Domestic Homicide Review (DHR)

South Worcestershire Community Safety Partnership

Overview Report into the death of “Mrs B”

March 2021

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Overview Report Author

v.7.1

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Contents

Preface

This is a Domestic Homicide Review Report referring to the life and death of Mrs B. This is the pseudonym chosen by the review chair and author and will be used throughout this report.

I would like to begin by expressing my sincere sympathies, and that of the panel, to the family and friends of Mrs B. I am sorry for their loss and hope that in some way this report provides an insight into her life and a voice to her story.

I would like to thank the panel and those that provided chronologies and individual management reviews for their time and cooperation.

1. Introduction

1.1. This report of a domestic homicide review examines agency responses and support given to Mrs B, a resident of Worcestershire prior to her death on a day in March 2021.

1.2. In addition to agency involvement the review will also examine the past to identify any relevant background or trail of abuse before the homicide, whether support was accessed within the community and whether there were any barriers to accessing support. The review seeks to identify appropriate solutions to make the future safer by taking a holistic approach.

1.3. The review will consider agency's contact and involvement with Mrs B and Miss M from 1st September 2020, when police received the first report of a domestic abuse related incident and an apparent decline in Miss M's mental health, to the date when Mrs B died.

1.4. The key purpose for undertaking DHRs is to enable lessons to be learned from homicides where a person is killed as a result of domestic violence and abuse. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change to reduce the risk of such tragedies happening in the future.

1.5. Every effort has been made to conduct this review process with an open mindset and to avoid hindsight bias. Those leading the review have sought the views of family members and made every attempt to manage the process with compassion and sensitivity.

2. Timescales

2.1. A referral was received by South Worcestershire Community Safety Partnership (CSP) on the 1st April 2021 with a first scoping meeting on the 29th April 2021. There was then a delay securing CSP authorisation for the DHR process, which occurred on 11th June 2021 with a decision on authorship being made on 13th September 2021.

2.2. The review concluded in August 2022. The Home Office Statutory Guidance advises that where practically possible the Domestic Homicide Review should be completed within six months of the decision to proceed with the review. The review was unable to be completed in the six-month time frame due to the delay in appointing a Chair and Author, and subsequently, the pressures created by the covid-19 pandemic during the initial stages of the review which delayed the return of Individual Management Reviews (IMRs)[1]. Once these delays became apparent the timeline for completion of the review was adjusted accordingly.

2.3. The first panel meeting was held on 6th December 2021. During this initial meeting, the draft terms of reference were discussed, amended and agreed. The panel met on three more occasions. The chair and author contacted agencies to gain additional information and clarifications outside of the formal panel meetings.

[1] In the winter season of 2021/22 NHS staff were being redeployed to administer booster vaccinations

3. Confidentiality

3.1. The findings of each review are confidential. Information is available only to participating officers/professionals and their line managers. Ordinarily pseudonyms would be chosen by the family or at least in consultation with the family, however as the family chose not to participate in this review the pseudonyms were chosen by the review author and chair. Pseudonyms were agreed with the panel and used in the report to protect the identity of the individual(s) involved.

4. Terms of Reference

4.1. Statutory Guidance (Section 2.7) states the purpose of the DHR Review is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;
- Apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;
- Prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a coordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;
- Contribute to a better understanding of the nature of domestic violence and abuse;
- Highlight good practice.

Specific terms of reference set for this review

- To identify all incidents and events relevant to the named persons and identify whether practitioners and agencies responded in accordance with agreed processes and procedures at the time of those incidents.
- To establish whether practitioners and agencies involved followed appropriate inter-agency and multi-agency procedures in response to the victim's and her mother's needs, and also the needs of the perpetrator.
- Whether, and to what extent did race, ethnicity or cultural factors affected the victim's understanding of Domestic Abuse, and their ability to seek help and access services.
- Consider the efficacy of IMR Authors' agencies' involvement in a multi-agency /multi-disciplinary team meeting regarding Domestic Abuse (where relevant).
- Consider the efficacy of IMR Authors' agencies' involvement in a multi-agency /multi-disciplinary team meeting regarding the perpetrator's mental health.

- Establish whether relevant single agency or inter-agency responses to concerns about the victim and the assessment of risk to her and others was considered and appropriate.

- Establish whether relevant single agency or inter-agency responses to concerns about the perpetrator and the assessment of risk to her and others was considered and appropriate.

- Establish whether relevant single agency or inter-agency responses to concerns about the mother of the victim and the assessment of risk to her.

- To what extent were the views of the victim (and where relevant, significant others), appropriately considered to inform agency responses.

- Identify any areas where the working practices of agency involvement had a significant positive or negative impact on practice or the outcome.

- To what extent did Covid-19, Lockdown and potential isolation impact on the victim and or offender accessing support, e.g. for domestic abuse or mental ill health services.

- Identify any gaps in and recommend any changes to the policy, procedures and practices of the agency and inter-agency working with the aim of better safeguarding adults where domestic violence is a feature.

- Establish whether there are lessons to be learned from the case about the way in which local practitioners and agencies carried out their responsibilities and duties and worked together to manage risk and safeguard the victim, her family and the wider public.

- To consider recommendations and actions from previous Domestic Homicide Reviews and assess if they are recurring/reappearing in this review, of particular relevance will be learning from Reviews where coercive control has been identified as a feature.

- Establish if the perpetrator failed to engage with the IMR author's agency what strategies, policies or procedures did your agency follow to engage with her. Were there any barriers to her accessing services, were there particular reasons why your agency was not appealing, did contact diminish after the initial engagement.

5. Methodology

5.1. The method for conducting DHR's is prescribed by the Home Office Guidelines. These guidelines state: "Reviews should illuminate the past to make the future safer and it follows therefore that reviews should be professionally curious, find the trail of abuse and identify which agencies had contact with the victim, perpetrator or family and which agencies were in contact with each other. From this position, appropriate solutions can be recommended to help recognise abuse and either signpost victims to suitable support or design safer interventions"

5.2. Following the decision to undertake the review, all agencies were asked to check their records about any interactions with Mrs B, Miss M and/or Mrs B's mother (Miss M's grandmother).

5.3. Where it was established that there had been contact the South Worcestershire Community Safety Partnership (SWCSP) ensured that all agencies promptly secured all relevant documents, and those who could make an appropriate contribution were invited to become panel members. Agencies that were deemed to have relevant contact were then asked to provide an Individual Management Review (IMR) and a chronology detailing the specific nature of that contact. Where contact was minimal or outside of the scoping period agencies were invited to complete a summary report.

5.4. The aim of the IMR is to look openly and critically at individual and organisational practice to see whether the case indicates that changes could or should be made to agency policies and practice. Where changes were required then each IMR also identified how those changes would be implemented.

5.5. Each agency's IMR covered details of their interactions with Mrs B, Miss M and/or Mrs B's mother, and whether they had followed internal procedures. Where appropriate the report writers made recommendations relevant to their own agencies and prepared action plans to address them. Participating agencies were advised to ensure their actions were taken to address lessons learnt as early as possible. As part of this process IMR authors, where appropriate, interviewed the relevant staff from their agencies.

5.6. The findings from the IMR reports were endorsed and quality assured by senior officers within the respective organisations who commissioned the report and who are responsible for ensuring that the recommendations within the IMRs are implemented.

5.7. On request from the independent chair, some authors provided additional information to clarify issues raised individually and collectively within the IMRs. Contact was made directly with those agencies outside of the formal panel meetings.

5.8. Those agencies who provided IMR's or summary reports are detailed within section 7 of this report.

6. Involvement of Family, Friends, Work Colleagues, Neighbours and Wider Community

6.1 Contact with Mrs B's family was initiated via West Mercia Police. They declined to be involved or to contribute to the DHR. As such this review has relied upon the information held and shared by the agencies involved, which predominantly related to Miss B. The report therefore focuses on the contact and involvement of agencies with Miss B.

7. Contributors to the Review

7.1 The agencies that have contributed to this review are as follows:

- West Mercia Police – IMR
- Herefordshire and Worcestershire Health and Care NHS Trust – IMR
- Herefordshire and Worcestershire Clinical Commissioning Group – IMR
- Worcestershire Acute Hospitals NHS Trust – IMR

- Cranstoun[2] - IMR
- Adult Social Care - IMR

7.2 IMR authors were independent with no direct involvement in the case or line management responsibility for any of those involved.

