# Domestic Homicide Review Overview Report

Report into the death of Mrs CR on 27th December 2012

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Independent DHR Chairman & Author

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**Executive Summary**

1. On the 27th December 2012 Mr AR killed his mother Mrs CR in her home. At the time of the incident he was under the care of the Central Wandsworth and West Battersea Community Mental Health Team (CMHT) and was being treated for paranoid schizophrenia. Mr AR was tried at the Central Criminal Court on Thursday 12th September 2013 where he pleaded guilty to manslaughter with diminished responsibility. Mr AR is currently held in the secure unit at Springfield Hospital.

2. A Domestic Homicide Review (DHR) commenced on 5th February 2013, (working within the Home Office – Multi – Agency Statutory Guidance for the Conduct of Domestic Homicides), to establish what lessons are to be learnt to prevent domestic violence and abuse homicide and improve service responses. DHR are not enquiries into how the victim died or into who is culpable, that is a matter for coroners and criminal courts, respectively to determine as appropriate. The rational for the review process is to ensure that agencies are responding appropriately to victims of domestic violence and abuse by offering and putting in place appropriate support mechanisms, procedures, resources and interventions with an aim to avoid further incidents of domestic homicide and violence. The review also assesses whether agencies had sufficient and robust procedures and protocols in place, which were understood and adhered to by their staff.

3. The DHR involved the following agencies: Wandsworth Borough Council, Metropolitan Police Service, Southwest London and St George's Mental Health Trust, St George's Healthcare Trust, Wandsworth MIND, Chelsea and Westminster Hospital NHS Foundation Trust and Viridian Housing. Relatives and family members of the deceased were contacted and given the opportunity to participate in this review.

4. Each agency produced an Individual Management Review that included a review of their responses and any learning and practice change requirements identified. The vast majority of issues of concern were also highlighted in the Mental Health Trust's (MHT) Root Cause Analysis Investigation. The MHT's Investigation Panel was satisfied that the medication management of Mr AR's needs was satisfactory. It concluded that there was no evidence to indicate that the patient's clinical presentations had changed in the two weeks leading to the incident. They recognised the shortfalls in the care of Mr AR and drew up a comprehensive list of recommendations to rectify these and improve care in the future.

5. During the course of his period under the care of the Mental Health Trust he had 11 episodes of hospitalisation – 5 of which were informal (voluntary) and 6 were related to sectioning under the provisions of the Mental Health Act. His first period of hospitalisation was in 1991 and his last ended in August 2011. His medication was administered by a depot injection replenished every three weeks. There is no evidence of him missing his prescribed medication.

6. He lived in a housing association flat provided by Viridian Housing since 1994. On two occasions Anti-Social Behaviour (ASB) procedures were instigated against him following complaints by neighbours when he was unwell but not progressed when Viridian Housing were informed that he was receiving treatment.

7. Mr AR did not have any criminal convictions. The Police were called out to a small number of incidents but none of these resulted in charges being brought

8. The quality of the communications between the agencies involved in this case was considered to be poor and in need of significant improvement. Nevertheless, there was nothing to indicate that the outcome would have been different if this shortfall in communications had not occurred.

9. Friends of Mrs CR recounted conversations with her when she told them that her son had told her she had to die before Christmas as she had lived too long. There was no corroborating evidence of the discussions with her son, whether she had reported them correctly and in the correct context. Similarly, we were aware that the friends recollected events with the benefit of hindsight and with the knowledge of the tragic events which followed. Mrs CR did not convey these concerns to any medical professionals treating her son. She did not inform her GP who she visited 14 days before her death and no sign of anxiety or distress was noticeable at this visit.

10. The MHT records of Mr AR show a recurring issue of paranoia and negativity about his mother when he was unwell but this was never explored to increase understanding. The MHT never relayed their concerns about her safety to her despite using this as a reason, at a Mental Health Tribunal, to prevent his sectioning being lifted and him being released back into the community. She was never given any briefing on his relapse indicators and how to spot them.

11. The DHR found that the treatment given to Mr AR by the MHT appears to have been focused almost in its entirety on the depot injection. There were large gaps in Mr AR's life history and the insight into him as a person. The lack of continuity in care co-ordinators, the frequent staff changes involved in his care and the use of agency staff in the MHT appears to work negatively against maintaining a strong collective memory within the team and reduces knowledge of the patient's risk and social history. These shortfalls were consolidated by the lack of formal handover or briefing between care coordinators. An overview of Mr AR's patient history was not easily obtainable by the staff caring for him. There was nothing to suggest compliance with the guidelines which recommends mental health professionals work in partnership with family members and carers and also offer family interventions to all families of people with schizophrenia who live with or are in close contact with the service user. Weaknesses were evident in the CPA planning for Mr AR; there was little evidence of a holistic recovery plan. The DHR panel were of the view that the care and treatment of Mr AR was not optimised.

12. The victim, Mrs CR was an 86 year old female in poor health who lived alone. She was not given a carer's assessment despite her regular involvement in his care and probably being the most significant support in his life and therefore did not have the benefit of the available support services such as carer's allowance, psychological support and family intervention as recommended by NICE guidelines. She was marginalised and her intimate knowledge of her son's life history was therefore not captured.

13. The DHR accepts that his clinical presentation did not change in the weeks prior to this incident and there were no warning signs that he was unwell. His medication was reduced by 40% in the 7 months prior to the homicide and this did concern us but we accepted the expert opinion that this is highly unlikely to have triggered a relapse. No external organisations or agencies had signalled any concerns about his mental state in the period immediately before the incident. We could not identify anything that if done differently would have made the incident more predictable or prevented the fatal outcome.

14. The DHR concludes that the events of 27th December 2012 could not, on balance, have been predicted or prevented. All contributing organisations and agencies have accepted their identified shortfalls and have made recommendations to correct and improve their service provision or

organisational behaviour.

15. The acceptance of the highlighted shortfalls by all the actively involved organisations and agencies has meant that the DHR panel could concentrate its recommendation on the core issues of concern. During the course of our deliberations we identified that the same recommendations for improvement seem to be repeated nationally across homicide reviews and inquiries and that lessons to be learned are identified and implemented but not consistently learned otherwise they would not continue to happen. We suggest that the Home Office should explore this problem as it would be a natural continuation of their recent publication – "Common themes identified as lessons to be learned.". We also recommended a local review of the risk assessment process and the involvement of other organisations and agencies to widen its risk assessment perspective. Finally, we concluded that policies and procedures are of little use unless they are applied consistently and recommended an audit mechanism be put in place to oversee compliance.

**Introduction**

16. This Domestic Homicide Review was conducted following the tragic homicide of Mrs CR on 27th December 2012. This was the first domestic homicide review to be carried out under the auspices of the Wandsworth Community Safety Partnership. It was carried out in accordance with the Home Office guidance and section 9 (3) of the Domestic Violence Crime and Victims Act 2004.

17. The review of Mrs CR's homicide began with an initial panel meeting on 5th Feb 2013. There was some uncertainty over how best to proceed as there were on-going criminal and legal proceedings which the panel did not wish to compromise by carrying out a parallel review. Following a request from the Metropolitan Police it was agreed to temporarily slow the pace of the review down until the criminal proceedings were completed. Rather than stay the review completely, it was agreed to work closely with the Senior Investigating Officer and take his advice on which aspects of the review could proceed without having any impact on the criminal case. Meetings continued to be held during the period leading up to the trial. The trial of Mr AR was completed on 12th September 2013 and his plea of manslaughter with diminished responsibility was accepted. The panel reconvened again at full pace shortly after this.

18. This report outlines the circumstances of the case and the findings of the review. This review was undertaken to examine the role of the agencies involved with a view to learning lessons from the case and, where needed, to alter practice in order to improve outcomes for victims and their families involved in future similar cases. The report: -

    a) summarises the key facts of the case and the sequence of events;
    b) summarises the key issues, key decisions and whether with hindsight different decisions or actions could have been taken;
    c) identifies examples of good practice and notes where systems need to improve;
    d) carries out an analysis on the Terms of Reference;
    e) outlines the conclusions and lessons learned from the review; and
    f) details both recommendations from individual agencies and from the Review Panel.

**Mrs CR Family input**

19. The panel wish to send their condolences to the family of Mrs CR and thank them for their hugely valuable input to this process. The only remaining family reside in Spain and the help of the Spanish consulate in acting as a liaison and providing translation was also greatly appreciated.

20. Further detail of Mrs CR's family involvement is given on page 34 of this report.

**Process**

21. On 27th December 2012, the Metropolitan Police discovered Mrs CR had been murdered at her home address by her son, Mr AR, on that same day. The Metropolitan Police subsequently made a request that a Domestic Homicide Review take place, as it met the criteria of a review, set out below:

22. A review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by¬

    (a) a person to whom he/she was related or with whom he/she was or had been in an

intimate personal relationship;

23. The Wandsworth Partnership took responsibility for this review as prescribed by relevant legislation and guidance. They appointed Patrick Watson as independent chair and author of this report (at that time he was Assistant Director of Administration at Wandsworth Borough Council but was scheduled to leave the Council's service at the end of March 2013). From April 2013 he was fully independent of all the agencies involved in the review.

24. A panel was formed of the following members:

Patrick Watson - Independent Chairman and Overview Report Author

Clive Simmons - Safeguarding Policy and Development Manager, Wandsworth Borough Council

Susan Hasler-Winter - Mental Health lead, Wandsworth Borough Council

Stewart Low - Head of Community Safety, Wandsworth Borough Council

Paul Gardner - Detective Inspector, Metropolitan Police Critical Incidents Advisory Team

Jim Foley - Detective Chief Inspector, Metropolitan Police Wandsworth

Colin Lydon - Anti Social Behaviour (ASB) Manager, Viridian Housing

Jeremy Walker - Wandsworth MIND

Justin O'Brien - Clinical Risk Advisor, South West London and St George's Mental Health NHS Trust

Richard Steel - deputising for Jeremy Walsh, Services Director, South West London and St George's Mental Health NHS Trust

Stewart Low, in addition to his role as a panel member, also worked closely with the chairman of the review panel on managing the significant associated organisational work involved.

Antonia De Lima minuted the meetings of the review panel and carried out much appreciated secretarial support.

Jenny Iliff, Domestic Violence Co-ordinator, acted as domestic abuse advisor to the panel.

25. In addition, the panel agreed to facilitate the attendance, on a variable basis, of additional representatives of the Metropolitan Police who were working on the case.

26. Invitations were given to the General Practitioners of Mr AC and Mrs CR to attend the panel meetings but they were of the view that their written submission fully covered their involvement and they could not contribute any further by attending the review panel meetings.

27. A representative of Wandsworth Council Housing Department attended one meeting and submitted a short written report but took the view that they were peripheral to this case and could not contribute anything significant by attending further review panel meetings.

28. The panel met on the following dates

5th February 2013
12th June 2013
9th August 2013
9th October 2013
6th November 2013
28th November 2013

29. The final version of the report was xxxxxxxxx xxxx(to be included at the appropriate stage). During this time further contact with Mrs CR's family was made to keep them fully briefed on the outcome and to answer any questions emanating from the report.

**Terms of Reference**

30. The key terms of reference for the review were to:

    a) Review the involvement of each individual agency, statutory and non-statutory, with Mrs CR and Mr AR between 2007 and 2012.
    b) Summarise the involvement of agencies prior to 27th December 2012.

31. The panel looked at the advantages and disadvantages of taking a retrospectively long view of this case and the interaction with the statutory and voluntary agencies and after weighing these up agreed on a proportionate approach in order to focus on more recent events. While a decision was taken to focus on the period from December 2007, each contributor to the review was nevertheless asked to examine their records prior to this period and report on any information that appeared to have significance to this case. As the review progressed further information did come to light that was considered significant and this is acknowledged and reflected in the narrative chronology of events.

32. The Serious Incident Governance Group (an NHS group covering Wandsworth) commissioned a Root Cause Analysis Investigation and a panel was convened for this purpose on 13th February 2013. The purpose of the investigation was to identify any possible root causes and key learning from the incident where a service user was alleged to have killed his mother at her home. It concluded its report on 17th June 2013. The Chair of this DHR offered to attend meetings of this investigative panel in order to maximise communication between the two reviews being conducted but they took the view that this was not necessary as other lines of communication were in place.

33. One of the purposes of the DHR is to address the circumstances of this homicide in the public domain. However, despite our criticisms, it is important to emphasise early on in this report that the Root Cause Analysis Investigation undertaken by the MHT was very thorough and comprehensive. It clearly and openly set out the shortfalls and addressed these with a comprehensive list of recommendations to improve care in the future both for service users and carers. Improvements were put in place at the earliest possible stage following this tragic death. The lessons to be learnt have been identified and an implementation action plan is in place. As we understand it, the organisation has moved on positively to ensure that the quality of care provided is greatly improved.

34. The agencies responsible for providing details of their involvement, through chronologies of contact and individual management reviews were as follows:

South West London and St George's Mental Health NHS Trust
Wandsworth MIND
Metropolitan Police
Viridian Housing

35. In addition, Wandsworth Council Housing and Children's Services Departments, gave information to the narrative chronology but given their limited involvement the DHR panel agreed there was no need for an individual management review.

36. The GP's for Mrs CR and Mr AR were interviewed and confirmed the accuracy of the notes of these meetings.

37. St George's and Westminster Hospital provided a written note of their involvement with Mrs CR and Mr AR and given their limited involvement the panel agreed there was no need for an individual management review.

38. The following agencies were asked to search their files but found no contact with either Mrs CR or Mr AR:

Wandsworth Council Adult Social Services Department (ASSD)

The involvement of ASSD was restricted to receiving and forwarding a referral from Police to the Mental Health Trust on the same day (08/06/11).

39. Where relevant each of the contributing agencies were required to:

c) Provide a chronology of their involvement with Mrs CR and Mr AR during the time period.
d) Search all their records outside the identified time periods to ensure no relevant information was omitted.
e) Provide an individual management review if necessary: identifying the facts of their involvement with Mrs CR and/or Mr AR, critically analysing the service they provided in line with the specific terms of reference; identifying any recommendations for practice or policy in relation to their agency.

40. In order to critically analyse the background to the incident, the terms of reference required specific analysis of the following:

f) Communication and co-operation between different agencies involved with Mrs CR and/or Mr AR

g) Identify lessons to be learnt from the case about the way in which local professionals and agencies worked together to safeguard the victim and her family.

h) Identify what those lessons are, how they will be acted upon and what is expected to change as a result.

i) Establish whether the agencies or inter agency responses were appropriate leading up to and at the time of the incident on 27th December 2012.

j) Establish whether agencies have appropriate policies and procedures and associated

monitoring procedures to respond to domestic abuse and to recommend any changes as a result of the review process.

k) Review the care and treatment, including risk assessment and risk management of Mr AR in relation to his primary and secondary mental health care.

and to:

l) Seek to establish whether the events of 27th December 2012 could have been predicted, prevented or the likelihood of it happening could have been reduced. (Post meeting clarification - The evidential standards applied being on the balance of probabilities. For example if an event 'probably' would have been avoided had certain steps taken place then the balance of probability test is satisfied. If an event 'possibly' would have been avoided had certain steps taken place then the test of the balance of probability is not satisfied.

m) Examine whether information sharing and communication within and between agencies regarding the family of Mrs CR was effective and comprehensive; did it enable joint understanding and working between agencies; were all appropriate agencies including the MIND centre, housing authorities and mental health authorities involved in the information sharing.

n) Examine whether the sharing of information was sufficient to facilitate "joined up working".

o) Examine whether previous "learning" from local or national cases had been acted upon.

p) Examine the quality of the information sharing with and assistance given to CR regarding the care and support of Mr AR.

q) Examine whether data protection issues or client confidentiality concerns impeded the sharing or dissemination of information.

r) Examine whether there were any early warning signs of aggression or violent behaviour and what actions followed.

s) Examine whether the level of risk posed by the perpetrator was assessed and addressed properly; whether there was an appropriate intervention plan.

t) Examine whether equality and diversity issues were considered appropriately by all the agencies involved with the family of CR.

u) Seek the involvement of the family, employers, neighbours & friends to provide a robust analysis of the events.

**Mrs CR Family Composition**

41. The family relationships of Mrs CR are set out below.

| Name | Gender | Relationship | Year of Birth | Location |
|---|---|---|---|---|
| Mr AR | Male | Son | 1963 | Springfield secure detention |
| Withheld | Male | Grandson (now adopted) | 1998 | UK |
| Withheld | Female | Granddaughter (now adopted) | 1998 | UK |
| AB | Female | Sister | Unknown | Spain |
| MG | Female | Niece | Unknown | Spain |

42. The extended family was very small and no relatives of her deceased husband could be identified.

**Profile of Agencies involved in the review**

43. Wandsworth Borough Council is the local authority for the area in which the homicide took place. Both Mrs CR and Mr AR lived in their catchment area and Mrs CR was a tenant of the local authority.

44. MIND – Wandsworth MIND is a local mental health charity dedicated to helping its service users to lead fuller lives. Their resource centre, also known as "The Foresters", supports service users with a variety of mental health needs by providing therapeutic groups as well as educational services and aims to encourage self-development within a supportive and positive environment.

45. St George's Healthcare NHS Trust is the largest healthcare provider in southwest London. The main site, St George's Hospital in Tooting – one of the country's principal teaching hospitals – provides the A&E services for the area where Mr AR was a resident.

46. Chelsea and Westminster Hospital NHS Foundation Trust is based in Fulham Road, London, SW10 and provides a range of specialist services for patients as well as general local services for people living locally. Mrs CR lived in the Battersea part of Wandsworth and this was her local hospital for emergency services.

47. South West London and St George's Mental Health NHS Trust – provide the secondary care mental health services for Wandsworth where the homicide took place. The Trust was formed in 1994 but has a long history of providing mental health services for more than 160 years. The headquarters are at Springfield University Hospital in Tooting and the Trust also operates from nearly 100 other locations, providing community and hospital psychiatric services to Kingston, Merton, Richmond, Sutton and Wandsworth

48. Viridian Housing - a local housing association and owners of the flat where Mr AR was the tenant. It provides social housing to over 30,000 residents spanning across London and the southeast, the Midlands and West Sussex. They have around 16,000 homes and work in partnership with local authorities, organisations and residents. They provide rented family housing, homes for shared ownership, care and supported homes for older and vulnerable people, assisted living, hostel accommodation, student accommodation, key worker accommodation

49. The Metropolitan Police Service provides the police service for London. It employs around 31,000 officers together with about 13,000 police staff and 2,600 Police Community Support Officers (PCSOs). The MPS is also being supported by more than 5,100 volunteer police officers in the Metropolitan Special Constabulary (MSC). The Metropolitan Police Services covers an area of 620

square miles and a population of 7.2 million.

