen's family via the police Family Liaison Officer, to request their involvement in the review.

Note: Initially, Karen's family said they wished to be involved and a date was arranged to meet with Joe who had agreed to represent the rest of the family. The meeting did not go ahead, following which several attempts were made to meet with Joe without success.

Following John's conviction, the panel became aware through media sources that John intended to appeal his sentence. The Chair met with the Senior Investigating Officer (SIO) in the case, who was unable to confirm that an appeal had been lodged and recommended that the panel contact the Crown Prosecution Service (CPS). The DHR contacted the CPS to establish whether an appeal had been lodged. In October 2016 the DHR received confirmation from Manchester Crown Court that John had not lodged an appeal.

The DHR re-commenced and a final draft report was submitted to the Coroner in January 2018.

3. CONTACT WITH AGENCIES – WHAT AGENCIES KNEW ABOUT KAREN AND JOHN

The DHR panel noted that both Karen and John had a long history of involvement with services and that both were diagnosed with paranoid schizophrenia (a severe and enduring mental health condition), for which both were ultimately treated in primary care.

The panel felt it important for the report to provide a brief summary of Karen and John's history with services, and to include life events that have particular significance to the context of the case. These events are not analysed in detail however they do provide opportunities for learning which are highlighted in sections four and five of this report.

3.1 Key to General Practitioners

Karen	John
GPK1 Out of area Prior to January 2013	**GP1J 2001-October 2010**
GPK2 January 2013 to March 2016	**GP2J10.10.10 -05.05.2011**
	GP3J –06.06.2011 – 06.02.15
	GP4J – 07.2015 - Custody

3.2 Key to Housing Providers

Karen	John
Out of Area provider to January 2013	**Living with mother 23.07.01 – January 2008**
(HP1K) January 2013 – March 2016	**(HP1J) 18.09.2009 – 03.10.10**
	(HP2J) November 2010 – April 2013
	Homeless/with mother April 2013 – March 2015
	(HP2J) March 2015 - Custody

3.3. Karen - Background Information on contact with services October 2001 to December 2012

Between October 2001 and March 2009 Karen was under the care of the local Community Mental Health Team related to a diagnosis of paranoid schizophrenia.

During this time there is no record of Karen having been admitted to hospital in connection with her mental health, either voluntarily or under the Mental Health Act. The electronic clinical record system for the Trust responsible for services at that time came into operation in 2005. It therefore only contains information regarding to admissions from that date however the DHR enquiries were cross referenced with risk assessment tools in place at that time and no there is no evidence to suggest that Karen was ever admitted to hospital in relation to her mental health.

Karen was assessed as not presenting any risk to herself or to others. She reported that she had experienced voices telling her to kill her daughter when she was acutely unwell. Her clinician judged that she had good insight into this as a symptom of her illness. At this time

concerns were noted about Karen's alcohol consumption, she reported that she was drinking a bottle of vodka a week. There is no evidence from the records that Karen's alcohol consumption was explored or that she was ever referred to a specialist service.

Karen was prescribed an anti-psychotic drug (Risperidone)[3] and it appears that her mental health was stable when taking medication. However, Karen experienced side effects to the drug and, for a short period of time, other medications were tried. However this resulted in a relapse of psychotic symptoms and the clinical decision was made for Karen to remain on Risperidone. She was discharged from Community Mental Health Services to the care of her GP in 2009.

2010

In April police were called out to a domestic abuse incident involving Karen and her partner.

There are no records of contact with any agency from April 2010 until 2012.

2012

Karen was referred to the CMHT in 2012 for medication advice as she continued to experience side effects. Advice was given about the risk of relapse of psychotic symptoms with a recommendation to remain on Risperidone if she was not experiencing any adverse effects. The referral was then closed and Karen resumed treatment in primary care.

Karen's case was closed to the CMHT and she was referred to her GP for ongoing clinical management.

There are no other recorded contacts with agencies during this year.

3.4. John - Background Information of contact with services 2001 to 2012

Note: Although outside of the scope of this review the panel note that police records in relation to John date back to 1996, when he was reported by a member of the public for indecent activity in relation to children. This information was recorded as intelligence.

In 2001 John had numerous contacts with mental health services. At this time John appears to have resumed contact with his family after a long period of estrangement.