8. The Review Panel Members

8.1 The DHR panel members were as follows:

Name	Role	Agency
Mark Dalton	Independent Chair	Review Consulting
Steve Cook	Detective Inspector	West Mercia Police
Daniel Gray	Head of Quality Assurance and Principal Social Worker	Worcestershire Children First
Julia Greig	Independent Author	Review Consulting
Suzanne Hardy	Safeguarding Services Manager	Herefordshire and Worcestershire Health and Care NHS Trust
Steve Cook Dave Knight	Detective Inspector Detective Inspector	West Mercia Police
Paul Kinsella	Advanced Public Health Practitioner	WCC
Jason Marshall	Practice Improvement Lead	WCC, Adult Social Care
Chanel Ovel	Access to Services Manager	West Mercia Women's Aid
Deborah Narburgh	Head of Safeguarding	Worcestershire Acute NHS Trust
Jeremy Newell Heather Manning	Deputy Designated Nurse for Safeguarding	Herefordshire and Worcestershire CCG
Annie Steele	Assistant Director of Services	Cranstoun

8.2 Independence and impartiality are fundamental principles of delivering DHR and the impartiality of the independent chair and report author and panel members is essential in delivering a process and report that is legitimate and credible. None of the panel members had direct involvement in the case or had line management responsibility for any of those involved.

9. Author of the Overview Report

9.1 South Worcestershire CSP appointed Mark Dalton to chair the review and Julia Greig to author the Overview Report. Mark Dalton is an independent registered social worker and experienced SILP (Significant Incident Learning Process) reviewer. He has

[2] Cranstoun Worcestershire operates the adult alcohol and drug recovery service across Worcestershire.

extensive social work experience in the statutory and voluntary sector and has undertaken DHR's for other Community Safety Partnerships. He has completed the Home Office approved course for Domestic Homicide Review Authors and over the years undertaken further training with Community Safety Partnerships, the Social Care Institute for Excellence, and Review Consulting. He is independent of all the agencies involved in this case and the South Worcestershire Community Safety Partnership. He has previously undertaken Domestic Homicide Reviews for Worcestershire County Council's Community Safety Partnerships.

9.2 Julia Greig is an experienced social work manager and Independent Reviewer. She has undertaken the Home Office online training for authors of Domestic Homicide Reviews and training in the SILP methodology. She is currently undertaking Safeguarding Adult Reviews and Domestic Homicide Reviews in other local authority areas. She is independent of all the agencies involved in this case and the South Worcestershire Community Safety Partnership.

10. Parallel Reviews

10.1 Criminal proceedings concluded in February 2022 when Miss M was found guilty of murder at Worcester Crown Court and given a life sentence.

10.2 A Mental Health Homicide Review was discussed with, and considered by, NHS England. However, as Miss B was not in receipt of specialist mental health provision the criteria was not met.

11. Equality And Diversity

11.1 The nine protected characteristics identified in the Equality Act 2010 were assessed for relevance to the DHR. Of particular relevance were gender, age, and disability.

11.2 Mrs B was 69 year old white British woman. A Home Office analysis of DHRs has shown that 77% of domestic homicide victims are female.[3] With regards to age it is estimated that approximately 120,000 individuals agreed 65 and over have experienced domestic abuse yet only 3% of victims over the age of 60 are accessing IDVA services.[4] For 44% of over 60s the primary perpetrator is an adult family member, as opposed to 6% of those under the age of 60.[5] Research has suggested that older victims of domestic abuse face systematic invisibility, long term abuse and dependency, an increased risk of adult family abuse, services that are not effectively targeted to older victims, and generational attitudes which make it harder to identify abuse.

11.3 Mrs B had no particular vulnerabilities that were known about. However, she was an informal carer for her mother. The Home Office[6] indicated that 8% of victims were carers. In 60% of these cases the homicide was carried out by a person being cared for, however, in this case there was no evidence that Mrs B was a carer for Miss M.

[3] Annex_A_DHRs_Review_Report_2020-2021.pdf (publishing.service.gov.uk)
[4] Safe Later Lives - Older people and domestic abuse.pdf (safelives.org.uk)
[5] Safe Later Lives - Older people and domestic abuse.pdf (safelives.org.uk)
[6] Annex_A_DHRs_Review_Report_2020-2021.pdf (publishing.service.gov.uk)

11.4 Miss M was a 49 year old white British woman. Miss M experienced both mental ill health and used cannabis, in addition she experienced physical health issues, therefore she was considered as having a disability in accordance with the Equalities Act 2010 as a result of both her physical and mental ill-health. Furthermore, seventy-one percent of perpetrators, in the DHRs reviewed by the Home Office, were recorded as having at least one vulnerability. The most common being illicit drug use, mental ill health and problem alcohol use. Miss M considered herself to be a carer, the review of DHRs found that 13% of perpetrators were carers.

11.5 With respect to the relationship between victim and perpetrator, the Home Office identified that in 33% of cases the relationship was familial and in 54% of these cases the victim was a parent.[7]

12. Dissemination

12.1 In accordance with Home Office guidance, all agencies and the family of Mrs B are aware that the final Overview Report will be published. IMR reports will not be made publicly available. Although key issues if identified will be shared with specific organisations the Overview Report will not be disseminated until clearance has been received from the Home Office Quality Assurance Group.

12.2 The content of the Overview Report has been suitably anonymised to protect the identity of the female who died and relevant family members. The Overview Report will be produced in a format that is suitable for publication with any suggested redactions before publication.

12.3 The Overview Report will be shared with the panel member agencies and the CSP and will be published on the Worcester City website.

13. Background Information

13.1 Mrs B lived in a privately owned property in Worcestershire. Mrs B had caring responsibilities for her 90-year-old mother and would visit her regularly to undertake housework and deliver shopping. Mrs B had five children, one daughter (Miss M) and four sons.

13.2 Miss M, Mrs B's daughter, lived in a housing association property. Prior to the incident, she was living between her flat and her grandmother's.

13.3 Miss M had a diagnosis of Obsessive Compulsive Disorder (OCD) with progressive depressive disorder. Miss M was known to frequently use cannabis and has physical health problems of on-going chronic joint pain and emphysema. Discussion at a roundtable meeting on 28th April 2021 suggested Miss M's diagnosis was more likely to be borderline personality disorder with anti-social traits, although this was not the formal diagnosis at the time of the incident.

13.4 Miss M reported a difficult childhood alleging ongoing emotional abuse from Mrs B whose focus of attention and affection was her sons. Miss M had no contact with her

[7] Annex_A_DHRs_Review_Report_2020-2021.pdf (publishing.service.gov.uk)

father or her other siblings. Miss M said her grandmother was emotionally cold and distant, buying her gifts as a way of showing affection and that at times it was difficult to live with her grandmother due to her grandmother's own mental health problems. She described the family as "broken."

13.5 Miss M had been in a relationship which had ended some time ago. They had remained friends and shared ownership of a dog. At the time of the incident, Miss M was not in a relationship and has no children. She described difficulties in maintaining relationships with others because she considered herself a bad person who struggled to manage her emotions, in particular, her anger.

13.6 On a morning in March 2021 Mrs B arrived at her mother's home to deliver groceries. Miss M had been upstairs in the bedroom. At approximately 10:30am Miss M came downstairs to the kitchen where Mrs B was cleaning. Mrs B and Miss M were arguing when Mrs B's mother heard a scream. Mrs B stumbled into the living room and collapsed into the chair, bleeding heavily.

13.7 Emergency services received a call from Miss M stating that she had attacked and stabbed her mother, Mrs B. Police arrived at the scene and Miss M was arrested for GBH. Mrs B was attended to by ambulance crew and was pronounced dead at the scene.

13.8 Whilst in custody and following confirmation of Mrs B's death, Miss M was arrested on suspicion of murder. Under formal interview Miss M said that she had suffered from mental health problems in excess of 10 years and had sought treatment. Miss M said she did not get on with her mother and reported that she 'flipped' and stabbed Mrs B in her back after Mrs B had passed a comment about Miss M being sectioned.