**Terminology**

50. This report refers to various parts of the Mental Health Act 1983 used when treating patients with mental health issues. To clarify here is a brief description of the acts used and their powers, as well as other relevant terms:

1. Section 2 of the Mental Health Act allows compulsory admission for assessment, or for assessment followed by medical treatment, for a duration of up to 28 days and an application can be made by a relative or an Approved Mental Health Professional (AMHP) and must be supported by two medical recommendations one of which must be from an approved doctor who has special experience in the diagnosis or treatment of mental disorder. The medical recommendations must agree that the detention is in the interests of the patient's own safety, or the safety of others, or the patient is suffering from mental disorder of a nature or degree which warrants detention for assessment, or assessment followed by treatment, at least for a limited period. Appeal to the Mental Health Review Tribunal is allowed within 14 days of admission.

2. Section 3 is the detention to a psychiatric inpatient unit for treatment of psychiatric illness and may be for duration of up to 6 months, although this can be extended.

3. Section 4 allows emergency detainment for the purpose of assessment for duration of up to 72 hours and the application can be made by the nearest relative or an Approved Mental Health Professional (AMHP) and must be supported by one doctor. The doctor must have examined the patient within the previous 24 hours. The recommendation should indicate the urgent nature of the application such that detention under Section 2 would involve unacceptable delay. A second medical recommendation from an approved doctor, under Section 12 of the Act, received within 72 hours will allow further detention under Section 2. Duration is for not more than 72 hours. Renewal is not possible. But by means of a second medical recommendation, which must be signed and received by the hospital managers within three days of the admission, Section 4 can be converted into Section 2.

4. Section 17 leave -This allows a responsible clinician (the approved clinician who has overall responsibility for the patient's care) to grant a detained patient under their care permission to leave the premises of the hospital where they are liable to be detained.

5. Section 25a was known as 'supervised discharge in the community'. This has now been superseded by the Community Treatment Order (Mental Health Act 1983, as amended 2007).

6. Section 37 can be used by the criminal courts if they think someone should be in hospital instead of prison. If someone were under a Section 37/41 it means that the Crown Court has decided that (on the advice of two doctors) instead of going to prison, they would benefit from going to a hospital to receive treatment for a serious mental health problem. The judge will have decided that, because of concerns about public safety, the person needs to be both Section 37 and also Section 41. Section 37 deals with treatment of the mental health problem.

7. Section 41 (often called a Restriction Order) means the Secretary of State decides when someone can be given leave and when they can leave hospital. If it is agreed that they can leave hospital, conditions will be attached to their discharge. This is called a conditional discharge and means that they could be brought back to hospital if they do not comply with these conditions.

8. Section 117 imposes a duty on health and social services to provide aftercare services to certain patients who have been detained under the Mental Health Act when they are discharged from hospital and this will involve a social care assessment to establish what services they might need.

9. Section 135 – under this section a warrant from a magistrate can be used to enter any premises where a person is believed to be and take that person to "a place of safety" without their consent. A police officer with a doctor and AMHP, after using the warrant to get in, can take a person from their home or some other private place, if there is "reasonable cause to suspect" that, if they are suffering from "mental disorder", are being "ill-treated" or "neglected" or not under "proper control", or unable to care for themselves and living alone. They must be released from the place of safety if they are not detained under the Act in a hospital within 72 hours.

10. Section 136 details removing a mentally ill person from a public place to a place of safety. It allows for the removal to a place of safety of any person found in a place to which the public have access who appears to a police officer to be suffering from mental disorder and to be in immediate need of care and control.

**Details of the homicide**

51. On Thursday 27th December 2012 at 11.29 am, police were called to an address in SW by a distressed male who made references to an assault. Police attended the address and found Mr AR sat calmly in the living room of the property. His mother Mrs CR was found in the kitchen with serious head and throat injuries. She was unconscious and breathing faintly. An officer attempted CPR. Despite medical intervention the paramedics who attended the scene declared Mrs CR dead at 12.15pm.

52. Mr AR was arrested for the murder of his mother having made admissions at the scene. He was subsequently charged with murder. He was also charged with assault on police having punched an officer escorting him in the custody suite.

53. Mr AR was interviewed in the presence of a solicitor and appropriate adult for the offence of murder. He stated that he had walked to the home of his mother after a visit to Barclays Bank. After a short while he went into the kitchen and started to strangle his mother and then he hit her a number of times with a saucepan causing her to fall to the floor. He then went upstairs and washed his hands, came back down and realised she was not dead. He said that he got a knife and cut his mother's throat and called the police. He made no attempt to save her and waited for the police to arrive.

54. Mr AR said after his arrest that he carried out the killing of his mother as a mercy killing as she had been in so much physical pain. He said in interview at the police station that he felt guilty about

what he had done but he said he knew exactly what he was doing.

55. MR AR was interviewed at the police station by DR 9 and CC 1 his care co-ordinator and was described as uncooperative in the interview. The care co-ordinator recorded that his impression was that Mr AR knew what he was doing, there was no evidence of psychotic symptoms, was fit to be interviewed with appropriate adult attendance; there was no need for any Mental Health Act assessment.

56. On 10th January 2013 at Westminster Coroner's Court the inquest into the death of Mrs CR was opened and adjourned pending police investigations under Section 16 of the Coroner's Act 1988 (adjournment of inquest in event of criminal proceedings).

57. Mr AR was tried at the Central Criminal Court (Old Bailey) on Thursday 12th September 2013 where he pleaded guilty entering a plea of manslaughter with diminished responsibility.

58. The Judge's sentencing remarks were as follows:-

"This case is a tragedy resulting from a misguided outbreak of extreme violence resulting from your mental illness of paranoid schizophrenia. No doubt you did love your mother and when you are lucid, no doubt you deeply regret what happened. Despite your good character and the lack of any history of violence before this incident, this illness over the last 20 years has had a devastating effect on you. It is quite clear from the reports of Dr Rogers from whom I have heard, Dr Joseph and Dr Durkin that you were at the time extremely ill and indeed, subsequent to that for a time, unfit to plead; having become fit to plead more recently.

I am entirely satisfied on the evidence I have heard that there is no doubt whatsoever that at the time of the killing you were suffering from severe symptoms of paranoid schizophrenia amounting to an abnormality of mental function that substantially impaired your ability to form a rational judgment and to exercise self-control. I am, as I say, satisfied that you are dangerous when you are ill. I agree with the doctors' assessment that the appropriate disposal here is that you remain at Springfield Hospital at least for the time being, but with an order which I make under Section 37 of the Mental Health Act combined with a restriction without limit of time under Section 41".

59. Mr AR is currently held in the secure unit at Springfield Hospital.

**Family Background**

60. The victim (Mrs CR) was the mother of the perpetrator (Mr AR). She was born on 27th April 1926 and she was aged 86 at the time of her death. Her nationality was Spanish and she moved to the United Kingdom in the late 1950s. Given her long period of residence she was completely fluent in English. She met her husband Mr TR (now deceased) and they had one son – Mr AR. They moved from Glasgow to London in 1965 when Mr AR was 2 years old.

61. Her husband, Mr TR, was born in Glasgow and there is no record of any siblings.

62. Mr AR was born in April 1963 and was 49 at the time of the incident. He described his parent's relationship as difficult and his father as an alcoholic who was physically abusive towards him on occasions. His mother had informed the mental health team in 1991 that his father was an alcoholic who often beat him up. She was concerned for her son's safety if he continued to live at

home. She felt that he should seek alternative accommodation.

63. The father and son had the same name until 20th June 2010 when Mr AR completed a Deed of Change of Name (Deed Poll) and changed his name from TR to AR. At the time of the name change he is recorded as saying that when visiting his father's grave (who had the same name as him) it gave him a weird feeling to see his name on the tombstone.

64. In February 1980, Wandsworth Borough Council granted Mr TR and Mrs CR a joint tenancy of the property in which the homicide took place. This was a two bedroom flat and it was assumed that their son Mr AR moved in with them. Mrs CR succeeded to the tenancy of the property on the death of her husband (May 2001) and there is no reference to any contact between her and the Council on any matter until her death in December 2012.

65. Mr AR became a tenant of Viridian Housing on 12th December 1994 and was nearly 15 years in his first property (London SW). In June 2001 he described feeling unsafe where he was residing at that time. He completed a mutual exchange with another Viridian tenant in August 2009 and moved to another property (still within SW) where he remained a tenant until the incident in December 2012. The walking distance between the properties was 115 yards.

66. In terms of employment, Mr AR had not worked since 1990 and was unemployed at the time of the incident. He left school at the age of 16 with 5 GCE's. His employment history is unclear but it is understood that he commenced an apprenticeship in the building trade at age 18 where he was employed until he was dismissed at age 24. He worked for a period as a courier for a local authority but his increasing consumption of alcohol impacted on his work and contributed to him being made redundant.

67. Social Services records (now held by the Children's Services Department) indicate that Mr AR was in a successful relationship with Ms FL over a 5-year period that ended when Ms FL gave birth to twins in November 1998. Both Mr AR and Ms FL were in receipt of mental health services. Mr AR ended the relationship after the twins were born because he could not cope with the stress of looking after them. The community health nurse providing services to Mr AR reported that the stress of caring for the twins had caused him to have suicidal thoughts.

68. The twins (a boy and a girl) became looked after by Wandsworth Council in April 1999 and an Adoption Order was made in February 2002. The children came into local authority care initially at the request of the mother. There is no evidence to suggest that either parent abused the children. The contact arrangements post adoption has been for annual letterbox contact only and there is a signed copy of Mr AR's consent to this arrangement dated 1st April 2002. Letterbox contact is a way of staying in contact with the children by exchanging letters, photos or presents subject to rules about what can and cannot be shared and is organised by the local authority that placed the children.

69. Mr AR had extensive involvement with inpatient and community health services since 1988. He has a diagnosis of paranoid schizophrenia and was under the care of Central Wandsworth and West Battersea CMHT at the time of the incident.

70. The physical medical problems of Mr AR were recorded as – Type 2 diabetes mellitus (diagnosed in December 2006), Pure hypercholesterolemia (diagnosed February 2007) and Psoriasis. His mother was also diabetic.

71. Mr AR has been described as a somewhat reluctant patient. He accepted that he had mental illness and needed medication to remain stable but he did not engage. He was not forthcoming and was guarded about many aspects of his personal life. No one had a comprehensive understanding of his relationships and family dynamics and/or their significance. He was not a person that it was easy to know and there is no evidence to conclude that anyone knew him well. In a psychiatric setting one would assume this to be a shortfall.

**Narrative Chronology**

72. Mr AR was referred to psychiatric services by his GP on 22nd Nov 1989 at the age of 26. He had early experience of psychotic thoughts at the age of 16 when he thought he "was going to be beamed away".

73. He was admitted to Springfield Hospital on 1st February 1991 and described hearing voices in his head and being able to read his parent's minds, which included thoughts of them wanting to kill him. He responded well to medication and was discharged on the 4th April 1991.

74. At the time of his hospital treatment in 1991 he was living in local authority provided hostel accommodation.

75. This was the beginning of a long history of treatment for mental illness. He was diagnosed with Paranoid Schizophrenia at age 28. He was treated with Flupenthixol depot (Depixol) 40mg two weekly injections and responded well to this treatment. He continued to attend day hospital after his discharge until February 1992. He complained about feelings of heaviness and asked about reducing his level of medication and this was agreed by his medical team and changed to 40mg Depixol four weekly.

76. He attended day hospital in order to provide structure to his day and to introduce the possibility of work training schemes. He attended the anxiety management groups and seemed to benefit from low-key groups. At the time of his discharge in February 1992 he was described by the manager as "still quite fragile".

77. On 25th July 1994 Mr AR was admitted to Queen Marys Hospital under Section 136 of the Mental Health Act. He was reported as missing his depot injection and developed signs of relapse of his mental illness, including auditory hallucinations and persecutory delusions. The day prior to his admission, he took an overdose of paracetamol but denied any intent to kill himself. He was placed on Section 2 of the Mental Health Act. On interview, he described that people could read his mind and others could control his thoughts. The assessor described that he lacked insight. He was transferred to Bluebell Ward at Springfield University Hospital. There was no evidence of depression, and he appeared to improve. He was discharged back to his accommodation on August 1994. He was referred to the Edward Wilson House Day Hospital in Battersea, London SW11.

78. He attended Edward Wilson House (EWH), a Day Hospital for seven months. During his stay he was described as remaining stable with good levels of insight. He found some of the groups unhelpful but was a consistent attender at the Day Hospital. He planned to engage in adult education and take an 'A' level in English. He was discharged from EWH on 31st March 1995.

79. At this time he was under the care of the West Battersea CMHT. His care co-ordinator (CC3) was a Social Worker. He was being seen regularly by a Community Psychiatric Nurse (CPN) on a monthly basis and from 1995 to 2000 was being seen regularly by the same CPN.

80. On 3rd November 1998 he was admitted to Springfield University Hospital following relapse of his paranoid schizophrenia. He described feeling pressure on him following the birth of his two children and was experiencing ideas directed at him from the radio and about a pact with the devil, which was to end with him giving his soul to the devil. These thoughts were very distressing for him and he had a number of suicidal thoughts. He was agitated and verbally aggressive at the time of admission. He was initially treated with Olanzapine, and on discharge was treated with Pipothiazine 75mg IM four weekly and Droperidol 10mg TDS. He was reported to improve and became more insightful. He was discharged on the 9th November 1998.

81. Mr AR's father died of a stroke in May 2001. It may be purely coincidental but the vast majority of Mr AR's hospital admissions (73%) took place after the death of his father.

82. Mr AR was described as remaining stable, but requesting a move to alternative accommodation. The patient described feeling unsafe where he currently resided. The patient had a stable relationship with his care co-ordinator CM who remained his care coordinator until 2005.

83. Between March 2002 and August 2011 Mr AR had eight further admissions to hospital as set out in the table below. His entire admissions history is shown for completeness. The status of his admission is also given and shows that five of the admissions were informal and the remaining six were formal under the terms of the Mental Health Act.

| **Admitted** | **Discharged** | **MHA Status** |
|---|---|---|
| 1st February 1991 | 4th April 1991 | Informal |
| 25th July 1994 | 4th August 1994 | Section 136 |
| 3rd November 1998 | 9th November 1998 | Informal |
| 7th March 2002 | 25th March 2002 | Section 2 |
| 3rd February 2003 | 17th February 2003 | Informal |
| 27th September 2004 | 11th October 2004 | Informal |
| 23rd August 2005 | 10th October 2005 | Section 3 |
| 27th July 2006 | 20th November 2006 | Informal |
| 24th August 2007 | 18th July 2008 | Section 3 |
| 31st May 2010 | 14th June 2010 | Section 2 |
| 6th June 2011 | 31st August 2011 | Section 4 then Section 3 |

84. Mr AR had also required management in a Psychiatric Intensive Care Unit (PICU) on at least two occasions during these admissions – 3rd September 2007 and 6th June 2011 – the background to these incidents is set out later in this chronology.

85. Allegation of assault. Police were called to a neighbour who alleged that Mr AR had assaulted him following an altercation regarding rubbish being left outside his (AR) flat. Police attended and spoke to Mr AR who alleged the neighbour was at fault and that there had been a verbal argument, which led to a physical altercation. Police spoke to both sides and advised about behaviour – no further action was taken.

86. Mrs CR turned up at CMHT team base concerned about her son. Mr AR was admitted to hospital

as an informal patient 27th July 2006 and discharged 20th November 2006.

87. Viridian Housing devised a support plan for Mr AR as part of the work of their supported housing team. A risk assessment was also completed as part of their vulnerability procedure. This additional support was given to Mr AR from 2004 to August 2009.

88. 1st August 2007. Mr AR was seen by Dr 3 who reported that he was relapsing with thought disorder and was having inappropriate conversation with his mother on the telephone. He was saying to his mother 'you pushed my head in my vagina when I was 4'. His mother rang to say that he had been deteriorating for about 4 days ago. He said that he had been taking clozapine regularly (100mg in the morning and 200mg at night). An increase in dose by 25mg was advised which he agreed to take.

89. Mr AR was seen again at team base the next day by Dr 3. who reports that he continued to exhibit inappropriate behaviour. Mr AR stood over doctor making inappropriate comments of a sexual nature (tits) and using rhyming words. Dr 3 concluded that given his disinhibited and inappropriate behaviour he should be detained under Section 3. In addition, Dr 5 reports that the patient had locked her in the treatment room and had behaved inappropriately and made inappropriate sexual comments.

90. Dr 5 reported speaking to the Home Treatment Team (HTT) and to Mrs CR who denied that he had a history of having harmed any women in the past but said that he does speak to them in a threatening manager. Mrs CR offered a spare key to Mr AR's flat to gain access.

91. Team doctor and Approved Social Worker (ASW) visit Mr AR in his home, but he refused to let them in. He was verbally aggressive and thought disordered. He appeared to have no insight into his illness. They made a decision to arrange a Mental Health Act assessment. They observed that Mr AR had covered up his windows from the inside with newspaper sheets. ASW reported not seeing the patient act before in such an aggressive manner

92. The patient usually came into hospital informally, but refused hospital admission and was too aggressive to be seen without police assistance

93. ASW called the police for assistance executing S135 Mental Health Warrant. Warrant executed with no issues and Mr AR was calm and compliant and accompanied the ASW to hospital. Officers noted that a large kitchen knife was stuck in the floor of the living room and completed a Crimit report in relation to this observation and the potential officer safety risk.

94. Mr AR was admitted to Laurel Ward QM Hospital under Section 3 due to relapse of mental state on 26th August 2007 as he had been responding to auditory hallucinations and was though disordered. He was very aggressive and threatening to staff who were aware of his risks. It was noted by one staff member that Mr AR presented with paranoia about his mother when he was experiencing a relapse in his mental state. This was a particularly long period of inpatient treatment for him and was not discharged until 18th July 2008.

95. Staff reported that Mr AR was elated and aggressive over the following weekend sometimes coming out of his room naked. A few days later, on 3rd September 2007, he was transferred to the Psychiatric Intensive Care Unit (PICU) from Laurel Ward after an unprovoked attack on another patient. The incident was described as completely out of the blue. He repeatedly

punched the patient and on later questioning, said he had been told via the Internet that the patient (who he attacked) was a paedophile. He said he had been responding to children's voices over the internet. He had to be nursed on 2 to 1 staff and was placed on 15 minute observations.