In 2001 John was referred to a consultant psychiatrist. Records from this time make reference to him being 'an extremely disturbed young man' requiring medication and possible detention under the Mental Health Act.

John's family history was briefly described in psychiatric records. The records made reference to adverse childhood experiences including domestic violence from his father towards his mother (in later reports mother made reference to the children suffering emotional abuse from father). It was also noted in John's records that Karen had received psychiatric treatment.

[3] https://patient.info/medicine/risperidone-risperdal

Psychiatric notes refer to John's condition as 'schizophrenic, delusional, obsessed with sex and with thoughts about sex with children.

It was recorded that John was adamant that he would not take medication and it was noted that he did not have insight into his mental health. It appears that no medication was prescribed to him during this period.

Medical notes from this period suggest that John had been unemployed for eight years and had been 'living rough'. Also at this time there is reference in police intelligence to John being attacked by members of the community for 'paedophilia related graffiti'.

John reported alcohol use to his GP and that this was increasing and he wanted to do something about it. There is no indication of any assessment or referral regarding alcohol at that time or at any time since.

At an appointment with a consultant psychiatrist John smashed a window and absconded. Following a police search in September John was arrested, he had a screwdriver and was behaving in a threatening manner. He was detained and assessed under the Mental Health Act (MHA) and admitted to a local hospital with suspected schizophrenia.

Mental health services had contact with John's mother who gave a history of abusive relationships and that John and his sister went into care as children, where she said they may have been abused, however she was not certain of this.

In the latter part of 2001 a hearing took place in relation to detaining John under the MHA. John was detained following some involvement from his father (who John objected to having recorded as his nearest relative).

John appears to have spent some time in a psychiatric hospital (although he may have absconded to his mother's address) until November 2001. At this time he was prescribed anti-psychotic medication and was receiving Cognitive Behavioural Therapy (CBT). Medical notes from November 2001 describe John as presenting a severe danger to others. Notes later in November suggest insight was being gained by John into his mental health and that there were 'some improvements'. There is also reference to John making an appeal against the Mental Health Act Section 3 detention.

In December John was discharged from hospital following assessment. It is recorded in notes that John disagreed with his diagnosis of schizophrenia. He appears to have been discharged to mother's address who is recorded as agreeing to support him. There is no evidence of support being offered to mother in relation to John's on-going mental health difficulties.

Information sent to the GP from the hospital was that John's psychotic episode was in remission. The records indicate that John had believed a dream that if he had sex with a girl then prominent people would die. He believed police had got hold of his written notes of the dream and were monitoring him as they thought he may be a risk to these prominent people. It was noted that John would not believe that he had had a psychotic episode and felt that it was reasonable that he believe his dream because he had had other premonitions in dreams before that had come true.

In 2002/03 John missed a number of appointments with psychiatric services. This was reported to his GP, however there appears to have been no follow up to his non-attendance, either by mental health services or by his GP.

In 2004 it was noted by the clinic that John 'has been sane and sober' for two years and has had no medication for the last 18 months. An entry from 2004 indicates that the Assertive Outreach Team would discharge John in six months' time and refer him to the community mental health team. There is no record of such a referral taking place.

In May 2005 John did not attend a pre-arranged appointment with mental health services, his notes were reviewed and he was noted as having recovered from his paranoid relapse and said not to be taking medication. It was recorded in his notes that he required regular monitoring and should be seen by the Assertive Outreach Team (AOT). This was reported to his GP. However there appears to have been no follow up, either from the AOT or from his GP.

In December (presumably following an appointment in November) he was noted to be 'quite well and free of medication'. It was noted that no new treatment would be provided and a further appointment was to be offered in six months.

The appointment was made but John did not attend an arranged appointment with psychiatric services in May 2006. Following this there are no records indicating further contact with mental health services from 2006 onwards.

The review has established that John continued to have contact with his GP in this period, however there appear to be no significant events until John reappeared in services in 2009.

2009

In August 2009 John underwent a tenancy interview with a HP1 in another part of Greater Manchester at which he provided proof of income. No medical or mental health issues were identified or disclosed. John took up his tenancy at a property. He said he had been living at his mother's address previously and that she was his next of kin[4].

John was still registered with GP1J at this time.

2010

In 2010 John had eight recorded contacts with GPs between October and December (he registered with GP2J in October 2010).