14. Chronology

Background history

14.1 There is little background history known about Mrs B and her mother. With regards to Miss M it is known that at the age of 11 she went to live with her grandmother. Miss M attended school but left with no qualifications. Miss M had worked for the past 6 years at a supermarket as a checkout operator but had been sick leave for the previous 7 months.

14.2 Miss M reported a difficult childhood and described her mother as cruel to her but loving to her brothers. She reports both loving and hating her mother and grandmother, and that she was unable to settle in other relationships.

14.3 On 18th June 2020 Mrs B's mother sustained a fall at home and the Falls Response Team discussed with Mrs B the need for a care package for her mother. A GP also spoke to Miss M regarding the fall. The GP attempted a follow up discussion to confirm whether Miss M had managed to contact Social Services, the call was recorded as a failed encounter.

Narrative chronology

14.1 On the 3rd September 2020 Miss M visited her previous partner at his workplace, she was in an aggressive mood and swore at his colleague. She visited again on the 4th September 2020, and he felt that she was looking for him. He attended the police station the following day to discuss the matter further, he stated '*she is stalking me. I am scared of her*.' He said that Miss M had previously assaulted him 9 years ago which led to the ending of the relationship, and it was his belief that she was on drugs.

14.2 Miss M's previous partner told police that he did not wish for Miss M to be contacted about the matter. Nevertheless, the police completed a DASH and Adult Risk Assessment which were both graded as medium risk. The Stalking risk assessment (SDASH[8]) was not completed. The completed assessments were forwarded to the Harm Assessment Unit (HAU) took no further action as they did not have consent to refer the matter on to partner agencies and specific safeguarding issues were not apparent.

14.3 Mrs B had a telephone consultation with GP1 on the 29th September 2020. She reported a flare up of Inflammatory Bowel Disease (IBD)[9] and reported that she had been under stress due to looking after her mother. Medical advice was given.

14.4 Miss M called Adult Social Care (ASC) on the 7th October 2020 and reported she was living with and providing support to her grandmother. Miss M stated it was near impossible to continue to care for her grandmother due to dementia and she expressed frustration and anger towards her grandmother. Miss M said she was unwell herself with cancer and had lost weight due to stress. The social worker reported that Miss M was 'very distressed' during the call.

14.5 A social care worker called Miss M back and Miss M reiterated she could no longer support her grandmother due to her own physical and mental health. Miss M described her grandmother's support needs. The social care worker attempted to contact Miss M's grandmother but there was no answer.

14.6 The following day, 8th October 2020, the social care worker spoke to Miss M's grandmother by telephone, and she denied needing any support. The grandmother asked, '*has she told you how each time she sees me she says to me 'I want to slap you in the face'?*' and said, '*she wants to burn my house down with me in it*'. The grandmother also reported that Miss M could be aggressive towards her. The social care worker discussed the conflicting information provided by Miss M and her grandmother with an Advanced Social Work Professional who advised a call back to the grandmother at later date to see if she had been able to retain information and repeat what she had said.

[8] Stalking and Domestic Abuse, Stalking and Honour Based Abuse (SDASH). The SDASH is a 'screening tool' for domestic and non-domestic cases. It is an integral part of the DASH toolkit. Practitioners are referred to it whilst working through a DASH assessment, and the SDASH is triggered if the answer to 'Does the abuser constantly text, call, contact, follow, stalk or harass you?' is a 'Yes'. Included within SDASH are questions concerning previous incidents, visits to the victim's workplace, threats, abuse of alcohol/drugs and previous incidents of violence. The three SDASH risk categories are identical to those of a DASH.

[9] Recto Sigmoid Colitis (a chronic digestive disease characterised by inflammation of the inner lining of the colon).

14.7 The social care worker called Miss M's grandmother on the 15th October 2020. During the call, she repeated that she required no social care support. ASC involvement was ended as a result.

14.8 On the 18th October 2020 Miss M contacted her GP surgery complaining of fever and neck pain after a car accident the week before and was triaged for a call-back which was made the following day. GP3 made three attempts to call Miss M, but none were answered.

14.9 On the 19th October 2020, Miss M attended a psychology appointment. Miss M was emotional and tearful but easy to build a rapport with. Risks were explored and none were identified. Miss M reported a difficult childhood with generational patterns of rejection which had left her with Obsessive compulsive disorder (OCD) and poor self-image. Six sessions were booked with the next appointment on the 26th October 2020 by telephone.

14.10 On the 21st October 2020 a female friend of Miss M contacted the police and alleged that she received malicious and threatening communication from Miss M sent via telephone and social media. The matter was graded as Safe Grade 4[10] and was dealt with over the telephone by the 'Public Contact Service Centre (PCSC).' An Adult Risk Assessment was completed as the complainant had suffered from a mental health condition in the recent past. The risk was recorded as being 'Standard'. Miss M did not feature in the Adult Risk Assessment and the completed form was referred to the HAU.

14.11 The next day, 22nd October 2020, GP4 had a telephone consultation with Miss M who complained of joint pain, night sweats, loss of weight, fatigue, no energy, and neck pain following a car accident, and said she was covered in bruises. Miss M was very tearful on the phone, and it was very difficult to get any history as she moved from one topic to another. GP4 decided to see Miss M for a face-to-face review.

14.12 The friend made a further complaint about Miss M on 23rd October 2020. Miss M had accusing her of stealing £50 and threatened to 'smash her face in'. There was delay in contacting the friend which did not take place until 12th November 2020. She said she had no contact from Miss M for two weeks and no longer wished to pursue the matter. Police did not speak to Miss M about the allegations made against her.

14.13 Miss M attended her second psychology session on the 26th October 2020. Miss M discussed a recent relationship breakup which had led to feelings of rejection, rage and sadness. Miss M described being in bed for the previous four days feeling sad and worrying getting angry with people. Miss M described fleeting thoughts of suicide but had no plans to act on them. The next telephone appointment was arranged for 9th November 2020 and consent to share information was agreed.

14.14 During Miss M's next psychology session, on the 9th November, the psychologist noticed patterns of Miss M judging herself. Miss M was assessed as having no suicidal thoughts. The next appointment was arranged for 16th November 2020 which Miss M did not attend despite several attempts to contact her by phone.

14.15 On the 18th November 2020 GP5 had a telephone consultation with Miss M regarding fibromyalgia and a review of pain medication. Miss M reported being tearful and labile

[10] Local Incident Management (contact by phone within 48 hours)

in mood at times[11], and fed up with her poor health. GP5 decided to review with GP4 as they knew Miss M's history.

14.16 Miss M's fourth psychology session took place on the 23rd November 2020. Miss M reported that she had been by the phone for the previous appointment but received no call. Miss M was given the service administration number in case it happened again and was advised that this would not count as a 'did not attend.' The session discussed the relationships with her mother. Miss M noted she had been feeling stressed which was impacting upon her health, so the psychologist explored meditation. No suicidal thoughts or risk to self were identified and the next session was arranged for the 30th November 2020.

14.17 On the 30th November 2020 Miss M had her fifth psychology session. The session continued to explore the impact of her relationship with her grandmother and began to think about ways to move forward from this. Miss M remained extremely angry with her mother and grandmother and even though she had put more boundaries in with her grandmother, this relationship still had an unhelpful effect on her. No suicidal thoughts were reported. The next appointment arranged for the 7th December 2020.

14.18 Psychology session six took place on the 7th December 2020. Miss M reported intense suicidal thoughts over the weekend and so was provided with the Crisis Resolution Team (CRT) number. Miss M did not think her anti-depressant[12] was working and was advised to see her GP for a medication review, Miss M agreed to do this. No immediate concerns about the risk to self were noted. The next appointment was arranged for the 16th December 2020.

14.19 On the 7th December 2020 Miss M contacted the GP surgery about changing her medication. The call was triaged for a same day call back.