96. He was seen by Dr 6 and was reported as lacking insight and continued to be thought disordered. Over the following week there was no further aggression, no evidence of responding to voices and seen as being compliant and mental state being stable whilst on the ward

97. 20th September 2007, staff reported that Mr AR was observed mumbling to himself, responding to voices and irritable in mood. Over the following six days he continued to exhibit psychotic symptoms and was observed speaking to himself and responding to voices. He was also observed to be abrupt, hostile, paranoid and exhibiting inappropriate behaviour. This continued until 27th September 2007 when he was reported to be compliant with the treatment and showing less signs of hallucinations.

98. On 25th September 2007, police were called to the Laurel Ward at Queen Mary's Hospital following a disturbance between patients in the tearoom. Mr AR had a minor altercation with another patient. He was assaulted by the other patient and sustained punches to head and shoulders. No formal allegations were made to police and no further action was required by police in relation to Mr AR. The other patient involved was moved to Springfield Hospital for further treatment. This matter was recorded on the CrimInt system by police for intelligence purposes only.

99. He was visited by his mother on 30th September 2007 and appeared quite unsettled after her visit. Allegedly expressed anger that his mother was wearing his ring.

100. 1st October 2007, it was reported that Mr AR was very thought disordered and that he disclosed to nurse that he was 'Jesus Christ'. Over the following week he continued to exhibit signs of thought disorder and responding to hallucinations and was placed on Level 4 observation. By the following week he appeared to be improving with less evidence of psychotic behaviour.

101. Period 10th to 15th October – plan was to return Mr AR to his accommodation. Section 117 meeting held (explanatory note - Section 117 of the Mental Health Act 1983 places a joint legal duty on the NHS and social services to provide free aftercare services to people who have been detained under sections 3, 37, 45A, 47 or 48 of the MHA. There is no definition of aftercare in the legislation, but services could include crisis planning, accommodation, help with managing money and services to meet other needs, such as psychological needs. The section 117 duty lasts as long as someone needs aftercare services for their mental health condition. It can only end when both the health and social services authorities have assessed that someone is no longer in need of aftercare services). Mr AR continued with unescorted leave.

102. 25th October 2007, described as grumpy, refusing to attend St George's Hospital appointment for diabetes. Went out for one hour. Over the following week no changes were reported, described as being low in mood. There was one observed incident of him responding to psychotic symptoms.

103. 5th November 2007 – Mr AR reports feeling low and responding to psychotic symptoms and also feeling that the medication is not working. Claims feeling that the devil is tormenting him, thinks about God a lot. Observed to isolate himself more and feeling low. A few days later he was visited by mother and felt better - states that he is no longer having 'devilish thoughts'. Stated

that the reason he was brought to hospital was because he shaved his head and people got scared of him.

104. The Viridian Supported Housing Officer visited the property but Mr AR was not in. The Supported Housing Officer telephoned Mr AR and was advised that he was in Springfield Hospital. A review of Mr AR's support plan was completed that same day.

105. By 13th November he stated he was feeling better and that the voices he is hearing is better with the medication. In the following week he was reported as calm and compliant with his treatment, appearing flat in mood. Staff reported he was not engaging well with nursing staff. He said that he was feeling better and acknowledged that he was spending more time alone. Continues with unescorted leave.

106. 30th November 2007 - In interview Mr AR reports to the doctor that his mood is numb and he is having problems with his memory. Could not articulate if he was hearing voices or whether they were his own.

107. No changes in presentation noted over the following 4 weeks. Continuing unescorted leave. He says that he has been hearing a lady's voice in his head saying 'are you Dan McClease'.

108. 7th January 2008 - Proceeded on one week's leave. Attending some daytime therapy.

109. 10th January 2008 - Mother reports that Mr AR was experiencing stiffness. He returned to the ward that afternoon; was found in hospital grounds by staff at 2.30pm. He said he wanted to come back to the ward. He was reported as being quite bizarre that afternoon. At times he had been running down the corridors, he shouted at another patient. He appeared to be responding to voices.

110. 11th January 2008 - Was acting in bizarre manner with lots of thought disorder, sexual inhibition and sexual harassment of females on the ward including staff. He was placed on level 3 amber zone. Over the next month he continued to be inappropriate on occasions with some thought disorder but appeared more stable.

111. 17th and 18th February 2008 - Mr AR admitted drinking 3 cans of lager. He had been aggressive when his mother visited. They were in the recreation room talking when suddenly staff heard him screaming at his mother and being very abusive and aggressive. His mother asked staff to let her out of the ward. Mr AR hit one of the tables in the recreation room very hard. The staff offered him PRN medication to manage the agitation and psychotic behaviour but he refused. The team was called; they went to his bed space and he took the PRN. He was swearing at staff during supper time and behaving very psychotic however he was manageable and calm by the time they wrote up the report of this incident.

112. Viridian Housing reviewed Mr AR's Support Plan on 20th February 2008.

113. 25th February 2008 – he continued to exhibit thought disorder but persisted with day leave. Two days later he appeared stable initially but went to the courtyard and assaulted another patient. He was throwing lots of punches and cut his hand after also punching a post. He later shoved a member of staff. PRN medication given and accepted. He told staff he was hearing voices and the patient he assaulted had killed his mother. Placed on level 3 amber zone.

114. Seen by Dr 2. Depixol increased to 120mg, and given 4 hours unescorted leave. On Level 4 amber zone.

115. 10th March 2008 - Preparing for MH tribunal, Mr AR was seen by an Approved Social Worker (ASW) who wanted to discuss hearing that he was still thought disordered. Mr AR refused to give him his mother's home telephone number. (explanatory note - Tribunals hear applications for people detained under the Mental Health Act Their main purpose is to review the cases of patients detained under the Mental Health Act and to direct the discharge of any patients where the statutory criteria for detention are not met). The nursing report for the Tribunal stated that his mother lived in Wandsworth and he has contact with her, but becomes paranoid with her when he is experiencing a relapse in his mental state.

116. Mr AR visited the Viridian Housing office in a distressed state and tried to end his tenancy. He advised that he had been sectioned. The Supported Housing Officer called the hospital. He visited the Viridian Housing office again the following day and again tried to end his tenancy. The Supported Housing Officer liaised with Wandsworth CMHT and was advised that the current CPN, SP, would get back to them.

117. 28th March 2008 – Mr AR informed the hospital staff that he had handed in his tenancy to his housing association, Veridian Housing, as he did not want to return to his flat. The Team considered with him the possibility of him living in Inner Park Road Hostel.

118. 8th to 18th April 2008 - No change in mental state. He met with ASW 2. Denied auditory hallucinations currently and stated that he does not want to experience psychotic symptoms again.

119. Mr AR attended tribunal hearing on 21st April and was discharged from his section and became an informal patient. The nursing and psychiatric reports had recommended that he was not ready to be discharged from his section.

120. Mr AR remained calm and stable over the next few months. He was accepted for a place at Arun Lodge and considered for Dafforne Road Hostel. His crisis and contingency plan was updated on 8th July 2008 and then again on 18th September with some additional relapse indicators added to this second update.

121. The risk assessment carried out on 17th June 2008 cites: the patient has been verbally aggressive to his mother when mentally unwell and tends to be paranoid about her at these times. Dr 3 (Associated Specialist and former care coordinator) is of the opinion that the patient may have actually assaulted her in the past.

122. 11th August 2008 – Mr AR returned to his flat at his own request.

123. A review of Mr AR's Support Plan was completed by Viridian on 25th November 2008. Their Supported Housing Officer visited him at the same time and provided assistance with his mutual exchange request. A risk assessment was completed on 15th December 2008 using the information already available to them and a week later the Supported Housing Officer visited Mr AR again and assisted him with his mutual exchange request. He visited again in February 2009 to discuss rehousing with a further visit on the same subject on 25th March 2009. A visit on 29th March also dealt with housing benefit. Visits also took place on 1st April, 28th April, 5th May, 21st

May, 28th May. At the visit on 1st April 2009 Mr AR advised that the current medication left him feeling lethargic and affected his motivation.

124. 1st January 2009 - Mr AR was referred to Wandsworth MIND by his then care coordinator GJ.

125. 2nd March 2009 – Mr AR was seen by Dr 2 and describes having no thoughts - can only think when talking - believes it is caused by his medication but also introduced idea of it being illness.

126. March 2009 - Attended clinic; was non-communicative but when prompted, reported keeping well; made further request for a male CPN.

127. On 23rd July 2009 a home inspection was completed in response to Mr AR's application for a mutual exchange. His mutual exchange with the tenant of the property in SW was completed on 17th August 2009 and he moved in on the next day.

128. On 26th Aug 2009, Mr AR was seen by Dr 2, describes feeling overmedicated like a zombie and says he feels angry about this. He said ''I have no life'....'if I had known it was going to be like this I'd have ended it 20 years ago'. Denied current suicidal intent

129. September 2009 to January 2010 - He continued to have fortnightly depot, attends Forester day services, visits mother, reported as remaining stable in mental state; reported that he planned to spend Christmas with his family in Battersea

130. 21st Jan 2010 - Team member reported that Mr AR expressed on-going problem with some negative symptoms of his illness, i.e. feeling tired, lacking motivation. He stated that does not think that his depot injection is helping. He was advised to discuss this with Dr 2. Over the next two months he was still complaining of side effects i.e. zombie like feelings when he attended the team base for his depot injection. His crisis and contingency plan was updated in February.

131. 27th April 2010 – Mr AR was seen by Dr 2 who reported that the patient appeared stable and was requesting male psychiatrist and male CPN. Dr 2 tried to explore his concerns involving women and Mr AR referred to previous events which he claims were fabricated i.e. Dr 5 and him being accused of locking her in clinical room. Dr 2 comments on the following describing the patient with: sexually disinhibited and aggressive behaviour when unwell and possible assault on Mother. Dr 2 requested change of male consultant on rota.

132. 10th May 2010 - Feedback received from The Foresters (MIND day centre) who expressed concerns regarding Mr AR's mental state and believe that he is becoming unwell. He had been quite aggressive towards the manager and informed her that he will be moving to Birmingham in a few days' time - very guarded and inappropriate in manner when she tried to get further information from him.

133. He was seen on the 13th May 2010 at team base and was reported as appearing calm and stable in mood and mental state but slightly argumentative in manner.

134. 20th May 2010 - Viridian Housing received a phone call from a concerned neighbour. Mr AR was reported to be throwing rubbish out the window, double locking communal doors and shouting on the street. An ASB case was opened. Viridian contacted the CMH team to express their concerns.

135. On 20th May 2010 Mr AR's GP surgery report that he pushed two patients in the waiting room, and was very aggressive with the doctor. The Practice Manager noted that Mr AR had collected his prescription one or two day days prior to this incident. The police were called to the incident and their records show that Mr AR attended his General Practitioner's (GP) surgery for an appointment. During the consultation he had lunged towards the GP and scratched her chest. The police were called to the incident. They spoke to the GP and she was obviously aware that Mr AR was suffering from mental health issues and was taking medication to manage this. The GP described Mr AR as confused. She did not want to take any formal action against him and signed the reporting officer's pocket book entry confirming this. The LAS were called and a MH assessment was arranged at St. George's Hospital. The LAS transferred Mr AR to the hospital for further evaluation. The police attending completed a crime report in relation to the incident. As they could not identify a next of kin for Mr AR, a 'found' report was created on the Merlin system. It was confirmed that he was released from hospital the same day. No further action was taken by police. The police records do not show any record of any update provided to police from the MH assessment.

136. Later that day (20th May 2010) he went to A and E with head injury and was seen by hospital liaison and no action taken. Seen by HTT and assessed as being thought disordered and experiencing lack of sleep and increased alcohol. To be monitored re admission to hospital. He was reported as being compliant with his medication. Contact made by the HTT to see the patient the next day to assess his mental state.

137. 21st May 2010 - Viridian Housing Anti-Social Behaviour (ASB) Officer contacted the CMHT to express concerns about MR AR - throwing rubbish out the windows, shouting in the street, double locking communal doors. He spoke to Doctor H and relayed the concerns raised by Mr AR's neighbours. The ASB Officer went to his mother's house in SW and she told him that she was concerned that Mr AR had stopped taking medication. Following this, CMHT tried to visit Mr AR at home but he was not in. CMHT agreed to try and visit again.

138. 21st May 2010 Mrs CR went to the team base and expressed concern that her son was becoming unwell and that he was not taking his medication. Following concerns expressed by mother that he was not taking his medication a domiciliary visit took place by an Approved Mental Health Professional (AMHP). He was not invited into flat but reported that Mr AR appeared dishevelled and wore no shirt. This dishevelled appearance was unusual for Mr AR - and he would not normally appear without a shirt - this was seen as a relapse sign. Mr AR was seen on this occasion as responsive, not hostile. The AMHP3 offered hospital admission but in the meantime to be followed up by HTT and Mr AR agreed with this approach.

139. During the period 21st May 2010 until 31st May 2010, Mr AR appeared to experience signs of relapse, and was referred to the Wandsworth Home Treatment Team (WHTT). Mr AR was seen twice daily during this period by the WHTT who were able to assess his living environment. They noticed his medication was mixed up and began supervising this. His mental state was being monitored during these visits. They were also aware that he had broken up with a girlfriend. At the same time the use of the Mental Health Act was being considered at each visit. No contact made with team for two days, but neighbour reported he was throwing things out of the window and kissing and hugging his black teddy bear

140. Following his mother's visit to the team base to express her concern that her son was becoming unwell and that he was not taking his medication, his care co-ordinator, CC1, asked if she was

concerned for her safety. She said that she was not afraid of her son and felt that she was not in any way in danger if he visited her at her home. She was advised to call the police if he threatened her and she could also call the WHTT (Wandsworth Home Treatment Team). The WHTT commenced visits to Mr AR on a daily basis to monitor his mental state and administer medication.

141. When she visited Mr AR's flat, his mother, as witnessed by a member of staff from the WHTT called out 'can somebody call the police, that's the only way he can get the medical help'.

142. 30th May 2010, during a joint visit by WHTT some men were observed removing furniture from Mr AR's flat. He was angry and irritable, confused and distressed. Initially refusing to let them (WHTT) leave by closing the kitchen door but then did so when staff asked again to leave. They approached the two men removing the furniture and it appeared that they gave some money to him for the items. Staff members concluded that he was quite vulnerable and needed the EDT (Out of Hours Emergency Team) to carry out Mental Health Act assessment.

143. 30th May 2010 – Mr AR was seen and assessed and detained under Section 2 of the Mental Health Act. A bed was found on Laurel Ward and he was placed under close examination in communal areas and all hazardous material was removed from his possession. He presented as distressed, confused and unkempt. On the ward, he was very uncooperative in manner and refused all physical interventions. On approach he was thought disordered and was muttering to himself on occasion. He refused to hand over the money he was paid for selling his property prior to admission. He tested positive for cannabis.

144. He seemed to quickly improve over the following few days and there were no residual concerns about his mental state and no paranoia reported. In terms of his mental health he appeared calm and spent most of the afternoon in the courtyard smoking and interacted with peers. He presented no management problem.

145. 30th May 2010 - His MHA status was changed to informal. Mr AR appeared stable in mood and mental state, he interacted well with staff and fellow patients, spent time in the communal areas smoking and listening to music. He complied with his prescribed medication, and was sleeping well. He was discharged from the ward on 14th June 2010 with a planned 7 day follow-up. He requested a female worker to visit him at his next appointment. A seven day follow up was undertaken.

146. 14th June 2010 - Mr AR telephoned the Viridian Housing Officer to advise that he was out of hospital.

147. 17th June 2010 - Seen on 7 day follow up, said that he had no regrets about selling his furniture. He felt that he was keeping well and was compliant with his medication. He told the staff that he was currently in the process of changing his name - no longer wanted to be known by his current name as it gives him a "weird feeling" when he goes to the Cemetery to visit his dad who has the same name as him. Believes it is a bit morbid to see his name on a tombstone. Informed GP his name would be called 'the patient'. He was seen at the team base the next day and was reported as appearing stable in mood, was neatly dressed and reported enjoying attending.

148. 6th July 2010 - Viridian Housing received a copy of the Deed Poll from Mr AR confirming his name change from TR to A*** C***** R****

149. 27th July 2010 - Viridian closed the ASB case as they were advised that their tenant had received appropriate medical care.

150. 18th June to 19th August 2010 - CPA review reported that he continued to have depot injection and appeared stable in mood. Smartly presented. Described that 2-3 days after depot (for about 48hrs) feels low/tired. He had a good insight that decrease in dose may risk relapse. Requesting move to neighbouring borough - as feels lots of difficult experiences in Wandsworth.

151. 12th January 2011 - Seen by a community nurse at the team base who described him as unpleasant and sarcastic in manner.

152. There were delays in allocation a care co-ordinator (CC) for Mr AR and he was without one from June 2010 to September 2010 and again from December 2010 to April 2011.

153. April 2011 – during one of the visits to the team base for the depot injection Mr AR is reported as commenting about his attitude to the medication he was on. He was seen by DR2. Talked about feeling that he is slowed, no energy can't think...'no life'. Sees medication as main cause although able to appreciate that his illness is also one of the causes. Thinks Depixol 'straightens me out' but does not like side effects. The staff discussed risk relapse with oral meds - but he was adamant that he wants to try and that he will know if deteriorating. The plan was to reduce Depixol to 100mg, then 80mg then 60mg and start and increase Aripirazole from 5mg. Mr AR was given his dosage of DEPIXOL 100MG IM on 19th May with the next due in 3 weeks on a reduced dosage.

154. 19th May 2011 - CPA review attended by Mr AR, care coordinator and team manager. Mr AR admits being well but wanted to come off his depot medication (Depixol). Said he knew Depixol keeps him well. He was aware this could lead to a relapse in his mental health.

155. 3rd June 2011 - Police were called to a neighbour disturbance. Mr AR's neighbour called the police at 8.31 am stating that her builder had been threatened by Mr AR. The neighbour was concerned that Mr AR had recently been displaying deterioration in his behaviour. He approached the neighbour's builder and spoke to him about disrespecting women, wanting to kill and bury him and made reference to tortuous execution. The builder was spoken to and did not wish to make any formal allegation to police. He believed that Mr AR was suffering from mental health issues and consequently felt that any action would make the situation worse. The builder did not wish to continue working at the location and therefore he left. No further action was taken by police.