In October John contacted HP1 to say that he had caused damage to the property (he cited a head injury that happened in 2009 as being the cause). John liaised with HP1 and offered to make good the damage. The property was inspected in July 2010 and found to be in, '*extremely poor condition with rotting waste and what appeared to be human excrement on the walls'.* John was not present during the inspection, he had left a set of keys at the office

[4] NICE guidance 2009 (1.5.3) makes specific recommendations in relation to primary care interventions and psychosocial interventions including support for families

and all communication was done by e-mail. At the end of August John gave notice to end the tenancy. The tenancy ended at the beginning of October.

In October John registered with GP2J. In November the GP received information that John had been assessed by the Mental Health Homeless Team that same month. The information stated that John reported suffering a head injury in 2009, which had resulted in flashbacks. There was a note for the GP to refer to the alcohol team, and primary care mental health for psychological support. *Note: There is no record that either of these referrals was made.*[5]

In November John applied for a tenancy with HP2 which began in December (he remained in this tenancy until April 2014).

2011

In 2011 John had 29 recorded contacts with GP2J and GP3J.

Following a charge of carrying an offensive weapon (a kitchen knife which John said he carried for protection) in February 2011 GMPT conducted a pre-sentence report interview.

In March John appeared at court and was sentenced to a 12 month community order with curfew and supervision. *Note: John attended all appointments with his offender manager and completed a number of activities/work programmes during the order.*

In March the GP received a letter from Primary Care Mental Health (PCMHT) saying John had not attended appointment, and was therefore discharged from the service. There was an outcome request for GP2J to follow up in surgery and refer back to PCMHT if appropriate requesting psychiatric assessment.

In April John's offender manager reduced his risk level from medium to low based on assessment. Mental health risk factors were not assessed. Alcohol use was raised by John.

In April John asked for a 'sick note' from his GP, he said did not want the word 'anxiety' on his sick note he wanted paraesthesia cited as the problem as this is what restricted his ability to work. *Note: There is no evidence of where he was working at this time***.** John stated that he is not depressed and 'not remotely suicidal and nor have I ever been'. He made a complaint to the GP in relation to his condition and that he had been waiting some time for a scan.

In May John left GP2J but briefly returned. He then registered with the GP3J.

At a consultation in August with GP3J the GP noted that John had several alarming 'medicalised' self-diagnoses and delusional type reasoning. The GP noted that John may benefit from further mental health assessment. John had presented asking for a 13 week sick note although there was no record that he was working at this time. The GP did not make a referral to mental health services.

In September the GP noted bizarre conversations and possible mental health issues. No referral was made to mental health services.

[5] NICE published clinical guidance on the management of paranoia and schizophrenia (revised 2014).

In November John contacted the Patient Advice and Liaison Service (PALS) regarding the outcome of an examination and refusal to give him a scan, with which he was unhappy. Following this complaint John was offered a scan which he did not take up. It later transpired that John had voice recorded conversations with clinicians without their knowledge. John's GP was made aware of this and noted it on John's records.

In June John again changed his GP and had several appointments regarding a range of symptoms and medical conditions.

In December John attended a GP consultation complaining of chest pain. John stated that he had sustained injuries in an accident which was the fault of the police, who were now working with doctors, radiologists and neurologists to cover up what had happened. NWAS were called to respond to the chest pain but no condition was identified. The GP noted that a psychiatric review may be needed however no referral was made.

2012

In 2012 John had fourteen recorded contacts with his GP. In February at a GP appointment John said that he was drinking a litre of cider a day to 'knock him out'. There is no indication that the GP made any assessment of John's alcohol consumption or considered referring him to a specialist service.

During 2012 John attended all his appointments with his offender manager (OM). His last contact was 13th March. The offender manager did not refer John for a mental health assessment at any point during the order although the OM had noted that John had begun to talk about litigation and claims in relation to head injuries.

In March John was stop checked by police for suspicious behaviour.

In March John attended his GP regarding paraesthesia. He said that the prescribed medication was not working. The GP recorded that paranoia may be present. John requested that if he dies from his illnesses that he has a public post mortem.

Several GP appointments took place regarding a groin injury and scans. In May results of scan showed right sided arachnoid cyst.

In November John was again stop checked by police for suspicious behaviour.