14.20 Miss M's previous partner contacted the police again on the 10th December 2020 reporting that Miss M had turned up at his place of work demanding to speak to him. He was invited to the police station and attended on the 12th December 2020. He stated that he had concerns about Miss M's mental health and said he wanted her spoken to informally and was happy that this would resolve the issue. Police completed the DASH which demonstrated a standard risk although the assessment lacked detail and some questions he refused to answer. The police recorded the matter as a one-off incident and did not complete the SDASH. No referrals were made by the HAU. The investigation summary stated that Miss M was spoken to and advised not to speak to or contact her ex-partner. Miss M said she was happy to keep to this.

14.21 Miss M had a telephone consultation with GP4 on the 15th December 2020 to discuss her medication. Miss M said she felt it wasn't working and said her mental health had taken a dip, feeling low and anxious. No suicidal thoughts and no thoughts of self-harm were noted. GP4 reviewed the guidelines for changing antidepressants and

[11] Labile mood is a psychological term. It is used to describe people who experience irregular emotional responses. Labile mood is associated with severe mood swings and with intense emotional reactions. Often the emotions will be particularly strong and disproportionate to the situation the person is in. Labile mood indicates that there is little control around emotional responses. It indicates a low ability to handle and process frustration.

[12] Citalopram 40mg - Citalopram is an antidepressant known as a selective serotonin reuptake inhibitor (SSRI). It is often used to treat low mood (depression) and also sometimes for panic attacks.

determined Miss M could switch directly to an alternative antidepressant. Sertraline[13] was prescribed noting that she may need a higher dose but to see how she goes on this dose for the first few weeks.

14.22 Miss M had her seventh psychology session on the 16th December 2020. Miss M was still having suicidal thoughts, but these had lessened since she interacted with her neighbour and discussed medication with the GP. No immediate concerns about risk to self or plans to act on suicidal thoughts were identified. The next appointment was arranged for the 4th January 2021.

14.23 On the 4th January 2021 Miss M attended her eighth psychology session. Miss M reported having intense suicidal thoughts and making plans to end her life over the past 2 weeks. Miss M was different to her normal presentation and said she had never had intense thoughts before. The psychologist noted that Miss M had started Sertraline 2 weeks ago and considered whether this may have been a side effect of the medication. The psychologist recommended that Miss M call her GP to discuss suicidal thoughts and reducing/changing medication. Miss M had resisted acting on thoughts for fear of not ending her life successfully and being in more pain. It was noted that there was no history of acting on suicidal thoughts and Miss M described wanting the pain to stop rather than a wish to die. Miss M said she had a dog which was considered a protective factor.

14.24 On the 8th January 2021 Miss M had a telephone consultation with GP6 after the psychologist arranged the appointment. It was noted that Miss M had been beset with suicidal thoughts since changing medication. Miss M was awake more, with a lack of energy, poor concentration, struggling to care for her dog and grandmother. Her anxiety had worsened. She was having thoughts about plugging the hosepipe into the car exhaust and going to a quiet place, and thoughts of stabbing herself. Miss M had been staying in bed to protect herself from acting upon her thoughts and said she had been living only to keep her grandmother alive. Miss M reported that if her thoughts continued, she may start to act on them. GP6 discussed Miss M with CRT who agreed to call her the same day. GP6 changed Miss M's antidepressants to Mirtazapine[14] and prescribed a low dose of Diazepam[15] to help calm her for the next few days.

14.25 Miss M also had her ninth psychology session on the 11th January 2021. Miss M said that part of her wanted to live as she did not act upon her thoughts over the weekend, she was unclear as to what stopped her. The Psychologist explained the potential physical damage Miss M may cause from a failed attempt. Miss M reported that she was not sleeping; was feeling anxious and smoking more cannabis than normal. She reported that she had never had such intense suicidal thoughts before. She was still managing to feed the dog. She did not feel able to call the GP as she felt too overwhelmed and anxious. She felt trapped by her hoarding behaviour and impulsive spending and felt powerless to help herself. Miss M had been contacting her mother and her grandmother for help and was feeling angry with them when they were unhelpful. She was aware that she was sabotaging herself as typically they were unable to help her. Risk of completing suicide was determined to be medium risk.

[13] Sertraline 50mg - Sertraline is an antidepressant known as a SSRI. It is often used to treat depression, and also sometimes panic attacks, obsessive compulsive disorder (OCD) and post-traumatic stress disorder (PTSD). It works by increasing the levels of serotonin in the brain.

[14] Mirtazapine is an antidepressant medicine. It is used to treat depression and sometimes OCD and anxiety. It works by increasing the amount of noradrenaline and serotonin in the brain.

[15] Diazepam is a benzodiazepine. It is used to treat anxiety, muscle spasms and seizures/fits. It works by increasing the levels of gamma-aminobutyric acid (GABA) in the brain.

14.26 GP7 called the psychologist on the 11th January 2021 to discuss Miss M's suicidal ideation. The psychologist was concerned that Miss M did not normally voice plans but was now. The GP agreed to telephone Miss M that day.

14.27 On the same day CRT undertook a triage assessment by telephone. Miss M shared she was having thoughts of suicide constantly since she started on Sertraline 16 days ago but the medication had now been stopped by her GP. Miss M reported poor sleep and feeling low in mood. Miss M was having thoughts of strangling the dog as she felt the dog was another bind for her to deal with. The clinician advised Miss M to give the dog up. Miss M stated that she had been having thoughts of strangling her grandmother and gassing herself so that they did not have to live like this. A further telephone assessment was offered for 8:30 pm that evening.

14.28 On the 13th January 2021 GP6 called Miss M but all calls went to voicemail. GP6 telephoned CRT to check whether they had had contact with Miss M, they confirmed they spoke to her on the 11th January 2021 and that she was open to the Home Treatment Team (HTT) for ongoing support. GP6 recorded that they would try to follow up with Miss M on the 15th January 2021.

14.29 On the same day the HTT made a crisis support phone call to Miss M. After many failed attempts, Miss M answered the phone at 16:40. Miss M reported that she was not having a good day. She spoke about housing and work worries. Her benefits had stopped; she was due to lose her bedroom tax allowance and believed this would lead to her being evicted. Miss M said she struggled with phone calls but her neighbour had offered to help. Miss M felt that she was not worth people's help. Miss M reported poor concentration, appetite and motivation to cook for herself. She agreed to focus on the need to eat and also give herself a routine.

14.30 Miss M reported she slept well last night following the new medications. Miss M had intended to visit her mother that day but had not felt able to and now felt that she should have. It was discussed whether she would benefit from further CRT/HTT support, Miss M declined and said that she would contact the CRT if she needed to manage her thoughts of suicide. Miss M was therefore discharged from HTT.

14.31 The following day, 14th January 2021, the psychologist spoke to Miss M about a Community Assessment and Recovery Service (CARS) referral. Miss M reported that she was sleeping better, and her suicidal thoughts had decreased in intensity. Miss M was struggling with anxiety but felt less overwhelmed. It was discussed that she may need more support from Mental Health services and Miss M agreed to a CARS referral. The psychologist made a referral to consider on-going support and monitoring as psychology sessions were due to end.

14.32 Miss M had her tenth psychology session on the 20th January 2021. Miss M was continuing to have suicidal thoughts and plans to end her life. She was staying at her grandmother's house. Miss M reported that the previous day she had put all her tablets together and got the hose from the shed and put all of this in her car. She wrote a suicide note and went to see her grandmother who worked out what she was planning and persuaded Miss M to stay overnight. Miss M was feeling overwhelmed as she had lost her job, had a poor housing situation, was hoarding and feeling unable to function. Miss M said she was feeling trapped now she had lost her job and she would not be able to afford the flat. Miss M had investigated giving the dog away but would need to fill out forms and did not have the motivation to do that. The risk of suicide was assessed as medium to high. Miss M agreed to stay at her grandmother's and knew that she could call CRT although reported that she was unlikely to do this.

14.33 The psychologist informed CRT who confirmed there was no role for them currently and spoke with the Clinical Lead to discuss the risk management plan that was in place.

14.34 The psychologist called GP5 and provided an update. GP5 was concerned that Miss M had all the medications she planned to overdose with. GP5 made a referral to Social Prescribing and Lifestyle Advisor[16].