156. 4th June 2011 – Police were called to a neighbour disturbance. Police received a call from another neighbour of Mr AR reporting that they had seen him at about 9.50 pm on 04/06/2011. The neighbour asked if Mr AR was ok and he replied that he was ok and "must have been dreaming." Mr AR then said, "It's Lucifer." The neighbour found this a bit odd. At about 10.10pm Mr AR rung another neighbour's doorbell and shook the caller's hand saying, "I'm Lucifer full stop." Several neighbours had discussed the issues between themselves. They raised concern around Mr AR's behaviour. They requested that police did not attend and speak to them or Mr AR at the time as they were concerned this would cause further issues. However, they did ask for the relevant Mental Health Team to be informed. A PAC report (Merlin – Pre Assessment Checklist used for recording incidents where a person comes to the notice of police and there are concerns about their wellbeing or safety) was created on 07/06/2011 and shared with Adult Social Services via CSS (Children's Social Services) on 08/06/2011 detailing the two incidents recorded above. A referral was then made for the attention of Adult Social Services sharing the above information and

highlighting that a further assessment of Mr AR was required to ensure that he was receiving the correct level of support.

157. Adult Social Services received this PAC report from the Metropolitan Police on 8th June 2011 and it was forwarded to the Mental Health Trust and followed up by telephone on the same day. There is no record of receipt in the MHT record system. Mr AR was already in Springfield Hospital at this time (6th June 2011 to 31st Aug 2011) and had received an assessment and therefore no action was taken in response to the referral.

158. On 6th June 2011 Mr AR was seen in a routine outpatient appointment by Dr 2. During the assessment, Dr 2 recognised, as she described, characteristic symptoms of the patient relapsing. These included significant thought disorder, whispering/shouting and swearing with sexually explicit thoughts. He would also stare intensely. He was described as significantly thought disordered, intimidating, verbally aggressive and agitated. He accused the staff of getting money by treating him with his depot medication. It was not possible to engage him in meaningful discussion about his current deterioration in mental state as he was incoherent during much of the interview. He appeared unable to process information and continually used rhyming words which did not have any recognisable substance. Dr 2 felt that his relapse was likely to be due to a decrease in his depot injection agreed previously.

159. Dr 2 reported feeling intimidated by his demeanour and immediately recognised that he was relapsing. She reported that he was doing strange posturing when he arrived and tried to shake her hand and was sexually inappropriate. He also invaded her personal space and presented generally as very aroused and agitated. The notes from Rio (the MHT case management system) stated that – "As the patient has a history of being paranoid about his mother who lives in the local area and has physically assaulted others when unwell, it was not appropriate for him to return to the community".

160. He was brought to Ward 1 Psychiatric Intensive Care Unit (PICU) at Springfield University Hospital by police under Section 136 of the Mental Health Act. On arrival he was assessed and placed under Section 3 of the Mental Health Act.

161. During the assessment, the Approved Mental Health Professional tried to contact the patient's mother as nearest relative by telephone, but the number was not correct. The patient refused to give his mother's contact details. The Approved Mental Health Professional wrote to the Mr AR's mother on the 6th June 2011. On the 13th and 14th June 2011, staff made contact with the Mr AR's mother who agreed to go to his flat to collect some clean clothes for him.

162. 14th June 2011 - He was transferred from the Psychiatric Intensive Care Unit (PICU) to Laurel Ward and it was reported that his mental state was improving. The nursing handover stated: the patient was relatively calm and settled on the ward. His mental state had been relatively stable and improving. He is compliant with his medication and he is eating/drinking adequately. He maintained minimal interaction with everyone and he is attending to his personal hygiene. He had his hair cut that evening and no report of any incidence/aggression at all in recent time.

163. On the 16th June 2011, Mr AR informed hospital staff that he had decided to change his name because he saw his original name on the tombstone of his father's grave and this had frightened him. On 19th June he was moved from level 4 to level 3 Amber zone following an assault by another patient on him. On the 20th June 2011, he was reduced to Level 4 observations on Amber

Zone. The Trust uses a traffic light tool called Zoning to monitor and categorises risk and the level of support/observations needed for each patient; Amber Zone is used for patients who are unwell and require frequent contact, but do not present major risks to themselves or others. One hour's unescorted leave was agreed. Mr AR was introduced to CC6 as his new care co-ordinator.

164. He attended a care-planning meeting with Dr 1 and was described as remaining thought disordered but more settled. He proceeded on leave for 3 nights on the 4th July 2011.

165. On the 15th July 2011 in discussion with one of the ward nurses the patient disclosed that 'his mother died in childbirth so he does not have a mother'. His medication whilst on Laurel Ward was Depixol 200mg IM every three weeks and Metformin 500mg om Procyclidine 5 mg tds. He was also commenced on Olanzapine 5mg nocte and it was recommended that he could have unescorted leave.

166. 6th July 2011 - Viridian opened a new ASB case. One neighbour had seen Mr AR behave very strangely to a workman on the street. In a separate incident, he hammered a nail into the neighbour's door. The elderly neighbours were extremely distressed. Viridian was informed that Mr AR previously threatened his neighbour's builder who lives adjacent before he went to hospital. The building work was continuing and there had been lots of banging. The ASB officer liaised with the Community Mental Health Team, police and neighbours.

167. 6th July 2011 the police received a call from Viridian Housing Association related to a Concern for Mental Health. Viridian stated that they had received notification from a neighbour that Mr AR had hammered nails to his front door and a cats head (later clarified as a door knocker in the shape of a lion's head). There was growing concern for both Mr AR and his elderly neighbours. The housing association related that they were aware that Mr AR was an on-going patient of Springfield Hospital. In light of the concerns raised a CAD was created and police attended the address. The elderly occupants of the neighbouring address were seen and spoken to by police. They were given reassurance and advice around calling for police and logging any further incidents. They were also advised to update Viridian Housing on a daily basis. Officers checked the front door, which had a metal letter 'B' nailed upside down to the door and a figure-head door knocker in the shape of a devil or something similar. No damage had been caused to the door, however the flat was open and insecure and there was no trace of Mr AR. A Crimint intelligence report was created detailing the officers concerns and actions. This information was passed to the local Safer Neighbourhood Team (SNT) for local PCSO'S to visit the informants on a regular basis to offer reassurance and to ensure that no further incidents had occurred. The CMHT were contacted directly by Viridian Housing. The police recorded that the housing association in liaison with the mental health team at Springfield Hospital were considering withdrawal of Mr AR's tenancy agreement.

168. On the 6th July 2011 the Central Wandsworth and West Battersea CMHT received a call from the Viridian Housing Officer, who reported concerns about Mr AR as set out above. Dr 1 and a Social Worker attempted to contact the patient, and visited his home that afternoon but he was not at home. They also went to the patient's mother's property but received no response. Details of Mr AR were circulated to police. He returned to Laurel Ward the next day of his own accord and denied any problems at home. He claimed he had given pornographic DVDs to builder as he didn't want them anymore. Calm in mood. No hostility or aggression. A little thought disordered. Agreed with plan to increase depot. Doesn't feel it does any good but willing to take advice from doctor.

There continued to be periods of aggression, damaging chairs and responding to external stimuli. He appeared to be responding to voices.

169. Viridian Housing made contact with police via phone and email to request full disclosure around Mr AR as they believed he had breached his tenancy agreement. The police complied with this request and full disclosure was provided to Viridian.

170. 8th July 2011 - Medical Report by Dr 2 on the patient recommending that the patient continues to warrant detention under Section 3 MHA. States in the report that the patient mother lives in Wandsworth and he has a good relationship with her when he is stable, but may become paranoid about her when he is experiencing a relapse.

171. Care planning meeting held 11th July 2011 – Mr AR was seen to be quite angry and aggressive and It was agreed to continue depot medication and that there would be no leave at the present time. Over the following week he appeared to be more settled with no episodes of aggression or violence. Remained on level 4 Amber zone.

172. 25th July 2011 - Requests not to have Dr 2 as his consultant.

173. Care planning meeting Section 117 was held on 1st August 2011. Part of the plan was to continue with escorted leave. Mr AR was reported as saying -"I'm better". But otherwise makes no eye contact and remains silent for much of the time. Does not answer questions regarding medication. Also wants to be called "Damien".

174. Mr AR had appealed to the MHA Tribunal and was awaiting outcome.

175. The care planning Section 117 meeting reconvened on 22nd August 2011 and a Care Plan was agreed. Six hourly leave unescorted was agreed and if day leave went well, he could be discharged soon. Mr AR was allocated a new care co-ordinator on this date. Mr AR had 6 hour leave and returned to the ward on time. It was reported that his eye contact was much improved.

176. 31st August 2011 - Mr AR was discharged from Hospital.

177. 5th September 2011 - Mr AR was seen at home as part of his 7 day follow-up. His mental state appeared stable and no psychotic symptoms were observed. It was noted that he was getting ready to attend The Forester day centre. He was requesting to move accommodation because he was having of problems with the tenant living down stairs (the elderly neighbour). CC 1 commences visits as care coordinator.

178. From 12th September to 15th November – Mr AR continued to have his three weekly depot injections. No change in his mental state was observed and he was considered stable. He was seen by his care coordinator on 15th November 2011 and was reported as being irritable.

179. There is no record of any contact again until 29th February 2012 when he was seen at home. His mental state remained stable, there were no psychotic symptoms and he was not paranoid. Stated again that he did not want to see Dr 2. Over the following three months the contact place was varied to being seen at home or at the team base

180. On 21st May 2012 Mr AR had a CPA review. The attendees included a hospital doctor, Mr AR, and his care co-ordinator (CC1). His Depixol injection was reduced to 160mg every three weeks.

181. 4th July 2012 – Mr AR was seen at home by his care co-ordinator. He expressed unhappiness with the depot medication because it made him feel different. He felt that he lacked motivation and he blamed the depot medication. CC 1 suggested that these symptoms were more to do with the negative symptoms of schizophrenia.

182. From 25th July 2012 to 26th November 2012 Mr AR remained on 160mg Depixol IM three weekly. He still expressed concern about the side effects of the depot, and reported feeling slowed down, sedated and stiffness. His mental state remained stable with no psychotic symptoms, but he complained of lack of motivation, loss of interest in anything and withdrawn from social interaction.

183. Mr AR was seen on the 13th December 2012 for his CPA review with Dr 1. Who reported that he looked well although he also reported that he was experiencing some side effects of his medication including stiffness, sedation and feeling slowed down. Dr 1 described his mental state as appearing settled but with some thought disorder. On reviewing the patient notes, Dr 1 altered his Depixol medication at Mr AR's request. The medication was reduced from 160mg to 120mg Depixol every three weeks. Dr 1 also discussed with Mr AR the possibility of using Paliperidone if this reduction was not effective. Information about Paliperidone was given to Mr AR. As part of this assessment four further relapse indicators were added to the crisis and contingency plan.

184. Mr AR was seen again on the 19th December 2012 by his care co-ordinator at Springfield Hospital with no psychotic symptoms reported and his mental state remaining stable. They discussed the option of change of depot to Paliparidone and Mr AR was given the explanatory leaflet to read and make an informed decision when he saw Dr 1 at the next visit. He was given his depot injection of DEPIXOL 120MG at this meeting. Mr AR had been seen by his care co-ordinator on a regular basis (three weekly), linked to his depot injection being due, during the period 25th October 2011 to 19th December 2012. The care co-ordinator appointments varied between meetings with the patient at his home or at the team base and the patient was, in the majority of RiO notes, documented as being stable in his mental health with no psychotic symptoms.

185. 24th December 2012 – Mr AR attended the Foresters Day Centre, where staff noted no concerns with his behaviour. He had been attending the Foresters (MIND) Day Centre on a regular basis.

186. 24th December 2012 – he visited his GP surgery to collect a prescription, where staff reported that they had no concerns about his presentation. They have confirmed that they would recognise if the patient was becoming unwell.

187. 27th December 2012 – Mr AR visits his mother's flat. At 11.29 am he telephoned the police to report that he had killed his mother and he was at her flat. He was breathing extremely heavily and the operator had difficulty understanding him. The police operator believed that he was reporting an assault. However, he had initially disclosed hitting his mother with a frying pan. Having arrived at the address police found him sitting calmly in the living room. He told officers, "I've murdered my mother, I've killed her." He gestured with his head towards the kitchen. He told the officers that he had hit his mother, Mrs CR, with a saucepan fifteen times until the handle broke off. Mrs CR was found lying in the kitchen. She was unconscious and breathing faintly having suffered serious head and neck injuries. It was reported that she been cut around the

neck and slit throat. Officers attempted CPR, but despite medical intervention she died from her injuries. Her life was pronounced extinct at 12.15 pm by the paramedics. Mr AR was arrested for murder.

188. Mr AR said after his arrest that he carried out the killing on his mother describing it as a 'mercy killing' as she had been in so much physical pain. He said in interview at the police station that he felt guilty about what he had done but he said he knew exactly what he was doing.

189. 5th February 2013 - In an interview with Dr 7 taken from RiO records Mr AR commented that on the morning of visiting his mother he had no plans to harm her, he wasn't feeling angry with mother.' He had no command hallucinations. Remembers thinking "what the hells this about?" "It's like something had entered me"...."I felt everything was very vivid...I was seeing everything very clearly". Unable to say what was in his mind when he went to mother's house. Just wanting to visit. Not angry. He had his own key. Went into kitchen. Hadn't armed himself beforehand. No intention to hurt or harm her. But then "it was like someone had taken over my thoughts....like it wasn't really me".

190. His mother entered the kitchen and he then heard a voice saying "now's your chance". He remembers pulling his mother down on to the floor. She didn't struggle or say anything; he wishes she had as it might have stopped him. He then picked up a saucepan and hit her over the head a few times (demonstrated his actions with what appeared to be a light tap) - again couldn't say what was in his mind. Not intending to hurt or kill her. Denies his actions being "made" or not under his control. He didn't remember picking up a knife, stabbing or cutting her although he is aware that she was found with knife wounds. Said he may have "nicked" her a couple of times. but couldn't say why. He just stopped when he saw all the blood. Realised what he had done then ...but not at the time /while he was actually attacking her. "I knew what I was doing but not why I was doing it". He immediately called the police who arrived and arrested him. Mr AR stated that he thought his actions were as a result of him having suffered a "breakdown" or relapse of his schizophrenia. Said it was "out of character".

**Treatment**

191. We have taken the approach that optimisation of treatment is the most effective way to reduce risk. We have evaluated the treatment provided to Mr AR from this perspective.

192. From an evaluation of all the evidence we arrived at the view that Mr AR's care was symptom led which manifested itself as - no symptoms then no problem. In a general environment of scarce resources it is difficult to see how there could realistically have been many other viable options.

193. Throughout his treatment, Mr AR acknowledged that on the one hand Depixol kept him well and stable and that not taking it could lead to a relapse in his mental health, but he felt that he was unable to live his life as he wanted because the side effects affected him and his daytime activities. He often complained that his dosage was too high and his care team would negotiate alteration of his injection often by extending the length of time between doses, for example changing from two weekly to four weekly injections. There were a number of occasions where he had thoughts of harming himself, and he had taken an overdose of Procyclidine in the past as well as on two occasions during inpatient admissions. He had also said in the past that he was being instructed by the devil to hang himself, which he had considered doing.

194. The expert CMHT advisor for the Mental Health Trust Investigation Panel concluded that she was of the opinion that it was highly unlikely that the dosage reduction of Depixol IM from 160mg to 120mg every three weeks and administered on 19th December 2012 would have had a direct major impact on the patient's mental state within eight days. She could find nothing to suggest the patient missed any doses of his depot injection following discharge from his last inpatient admission in August 2011 and found it notable that there was a first dose reduction in Depixol from 200mg to 160mg three weekly in May 2012 and that in addition to the depot formulation, the patient was also prescribed an oral antipsychotic (Olanzapine 5mg).

195. A comprehensive review of Mr AR's medication history was under taken by Senior Pharmacists at the Mental Health Trust for the period 1989 – 2012.

196. The summary review of his medication identified that between 1991-1994 he was maintained on Depixol 40mg IM four weekly. In more recent years, he required higher doses at shorter intervals often in combination with other antipsychotics. Since 2010 his dose of Depixol had increased from 120mg three weekly to 200mg three weekly when unwell in 2011. Furthermore he had complained of depressive or negative psychotic features while on Depixol and other antipsychotics. It was unclear whether these features were side effects or if they were caused by his underlying mental state as this was not explicitly addressed in his medical notes.

197. Two members of the DHR panel had an opportunity to interview Mr AR in November 2013 in the secure unit at Springfield Hospital. He refused to speak about his relationship with his mother saying that it was personal. He did volunteer the reason, as he saw it, for his relapse as attributable to the reduction in medication eight days before.

198. The treatment given to Mr AR appears to have been focused almost in its entirety on the depot injection. He was very concerned with its effect on his ability to lead an ordinary life and discussions about the level and type of medication dominated the discussions with his care team to the detriment of introducing other treatments. This focus on medication appeared to mean that Mr AR controlled the way the discussion progressed. He appeared to be quite determined and staff had to tread a careful line in the negotiations to achieve the right balance between his personal wishes and compliance with effective treatment. This was particularly difficult as the team were of the view that Mr AR was able at times to mask some of his symptoms.

199. Those that knew him described him as a guarded person who controlled what others knew about him. Discussions had to be on his terms or he terminated the dialogue. He was particularly guarded about his family, making it difficult for clinicians to explore his relationships with his family. The representative from Foresters Day Centre also reported in her interview that the patient occasionally spoke to her about his children, but would follow any mention of them up with "I don't want to talk about it". She added this was not confined to this topic, but any discussion about his personal life. He often opened discussions about personal issues but stopped them abruptly when he felt there was a danger of them becoming intrusive.

200. He could be aggressive at times and this may account for the reluctance to have exploratory conversations which might have enabled them to assess his mental state more easily on those occasions. As a result there were large gaps in his life history and in the insight into him as a person. There does not appear to have been any real attempt to probe behind his periodic sexually inappropriate behaviour, his attitude towards females and his relationship with his mother. Given the regularity of reported instances of verbal aggression or negativity towards his

mother it is difficult to understand why this was never earnestly probed in order to gain some insight and understanding. To some extent his life in terms of experiences, concerns, anxieties, hopes and fears and general perceptions could be described as a closed book.

201. The frequent changes in the staff who cared for Mr AR mitigated against the creation of trust and relationships which are an essential component of successful treatment.

202. The lack of continuity in care co-ordinators and the frequent staff changes and use of agency staff appears to work negatively against maintaining a strong collective memory within the team and reduces the knowledge of the patient's risk and social history. These shortfalls were consolidated by the lack of a formal handover or briefing between care coordinators.

203. This resulted in some fragmentation of care and practitioners were working without access to all relevant information. For users of services it is important that continuity is provided by consistency of worker and a continuous caring relationship.

204. The change from records being held in hard copy to the RIO electronic case management system seems to have had both benefits and negatives. Records were available at the touch of a button but it would seem an overview of the patient's history was less easily obtained. The documentation of records do not appear to have been maintained in a sufficiently factual and detailed way as to give clear insight into the patient's life experiences and history.