3.5. CONTACTS WITH SERVICES DURING THE PERIOD JANUARY 2013 TO MARCH 2016

Both Karen and John changed housing provider and general practitioners during the period this period. A key to both GPs and housing providers is given at the beginning of this section of the report.

2013

Karen

In January Karen took up a new tenancy with HP1K she also registered with a new GP (GP2K). Over the following weeks Karen had numerous contacts with the HP1K regarding repairs. *The*

review has noted that, in retrospect, the number and frequency of these contacts may be indicative of increased anxiety, however it would not have been possible to have picked this up at the time without Karen asking for help or support.

In April Karen reported anti-social behaviour issues with neighbours. These reports were investigated by HP1K and appropriate action was taken.

Karen had two consultations with the GP in March and July. At the July consultation Karen told the GP that she was trying for a baby. The GP appears not to have made any further enquiries about Karen's plans which is not unusual given her age and general health.

2013

John

John had eighteen recorded contacts with his GP in 2013. Many of these were for health concerns raised by John, for which no cause could be established. John's GP referred him for cardiac investigations, treated him for pain and recorded on one occasion that John's communication was 'bizarre'.

In March HP2J received notification from John that wished to leave his tenancy. In April the tenancy ended and the property was found to be in poor condition – dirty with rubbish around and graffiti on walls. *Note: The review made enquiries to establish that this was not malicious or offensive graffiti.*

When John gave up his tenancy with HP2J in March a long dispute began over arrears and payments for damage to his property. John had many contacts with HP2J over the course of the year.

It is not clear where John was living after giving up his tenancy. He had not taken up another tenancy and medical notes make reference on one occasion to him living with his mother.

In October police received intelligence that John was sleeping rough and making threatening remarks on social media. The intelligence indicated that he was known as someone who had mental health issues. This information was third hand and the threats were general threats not made against anyone in particular. Police noted that the description matched previous reports made by a member of the public. The intelligence was noted in line with usual practice as no crime had been reported.

In November the GP received what they noted to be a bizarre email from John saying his email had been taken over by a 'master controller'. This was noted by the GP but no action was taken to follow up or discuss this with John.

2014

Karen

On 7th March Karen was seen by her GP for a review of her mental health and medication. She reported that auditory hallucinations were persisting and the side effects that had

previously been noted were still present. There were no risks identified to self or to others at this review.

Karen was re-referred to mental health services through the central gateway (referral pathway). On 14th April a response was received by the GP saying that Karen did not meet the criteria for services from the CMHT and that the referral had been forwarded to a Consultant Psychiatrist for an out-patient appointment.

The outcome of her consultation with the consultant psychiatrist was that there were no immediate concerns and Karen was discharged back to the GP to continue with existing medication.

In October Karen attended a GP consultation complaining of pain. She was prescribed pain medication.

2014

John

In 2014 John had eleven recorded contacts with his GP.

In February John was seen by the GP, he said he was sleeping rough. In March the GP received a letter from John's mother saying that he was living with her.

In September John was stop checked on foot by a police officer. He was searched and found to be carrying a large amount of cash. The officer advised him against carrying large sums of money. John had relevant paperwork to show that he had withdrawn the money from his own bank account. He was taken to the local branch of his bank and deposited the money back into his account.

On 19th November Intelligence was submitted by a police officer (who believed that John was the male referred to in reported suspicious circumstances whereby a male had been seen taking photographs of children in a park and passing a note to a female at a bus stop). Intelligence was recorded on the OPUS system to make officers to be aware of John's background and the concerns that the police officer had with regards to any future reports of a similar nature, and for John to be considered as a potential offender.

2015

Karen

There are no recorded agency contacts with Karen other than a note being entered on Karen's GP record that she was a carer for her father who was admitted to a nursing home in November.

In October 2015 Nat spoke to a member of college staff and told them that she was having difficulty coping with Karen's mental health, and that Karen abused her mentally and physically. Nat said that she wanted to move to her own home and that Karen did not want support from health services. Nat said that, although there were difficulties between them, she was worried about leaving Karen alone.

Nat was given an emergency support contact number and an appointment for the following week.

On 19th October Nat had a further one to one with a member of college support team. Three days later Nat was due to attend an appointment regarding alternative accommodation but did not attend this appointment.