14.35 The following day, 21st January 2021, Miss M had a telephone consultation with GP5. GP5 recorded that there was a safety plan in place in via CRT, the grandmother was on board. The psychologist had spoken to Miss M and had made clear that she was not currently suicidal. GP5 spoke to the psychologist who was still concerned but felt that everything has been done to keep Miss M safe and as she has capacity, an admission (under the Mental Health Act) was not currently indicated. GP5 agreed that contact from Primary Care should continue ideally by a GP who knew Miss M well. GP 5 discussed with GP4, who Miss M trusted, and GP4 agreed to call Miss M.

14.36 GP4 spoke to Miss M, who confirmed she was staying with her grandmother. Miss M said she was not currently making plans to harm herself. She felt life was pointless but said she did not have the motivation or energy to harm herself. Miss M planned to stay at her grandmother's for the time being. GP4 agreed to issue a week's supply of Diazepam and Mirtazapine. GP4 confirmed that Miss M and her grandmother had the CRT number if needed over the weekend.

14.37 On the 22nd January 2021 Mrs B phoned Miss M's GP surgery. Mrs B was concerned as Miss M had gone to her grandmother's and locked herself in her room. Mrs B wanted a doctor to visit straight away. Mrs B was advised to call the police if she was concerned about Miss M's welfare.

14.38 On the 27th January 2021 the psychologist called Miss M following a CARS referral meeting and informed her she would be offered an assessment within 4 weeks. Miss M reported that she still felt overwhelmed although she did shower that morning and she had cut her hair off as it was starting to matt. Miss M said she remained at her grandmother's house and planned to go to the flat that day as she had a gas service. She was feeling apprehensive as she was planning on ending her life when she was last there. A letter was sent to Miss M on the 29th January 2021 inviting her to a CARS telephone assessment on the 11th February 2021.

14.39 On the 9th February 2021 GP4 reviewed Miss M by telephone. Miss M reported feeling better, with mental health more stable, and the Mirtazapine helping. Miss M reported no longer feeling suicidal with no thoughts of self-harm. Miss M felt more motivated and was trying to sort out her debt issues. Miss M said she was staying mainly at her grandmother's house. Miss M said she had not smoked cannabis for 3 weeks and taking Diazepam only occasionally. A further appointment was booked with GP4 for the 23rd February 2021.

14.40 Miss M had her eleventh psychology session on the 10th February 2021 during which her discharge from psychology was discussed. Miss M described feeling hopeless and could not cope with her life. Miss M said her sleep had improved and had no intentions

[16] Social Prescribing is suitable for any patient whose health & wellbeing is being impacted by practical or social issues, such as: Benefits and money, Employment and education, Unemployment, Loneliness and isolation, Family, Housing. Lifestyle advisors: The key areas of focus are weight management, smoking cessation, alcohol reduction, improved wellbeing and becoming more active. They work with people for up to 6 months by setting goals with them and creating a plan to support positive change.

to end her life. Miss M was ruminating on her relationships with her grandmother and mother and was having thoughts of wanting to stab her mother. This was not felt to be a serious threat but more an expression and reflection of the level of her emotional distress. She described feeling intense self-hatred and this undermined any positive changes she achieved. She had stopped smoking cannabis as she had run out of money. The psychologist discussed that therapy had not been helpful and Miss M was apologetic for "failing" therapy. Miss M said that she did not wish to meet again but thanked the psychologist for her time.

14.41 On the following day, 11th February 2021, Miss M had her first assessment with CARS. A medic did not attend the assessment but did subsequently review Miss M's treatment plan. A medic review was booked for the 4th April 2021.

14.42 On the 17th February there was a multi-disciplinary team meeting to discuss Miss M's first assessment. It was suggested that Miss M would benefit from Dialectic Behaviour Therapy (DBT)[17]. The team agreed a referral to the job retention services would be beneficial as Miss M was at risk of losing her job. It was noted Miss M would benefit from a referral to social prescribers to support with accessing benefits and housing needs. Miss M was informed on the 19th February 2021 that she had been accepted into CARS and would be allocated a care coordinator and medic.

14.43 Also on the 19th February 2021, Miss M had a telephone consultation with GP7. GP7 reported that Miss M was clearly struggling, with anhedonia, poor sleep, appetite awful, no motivation and anxiety persisting although noted she was no longer suicidal. The Mirtazapine dose was increased to 30mg for review in one week.

14.44 On the 23rd February 2021 GP4 had a telephone consultation with Miss M. Miss M said the social prescriber had made her feel more anxious and had told her that she would probably lose her flat. Miss M said she was still staying at her grandmother's house. She also said she was thinking about going back to work. A telephone review was arranged for the following week with GP4.

14.45 The next day, 24th February 2021, Miss M met with her care co-ordinator. Miss M spoke about her past mental health and suicidal ideation. Miss M reported she was currently staying at her grandmother's house but felt that her grandmother was the cause of her difficulties, she felt aggressive towards her grandmother but would never hurt her. Her grandmother was her only contact and she had no friends, she had lost contact with her friends due to her narcissistic behaviour. Miss M had tried to reach out to her mother recently but found that she said unhelpful things which she then ruminated over which resulted in her feeling worse. Miss M had thoughts of setting fire to her flat as it was easier to deal with clutter, clothes and paperwork that was overwhelming her. The care co-ordinator discussed the potential of services and support such as Occupational Therapy, reablement, Individual Placement Services (IPS), the anxiety group, social prescribers and social care. A further appointment was booked, and a referral was made to IPS for job retention support.

14.46 On the 25th February 2021 the social prescriber telephoned Miss M. Miss M was distressed on the phone and said she was not coping. Miss M said she had been thinking about ending it all and said that she had been thinking about setting her house on fire. She reported that she had petrol in her shed, and she was waiting to get the courage to start the fire. Miss M was asked if this was something she was going to do,

[17] DBT is a therapy which focusses on providing the patient with the skills and strategies to regulate and manage their emotions better.

and Miss M said she did not know. Miss M was advised against doing this for her own safety and the safety of others in her building. Miss M explained that no one would be able to help, and they would be stopping her from doing something she wanted to do. The social prescriber immediately rang 999 and requested an ambulance.

14.47 Paramedics attended Miss M's address and called CRT for advice. Miss M spoke with CRT. Miss M said that she needed petrol but did not have any and then the ambulance had arrived. It was determined that Miss M did not have a fixed plan to end her life. She had thought of a few ways that she could do it but there was no intent to act on these immediately. A safety plan was put in place for Miss M to stay with her grandmother overnight to keep herself safe. CRT advised they would request that the care co-ordinator contact Miss M the following day and she was provided with the CRT number.

14.48 Also on the 25th February 2021 the IPS support worker called Miss M. Miss M reported she was having a bad day, she felt overwhelmed and did not know where to start to get her life back on track. Miss M felt unable to decide about returning to work or if new employment would be a better option but believed she would be sacked soon as she had been off sick for 7 months. Miss M spoke about not feeling presentable and wanted help with her appearance and she agreed to speak with her care co-ordinator about this. It was agreed that Miss M would produce a support list to help her return to work. A further appointment was made for 2nd March 2021.

14.49 The next day, 26th February 2021, Miss M was telephoned by the care co-ordinator. Miss M said, in relation to the previous day's events, that she had had enough and only gets respite when she sleeps. Miss M said she was not sure how she would keep herself safe due to feeling so overwhelmed. Miss M reported being stressed about work as she had received a letter for a meeting on the following Monday. The care co-ordinator spoke to the IPS worker who agreed to call Miss M's employer to let them know the meeting would not take place on the Monday.

14.50 The care co-ordinator discussed Miss M with the HTT Manager who advised a face-to-face visit that afternoon. During the visit, the Miss M presented with a much brighter attitude. She was informed that the meeting with her employer on the Monday had been cancelled, and Miss M felt relieved by this. The care co-ordinator confirmed she would see Miss M again on 1st March 2021 and they would discuss what needed to be dealt with now and what could be dealt with later. Miss M spoke about not seeing a way out and her options were to either get a full-time job or commit suicide. This was explored further and concluded there was no current intent or plan.