205. The factors considered above raise concerns about how well the CMHT knew Mr AR and to what extent their knowledge of him was superficial.

206. Viridian Housing in an interview for the MHT Root Cause Investigation Panel (April 2013) voiced related concerns from a different perspective. They contacted the duty CPN to give notification of the incident in May 2010 and stated – "They were unaware of Mr AR's existence which is quite unusual…..he wasn't known. That was quite disturbing so we contacted the police…… The only port of call we had was CMHT and nobody knew what was happening". The general impression that emerged to them was of a view of an unstable team and having to talk to someone different each time they telephoned.

207. The MHT in their Root Cause Analysis identified that there was no written evidence that psychological therapies as recommended by NICE guidance on management of Schizophrenia 2009 were offered to the patient or at least followed up in the community. There was also nothing to suggest compliance with the guidelines which recommends mental health professionals work in partnership with family members and carers and also offer family intervention to all families of people with schizophrenia who live with or are in close contact with the service user.

208. The absence of any psychotherapy, as a driver, in the treatment of Mr AR could possibly explain what appears to be a lack of professional curiosity as to the greater understanding of the significance of family relationships, the impact of historical and current experiences and in understanding his behaviour and moods.

209. The MHT records show the recurring issue of paranoia and negativity about his mother and yet no one had anything other than a superficial understanding of the relationship between mother and son. Similarly the family dynamics at the various points in his care history were not explored to increase understanding.

210. The Mental Health Trust's Investigation Panel were satisfied that the medication management of Mr AR's needs was satisfactory. His concerns were always responded to and side or adverse effects of dosage were considered as were alternative medication. When he was unwell, rapid action was always taken to ensure his safe admission to hospital for treatment and follow-up standards following discharge were routinely maintained. CPA meetings and outpatient clinic appointments were consistent and timely.

211. The MHT Investigation Panel however identified the possibility that the patient's mental state had become more treatment resistant over time.

212. Weaknesses were evident in the CPA planning for Mr AR. Apart from the lack of involvement by his GP and MIND, there was little evidence of a holistic recovery plan including recovery goals and where they did exist they were brief and limited.

213. The Investigation Panel concluded that there was no evidence to indicate that the patient's clinical presentation had changed in the two weeks leading up to the incident. There had been no reports of any concerns regarding his behaviour by external multi-agency partners which may have indicated a relapse. Additionally, evidence from his visit to the GP on 24th December 2012, his appointment with his care co-ordinator on 19th December 2012 and his review with Dr 1 on 13th December 2012 all indicated to them that the patient's mental state was considered stable.

214. The DHR panel were of the view that the care and treatment of Mr AR was not optimised. It appeared to be controlled heavily by the patient himself and it was felt that a more balanced approach would have been more appropriate. The concern that Mr AR would refuse cooperation and would sometimes be aggressive may have led the team to be reluctant to have exploratory conversations which may have enabled them to assess his mental state more easily on those occasions. We took the view that the management of his treatment was at times insufficiently assertive and authoritative. It is understood that this approach is easier said than done and suggest that assertiveness training (if it does not already exist) is an essential part of the role of care co-ordinators in the future.

215. Knowledge about Mr AR's background and thought processes were superficial and this was consolidated by the lack of any psychological therapies. The apparent reliance on medication alone was not satisfactory. The DHR panel identified a need for practitioners to be curious and to think critically and systematically in order to understand what is happening to people under their care. Mr AR's reticence to divulge personal information and elaborate on his thinking should not have been accepted so easily given the seriousness of his diagnosis. Little effort was made to understand Mr AR's thought processes and content. This is in spite of the long-term involvement of the services and of the numerous outpatient sessions over the years. Nor is there reference to any plan or strategy to get round this reluctance on his part by, for example, talking separately to his mother or other agencies. Nor was there consideration of re-referring Mr AR to a psychologist who might have been able to drill deeper into his thinking.

216. A better understanding of the thought content might have identified the full extent of the risks posed by him.

217. The fact that Mr AR had not been a major problem in the many years under the treatment of the MHT meant that he did not feature high on their risk list. The service to Mr AR appeared in the main to be a reactive one. We heard on many occasions during the course of our deliberations

about the need to direct scarce resources to the areas of highest risk. This case stands out because there were no obvious clinical points, no regular requests from the family for action, he took his medication – he was no trouble. The Root Cause Analysis Investigation Panel identified the need to periodically stand back and comprehensively review long term patients such as Mr AR from a fresh perspective. This is a very sensible innovation which is necessary to combat the onset of complacency with all the negative side effects that can follow such as decline in vigilance.

**Family and friends**

218. A domestic homicide of this nature can take a terrible toll on family members and friends and they can often feel side-lined and ill informed. With this in mind the DHR panel sought to make every effort to ensure that the needs of family and friends were at the forefront of our deliberations and sensitively handled.

219. We sought to ensure that family and friends were given every opportunity to be fully involved in this review and felt able to make a positive contribution. We were fully aware that family and friends could critically inform the review and provide insight into how Mrs CR and Mr AR saw their choices and fill in information gaps about the effectiveness or appropriateness of services or lack of them.

220. In this case the family network was quite small and the opportunities to engage with them and to obtain information to inform the review were quite limited.

221. Earlier in this report (paragraph 62) we relate that Mr AR described his parent's relationship as difficult and his father as an alcoholic who was physically abusive towards him on occasions. His mother had informed the mental health team in 1991 that his father was an alcoholic who often beat him up. She was concerned for her son's safety if he continued to live at home. She felt that he should seek alternative accommodation. The domestic violence he experienced as a child may have impacted on his relationship with his mother.

222. Mrs CR was an 86 year old widow. Her husband who was from Glasgow had died of a stroke in 2001 and the DHR team were unable to obtain any information of any family members on her husband's side.

223. She, herself, was from Andalucía in Spain but had left there in the late 1950s to come to the UK. She had one surviving sister who was in very poor health at the time of the homicide and her family did not feel she was well enough to be informed of her sister's death. All information flows to the family in Spain were made to the surviving sister's daughter MG. The family in Spain do not speak English and all communication to them was made through the Spanish Consulate who interpreted and translated as appropriate.

224. The family in Spain were supplied (via the Spanish Consulate) with a copy of the Home Office explanatory leaflet so that they could be fully informed as to the role and purpose of the DHR.

225. Mrs CR and Mr AR regularly went on holiday together to visit the family in Spain. The last trip was in April 2012. A trip was planned for the previous Christmas but could not progress because of Mr AR's hospitalisation. Mrs CR would ideally have liked to return to Spain permanently on the death of her husband but her concern for Mr AR kept her in the UK.

226. The family in Spain were aware of Mr AR's mental health illness and confirmed that this was a source of great concern and worry for Mrs CR.

227. MG relayed to the DHR panel that in her view the mother and son had a normal relationship: they spoke regularly by phone and met up for lunch at Mrs CR's house. They seemed to share a mutual concern for each other with Mr AR always very concerned and worried about his mother: looking after her, calling her. The same could be said about her towards him (she used to visit him at his flat, cleaning the flat, cooking, etc.).

228. MG mentioned that Mrs CR was quite a private person and did not openly discuss Mr AR's illness outside the family circle. The number of people who knew about his illness was quite limited and while the family in Spain knew it, her best friend in the UK did not. Therefore, the number of people she could confide in or share her concerns with was extremely limited and she carried the burden virtually alone without any other support.

229. Mrs CR's best friend ZM had known her for many years and they used to walk and talk nearly every day. She also knew Mr AC but she only knew about his mental condition after Mrs CR's death. ZM thought that Mr AR could behave rather strange, but never thought he suffered from a mental illness.

230. MG related that even if Mrs CR was having a walk with her friend in the afternoon, she would rush home because she knew Mr AR would call her and could be worried if she was not at home.

231. MG was asked if Mrs CR ever discussed the treatment he was getting and did she express a view as to whether she felt it was good or bad or could be improved? The reply was that she never complained about the treatment or suggested that the treatment did not work or should be changed - at least with the family. When they travelled to Spain to visit the family there, Mrs CR was always looking after him, making him avoid drinking alcohol and making sure that they did not spend more than 15 days in Spain because of his three weekly medication regime. Beyond being naturally concerned about her son and his illness, she did not seem to be worried about any danger or anything more specific.

232. MG was asked if Mr AR's relationship with Mrs CR changed in any way following the death of her husband (his father) and she replied that did not know but she believed that the critical issue for him was losing his job.

233. Mrs CR had explained they could not live together or Mr AR would lose the flat. One of the drawbacks voiced when they were thinking of going to Spain to live was that Mr AR would not have got all the benefits that he could be entitled to in England. Mrs CR had never voiced a view that Mr AR should be permanently institutionalised.

234. MG was asked if Mr AR was ever hostile or aggressive towards his mother. She described him as "always a very calm down guy". He never showed aggressiveness. According to MG, Mrs CR sometimes had a bad temper which caused impassioned arguments between both of them. They would often finish by not talking to each other for a few days but none of the fallouts was ever very serious. MG underlined this point to state that it was not always Mr AR's fault as Mrs CR was sometimes difficult.

235. MG did not know if the MHT kept Mrs CR informed about his treatment.

236. She however volunteered that the last time he was admitted in a hospital, they had arranged to travel to Spain. They had to cancel the trip as Mr AR got worse. He spent some time at the hospital. Apparently he got worse in October, because in that month it was birthday of his two children. He used to receive their photographs and this upset him and he became worse.

237. MG could not believe what happened when the police informed her. She knew they sometimes argued. He had a mental health condition (which she described as depression) but, as he was always very concerned about his mother and trying to look after her, she could not believe that Mr AR could attack Mrs CR.

238. This reluctance to confide in others seems to be a characteristic that Mrs CR shared with her son (Mr AR).

239. After the initial contact following the incident the family in Spain felt ill informed. To use a colloquium, the issue of communication with the family seemed to fall between two stools and each agency assumed that someone else was maintaining contact. The DHR panel found itself having to fill the information gap and kept the Spanish family informed about funeral arrangements and the outcome of the criminal proceedings, etc.

240. The Spanish family have requested that they kept informed about the progress and outcome of this DHR.

241. The only other family members who were known were the two children of Mr AR. The children (a boy and a girl) were born in November 1998 following a relationship with a female who also suffered from mental illness. The children were taken into care and adopted with the consent of both parents. The contact arrangements post adoption with Mr AR was for annual letterbox contact only.

242. As the children were below the age of consent no direct contact was made with them. Their grandmother had been murdered and they had a right to be consulted and invited to have an input. All contact was made with the adoptive parents who answered in their best interest. They declined the offer to be involved in this review and did not wish this issue to be raised with the children. The DHR panel respected this request and no further contact was made.

243. Contact was made with some of Mrs CR's neighbours but their knowledge of her was quite superficial and limited to normal neighbourly pleasantries. The neighbours remembered her husband when he was alive but were unaware that she had a son. They never saw visitors at her home. They saw Mr AR on the day before the murder of Mrs CR which was Boxing Day – 26th December as he was talking to their grandchildren about their Christmas toys. Their recollection was that his speech was slurred as if he was drunk. Their impression was that he was odd.

244. Two close friends (LZ and ZM) of Mrs CR who had known her over many years were identified and interviewed separately. Despite their closeness Mrs CR never revealed to either of them that her son suffered from mental illness. They had each met Mr AR and felt that there was something "odd", not quite right about him.

245. One of the close friends, ZM, had worked with Mrs CR in a London hotel over 30 years ago, had lost touch and were reunited about 6 years ago. Her family also became friendly with Mrs CR. They described how ZM and Mrs CR went for walks and on some occasions the daughter RM also met up separately with her. They recollected that Mrs CR was always praising her son and mentioning little things about how he helped her. She would always defend him and would never admit anything negative. Her defensive guard slipped in the final year of their friendship and she became a little more open.

246. They told of comments she made on three or four occasions which seemed to distress her. These comments were made regularly from about six months before her homicide on December 27th 2012. She told ZM that Mr AR had said that she had to die before Christmas as she had lived too long. They tried to reason with her about this but she said that they she felt it was going to happen. ZM told her daughter, RM, about this conversation after Mrs CR had left. The same comments were made on another occasion when another family member was present. They recollected that the closer it got to Christmas the more her demeanour changed from quite a cheerful person to someone clearly more distressed, anxious and tearful which was quite unusual for her.

247. They also told of an unusual event that occurred the week before Christmas (18th December) when Mrs CR arrived at their home unannounced. This was very unusual as she would always plan their meetings in advance. She arrived at their home in a distressed state. She said that she called in person because she was worried about them as they had not been answering their phones but they felt that this was just an excuse to justify coming to the house unannounced. The husband of ZM had to give her something to calm her down as she was tearful, very distressed and anxious. She did not reveal the underlying reason why she was in this state and they recalled feeling that she was scared. When she was leaving and they said their goodbyes she said it with finality and added that she was saying goodbye to them and that this would be the last Christmas that they would see her.

248. With hindsight they re-evaluated two other issues in the light of her homicide. On two occasions Mrs CR had injuries where the reasons given seemed slightly implausible at the time – walked into a door for one incident and a similar type of excuse for the other which they could not recall. The second issue they recalled was a dinner she arranged for her friends in a local restaurant about five days before her death which she paid for stating firmly that it was “my shout”. She herself had little appetite but was persuaded to have some soup. The mood at the dinner was sombre. This was uncharacteristic and puzzling at the time and with hindsight they see this as a farewell dinner.

249. The DHR found no evidence that corroborated Mrs CR’s alleged state of mind, namely that she had accepted that she was going to die before Christmas.

250. The DHR panel was not able to find anyone who heard Mr AR make these statements to his mother about dying before Christmas. It follows logically that we could not therefore be certain that she reported them factually and/or in the right context. Similarly, we were aware that the friends recollected events with the benefit of hindsight and with the knowledge of the tragic events which followed. Mrs CR did not convey these concerns to any medical professionals treating her son. She did not inform her GP who she visited 14 days before her death and no sign of anxiety or distress was noticeable at this visit.

**Mother and Victim**

251. Mrs CR has been described as a very nice friendly person. People who knew her in Battersea where she lived thought very highly of her and were very sad and upset to learn of her death.

252. She was friendly but reserved – she was very protective of her personal life and did not share information lightly, a trait she seemed to share with her son.

253. She had friends but spent a great deal of her time alone in her flat. Her neighbours saw her as a friendly person who seemed relatively isolated confirmed by the many hours she spent each day standing at the bedroom window alone looking out.

254. Her son was her passion and her life revolved around him and his needs. They had a good relationship when he was well. He showed concern for her and this was demonstratively reciprocated.

255. In paragraph 230 it was described how she would rush home from visits to her friend to make sure she was home when he called in case he got worried. The police in their IMR gave an example of how a missed call from Mr AR to his mother manifested itself. On 5th September 2008 Mr AR reported his mother as missing when he was unable to contact her by telephone. He had last seen her on 1st September 2008. The police considered her a high risk missing person because of her age and her diabetes medical condition. Hospital checks by the police located her at the Chelsea and Westminster Hospital having being admitted overnight with stomach pains.

256. It was noted that when he was unwell the patient was often accompanied by his mother to the GP. On one occasion she apparently felt uneasy in talking in front of him when he presented as unwell and she returned to the surgery to convey her concerns without his presence. The GP surgery has no record of what was said at this return visit.

257. We have already mentioned that it was concern about her son's health that kept her in the UK after the death of her husband rather than move back to Spain to be with her family. Her concern for him was very strong. The Viridian Housing Officer (in May 2010) related how she said "she wanted to move back to Spain and she couldn't. For myself she sounded trapped. She was upset, didn't want to be where she was but she hadn't moved".

258. Neighbours reported an incident of her crying outside his address and voicing concerns about his condition. She was shouting – "let me in, let me in – can someone call the police, that's the only way he can get medical help."

259. Mr AR's care co-ordinator asked her (May 2010) if she was concerned for her safety. She said that she was not afraid of her son and felt that she was not in any way in danger if he visited her at her home.

260. Given the reluctance of Mrs CR to share details of her private and personal life with even close friends it is not surprising that she did not express concerns about her own safety or any danger from her son she may have felt if indeed she had any such misgivings. Concerns would only materialise at unguarded moments. The MHT were of the view that the available evidence

suggested she expressed different experiences at different times in her relationship with her son, which were dependent upon her immediate concerns at that time.

261. Following an incident in May 2010 at Mr AR's flat a worker from Viridian Housing went to see Mrs CR at her home. She said that he (Mr AR) had just left after an argument and she was scared of him. On reflection , in November 2013, the Viridian officer felt that this comment may well have been misconstrued and may have been more likely to be – "scared for him or scared about him" and not "scared of him".

262. The Viridian Housing officer described her as noticeably distressed and said that "I felt she knew more than what she told us, but I think there was fear about him losing his tenancy". The impression by the housing officer would seem to fit in well with her protectiveness or defensiveness and reluctance to make things worse for him.

263. When he was unwell the close intimate relationship did not exist. The records of the MHT are peppered with comments that Mr AR was paranoid and aggressive about his mother and she was increasingly worried for his future. However, there is little actual evidence of this aggression or paranoia and the MHT representative on the panel speculated that remarks made by Mr AR in 1991 were continuously recycled and embellished by hospital staff as if they were of more modern origin. This proposition however conflicts with the statements for example made to a Mental Health Tribunal where the aggression towards his mother was used as one of the arguments for maintaining his sectioning.

264. The MHT Investigation Panel analysed Mr AR's records dating back to 1991 and noted references to and reports stating that the patient had been angry with his mother or made remarks from a thought disordered perspective.

> Bluebell Ward 1991. In interview with nurse: "Hears voices which criticise him, also believes he can read his parents thoughts (and they his) and they want him to kill them.'' "Has threatened to kill his parents - verbally expressed this"
>
> Also in interview with a doctor on 1st February 1991: 'He used to get very bad thoughts in the past as if they (his parents) wanted him to kill them, but not anymore.'
>
> On interview Mr AR said his "mother came to his flat earlier to clean it. She called Dr 3, that's why I'm here; it all makes sense now she's jealous of me, that's why she's done it".
>
> 17th and 18th February 2008 – mother visited him on ward and he started screaming at her and being very abusive and aggressive and she asked staff to let her out of the ward.
>
> 27th February 2008 – assaulted another patient and told staff that the person he had assaulted had killed his mother.
>
> 24th August 2007 - note from Dr 3: On the patient 'He has contact with his mother but becomes paranoid about her when he is experiencing a relapse'
>
> 31st August 2007 - recorded on RiO that the patient had inappropriate conversation with mother on the phone. He said to her 'you pushed my head in your vagina when I was 4'.
>
> 31st September 2007 - whilst on the ward: 'Informed staff that he is angry that his Mum

wore his ring when she came to see him this afternoon'. He was unsettled after her visit.