In early November Nat spoke to a member of staff at her college. The record of the conversation described Nat as being very emotional. Nat said that she did not attend the last appointment because she had no money to get to college.

Two further discussions took place regarding Nat's college course and in early December Nat reported that she was now OK and was coping at home.

2015

John

In February John changed GP to a practice where he had previously been a patient. He had six recorded contacts with the practice during the year.

In March John was rehoused by HP2J. As part of the application checks were carried out, including 'Serious Offenders' checks. No concerns were identified from John's responses.

In March a phone call was received by police from a member of the public. The call was in relation to John posting comments on Facebook about 'not all children being innocent' and that he had done things with children that he could not talk about. The caller had also noticed on John's Facebook some You Tube videos involving young girls at 'beauty pageants'.

Police officers attended at John's last known address following the report made by the caller. The flat was sparsely furnished but police noticed that John had two laptop computers running in his living room. John was spoken to about comments he had made on social media sites and he stated that he had only posted these comments to get a reaction. He was strongly advised regarding his behaviour.

In April John attended a consultation with his GP saying that he was concerned about internal bleeding. This was his last contact with GP3J.

In July John changed GP to GP4J. John made two visits to his GP in July complaining of chest pain and requesting an angiogram. His notes had not yet been scanned onto the system and he was asked to make a further appointment.

He attended again twice in August, firstly requesting an Angiogram and then requesting Morphine. Naproxen was prescribed and John was advised to make another appointment for a more detailed discussion with the GP. There is no record of a further appointment having been made.

John presented again to his GP in November requesting stronger painkillers, Naproxen was again prescribed. The GP determined that a referral for angiogram was not required.

In November John was stop checked by police on a car park where he was looking into cars. No further action was taken as no offence had been committed.

Other Events in 2015

Later that month Karen and John's father was admitted to a local nursing home having been diagnosed with a terminal illness.

Karen and her sister were regular visitors to the care home and Karen was recorded as father's next of kin.

John contacted the care home on two occasions asking to see his father (who was refusing to see him). John sent several emails to the care home. *The content of the emails related to father's care and John's suspicions that Karen was trying to 'get money out of' their father.*

John presented to the home manager as being annoyed and he referred to the manager of the home as a "jailer". He was observed kicking his bike in the car park after being upset that his father had refused to see him.

2016

Karen and John's father died in January 2016.

In early February Nat contacted Karen's GP to say that she had concerns about Karen's mental health. The GP responded saying that he had not seen Karen about her mental health for some time. No follow up was made by the GP to Nat's concerns.

After his father's death John sent two emails to the care home manager. In the emails John said that he believed that staff had poisoned his father and that toxicology reports should be completed. In a second email John said that he was his father's next of kin and that the Home Manager should have been dealing with him, not his siblings. Although the care home noted John's behaviour as aggressive he did not make any direct threats and there was no reason for the care home to raise any concerns based on John's behaviour.

In early February Nat was observed at college to be very upset. A member of staff spoke to Nat. Nat disclosed that she had a very difficult relationship with her mother and that mother had ongoing mental health problems. She told the staff member that Karen was both verbally and physically abusive to her. She reported that on that morning Karen had hit her and had threatened her with a meat cleaver.

The member of staff spoke to Nat and said that she felt concerned about Nat's immediate safety and that she wanted to make a referral, possibly to CAMHS, to offer support. The staff member also suggested contacting the police, however Nat said that she did not want the police involved and that she was used to these behaviours from her mother.

The staff member checked that Nat had a place of safety and Nat advised that she would temporarily stay with her aunt. The staff member spoke to social care services (the Manchester City Council Contact Centre).

It was passed by the contact centre to the mental health gateway who contacted Karen's GP who said they had not seen her since 2015 and had had no recent contact regarding mental health issues. A Letter was sent to Karen from mental health with an outpatient appointment which was copied to her GP. Karen rang the service asking to be discharged as she did not feel the need to see a psychiatrist at the time. There is no evidence that Karen's GP contacted Karen to discuss the concerns expressed by Nat to the college.

That same month John attended a new patient health check at the GP Practice. He made two further visits on 25th and 26th February complaining of groin pain. At the second visit the GP made a referral to orthopaedics.

At the end of February the incident leading to this review took place.