14.51 On the 1st March 2021, the care co-ordinator visited Miss M at her flat. Miss M became tearful and said her home overwhelmed her, and she was worrying about work and her home. She confirmed she was currently staying with her grandmother. The care co-ordinator suggested a stepped approach to address her issues. Miss M confirmed she had not smoked cannabis for a month except for the day before to help her sleep, she described cannabis as her 'best friend'. Miss M said she received Universal Credit and that a previous debt had been paid off by her grandmother. They discussed Miss M's relationship with her grandmother. Miss M said she felt resentful of her grandmother and spoke about a very inconsistent relationship with her mother. The care coordinator agreed to visit next week and liaise with Social Prescriber.

14.52 GP4 had a telephone consultation with Miss M on the 2nd March 2021. Miss M said she was currently back at her flat, still struggling and feeling overwhelmed. Miss M was hopeful that the situation would improve and was not feeling suicidal that day. A further review was booked for 9th March 2021.

14.53 The Social Prescriber called the care co-ordinator. Miss M had informed the Social Prescriber that she could not afford her property and needed to move to a smaller property. The care co-ordinator reported Miss M was saying that she had to move, but this did not appear to be the case, Miss M was not in arrears and had not received any eviction notices. Citizens Advice Bureau were helping with forms for benefits. Social Prescriber had referred Miss M to 'House for You'.[18]

14.54 Also on the 2nd March 2021 the IPS worker contacted Miss M. The IPS worker confirmed they had spoken with Miss M's employer, and there was a new manager who was supportive of her recovery. Miss M was relieved to hear this. Benefits were discussed and Miss M reported her fit note was coming to an end and she was not motivated to call the GP to extend this. The IPS worker arranged a GP appointment for the 4th March 2021.

14.55 On the day of Mrs B's murder GP4 attempted to telephone call to Miss M at 11:37 and 11:44am but she did not answer.

15. Overview

15.1 The overview will summarise the information that was known by the agencies and professionals involved about the victim, and the perpetrator, and any other relevant facts or information about the victim and perpetrator.

Overview of Involvement with Cranstoun

15.2 Cranstoun were not involved with either Mrs B or her mother. Their involvement with Miss M occurred in 2016 and in 2018 whereby Miss M underwent treatment journeys in relation to substance misuse.

15.3 In 2016 Miss M attended six out of the eight offered appointments and reduced her use of cannabis from 1g to 0.5g per day. She was closed to treatment after saying she was unable to focus on reducing her cannabis use further due to caring for her grandmother.

15.4 In 2018 Miss M attended five out of ten appointments offered. Miss M was smoking around 2g of cannabis daily. She reported she had been diagnosed with emphysema and had been advised she had 6 months before she would be in a wheelchair. Miss M was closed to treatment following missing three appointments, and failure to responding to telephone calls and a letter requesting contact within 14 days. Miss M reported that she had reduced her cannabis use to 1.5g per day.

15.5 During both treatment journeys Miss M reported low mood and said she had been prescribed medication by her GP. On both occasions risk assessments did not identify any concerns of risk of violence and Miss M did not refer to Mrs B at any time.

[18] 'House for You' - a portal that allows you to register with a Local Authority for housing support. Aligned with Jigsaw (a group for relatives and carers of people with mental health issues)

Overview of Involvement with Herefordshire and Worcestershire Health and Care NHS Trust

15.6 Herefordshire and Worcestershire Health and Care NHS Trust records indicated involvement with Miss M from 2019. Between November 2020 and February 2021 Miss M received eleven sessions of counselling to process the past so that Miss M could let go of the pain of relationships with her mother and grandmother, to think about boundaries with her family and process her feelings around ill health. Counselling was not successful for Miss M, it caused her to ruminate further, and her mood became more depressed with increased suicidal thoughts which resulted in brief CRT / HTT support for two days in January 2021.

15.7 Miss M was subsequently referred to the Community Assessment and Recovery Service (CARS) for increased support due to not progressing as expected with her psychological input. She was accepted into the CARS service on 17th February 2021 for onward support and a medical review. A Care Co-ordinator was allocated on 22nd February 2021 who completed two phone assessments and on two occasions met Miss M at her home.

15.8 During the final session with the Psychologist Miss M disclosed thoughts of stabbing her mother. The Care Coordinator had, prior to the incident, reviewed Miss M on three occasions during which time she had not expressed any thoughts of harming her mother.

Overview of Involvement with Herefordshire and Worcestershire CCG

15.9 Mrs B had been registered with Surgery 1 since 1989. Mrs B had a chronic physical health condition and long-standing anxiety. During the scoping period, there was only one contact with the GP, in the form of a telephone consultation and advice regarding her condition during which she disclosed she was a carer for her mother.

15.10 Miss M had been registered at Surgery 2 since 1971. Miss M had a rare, inherited medical condition, which can cause lung and liver problems and had long standing mental health issues. Many aspects of Miss M's condition contributed to an impairment of her quality of life. Miss M was monitored for these conditions under the care of a specialist consultant.

15.11 During the scoping period, Miss M had contact with professionals at the surgery on sixteen occasions, both face to face and via telephone. Thirteen of the consultations were regarding continuing and escalating mental health concerns.

15.12 Mrs Bs mother, also registered with Surgery 2, did not have any consultations with professionals at the surgery during the scoping period and none prior to this period that were considered relevant to the review. By all accounts she was a fit and healthy 90-year-old woman.

Overview of Involvement with West Mercia Police

15.13 Neither Mrs B nor her mother were known to any police force, locally or nationally.

15.14 Miss M first came to the notice of West Mercia Police in 1990 when she was convicted of a minor assault and sentenced at Worcester Magistrates Court. There was further

local police intervention with Miss M in 1997 when she was accused of a further minor assault.

15.15 Miss M is recorded as being the victim of minor damage, harassment, damage, and further damage in 1998, 2009, 2010 and 2011 respectively. In 2019 Miss M was the victim of an indecent assault.

15.16 In 2020 Miss M's former partner reported, on two occasions, three incidents of harassment by Miss M to the police. Police spoke to Miss M following the third incident and Miss M accepted the advice to cease contact with him.

15.17 A former friend of Miss M also reported that she had been the subject of malicious communication from Miss M. At the request of the person reporting, no action was taken, and Miss M was not spoken to by the police.

Overview of Involvement with Worcestershire Acute Hospitals NHS Trust

15.18 Worcestershire Acute Hospital NHS Trust (WHAT) had minimal contact with Mrs B, her mother and Miss M.

15.19 Mrs B had four Emergency Department attendances at WAHT, the last one being in 2017. Between 2017 and 2020 Mrs B attended the Gastroenterology Clinic for Specialist Nurse Clinic Support for IBD. In respect of these attendances, there were no concerns expressed about injuries being inconsistent with the explanation given nor were any safeguarding concerns suspected or raised.

15.20 Mrs B's mother attended the Emergency Department in July 2017 with an injury to her wrist. There were no safeguarding concerns noted.

15.21 Miss M attended the Emergency Department on four occasions between 2015 and 2020. During her attendance in March 2017, Miss M stated she was a carer for her grandmother.

15.22 Miss M attended forty outpatient appointments between 2015 and 2021 for rheumatology, respiratory and sleep clinics. She attended all but four appointments. Miss M had no acute admissions.

Overview of Involvement with Adult Social Care

15.23 Adult Social Care had contact and involvement with Miss M, as a carer for her grandmother, and then with her grandmother as a person with potential care and support needs, over an eight day period in October 2020.

15.24 Miss M reported the mental and physical health impacts of the caring role and expressed a wish to end this role. She further reported that her grandmother had dementia. Miss M was referred to primary health care concerning a dementia diagnosis for her grandmother.

15.25 Miss M's grandmother was contacted directly and was assumed to be able to make her own decisions with regards to care and support needs. Miss M's grandmother reported psychological and verbal abuse by Miss M. The duty to make enquiries was not initiated.

16. Analysis

16.1 The analysis section will examine how and why events occurred, information that was shared, the decisions that were made, and the actions that were taken or not taken. It will consider whether different decisions or actions may have led to a different course of events and address the terms of reference and the key lines of enquiry within them through the themes identified. It will also highlight examples of good practice.

16.2 The chronology and overview of involvement from each of the agencies demonstrate very minimal involvement with either Mrs B or her mother, whereas Miss M had significant involvement from agencies, predominantly for her mental health. By November 2020 Miss M was having contact with professionals almost weekly, by January 2021 she was having multiple contacts per week. On that basis the analysis predominantly focuses on Miss M and her interactions with the agencies.