18th February 2008 - in ward review: 'Patient has been aggressive yesterday when his mother visited'. Also 'patient said he tried to suffocate his mum when he was six'. He said 'he got angry yesterday because he is frustrated about being in hospital'

31st March 2008 the patient says 'he wants to distance himself from mother and does want to see her die as it reminds him of his father's death'

17th June 2008, the risk assessment at the time cites: the patient has been verbally aggressive to his mother when mentally unwell and tends to be paranoid about her at these times. Dr 3 (Associate Specialist and former care coordinator) is of the opinion that the patient may have actually assaulted her in the past.

July 2008 Risk Assessment – The patient has been verbally aggressive to his mother when mentally unwell and tends to be paranoid about her at these times.

27th April 2010 – Dr2 voices suspicion that Mr AR had possibly assaulted his mother.

June 2010 Mental Health Act Tribunal; nurse's report: - 'he has been verbally aggressive about mother when unwell in the past and tends to be paranoid about her at these times. Some members of the CMHT think he may have actually assaulted her in the past'.

6th June 2011 Social Worker describes MHA assessment for Section 4 - 'As the patient has a history of being paranoid about his mother who lives in the local area and has physically assaulted others when unwell, it was not appropriate for him to return to the community'.

265. In addition to this list of paranoia and aggression towards his mother we need to add the disturbing information supplied by her friends (paragraphs 246 to 250) which the MHT were unaware of at the time of their report.

**The Victim and the relationship with the MHT**

266. Mrs CR was an 86 year old female in poor health who lived alone. Her only remaining family lived in Spain. She did not confide in people other than her immediate family who, because of distance and a lack of understanding of the British medical system, could not give her any support.

267. Her maternal loyalty and commitment to her son meant that she carried the burden of his fragile mental health alone and unsupported.

268. The evidence we have examined indicates that it would be difficult to come to any other conclusion other than she was ignored and therefore marginalised by the MHT.

269. Compliance with the NICE guidance on management of Schizophrenia 2009 whereby mental health professionals should work in partnership with family members and carers and also offer family intervention to all families of people with schizophrenia who live with or are in close contact with the service user appears to have been ignored.

270. If we break this guidance down into its two main component parts – partnership and support - the seriousness of the lack of compliance can be much better appreciated.

271. **Partnership.** Mrs CR knew her son better than anyone else and had more frequent contact with him than any other person. Because of his reluctance to engage with professionals on any personal issues, she alone had insight into his early life and background. Other than Mr AR himself, she was the only person in a position to give clarity to the family dynamics that may have helped explain the underlying reason for his behaviour at specific times.

272. In between depot injections she was in a better position than anyone else to observe his behaviour and identify lapses. Partnership with her could have brought clear positive benefits in terms of more comprehensive understanding of Mr AR. Mrs CR was a potential treasure trove of information about Mr AR and a potential important ally in monitoring his behaviour which went untapped. She was given no opportunity to be involved or engaged in his care planning process. Instead she was kept at the margins of his care. The failure to engage with her was therefore a serious omission on the part of the MHT.

273. During the course of this review the panel gained the impression that Mr AR had a history of threatening to withdraw his cooperation if they (the CMHT) engaged with his mother. This demonstrates the extent of the control that Mr AR held over his treatment history.

274. Under the terms of the MHA (Section 3) Mrs CR, as the "nearest relative" had a role to play in the hospital admission of Mr AR but was not given the opportunity to exercise this right by the MHT. The MHA states that where admission under Section 3 is being considered, the AMHP (Approved Mental Health Professional) must consult the nearest relative unless this is not 'reasonably practicable' or would involve unreasonable delay. It also states that if the nearest relative objects to the application being made then the AMHP cannot make the application. The admission under Section 3 cannot then go ahead unless the nearest relative is displaced. (Displaced in this context means removed because the nearest relative is not a suitable person to carry out the role. Nearest relative is not the same as next of kin) The AMHP attempted to contact Mrs CR on one occasion by telephone but gave up the attempt for personal contact when it was found that the telephone number held by the MHT was incorrect. A letter was instead sent to Mrs CR on the same day. The Root Cause Analysis report noted – "In the light of the patient having been detained for 72 hours under Section 4, there is no apparent mitigating factor explaining why the AMHP did not consult the nearest relative, if not by telephone, then in person, as her address was known, local and easily accessible".

275. Engagement under the MHA Section 3 assessment process, each time it was applied, were missed opportunities to work in partnership with Mrs CR and to initiate a dialogue to the benefit of both parties.

276. The value of regular contact as a maintenance function does not appear to have been fully appreciated by the mental health professionals working with Mr AR.

277. As previously mentioned Mr AR's treatment did not include psychological therapies as recommended by NICE guidance. The absence of the psychotherapy driver for greater insight of his background, social history and thought processes may also help provide greater understanding as to why his mother was kept at the margins of his care.

278. **Support** In addressing the issue of support it was clear that the needs of Mrs CR were not considered. Her concern for her son and his treatment dominated her life. She remained tied to

residing in the UK away from her family in Spain because she felt she could not leave him uncared for.

279. She should have had a carer's assessment but didn't. This would have facilitated her needs (emotional, psychological and physical) being systematically assessed. This would also have been an opportunity to assess the level of risk she may have been exposed to over a period of time. The MHT records show that Mr AR did not want his mother to have a carer's assessment when staff approached him on the matter. She herself was never directly offered a carer's assessment and the one offer that was made was indirectly via her son who made the decision to reject it.

280. The DHR panel was perplexed as to why Mr AR was allowed to refuse a carer's assessment for his mother and why he was not told that it was for his mother to decide and not him. Elsewhere in this report we have referred to the control that Mr AR exercised and the lack of assertiveness on the part of the CMHT.

281. There was no attempt to follow up or revisit this initial offer or to initiate contact with Mrs CR. There was no recognition that just because help was refused in the past that it may not continue to do so in the future.

282. The lack of contact with Mrs CR can best be illustrated by the MHT records which only show four occasions when Mrs CR was seen by the MHT or spoken with by telephone and some of this interaction would have been initiated by her. On one important occasion when they needed to make contact with her to comply with the Mental Health Act Section 3 they found that the telephone contact details they held were incorrect and accepted this fact and sent a letter. No personal contact was therefore made.

283. There was no formal education or training given to Mrs CR in respect of the mental health issues faced by her son in order to help her have a greater understanding of his behaviour and subsequent treatment. She was never briefed on the relapse indicators that she should look out for which would indicate that his condition was deteriorating.

284. She was never informed of the concerns of the MHT that she could be at risk from her son.

285. Two underlying reasons behind the lack of partnership and support given to Mrs CR appears to have been the MHT apparent reluctance to cause friction with Mr AR if they engaged with his mother and a lack of inquisitive inquiry or consideration of the mother and son's relationship (both current and historic). During the course of this review one of the major points that emerged was of Mr AR's control and effective management over the system which was facilitated by the lack of apparent authoritative and assertive management by his carers.

286. The MHT should have regularly revisited the offer to give Mrs CR a carer's assessment and the offer should have been made direct to her. In this case there is no evidence that the offer of support was ever made directly to Mrs CR who may have taken a different approach to that of her son. We were concerned that Mr AR had been effectively given the power of veto over the support his mother could have been given and questioned why the care coordinator had not told him that this was for his mother rather than for him and for her to decide and not him. She had a right to a carer's assessment and confidentiality issues would not have been a barrier to this taking place.

**Individual Management Reviews (IMR)**

287. IMRs and written responses were received from the list of agencies and bodies below and have been summarised for the purpose of this report.

South West London and St George's Mental Health NHS Trust
Wandsworth MIND
Metropolitan Police
Viridian Housing

288. The GP's for Mrs CR and Mr AR were interviewed and confirmed the accuracy of the notes of these meetings.

289. Wandsworth Council Housing and Children's Services Departments and St George's and Westminster Hospital, gave information for the narrative chronology but given their limited involvement the DHR panel agreed there was no need for an individual management review.

**IMR - South West London and St George's Mental Health NHS Trust**

290. Most of the information provided for the IMR by the MHT was taken from the Trust's internal and comprehensive Root Cause Analysis Investigation. This was followed up by a set of questions to the MHT where further clarification was felt to be beneficial. Much of the content of this report has been derived from these three information sources and there would be no benefit repeating it again under this heading.

291. The IMR provided by the MHT was very detailed, forensic and informative. It identified weaknesses in the system where they were seen to exist. The vast majority of issues of concern mentioned in the DHR were also extensively highlighted in the MHT's Root Cause Analysis Investigation. They recognised the shortfalls in the care of Mr AR in their very thorough investigation and drew up a comprehensive list of recommendations to rectify these and improve care in the future.

292. We fully accept that the MHT has a comprehensive staff training program and do not attribute these shortfalls to gaps in training.

293. The IMR repeated the conclusion of the Root Cause Analysis Investigation that the murder of Mrs CR could not have been predicted and the reduction in medication was unlikely to have triggered a relapse.

294. The MHT were not aware of the concerns reported to have been expressed by Mrs CR in the last six months of her life and were therefore unable to take this into consideration when reaching their conclusion that there were no warning indicators and consequently the murder was not predictable.

295. In between the 3 weekly depot injections the CMHT relied on others (agencies or family) to contact them if they had concerns but at the same time had not communicated or developed any sort of relationship that would have encouraged this sort of cooperation or close working. Each agency in contact with the CMHT in this case has been critical of their communications approach and the term "silo mentality" was what often sprung to mind.

296. The shortfalls in the treatment and care of Mr AR restricted the areas in which they could assess any risk associated with him. We do not say or know that these factors are peculiar to this particular case. Optimisation of care and close working relationship with all the key partners is, in our view, the most effective way to monitor and be able to respond to risk.

297. The IMR identified the followed key care and delivery issues:-

a) The patient's mother was not involved or engaged in the patient's care planning process and did not have a carers assessment, which resulted in her needs not being systematically assessed nor the level of risk she may have been exposed to over a period of time being assessed.

b) The risk assessment failed to capture over a period of time (2007 - 2012) important information on the degree of risk that the patient presented when unwell, and particularly in relation to relapse indicators and that there was reluctance to have exploratory conversations which might have enabled team members to assess his mental state more easily.

c) There was insufficient evidence of a holistic recovery plan, including recovery goals, in the patient's CPA care plan.

d) There were a number of significant changes affecting the patient's care team prior to and during the period of the incident (particularly the period 2011 – 2012). This included team amalgamations, team base moves, changes to structures/systems, and a lack of stability in leadership/management which impacted on the team's ability to provide professional supervision to the nurses. There was also a lack of opportunity to have a regular team reflective space to think about practice and evaluate systems which all impacted on the overall quality of service delivery. The team also experienced a high level of locum agency staff use that impacted on consistency in the team and continuity of care.

298. The Investigation Panel identified particular lessons to learn from in respect of this incident:-

e) The need to ensure teams are meaningfully involved in, and supported through significant or high volumes of change, with contingency plans put in place to manage this; additionally, for staff to feel empowered to escalate concerns of significant or high volumes of change.

f) The need to adopt a more universal understanding, interpretation and implementation of the Trust's Recovery Strategy

g) The patient's risk towards his mother had not been sufficiently explored despite the fact that members of the team were aware that the patient could be aggressive and threatening to his mother when unwell. The Investigation panel felt there was clear and important learning about the understanding of the degree of risk to others, and for a more robust approach to exploring the risk and clearly documenting it, with regular reviews and updates to reflect formulation and processing.

299. The recommendations from the Investigation Panel carried over to the IMR were as follows:-

1. The Trust Care Programme Approach (CPA) policy should be reviewed and updated with the following areas to be considered:

a) Communications and involvement of families and significant others relating to the service user, subject to the CPA

b) The incorporation of the Trust's 2007 Recovery Strategy (Promoting Recovery and Facilitating Social Inclusion: A Strategy for Practice and Implementation Plan)

c) Improve the care planning processes in the document that highlights the importance of the service users inclusion in the care plan with a focus on safety and recovery

d) Emphasis must be given to working with external/multi-agency partners involved in a service users care

e) The policy should follow a communications process so that it is widely shared throughout the Trust when republished.

2. The Investigation Panel recommends that the CMHT undertake a service review. This would include:

a) Caseload management

b) Caseload Capacity

c) Operational systems in respect of zoning

d) Communication systems both internally and with the wider organisation

e) Clear supervision and management systems and adherence with all mandatory training

f) This review should be externally facilitated to ensure compliance with internal guidance, national guidance and any local objectives.

g) The Investigation Panel also recommends that all community teams have an annual team day that reviews systems, local policies and communications with other agencies, particularly where a team has experienced significant change. This guidance is already cited in the 2011 Operational Policy for CMHT's

3. The Investigation Panel recommends that all clinicians undertaking assessment apply this important learning point. Where there are risk indicators identified, that these are comprehensively explored. This would include an assessment of the risk indicators that includes evidence of both in-depth discussion with and involvement of the patient.

For example, when a carer's assessment is offered but declined by the patient, the reasons for this should be explored. There should be a formulation that describes the nature of the risk the plan that addresses this and how and when this is reviewed. This must be fully documented in accordance with the Trust's Clinical Risk Policy and guidance, and must also be entered in the appropriate fields on RiO.

4. The Investigation Panel recommends that where a service user has been the care of the Trust for a prolonged period time (consider five years as a benchmark) and continues to present at risk of harm to self or others and/or presents as treatment resistant, that a full and comprehensive review of care is undertaken including a review of all pre and post RiO medical records, a pharmacological review and input/feedback from multi-agency partners. If appropriate, an independent or second opinion should also be sought.

**IMR - Wandsworth MIND**

300. Social services financial records indicate that the care provided by MIND at the time of the incident was provided under the provisions of Section 117 of the MHA. S117 imposes a joint legal duty on health and social services to provide after care to patients detained in hospital for treatment under Section 3,37,40,5A,47 or 48 of the Act who then cease to be detained. The duty to provide S117 after-care services continues as long as the person is in need of services to improve their mental health condition and are provided free of charge, to encourage engagement with the wide range of provision to enable them to cope with life outside hospital and to minimise risk of relapse. The care coordinator is responsible for monitoring and modifying the plan together with the patient as indicated by their progress.

301. Mr AR was referred to Wandsworth MIND in January 2009 by his care coordinator. The referral was 'to provide structure to his day's activity; to socialise with peer group; social inclusion and a purpose to his life'. There are no records of requests for reports or progress reviews or of any contact between MH Trust care coordinators and MIND staff during the following 4 years that AC attended the centre. MIND records had no updated risk assessment or information about the incidents that gave rise to concern during the period.

302. The referral in 2009 was as part of the new personal budget approach to the provision of the social care elements of mental health support. Personal budgets were introduced in 2008 as part of a new process to give people greater control over the way they receive their support. Invoices were paid by the Council Finance Department. In June 2011, the CMHT contacted Wandsworth Council to inform them that this support would now be Section 117 aftercare. MIND were not informed that the support they were now providing was aftercare following a discharge from hospital.

303. It appears that his Section 117 aftercare that was supposed to help him settle back into the community and to prevent him from going back to hospital for treatment of his mental health problems was simply his personal budget care package (established two and a half years earlier and unchanged) "relabeled". There is no indication that his needs were reassessed specifically from the perspective of rehabilitation and all that this entails.

304. Wandsworth MIND was not informed whenever Mr AR was admitted as a formal or informal patient nor were they told of his discharge. They were not informed of any discharge planning despite their key role in the community. We were mindful of the recommendation of The National Confidential Enquiry into Suicide and Homicide by people with mental illness completed by the University of Manchester in June 2011 that "Services should ensure that comprehensive care planning takes place prior to hospital discharge as a key component of the management of risk."

305. The section of the referral form headed "Risk Assessment – please provide a full risk assessment" was blank when sent to MIND. Under "Brief Social History", it reads: "he has contact with his mother but becomes paranoid about her when he is experiencing a relapse". The entry doesn't specify the ways in which or the extent to which he became paranoid, any risks associated with his paranoia, or any signs or indicators of possible paranoia. A printout of a risk overview dated July 2008 was included. If the completion of this referral form was not satisfactory or the risk assessment considered inadequate then MIND should have raised this at the time with the CMHT rather than simply accepted them.

306. The referral form was very general and minimal. It is hard not to see the referral as a tick box exercise to demonstrate that Mr AR had been given the required support and aftercare. It does not come across as a serious attempt to support Mr AR in coping with life in the community. The lack of communication with MIND and absence of any form of follow up is concerning.

307. The cost of the Personal Budget care and subsequently the Section 117 aftercare for Mr AR was met from the public purse. ASSD satisfied us that they have adequate and robust fiduciary procedures in place to control their side of this arrangement. They informed us that Direct Payment (DP) service user's financial arrangements are subject to regular monitoring by the DP Team which comes in the form of monthly bank statements and invoices to evidence all out going transactions on the DP account. They regard these steps as an essential requirement for receiving a DP and to ensure that Council monies are being used for the purposes laid out in the Support Plan, the correct amounts are being used for each service and that accurate receipts and records are being kept. If it appears that the service user is using DP money for purposes other than that prescribed in the Support Plan and is not compliant with the Terms and conditions of the Agreement, the respective Social Work Manager will be informed immediately in writing with copies to the Team Manager and Finance Manager.

308. Unfortunately, there was no monitoring of the Support Plan by the Mental Health Trust to ensure that it was being provided appropriately in accordance with the wishes of Mr AR who had chosen to spend his Direct Payment with MIND and that it was achieving the brief outcomes stated on the referral or indeed that he was attending. The MHT saw that on-going monitoring was the responsibility of the Adult Social Services Department (ASSD) and gave this as their reason for the lack of monitoring or follow up.

309. The ADSS Department were quite unequivocal regarding where responsibilities lay. They informed us that the social work staff are seconded to the Mental Health Trust who are accountable for their day to day line management under a formal S75 Partnership Agreement. Health and social care are therefore delivered by integrated Community Mental Health Teams (CMHTs). The Council's role is to performance manage the delivery of social care by the Trust through monitoring the S75 Partnership Agreement. It is the care coordinators' role to continue managing and coordinating the individual arrangements, conducting, at minimum, a comprehensive annual review Mr AR to ensure that his eligible assessed needs are still being appropriately met by his chosen provider, in this instance MIND. It is the responsibility of the Trust to provide integrated health and social care delivery and this was particularly important in the case of AR who had a long-term mental health condition with complex health and social care needs. The care coordinator and CMHT are responsible for meeting, reviewing and monitoring AR's on-going health and social care needs, coordinating and collaborating with all agencies involved in his care and requesting information about attendance patterns as part of the Trust Care Programme Approach (CPA). This is crucial information in assessing mental state, potential isolation and other risk indicators.