4 WHAT DO WE LEARN FROM THE REVIEW

4.1 Addressing the key lines of enquiry

4.1.1 Did any agency know that Karen was subject to domestic abuse by John at any time during in the period under review?

The review saw no evidence that any agency had knowledge that Karen was a victim of domestic abuse by John. Similarly none of the agencies knew that John was a perpetrator of domestic abuse. The review identified that on one occasion Karen had been subjected to domestic abuse in a previous relationship and had reported this to the police, this took place outside of the period under review.

4.1.2 If so, what actions were taken to safeguard Karen and were these actions robust and effective?

No actions were undertaken as agencies were not aware that there was domestic abuse in the relationship.

4.1.3 Was John known to any agency as a perpetrator of domestic abuse and if so what actions were taken to reduce the risks presented to Karen and/or others?

John was not known as a perpetrator of domestic abuse by any of the agencies involved in this review.

4.1.4 Did any agency have knowledge that Karen or John were experiencing difficulties in relation to drugs, alcohol, mental health or other vulnerabilities/risk factors?

Both Karen and John were diagnosed with paranoid schizophrenia, a severe and enduring mental health condition. This was known to both specialist and primary care services. It was not known to other agencies who had contact with Karen and John.

Information received in relation to Karen indicates that she was diagnosed with paranoid schizophrenia as a young adult. The review received information from mental health services dating back to 2000. At that time Karen was under the care of mental health services in another area.

John was diagnosed with paranoid schizophrenia at a young age. The review has seen medical records for John dating back to 2001. Between 2001 and 2003 John experienced acute episodes of paranoia and was treated accordingly. A summary is provided of John's contact with mental health services at section three of this report.

4.1.5 Did the victim disclose domestic abuse to family and/or friends, if so what action did they take?

Family members have not participated in the review, however there is no indication from records or from witness statements that Karen ever disclosed domestic abuse to them in relation to John

4.1.6 Did the perpetrator make any disclosures regarding domestic abuse to family or friends, if so what action did they take?

As stated above it is not possible for the review to comment on whether John disclosed that he was a perpetrator of domestic abuse.

4.1.7 Are there any matters relating to safeguarding vulnerable adults and/or children that the review should take account of?

The review looked into one matter with regard to safeguarding Nat. This is dealt with in sections 3, 4 and 5 of this report.

4.1.8 Were issues of race, culture, religion and any other diversity issues considered by agencies when dealing with the victim and alleged perpetrator?

Applying the protected characteristics set out in the Equality Act[6] both were diagnosed with paranoid schizophrenia, a severe and enduring mental health condition. It is not evident that either Karen or John were considered by agencies to have a disability in relation to their mental health.

There is no evidence that either Karen or John received assessments regarding their mental capacity (as defined in the Mental Capacity Act[7],[8]), nor any evidence that either was recorded as lacking mental capacity during the period under review.

4.2. Analysis of professional practice in relation to contacts with Karen

In the period 2001-2012 Karen had mostly routine contacts with services, although she did receive specialist services in relation to her diagnosis of a severe and enduring mental health condition. The historic information seen by the review in relation to Karen's treatment and care in these services has not been analysed in detail. The review has concluded that, during this period Karen received appropriate mental health services including review and referral as required.

[6] age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership and pregnancy and maternity.

[7] https://www.mentalhealth.org.uk/a-to-z/m/mental-capacity

[8] https://www.scie.org.uk/mca/introduction/mental-capacity-act-2005-at-a-glance

At this time mental health services were aware that Karen had children and that Nat was a dependent child living with Karen. Karen's auditory hallucinations involved voices telling Karen to harm Nat. These thoughts were discussed with Karen and it was assessed that she did not present any risk to herself or to Nat. There is no evidence that any safeguarding concerns were identified in relation to Nat. However, there is no indication that any agency took into account clinical guidance published in 2009 recommending support and risk assessment for the families of patients with a diagnosis of paranoid schizophrenia.

During this period there is no record of Karen requiring any other medical interventions. She did not have contact with police or social care services and she appears to have maintained a stable tenancy with a social landlord.

The panel noted that at one point during her treatment the CMHT noted that Karen's alcohol consumption was of concern however there is no indication of assessment or referral to alcohol services.