Impact of Covid-19 and lockdown

16.3 In March 2020 the UK Prime Minister introduced a nationwide lockdown. All non-essential contact and travel was prohibited, and many services moved to remote working. Restrictions began to ease in July 2020 and people were able to meet up in limited numbers outside. There was further easing of restrictions in August 2020.

16.4 There was a further national lockdown introduced for four weeks on the 2nd November 2020 and from the 21st December 2020 London and the Southeast entered its third lockdown, this was extended nationwide on the 6th January 2021. The 'stay at home' order was finally lifted on the 29th March 2021 with most legal limits on social contact being removed on 19th July 2021[19]. Therefore, throughout most of the period in the scope for this review the country was in lockdown.

16.5 In some cases, victims' access to ongoing support or help with caring responsibilities or mental or physical health conditions was reduced during the lockdown, anecdotally people chose not to access services so as not to burden the reportedly overwhelmed services. This may account for the lack of involvement with services by Mrs B and her mother. Conversely Miss M's access to services did not appear to be affected by the impact of covid-19.

16.6 Most of Miss M's appointments and interactions with professionals were by telephone. There were occasions when face to face appointments were made to maximise two-way engagement between Miss M and practitioners.

16.7 Whilst the disadvantages of remote consultations have been widely reported this may have been beneficial for Miss M given her frequently cited lack of motivation. It is possible that if all her appointments had been in person there may have been an increased number of 'did not attends'.

[19] timeline-coronavirus-lockdown-December-2021 (instituteforgovernment.org.uk)

16.8 However, Miss M was an isolated individual, which she attributed to her mental health. The effects of lockdown on peoples' mental health have also been widely reported and it is noted that Miss M's deterioration in mental health coincided with the second and third lockdowns.

Carer Support

16.9 Mrs B identified as a carer and had cited this as a source of stress, which may have exacerbated her IBD[20]. However, there is no evidence that further support regarding her caring role was explored or that she was signposted for a Carer's Assessment.

16.10 Miss M also identified as a carer for her grandmother (a fact that has been disputed by family members) which she communicated to many of the professionals that were supporting her. Save for the GP signposting Miss M to ASC in 2019 to request support for grandmother, her caring role was not explored with her again. Considering Miss M's feelings towards her grandmother, and indications that her grandmother had care and support needs, there was significant potential for her grandmother to be an adult at risk.

16.11 Agencies were also aware that Miss M was residing with her grandmother during periods of poor mental health and suicidal ideation. The GP had, on two occasions, ensured that both Miss M and her grandmother had the contact details for CRT. Miss M's grandmother was considered a protective factor and Miss M was encouraged to stay with her when experiencing suicidal ideation as part of Miss M's protection plan. However, there was no consideration given to whether her grandmother would benefit from support from other agencies, with regards her own needs, as well as supporting her to support Miss M.

16.12 As both Mrs B and Miss M identified themselves as a carer to Mrs B's mother, agencies should have formally referred both Mrs B and Miss M to Adult Social Care for a formal carers assessment to be undertaken by Adult Social Care in accordance with section 10 of the Care Act 2014.

Risk Assessment

16.13 Miss M cited that her caring role caused her stress and was open about her feelings towards her grandmother, as well as her mother, which were well documented. The first instance was in October 2020 when Miss M expressed her anger and frustration towards her grandmother in a telephone call with ASC. During this brief period of involvement with ASC Miss M's grandmother also disclosed abuse by Miss M. This disclosure should have triggered a duty to make enquiries under safeguarding procedures (s42, Care Act 2014) and to undertake a carers assessment s10, Care Act 2014) but neither was not considered, and ASC closed its involvement satisfied that the grandmother did not have any care and support needs.

16.14 In January and February 2021 Miss M told professionals that she felt anger and aggression towards her grandmother and had thoughts of strangling her. Miss M also

[20] Psychological stress in IBD: new insights into pathogenic and therapeutic implications | Gut (bmj.com)

stated in January 2021 that she had thoughts about strangling her dog and in February 2021 had thoughts about stabbing her mother.

16.15 Professionals consistently assessed Miss M's risk to others as low, her thoughts were determined to be without intent, the focus of interventions was on the risk of harm to herself. There was a lack of professional curiosity around Miss M's statements of harm towards others, particularly given her grandmother's assumed vulnerability by virtue of Miss M being her carer, and this information should have been shared more widely with other professionals and agencies. Miss M was encouraged to stay with her grandmother during periods of suicidal ideation and low mood without consideration of the potential impact this may have on her grandmother.

16.16 When West Mercia Police responded to the first complaint of harassment made by Miss M's ex-partner on the 5th September 2020, officers recognised that both harassment and mental health indicators were present and incorporated details of both within their report.

16.17 As he and Miss M had been in a relationship and officers recognised that both he and Miss M fulfilled the definition of vulnerability,[21] officers completed a DASH Risk Assessment and an Adult Risk Assessment and forwarded them to HAU enabling them to consider referral to partner agencies.

16.18 Following the second report to police by Miss M's ex-partner, the SDASH[22], was not completed which would have provided further information to the HAU. A 'course of conduct' was made out and a stalking offence was recorded in December 2020, it being a continuation of offending against her ex-partner. Although the need for a DASH was identified, it was scant of meaningful information which meant an SDASH was not completed. Vulnerability was acknowledged in respect of both Miss M and her ex-partner but not conveyed to the HAU by way of Adult Risk Assessment. Consequently, HAU considered the incident in isolation as a 'Standard Domestic Incident' and referrals were not considered, the existing mental health concerns for Miss M being undetectable by HAU. Unfortunately, in complying with the ex-partner's wishes earlier intervention with Miss M did not take place. Onward referrals could not take place as the absence of a significant safeguarding issue meant that consent was required.

16.19 Furthermore, following the first complaint, officers could have considered generating an information marker alerting other police personnel of the mental health concerns for Miss M. Such information markers would have allowed any subsequent police intervention with Miss M to be informed, potentially affecting the outcome of that intervention. In this case, an information marker and mental health indicators may have influenced the officer speaking with Miss M and would have conveyed a need for that officer to broach the subject of Mental Health and support, even though she presented as being 'coherent and logical.'

[21] ' A person is vulnerable if, as a result of their situation or circumstances, they are unable to take care of or protect themselves or others from harm or exploitation. ' National Police Chiefs Council (NPCC)

Engagement with services

16.20 The review found no evidence of Miss M's family members raising concerns about Miss M, her mental health or the risk she posed to herself or others to agencies, although it is possible that family members raised concerns with one another or within their social network. However, Mrs B did make one call to the GP surgery with concerns for Miss M and was signposted to the police; Mrs B's mother only shared information when approached by ASC. This review was unable to establish the reason for the lack of contact with services and should be mindful of the barriers that exist when seeking assistance from services, the accessibility of services and the impact of the covid-19 pandemic as referred to above.

16.21 Miss M engaged well with services and attended all scheduled telephone appointments. Miss M engaged particularly well with the GPs at her surgery and with the psychologist.

16.22 It is unfortunate that Miss M had contact with seven different GPs throughout the scoping period and it is widely recognised that this has the potential to create barriers for the patient, by having to re-tell their 'story' many times. For a patient with complex mental health needs, it would have been judicious for one GP to have oversight of Miss M's care providing continuity but also so she didn't have to repeat her story to different professionals[23]. This does present a challenge, on a day-to-day basis patients are triaged and will be allocated an appointment on the day according to clinical need. For example, when Miss M presented in crisis the GP who knew her history may not have been available and therefore it was important for Miss M to have a consultation with any GP. However, Miss M's good relationship with GP4, along with their significant knowledge of Miss M's case, was recognised and promoted where possible.

Mental health support

16.23 NICE guidelines recommend that people at risk of mental health crisis should receive care and referral quickly[24]. It is evident that Miss M's surgery and the psychologist worked together and in a timely way to support Miss M's mental health needs at the point of crisis and need for ongoing support.