310. Mr AR used the MIND Centre often but with varying degrees of frequency. Latterly he dropped in three times a week even though he was entitled to attend each weekday. He told the centre manager that he only came because his flat was just a few hundred metres away.

311. In general, his behaviour gave no cause for concern. There were the occasional incidents but nothing considered particularly significant. He was not demanding of staff time. He was considered a very private person (guarded or reticent could be a better description) who did not volunteer what he considered to be private information. He was felt to be a reluctant service user who many health professionals found to be enigmatic, inaccessible and difficult to read. The one to one sessions he had with staff were generally unproductive because of this reluctance to engage.

312. The flow of information between Wandsworth MIND and MHT staff both about Mr AR and other service users tended to be one way. That is to say, the centre manager (CM), would always contact the care coordinator or CMHT if she felt a service user was becoming unwell but it was very rare for information to travel in the other direction – for example, if there had been a new risk assessment or risk event. The Centre diary shows that the only time in the eighteen months before Mrs CR's death that they were contacted by MHT staff was the day of the incident itself.

313. Wandsworth MIND did not go (were not invited) to any of Mr AR's CPA meetings, though they did for a number of other service users.

314. Mr AR last attended the MIND premises on 24th December 2012 which was just three days before the murder of his mother and staff noted no concerns about his behaviour.

315. Wandsworth MIND was in an ideal position to support and monitor Mr AR as it almost certainly had much more contact, and more revealing contact, with him than his CMHT. Ideally, they might have had a wider focus, inquiring into the rather uninformative risk assessment that accompanied him to the Centre, being involved in CPA and other hospital meetings (with his permission), asking for information about whether he was having his medication as prescribed, and learning more about stressors and key relationships outside the Centre, rather than simply monitoring his behaviour and any symptomatology inside the Centre. MIND describes itself as in a similar financial position to many other small organisations supplementing formal NHS services. They informed the review panel that apart from CM, it relied on very inexperienced and sometimes rapidly changing staff because of the way in which it is funded and the weakness of the 1:1 sessions he did have demonstrates this clearly.

316. The failure by the MHT to engage meaningfully with Wandsworth MIND was a missed opportunity to enter into a fruitful partnership with the one mental health specialist agency working in the community who had regular contact with Mr AR. In addition the lack of contact about incidents of violent behaviour could potentially have put the staff at MIND at risk.

317. At the same time Wandsworth MIND could have been more proactive in encouraging the MHT into adopting a more joined up approach to the support of their patient and in acting together purposefully and effectively. This appears to be what they are aiming to achieve through the recommendations set out below.

318. MIND made the following recommendations in the light of their experience that risk is minimised where treatment of mental illness and support to the service user through the medium of a sound and trusting therapeutic relationship are optimised:-

a) that the Trust and Wandsworth Mind meet to discuss expectations of each other when there is shared working with service users with severe and enduring mental illness

b) that more emphasis is given by both agencies to the exploration and understanding of risk at key points so that Wandsworth Mind staff can be more alert to possible risks – e.g. referral, discharge from hospital, and CPA or similar meetings

c) that the purpose, nature, frequency etc of 1:1 named worker meetings are reviewed

d) that regular, evidence-based training about risk and risk management is provided to all social inclusion staff at Wandsworth MIND

**IMR – Metropolitan Police**

319. The IMR from the Metropolitan Police Service was compiled by the Critical Incident Advisory Team SC&O 21(2) of the Specialist Crime and Operations section. Much of the factual content of the IMR has already been used in this report and there is nothing to be gained by repeating it. Both parties (Mrs CR and Mr AR) had limited and sporadic contact with the police and having analysed the specific incidents, each one was dealt with in accordance with the relevant policies and procedures in place.

320. The execution of a mental health warrant on 24th August 2007 was the first record of Mr AR coming to the notice of police for mental health issues. A total of 7 issues and/or incidents were recorded by the police in the IMR. None of the incidents resulted in criminal proceedings. The IMR included a request for full disclosure around Mr AR from Viridian Housing Association as they believed he had breached his tenancy agreement. Full disclosure was provided to Viridian.

321. The MPS pointed out as worthy of note that on all but two occasions where Mr AR had come to the notice of police there were obvious concerns surrounding his mental health.

322. The MPS related that during the 5 year period under review by the DHR there were occasions where the police did not appear to have sufficient information provided to them to allow an effective assessment of the risks posed by Mr AR. Additionally, there were several missed opportunities to adopt a multi-agency approach to information sharing. They quote an example back on 24/08/2007 when Mr AR had locked a female psychiatrist in a room and behaved in a sexually uninhibited manner and had then been violent to both his doctor and social worker. They contended that other agencies held additional detail which, if shared, would have ensured a greater understanding of the overall circumstances and could have led to a more effective approach to identifying, assessing and managing the potential risk posed by Mr AR.

323. Conversely, they make the point that, the police were also responsible for ensuring that any information that was shared with external agencies, either by way of a PAC or other means, should have been followed up effectively and a request made for an update or additional information in return from CMHT and Viridian. On the last occasion when Mr AR had come to the attention of several agencies, including police, CMHT and Viridian Housing, consideration should have been given to holding a risk strategy meeting with those relevant agencies.

324. A strategy meeting, in their view, would have allowed full disclosure of the information held by individual agencies and this in turn would have revealed a comprehensive picture of Mr AR and enabled an effective assessment of any potential risk to himself, his neighbours or the public. A

risk management plan could have been drawn up between the relevant agencies to ensure that the individuals involved were offered support and may have even identified that Mrs CR was Mr AR's only living relative and that she may have needed further assistance and advice in relation to his behaviour. In addition it may have identified that Mrs CR was also a vulnerable person that may have needed additional care.

325. The police relate that lessons have already been learnt around the way in which local professionals and agencies share information in relation to vulnerable adults. The police refer to a neighbour disturbance on 4th June 2011 in their IMR when a PAC report was created and shared with ADSS on 08/06/2011 detailing the incident and highlighting that a further assessment of Mr AR was required to ensure that he was receiving the correct level of support. They explain that at the time this incident occurred in 2011 there was a local information sharing process in place between the police and ADSS (since 2009). However, this was not universal across London and in the main there was no formal information sharing process between the MPS and partner agencies around mental health or vulnerable adults. The lack of formal information sharing process has now been identified and acknowledged as a risk area by the MPS and partner agencies. Processes and procedures in relation to mental health issues were looked at in the recent Independent Commission for Mental Health and policing, led by Lord Adebowale. The Report has been published and there are 28 Recommendations, these include professionalising the role of police Mental Health Liaison Officers (MHLO), improving working practices with partners and ensuring adequate training is given to staff and improve information recording and sharing.

326. In addition recent improvements have been made to the vulnerable adult policies and procedures through the introduction of recording vulnerable adults on MERLIN via Adult Come to Notice (ACN) reports. In April 2013 the recording of ACN reports was introduced across all 32 Boroughs within the MPS.

327. We raised three specific clarification queries with the MPS in respect of their IMR. Why did it take 4 days for the incident referred to above in paragraph 309 to be notified to ADSS but no explanation could be given for the delay. We asked whether the change of name by Mr AR had been formally notified to them and they responded that it had not but this did not impede their ability to access records relating to his background. We asked whether the protocol of contacting the CMHT via Social Services rather than direct was an impediment and they responded that this agreed approach worked well.

328. The Terms of Reference for this Domestic Homicide Review were considered by the MPS in their IMR and they concluded that although there are lessons to be learnt, particularly in relation to the sharing of information, they had no specific recommendations to make on this occasion.

329. The recollections of the friends of Mrs CR that she had been told by her son that she had to die before Christmas and of the occasion of her making her final goodbyes to these friends were given to the police in the statements provided just after the murder. This was a crucial piece of information that would have focussed minds if it had been made available to the review panel early in their proceedings. It may also have influenced the Root Cause Analysis if it had been made available to the MHT. Unfortunately this information did not come to our attention until the final phase of the review when we interviewed these friends and they repeated these recollections to us directly. This was an unfortunate omission by the police in the briefings they gave to the DHR review panel. It was accepted that the Murder Team cooperated fully in this review and this omission was simply an oversight.

**IMR – Viridian Housing**

330. Most of the factual detail contained in the Viridian Housing IMR has already been set out elsewhere in this report. Mr AR was a tenant of Viridian Housing since 12th December 1994 until he voluntarily relinquished his tenancy on 23rd April 2013. They had no contact with Mr AR in the period immediately before the incident and had no information that would have indicated that he was a risk to others at this time.

331. Viridian differentiated between 'supported schemes' where residents receive 24 hour, high level cover and 'floating support', which Mr AR received at his first address. This meant that Mr AR could live independently but received some additional support when required, such as with benefits, wellbeing activities, rehousing and emotional support. Mr AR wanted support with moving house through mutual exchange and the floating support ended once this was achieved.

332. Viridian related that although the risk assessments and support plans described Mr AR's psychological issues, Mr AR did not want to talk about or get support on these issues. It was noted that he was a private person and only wanted help on specific issues.

333. The risk assessment did not indicate that Mr AR was a risk to women, and a female manager provided him with support. When questioned Viridian made clear that the allocation of a female support worker was made before they were aware of Mr AR's risk history and in retrospect it is unlikely that this would have happened if they had known then what they knew now.

334. Viridian were Mr AR's social landlord and as such were in a good position to be aware of his lifestyle and behaviour through their own interaction with him and the dialogue with other neighbouring tenants. They had an important role to play in maintaining Mr AR living independently in non-institutional accommodation in the community. In 2010 and 2011 they dealt with two ASB cases attributable to his mental health which put his tenancy at risk. Both cases were withdrawn when the CMHT confirmed to Viridian that his condition was stable.

335. Mr AR's neighbours were concerned about his behaviour and there is no indication that Viridian were given any support from the CMHT in dealing with these concerns. Confidentiality about Mr AR's health history was clearly of concern and an important factor in restricting the flow of information to Viridian. The CMHT was in a difficult position about how much to divulge but this problem could have been eased by some regular meetings and the development of a working relationship.

336. If Viridian had been more fully involved in the community care of Mr AR they would have been more vigilant in noting information about his activities and behaviour and in picking up seemingly trivial comments made by neighbours. For example neighbours reported to the DHR panel a regular weird burning smell from his flat which smelt like burning grass. Given his inclination towards cannabis this may have been useful intelligence for the CMHT.

337. Viridian had in place a vulnerability policy but it was not specifically triggered in this case and they have recognised the need to roll out awareness training to all front line officers and operatives so they know what to do if they identify someone who requires additional help. Viridian's attention in respect of the two ASB incidents focussed on the vulnerability of Mr AR. We questioned Viridian on their duty of care for third party individuals as the neighbours related how they felt vulnerable and neglected and were critical of their landlord for this reason. Other tenants and neighbours felt that their needs and concerns were not addressed although it is difficult to see what Viridian could realistically do other than offer platitudes because they themselves were in possession of very little information.

338. Viridian was very critical of the CMHT's lack of engagement with them given their pivotal role in maintaining Mr AR in social housing accommodation in the community. They recounted a general pattern of one way communication which they considered highly unsatisfactory. When Mr AR's behaviour was of concern they took the view that a more informative dialogue would have been beneficial. Of particular concern was the lack of information at times when Mr AR was being discharged from hospital as they were forced to rely on being informed by neighbours that he was back in the property. This lack of knowledge frustrated any attempts to plan a smooth and successful reintegration. This problem highlighted by Viridian cast doubt on whether proper discharge planning had been instigated by the CMHT.

339. The police forced entry into Mr AR's flat and their contractor made the shared front door secure but this was done in such a way that the elderly tenant of the ground floor flat was not able to gain entry when returning from a family visit that evening. With the help of her family she was eventually able to gain access. The tenant was highly critical of both Viridian and the police for putting her in what was an extremely stressful situation. Viridian had not been contacted by the police and only found out about the forced entry when the tenant contacted them for support. Viridian were critical of being put in this position as prior knowledge would have enabled them to manage the situation much more effectively.

340. Following this incident Viridian appreciate the importance of maintaining a flow of information with their tenants. Viridian have also indicated that a CMHT change of approach regarding partnership working and communication must be one of the important lessons to be learnt from this incident. They take the view that lack of linkage with external agencies increases risk as it can create gaps in the information held by the CMHT. Working more effectively with other agencies can help deliver more holistic care and successful community care solutions.

341. All agencies have a part to play in ensuring there is good inter agency communication. As with the other agencies Viridian should have been more proactive in ensuring that there were good lines of communication between them and the MHT. If the communication was not considered satisfactory then they should have taken the initiative.

342. Viridian Housing will go forward with two main learning and action points from this review as follows:-

    a) Viridian have commissioned a trainer to provide vulnerability awareness training to all frontline colleagues. This programme will start in the first quarter of 2014/15 (i.e. between April and June 2014). Expected outcomes are for colleagues to gain confidence in identifying various vulnerabilities / safeguarding issues, know how to report concerns and increased reporting of 'vulnerability / safeguarding' concerns.
    b) Arrangements are underway for Viridian to meet with the CMHT representatives in order to develop stronger partnership working. Viridian take the view that this review has highlighted the need for improved partnership structures with CMHT generally and the Community Safety Partnership is best placed to lead on this task as they and other similar agencies look to their statutory partners to provide a structured conduit to troubleshoot problems when they come across barriers to partnership working. They propose that a new approach is needed as existing meetings or arrangements have not delivered the level of partnership working and information sharing that the review highlighted as necessary for effective partnership working.

**Interviews with the GPs of Mrs CR and Mr AR**

343. Mr AR is recorded as attending a GP surgery in London SW18 since 1998 when records were computerised. The surgery has over 17,000 patients and therefore patients are not always seen by the same doctor.

344. Mr AR last visited the surgery on 24th December 2012 (3 days before the incident on 27th December) to collect a prescription. The staff reported that they had no concerns about his presentation. They confirmed to the Root Cause Investigation Panel that they would recognise if the patient was becoming unwell. This view was based on an instinctive understanding as they had never been given any briefing on relapse indicators and how to spot them.

345. We asked for clarification of the role of his GP in support of CMHT responsibilities? Response - The GP has responsibility in caring for the patient's physical and mental health needs. We were aware that Mr AR's MHT key worker would maintain contact to ensure that he is receiving his medication. Medication was supplied three weekly and during that contact enquiries with the patient should be explored to see how he is.

346. We sought to explore the extent of the communication between the surgery and the CMHT and asked what communication they had received from the Trust regarding Mr AR. Response - There is little documented communication attached to his medical records for the period July 2007 onwards. The last communication prior to his annual review on 5/11/12 was a discharge summary sheet from the MHT which relates to his medication only (August 2011). Prior to this we have letters from 15/10/10 (review by Psychiatrist and CPN), 14/6/10 and the 26/5/10 (review by Psychiatrist whilst under care of Crises and Home Treatment Team). Two other letters dated 19/2/10 and 19/12/08 were received indicating mental health reviews by the psychiatrist. The next letter then dates back to 27/7/07 which was also a mental health review.

347. According to records following the events at the surgery on 20th May 2010 there was a phone call by GP1 (who arranged Mr AR's admission to hospital) to his psychiatrist. Part of that conversation appears to have been about risk assessment re future management / contact with Mr AR when he attends the practice. A subsequent decision was made by the practice that Mr AR would only be seen by a male doctor.

348. We asked some questions in order to build up a picture of the relationship between the CMHT and the surgery.

349. Was the surgery kept informed when the care co-ordinator changed? Response - No.

350. Was the surgery kept informed when Mr AR was a formal or informal patient and the dates of his discharge? Response - The information held is that he was assessed in May 2010 and that he had been discharged in August 2011. There is no other information on file relating to admissions for period 2007 onwards.

351. We have a list of violent or aggressive acts by Mr AR – was the surgery always kept informed about these? Response - No. There is no record of information being provided for period 2007 onwards.

352. What was the quality of the communication and information sharing? Response - It was less than expected. The letter received 31/8/11 only informed the practice that the patient was discharged, listed his discharge medication and indicated that he would receive a care coordinator review in next 7 days. We would normally receive a discharge summary which would provide detailed information re the circumstances of his admission, his mental health on the ward and progress

made, in addition to his discharge plan and management. The patents file indicates a much better flow of information prior to July 2007.

353. Did the frequent changes of care co-ordinator impact on being able to provide effective care? Response - The practice was not made aware of any changes of care coordinators

354. What was the purpose of the annual review? Was there always an annual review carried out. Did the outcome of the annual review differ over time? Who was the annual review report shared with? Response - This is a 20 minutes appointment to check on the patient's physical and mental wellbeing. I undertook this review on 5th November 2012. Mr AR was a diabetic and has high cholesterol. Conversations with the patient included asking him about their medication, how he is coping, looking for signs of self-neglect and whether he had feelings of self-harm or to harm others. No concerning issues were evident at this review. Mr AR was cooperative and engaging.

355. Did the practice have any communication with Mrs CR (Mr AR's mother)? There is mention that she went to the surgery with him but then came back later on her own to discuss his condition more freely. Was the content of this discussion documented? Response - We have no communication with Mrs CR, this would have been expected as she was not our patient. There is no documentation in the notes which recorded any attendance by Mr CR with Mr AR or separately from him.

356. Did Mr AR ever talk about his relationship with his mother and if so in what manner / context? Response - There is nothing within the file that indicates any conversation about his mother.

357. Was Mr AR a cooperative or reluctant patient – did he engage? Did he offer information or was he withdrawn and guarded? Response - He was interacting and cooperative during his annual review appointment on 5/11/12

358. Was Mr AR ever aggressive at the surgery or to staff (note: 20/5/2010 GP surgery reports that he pushed two patients in waiting room and was very aggressive to doctor)? Was any action taken following these incidents? If not then what was the reasoning behind this approach. Response - The event on the 20th May 2010 was dealt with by GP1 who arranged for his urgent admission to hospital. She contacted Mr AR's psychiatrist the following week to discuss his presentation and behaviour. The decision was then made at our Practice meeting that the patient would only see a male Dr.

359. Was the GP practice involved in any Care Planning meetings concerning Mr AR? Was the outcome of care planning meetings shared with the GP? Response - No.

360. Does the GP practice apply any risk assessment with regards to patients receiving treatment for mental health? Response - The practice regularly reviews any areas of risk to improve patient / staff safety.