When Karen moved to her most recent tenancy, she had almost daily contact with the housing provider in relation to repairs to her property. With hindsight it may be that this was an indication of Karen's mental health at that time. However, Karen did not discuss her mental health with the housing provider. It would not be expected that the housing provider would routinely make enquiries about mental health issues, unless this had been disclosed when taking up the tenancy.

On moving to another area Karen was appropriately referred to mental health services and GPK2 was informed about her mental health history. GPK2 continued to prescribe anti-psychotic medication for Karen. Whilst there do not appear to have been proactive reviews of Karen's mental health, GPK2 referred Karen to a psychiatrist in March 2014 when she was experiencing an increase in symptoms. She attended the consultation and was assessed as not requiring interventions from specialist mental health services. She was referred back to her GP for continuing care.

There is no indication that GPK2 took into account clinical guidance recommending support for family members of patients diagnosed with paranoid schizophrenia.

In 2015 GPK2 made a note on Karen's records that she was a carer for her father although there is no record that Karen discussed her father's declining health with her GP or with any other professional.

Nat's disclosures regarding her concerns for her own safety, made to the college in November 2015 and February 2016 did not result in robust safeguarding action, although the college did ask Nat whether she felt safe with Karen. The college also attempted to meet Nat's housing needs. Nat did not follow up her request to the college to assist her with rehousing, however the college did not proactively pursue further contact with Nat in this regard.

Following Nat's disclosures regarding Karen's mental health in November 2015, the GP did not take any action to contact Karen or to consider matters of safeguarding in relation to Nat.

It appears that Karen and her sister supported father before he entered a care home and spent considerable time with him between November 2015 and his death. It is around the time of father's death that tensions between Karen and John appear to have arisen. John appears to have begun to harbour thoughts that Karen had plotted to kill their father. Text messages and social media messages, which were not known to any agency at the time, reveal that John was becoming fixated on his ideas around Karen's imagined role in father's death. No agency was aware of these ideas or of any potential risk to Karen.

4.3 Analysis of professional practice in relation to John

John's mental health history is complex and goes back over a considerable period of time. This review accessed information regarding John's mental health from 2001 to the date of the incident.

Between the years 2001-2003 John had frequent contact with mental health services. He appears to have received appropriate treatment and care that included assessment of potential risk to self and others. He is recorded as having poor insight into his diagnosis and was opposed to taking medication when treated in the community. During this period John was sectioned on one occasion under the Mental Health Act and spent periods of time in psychiatric hospitals.

Although historic, the review has identified particular concerns about John's treatment in mental health services between the years 2003 to 2006 when John was a patient with the Assertive Outreach Team.

The review learned that, at this time, this service was specifically targeted to people with significant mental health issues who required treatment and review, but who had difficulty engaging with services. The service was predicated on the clinical understanding that some patients with a severe and enduring mental health condition require support in engaging with services, and should be regularly reviewed and their risks assessed. The review has seen little evidence that John's refusal to engage in treatment was addressed in this service.

Between 2003 and 2006 there were numerous missed opportunities to engage John in specialist mental health treatment and care services and he was allowed to drift away from services. There appears to have been no multi-agency work done to engage John at this time. He appears to have been allowed to drift away from mental health services at this time with no evidence of a care planned approach to maintaining contact with him.

John was a frequent attender at GP services. He changed GP on four occasions in the period 2001-2016 and it appears that the flow of information between GPs was poor. *Note: The review has observed that this may be a result of national issues in relation to the transfer of records and updating of GP notes.*

Historically and throughout the period under review John displayed symptoms of paranoia and psychotic behaviours. Despite frequent contact with general practice, John's behaviours

and presentations did not result in review or referral to specialist mental health services by any of the GPs with whom he was registered.

John completed a community order in March 2012. During the entire period of his contact with GMPT John did not receive a mental health assessment, nor was he referred to a specialist mental health service. Information regarding John's historic mental health issues was not made available to GMPT as a matter of course as he was not in current contact with mental health services.

In December 2012 John's GP noted that a psychiatric review should be considered however no referral was made. This was a missed opportunity to review John's mental health.

There is no indication that any of the services who were aware of Karen and/or John's diagnoses of schizophrenia followed NICE guidance in relation to clinical management, assessment and referral, family support or alcohol misuse as set out in guidance published in 2009 and updated in 2014. The review considers this lack of clinical management to represent significant missed opportunities to improve outcomes for Karen and John, to safeguard them both and to support their family and carers.