16.24 The GPs were responsive and demonstrated a person-centred approach when working with Miss M and reviewing her medication. Whilst Miss M spoke to a number of different GPs at her surgery this did not appear to be detrimental to the care she received.

16.25 Miss M was appropriately referred onto CARS for ongoing Mental Health support and referrals were made to other agencies to support her with aspects of her life which were impacting on her mental health, for example, social prescribing and IPS.

16.26 When Miss M's mental health reached crisis, she was appropriately referred to the CRT. However, the focus was on the risk of harm she posed to herself and did not fully consider the risk to others.

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[23] Understanding the health care needs of people with multiple health conditions.pdf

[24] Overview | Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services | Guidance | NICE

16.27 It is usual practice that a first assessment is carried out jointly with a medic and a community clinician. However, due to an identified conflict of interest with the Medic they did not attend the first assessment with Miss M. No alternative medic could be identified at short notice. The Medic did review Miss M's treatment plan and was satisfied with the medication regime prescribed.

Multi-agency working

16.28 There was one multi-disciplinary meeting that took place when CARS considered the initial assessment for Miss M, although it is not known who was party to this meeting.

16.29 There were occasions when health professionals liaised with each other with regard to Miss M's mental health. The psychologist liaised with the GP, and vice versa, sharing appropriate levels of information, and both made appropriate onward referrals for Miss M.

16.30 A contact between the social prescriber and the care coordinator demonstrated the ability to triangulate information that Miss M was sharing with regards to her housing concerns which were found to be contradictory.

16.31 However, the multi-disciplinary working was contained to health services. Greater professional curiosity regarding the caring roles and potential vulnerabilities of all those involved would likely have initiated multi-disciplinary conversations with other agencies including ASC.

16.32 With regards to West Mercia Police, it was the understanding of the officers investigating the first harassment incident that HAU would progress the subsequent safeguarding action. The HAU have explained that in these circumstances action would normally be taken to progress a referral to Health upon obtaining the consent of the subject. On this occasion, this did not take place and the rationale for not taking this action is not recorded and remains unclear. However, the crime report clearly conveyed the ex-partner's wishes that he did not want Miss M contacted in pursuance of his complaint.

16.33 It is acknowledged that Miss M stated she had suffered from mental health problems for over 10 years and had already sought treatment and support. Notwithstanding this, further referrals would have alerted partner agencies to recent incidents, enabling existing support strategies to be adjusted.

16.34 The NPCC definition of Vulnerability is wider than that of 'adults at risk' provided by the Care Act 2014. The need to train frontline officers has been identified to ensure referrals contain the necessary information to ensure it is shared when the legislative criteria is not met.

17. Conclusions

17.1 This is a tragic case where Mrs B's life was taken at the hands of her daughter, Miss M.

17.2 It is unfortunate that Mrs B's voice is not represented as well as the Review Panel would have wished. The review has relied upon the information held and shared by the agencies involved, which predominantly related to Miss B. Mrs B had minimal contact with agencies both during the period subject to review and historically. As such, this review, and the learning which has been identified as a result, is primarily focused on the services provided to Miss M as a result of her mental health.

17.3 Although there was no recorded history of domestic abuse Miss M's grandmother did disclose abuse during the scoping period. A previous partner was also the subject of stalking and harassment during the period under review and disclosed historical abuse. A friend of Miss M's reported malicious communications from Miss M. Miss M also disclosed that she had a difficult relationship with her mother and grandmother which she reported stemmed back to childhood.

17.4 Miss M's mental health appeared to deteriorate from September 2020 and she accessed and was referred to a range of agencies to support her with her mental health and to help address the factors that had been identified as contributing to her feelings of being overwhelmed.

18. Lessons Identified

18.1 Miss M received support from Mental Health and primary care services that focused on the risk she posed to herself and risk of suicide. This review has identified that the risk to others was not fully considered and there were missed opportunities to explore this and share information with other agencies. Where a potential risk to another is identified, consideration should be given to contacting other agencies to share information i.e., other GP practices, and referrals to, for example, Adult Social Care.

18.2 Miss M and her mother regarded themselves as carers and Miss M's grandmother also took on a caring role supporting Miss M with her mental health. However, on no occasion were any of the parties signposted to carer services or offered a carers assessment. Carers should be given consideration in their own right and be offered an assessment of need, which would include an assessment of risks. A review of DHRs identified that none of the victims that identified as carers had received a Carer's Assessment and only 1% of perpetrators had received a Carer's Assessment.[25]

18.3 The review also identified the need to consider risk to other adults. Where a person appears to be in need of care and support, is experiencing, or is at risk of, abuse or neglect, and as a result of those needs is unable to protect themselves against the abuse or neglect or the risk of it, the local authority must make enquiries to enable it to decide whether any action should be taken.

[25] Domestic Homicide Reviews: Key Findings from Analysis of Domestic Homicide Reviews. September 2021. Domestic Homicide Reviews (publishing.service.gov.uk)

19. Recommendations

South Worcestershire Community Safety Partnership

- Increase awareness of the Complex Adult Risk Management pathway across all agencies.

- Improve practitioners understanding of, and competence in responding to adults who are experiencing or at risk of abuse.

- Improve carer awareness and increase signposting to carer services.

- For agencies to understand when a disclosure which indicates a 'risk to others' is shared and who with

The following organisations made specific recommendations for their agency:

Primary Care GP Services, Herefordshire and Worcestershire CCG

- To improve clinicians understanding regarding Carer's Assessments (as per the Care Act).

- To improve knowledge so that clinicians for the GP Practice will understand when/how the Complex Adult Risk Management (CARM) process can be initiated and by whom.

Herefordshire and Worcestershire Health and Care NHS Trust

- At first contact with services to ensure that all patients are provided with contact details of reception desk should technical issues arise at appointments.

- GRIST assessment training to be provided to individual clinicians where there have been omissions in completing the GRIST risk assessment.

- Further training and education to be rolled out to all Mental Health staff in assessing patient risk towards others and exploring intensity and frequency of thoughts, asking the question of past behaviours – as an indicator for future behaviours. The requirements to complete GRIST risk assessment accurately and in detail.

- If for any reason the medic is not able to attend the initial CARS triage assessment, then for the medic to review the patient notes and treatment plan and document the of outcome of the review in the patients notes and an appointment for a medical review to be arranged.

- IPS workers when working with patients to assess the patient's reading and writing abilities and document this within the patient's notes.

- For all community Mental Health staff to familiarise themselves with the Adult Safeguarding Policy.

- For it to be communicated widely across the organisation that if a patient reports thoughts of harming another then for this for be taken extremely seriously and for contact to be made to the safeguarding team for further advice on management of the identified risk.

- For individual supervision to take place and discussion and reflection on raising any expressed harm towards others with the safeguarding team for further advice/ support.

- A reflective supervision session to be held for CARS team highlighting that if any patient expresses harm towards others this is raised with the safeguarding team for further advice and support.

- A reflective supervision session to be held for CARS team highlighting the need to read through all the available information about the patient before the first meeting as allocated care co-ordinator takes place.

- All GPs within Worcestershire to be made aware of this incident and that change to medication may have impacted on this patient's impulsivity and agitation. For GPs to be provided with information of how to access advice from the CARS team for complex patients/frequent changes to anti-depressant medications.

- That carer's are aware of their right to support under the Care Act in respect of a carers assessments. This should be made clear to all patients who disclose that they are carer a carer to someone as this may be causing the considerable distress.

West Mercia Police

- Review current attachment programme to expand and include opportunities for new recruits and CPD training for existing staff / officers for role experience within vulnerability teams and HAUs to enhance understanding of referral requirements and agency requirements

Cranstoun

- County Manager to disseminate a reminder to the service on the ability for signposting of individuals on how they can access a Carer Assessment should the service user identify as a carer.

Adult Social Care, Worcestershire County Council

- An induction process is developed and implemented for new staff that ensures specific skills and knowledge appropriate to role and duties are identified and that progress is recorded.

- Formal guidance to be drafted to formalise the current allocation procedure considering level of skill/role of staff.

- Supervision guidance do be developed/updated to ensure that quality standards (qualitative and quantitative) are met by existing staff and to support the development of new/less experienced staff.

- Staff must be directed in recording impromptu supervision

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