The review has seen no evidence that Karen's mental health was monitored or reviewed by GPK2 following referral back to primary care in 2014.

5 KEY FINDINGS

The key findings from the review are summarised below under thematic headings:

5.1 Mental Health

Clinical guidance in relation to the management of paranoid schizophrenia was not adhered to in either primary or secondary care.

Karen's mental health was well managed for the most part, however, following referral to a consultant psychiatrist in 2014 that resulted in referral back to primary care, Karen did not receive any further review in line with clinical guidelines.

Nat's concerns regarding Karen's mental health were not explored by GPK2, nor was there any follow up or support provided to Nat in line with clinical guidance.

John's mental health was poorly managed between 2003 and 2006, and many opportunities were missed to engage him in services.

John was allowed to drift away from mental health services after 2006 and, other than one referral to mental health services in 2012 (which John did not attend) his mental health needs remained unmet.

John's general practitioners between 2006 and 2016 did not appropriately respond to signs and symptoms of mental ill health and missed opportunities to review and refer John to specialist services.

Historically John's mental health appears to have been appropriately responded to by primary and secondary services. However between the years 2003-2006, despite John being under the care of the Assertive Outreach Team (which should have offered a more robust service based on potential risk and non-engagement) John was allowed to drift away from services. He appears to have been offered six monthly review appointments, some of which he did not attend. No action was taken to engage John in services or to deal with his non-attendance at these appointments. There was no assessment of potential risks that John may present to himself or others during this period.

John's diagnosis of paranoid schizophrenia was unknown to offender management services. The review recognises that there are complexities in relation to information sharing across agencies in different areas of public service. The review understands that in current practice, if John had been identified as a 'high risk' offender, then information in relation to his mental health would have been shared.

5.2 Alcohol Misuse

Both Karen and John disclosed to medical services that they consumed excessive amounts of alcohol. Neither were ever assessed in primary care or mental health services for alcohol misuse, nor were referrals made to specialist substance misuse services. Clinical guidance in relation to the management of schizophrenia makes explicit reference to the importance of managing alcohol consumption and recommends on-going assessment and referral. The 2009 clinical guidance was not adhered to in this case.

5.3 Domestic Abuse

There is no evidence that John was ever physically abusive to Karen before the incident leading to this review.

There is one reported incident of domestic abuse from Karen in relation to her previous partner.

Retrospective information viewed by the review, both in witness statements and text messages between Karen and John indicate that John could be violent, aggressive and controlling in his relationships. However, there was no specific evidence of domestic abuse by John towards Karen.

Police intelligence highlighted in the contextual information set out in this report indicates that John demonstrated obsessive and compulsive behaviours and, on at least one occasion, appeared to be 'stalking and harassing' a female who was not known to him. The review is satisfied that recent legislation in relation to stalking and harassment would now result in further investigation of such an allegation.

The relationship between Karen and Nat appears to have been volatile and difficult. In November 2015 Nat reported to a member of college staff that Karen had been verbally and physically abusive to her (threatening to assault her with a meat cleaver). Nat also disclosed that she had been dealing with abusive behaviour from Karen for many years.

This was a disclosure of significant domestic abuse. Whilst the college acted appropriately in asking Nat about a place of safety and whether she wished them to make a referral to police, there appears to have been a lack of recognition of the incident as domestic abuse or of the domestic abuse pathway.

6 RECOMMENDATIONS

The DHR makes the following recommendations to the Community Safety Partnership based on the learning from this review:

1. The CSP should seek assurance from the CCGs and their respective providers of mental health services that the management of severe and enduring mental health problems is in line with clinical practice guidance. This should include support for families and psychosocial supports as set out in the NICE guidance.
2. The CSP should seek assurance from the CCGs that GPs are aware of and implementing the mental health toolkit set out by the Royal College of General Practitioners in relation to the management of mental health issues in primary care.[9]
3. The CSP should seek assurance that multi-agency systems for sharing information in relation to risk of self-harm and harm to others are in place across the Partnership area, including information sharing between health services and offender management services.
4. The CSP should make representation to NHS England regarding the criteria for Mental Health Homicide reviews. The panel believes that this case would have benefited from such a review

[9] http://www.rcgp.org.uk/clinical-and-research/toolkits/mental-health-toolkit.aspx