361. Was the surgery made aware of the relapse indicators by the CMHT and whether this information were kept up to date? Was there an agreed approach to be adopted when these relapse indicators were spotted? Was the nature of Mr AR's illness fully explained to the surgery? Response - No.

362. One of the recommendations following an earlier homicide in December 2000 was that there should be a shared protocol drawn up between the Trust and the Primary Care Groups (PCGs) to establish clear shared care arrangements between CMHTs and GP's. Are you aware of the

protocol? Have respective roles been explained? Are these protocols being followed and do they work? Response – I have spoken to all my partners and none are aware of the existence of such a protocol.

363. The liaison and communication between Mr AR's GP surgery and the CMHT was unsatisfactory and contrary to the improvements that were introduced following a homicide in 2000. The protocol followed a recommendation of the independent inquiry which sought to ensure close working collaboration between the CMHT and GPs.

364. The GP surgery could and should have taken the initiative to improve communications.

365. We also contacted the GP of Mrs CR to ascertain whether they could add to our knowledge of her and identify any issues that could help further our enquiries. She was a patient of the practice since 1990. Her husband attended the same surgery up until his death in 2001. Both she and her husband always attended the surgery alone and never together. Her medical illnesses were high blood pressure, high cholesterol and type 2 diabetes which were all controlled by medication and she had no complications from these illnesses. Despite her medical conditions she was generally fit and healthy as well as independent. She always attended the surgery and never requested a home visit. She never sought help or treatment for stress, anxiety or depression and there was no record of any effect of stress or anxiety on her medical illnesses. Her command of English was good and did not affect her ability to communicate or hinder understanding.

366. She was last seen at the surgery on 12th December 2012 for a follow-up appointment as she had been seen two weeks earlier after she had a fall as she continued to have musculoskeletal chest pain. Her injury was consistent with a fall. She had no record of any previous injuries suggestive of assault.

367. The surgery was not aware that she had a son or any other relative as she always attended the surgery alone. There is no record of her discussing family or domestic problems. She was considered to be a friendly and likeable person and was held in high regard by the practice staff.

**Analysis of the Terms of Reference (ToR)**

368. The three ToRs relating to communications and working together are taken together because of their interrelationship.

- Communication and co-operation between different agencies involved with Mrs CR and/or Mr AR

- Identify lessons to be learnt from the case about the way in which local professionals and agencies worked together to safeguard the victim and her family.

- Identify what those lessons are, how they will be acted upon and what is expected to change as a result.

369. **Analysis** The communication approach of the MHT has been criticised by all the agencies involved in this case. The term "silo mentality" has been used on a number of occasions throughout this review to describe how the approach adopted by the MHT appears to the other agencies. Information flows were seen as one way traffic. The MHT although at the centre of the care of Mr AR was not seen as proactive in terms of initiating dialogue with other agencies and

this had a detrimental effect and reduced the effectiveness of how they dealt with Mr AR. The failure to engage would also have the reduced the comprehensiveness of information held by the MHT on Mr AR and narrowed their view of his functioning and the risk he may pose.

370. The lack of communication on acts of aggression and threats of violence were seen by the other agencies as potentially putting their staff at risk.

371. The MHT failed to foster close working relationships with other bodies involved in his functioning in the community and in our view this was a missed opportunity to optimise his care.

372. Nevertheless, if inter-agency communication was not satisfactory then all agencies must bear part of the responsibility for this shortfall. Waiting for others to take the initiative is not satisfactory.

**ToR** Establish whether the agencies or inter agency responses were appropriate leading up to and at the time of the incident on 27th December 2012.

373. **Analysis** The agency responses at the time of the incident and immediately leading up to it were appropriate. Policies and procedures appeared to have been followed and complied with.

374. In the immediacy of the police response to the incident the decision was taken that there was an urgent need to gain admittance to his flat to rule out any related occurrences there. Forced entry was necessary. This was a good display of initiative given the circumstances at the time. The purpose of raising it here, even through it is peripheral to the DHR, is because of the after effects of the forced entry. The elderly neighbour was very distressed on returning home to find she could not gain entry as her front door was boarded up. No one could give her an explanation or reassurance and it also took an inordinately long period of time before the door was repaired. No one had informed Viridian, the landlord, that forcible entry had been necessary. This unnecessary increased the distress of an elderly frail neighbour who was already highly stressed following the revelations about her neighbour Mr AR. This is an important lesson to be learnt about vulnerable third party people affected by the incident.

**ToR** Establish whether agencies have appropriate policies and procedures and associated monitoring procedures to respond to domestic abuse and to recommend any changes as a result of the review process.

375. **Analysis** The case did not appear to have domestic abuse associations and policies and procedures were not examined in any great deal. The case did however highlight the need for vulnerability policies and procedures and for these to take a wider outlook to cover more than simply the patient or client.

376. The friends of Mrs CR, with hindsight, speculated that certain minor injuries she had sustained which were accounted for at the time with unconvincing explanations were in facts indications of domestic abuse. If this was indeed domestic abuse then Mrs CR's loyalty to her son may, with some speculation, explain why she concealed what really had happened.

**ToR** Review the care and treatment, including risk assessment and risk management of Mr AR in relation to his primary and secondary mental health care.

377. **Analysis** As previously stated, we took the perspective that optimising care was the most effective way of reducing or containing risk. In this report we have identified a number of areas

where care and treatment could have been improved. The main failing in our view was the narrow perspective in terms of understanding the patient of those providing him with care. The insight into his past history, functioning and his perception of his life was very narrow and little effort seems to have been made to expand this view by probing or tapping into information held by those outside the hospital network. Those best placed to provide a greater insight were not effectively engaged. The last two care co-ordinators did not have any formal caseload handover which must have significantly limited their knowledge of the patient in their care. The lack of any inquisitiveness and curiosity about the reasons behind his behaviour was consolidated by the absence of psychological treatment as recommended by NICE on the management of schizophrenia.

378. Continuity of care is a vital component of quality care for people with serious mental health illness. The high use of agency staff and frequent change of care co-ordinators worked against the cultivation of good relationships which are essential for trust and cooperation especially for a patient such as Mr AR who managed the extent of the information that others knew about him. While the lack of continuity of care of MHT staff was detrimental to the care of Mr AR at a 1:1 level it would also have contributed to a lack of knowledge of the other key agencies and staff thus hindering liaison/communication with family and outside agencies.

379. The documentation relating to the degree of risk he presented when unwell was not fully embedded and therefore not always carried over meaningfully into on-going risk assessments.

380. The transition from inpatient to life back in the community appears to have been poorly managed. There is little substantiation of effective discharge planning evidenced by the lack of collaboration between the MHT, his mother and the community based organisations regarding continuity of care management. There was poor communication and involvement with community providers which meant that discharge was not planned in cooperation with them. They were not adequately informed about dates of discharge, changes or developments in his treatment history, his progress while an inpatient, his medication regime or his relapse indicators. They were not involved in planning how he could be supported in the community to maintain recovery and this was a serious weakness.

381. The control exercised by Mr AR over some parts of his treatment (when not hospitalised) has been demonstrated in this report. We understand and appreciate that treatment must be negotiated and managed in cooperation with the patient in these cases and do not underestimate the difficulties and the tact and diplomacy needed. The concern that he would withdraw cooperation meant that he was allowed to dictate that his main carer was excluded from formal inclusion in his care planning. It also limited the probing into his perceptions, feelings and relationships. Changes and reductions in medication were led by him. We were of the view that a more authoritative and assertive approach would have been more effective. Applying this more assertive approach would have been more feasible if trusting relationships had been developed.

382. There is great pressure on mental health professionals to predict and minimise risk and we recognise and do not underestimate the difficulty of the decisions that must be made. Risk can never be eliminated and accurate prediction is never possible for individual patients. The risks posed by those with paranoid schizophrenia are less susceptible to prediction because of the often multiplicity and complex interrelation of factor influencing behaviour. Good effective risk management and sensible contingency planning however can mean that some negative outcomes can be avoided or reduced. Risk assessments were routinely carried out by the CMHT in a timely manner. The outcomes in relation to risk to others were not shared with others outside the hospital community and neither were they involved in the assessments and we saw this as a

weakness. The care team viewed the risk to others from their own perspective and it was our view that the involvement of others who knew Mr AR well from other types of relationship would have enhanced the quality of the assessment undertaken. In addition, the involvement of other agencies such as the police who have great expertise in risk evaluation would have given a different professional dimension and input to the evaluation. It was our impression that risk assessments were an evaluation of the current situation and that the involvement of other specialists such as the police would have in addition promoted the consideration of cumulative factors. Finally, there needs to be an acknowledgement that a risk assessment is only as good as the information available to complete it and in this case there was no strategy to gather information from any agencies or persons outside the hospital community.

383. His GP was not fully involved in his care planning. Communications with the surgery was poor from 2007 onwards. The surgery was not aware of changes in care coordinator and were not invited to CPA reviews nor informed of their outcome. The MHT nor the GP were aware of the collaboration protocol agreed following a previous homicide. The Inquiry Panel at that time identified the need for closer collaboration between the CMHT and the GP when a patient is discharged into the community. Collaboration between the surgery and the CMHT should have been better.

384. The depot medication given to Mr AR on a three weekly basis was reduced by 40% since May 2012 and we have no expertise to determine what, if any, effect this would have had on his stability. It is outside our area of competence. We noted the expert opinion provided to the Root Cause Investigation that this reduction was highly unlikely to have triggered a relapse. However, from a lay (commonsense) perspective we were left wondering why 200mg was originally prescribed if indeed a reduction to 120mg was subsequently acceptable. We asked the MHT to clarify the position on a reduction in medication and the expert advice they obtained and provided to us was that the reduction of the dose of medication over the 7 month period was done in a sensible manner and demonstrating good pharmacological practice

**ToR** Seek to establish whether the events of 27th December 2012 could have been predicted, prevented or the likelihood of it happening could have been reduced.

385. **Analysis** We support the conclusions of the MHT Root Cause Analysis Investigation Report that the events of 27th December 2012 could not have been predicted. The DHR found no evidence to corroborate the information given by the friends of Mrs CR that she was reconciled to her life ending prematurely in 2012. Should Mrs CR have been fearful as suggested it is highly unlikely that she would have confided her concerns with health professionals as demonstrated by the fact that her GP was not aware that she had a son and she was last seen at the surgery on the 12th December 2012, some six days prior to the last meeting that the friends had with her. Unfortunately, no one had the complete picture and all those who could potentially have done something only had a partial view. The friends who knew of her concerns did not know that her son suffered from paranoid schizophrenia and had a history of paranoia towards her and therefore did not give due significance to what she told them. The MHT knew of his condition and his history but were totally unaware of the comments reported to have been made by Mrs CR to her friends.

386. The Root Cause Analysis Investigation honed in on the period immediately following the reduction in medication eight days before the murder and concluded that the reduction in medication was unlikely to have caused a relapse. This information from friends, if accurate and not

misinterpreted, indicates that perhaps the relapse in his condition could have been happening much earlier than thought feasible but there was an absence of warning signs.

387. We cannot identify any specific action or activity that if done differently could have led us to believe that the murder would have been prevented.

388. We did however take the overall view that the likelihood of it happening may well have been reduced if his care had been more comprehensive with greater insight into Mr AR the person.

**ToR** Examine whether information sharing and communication within and between agencies regarding the family of CR was effective and comprehensive; did it enable joint understanding and working between agencies; were all appropriate agencies including the day centre, housing authorities and mental health authorities involved in the information sharing.

389. **Analysis** Information sharing was weak and unsatisfactory although there is no evidence to suggest that there would have been a different outcome if it had been improved. Joint understanding of the issues surrounding the family of Mr AR was weak. All the non CMHT agencies and bodies were critical of the lack of information sharing by the CMHT and there was an expectation that they would take the leadership and coordination role which they did not. The management of expectations is clearly an issue here. To some extent the non CMHT bodies and agencies must take some responsibility for the paucity of information shared even if this means criticism of their willingness to sit back and wait for flows to them. If the flow of information was unsatisfactory then they could have been more vocal about their concerns and less accepting.

**ToR** Examine whether the sharing of information was sufficient to facilitate "joined up working".

390. **Analysis** There was no evidence of joined up working. Inter-agency meetings never took place. All bodies and agencies worked independently.

**ToR** Examine whether previous "learning" from local or national cases had been acted upon.

391. **Analysis** If the "learning" from previous local or national cases had been acted upon then this report would have been very brief. Nearly every significant issue or shortfall highlighted throughout this report has been the subject of the multiplicity of recommendations made by previous inquiries and reviews.

392. We do not doubt that lessons have been identified and incorporated into staff training courses but we cannot with any conviction see that the lessons have been learnt. There is a large divide between the identifying of lessons and the learning of lessons and often they are misconstrued as one in the same.

393. The recommendations from this report will not be extensive as we have very little new to say that has not already been comprehensively covered before on numerous occasions. We do not need another flurry of action plans, new policies and procedures and another section added to existing training schemes because in the main they already exist but for some reason they do not get followed. It is clear that new policies and procedures do not work on their own and the most fundamental question we need to pose is why do these improvements not get incorporated or internalised into daily practise. The most single factor that will reduce the chances of serious incidents taking place is sound professional practice aided by good quality supervision.

394. This case revealed to us the extent that professionals are on the periphery of patient's lives but tend to overestimate the importance of the information they have while underestimating that which others in the network hold. A casual survey of other inquiry reports and reviews seems to lead to this as an endemic problem and as one of the main lessons that fails to be learnt. If inter agency communication, involvement of family, good discharge plans, etc. get done simply for administrative reasons and to tick a box that a procedure has been complied with then eventually it will fail – either in effectiveness or be omitted. The way to ensure good inter-agency communication and collaboration, involvement of family, etc. gets done well is for staff to see the benefits and rewards of it for good clinical reasons. Involving and communicating with others involved with the patient will give greater insight, different and wider perspectives and a more comprehensive understanding which can lead to better decisions being made. If there is one issue that we would wish to emerge from this review it would be for the Home Office to explore the most effective way of assimilating the lessons learnt into everyday practice.

**ToR** Examine the quality of the information sharing with and assistance given to CR regarding the care and support of Mr AR.

395. **Analysis** Elsewhere in this report we have shown that Mrs CR was not engaged and therefore marginalised by the authorities. The contribution she could potentially make and the support she herself needed was not recognised. There was no obvious reason for this exclusion and there is nothing to suggest that there were any characteristics about her that determined this approach. We can only surmise that that ignoring the family was not deliberate but due to a general assumption that families have little positive to add.

**ToR** Examine whether data protection issues or client confidentiality concerns impeded the sharing or dissemination of information.

396. **Analysis** Confidentiality is a fundamental part of dealing with agencies that provide care or support. People entrust professionals with extremely sensitive information and have the legitimate expectation that they will respect their privacy and act appropriately. Staff should rightly always be cautious about who and when to disclose information. We did not identify any incidents of failing to share information due to misplaced concerns over data protection rights.

397. On occasion patient confidentiality was mentioned during the course of this review as a reason for not sharing information – for example when questions were asking about providing information to Viridian Housing that they could use to inform their tenants- but this was not a reoccurring theme and in any event the reluctance in this case had some justification. The general lack of sharing to other agencies was not for reasons of confidentiality but because they (MHT) did not see there was a need to.

**ToR** Examine whether there were any early warning signs of aggression or violent behaviour and what actions followed.

398. **Analysis** There were signs of or threats of aggression at various times throughout Mr AR's mental health history and these have been documented elsewhere in this report. Details of aggression or violence should always be researched and accurately recorded as violent behaviour intent is as significant as outcome in the calculation of risk. Because he was a mental health patient Mr AR was always given the benefit of the doubt and no criminal action or charges were made. This meant that Mr AR had a "clean" record and it appears that because of this "clean" record the acts or threats of violence (admittedly not many) were underrated or omitted in future

risk assessments. Action was taken after each incident but on none of the occasions was there any inter agency meetings held to discuss the issues, share experiences or gain other perspectives.

399. The two ASB cases initiated by Viridian following incidents were withdrawn without even talking to Mr AR or meeting with the CMHT to discuss any risks he posed or collaboration on the best ways of maintaining him living independently in the community. They were withdrawn for "humane" reasons on being informed that he was receiving treatment. Even through the cases only involved lower level antisocial behaviour and threatening behaviour, they were nevertheless missed opportunities by Viridian to establish a partnership relationship with the CMHT and to turn on a mutual information flow that would have left both sides better informed.

400. There were no signs, threats or acts of aggression or violent behaviour obvious to the authorities in the period immediately leading up to the incident on 27th Dec 2012. Mrs CR reportedly confided to her friends the comments about her forthcoming death before Christmas and as already mentioned the tragedy is that she did not share these comments with anyone who could have done something about them. The friends were not aware of Mr AR's medical background and history and therefore did not appreciate the significance of what she told them.

**ToR** Examine whether the level of risk posed by the perpetrator was assessed and addressed properly; whether there was an appropriate intervention plan.

401. **Analysis** We have previously commented on certain weaknesses in the risk assessment process which we saw as relating to a concentration on the current situation and the lack of a cumulative perspective. While the level of risk was assessed and addressed by the CMHT, the involvement of others outside the hospital network would have given additional perspectives which may have been valuable. The absence of any inter agency meetings or family involvement narrowed the potential broad perception that could have been obtained.

402. The MHT used a preferred system of zoning based on a traffic light system to indicate the level of risk presented by patients. This is a system that in order to be effective requires standardisation and consistent application of assessment tools capable of recognising changing risks. It uses familiar colour-coding with red for high risk, amber for medium, and green for low risk clients and has the benefit of being informative and could quickly alert the team to changes (particularly increases) to risk level. Although used in the hospital, the CMHT caring for Mr AR did not use this zoning system and there was no evidence available to explain why this omission was allowed to continue.

**ToR** Examine whether equality and diversity issues were considered appropriately by all the agencies involved with the family of CR.

403. **Analysis** Mr AR was a white heterosexual male who had a serious mental illness. No diversity, equality or disability issues were uncovered during this review. Mrs CR was an elderly white lady of Spanish nationality who was a long term resident of the UK and completely fluent in the English language. No diversity, disability or equality issues were uncovered during this review. She was marginalised but we are not aware of the reasons for this.

**ToR** Seek the involvement of the family, employers, neighbours & friends to provide a robust analysis of the events.

404. **Analysis** All appropriate steps were taken to involve family, neighbours and friends in this review. The size of the extended family was very small and the only family members interviewed

were those based in Andalucía, Spain. A valuable insight was gained from the information they provided. Similarly the neighbours of Mrs CR and Mr AR helped ensured that we had a more complete understanding of the victim and perpetrator. No friends of the perpetrator could be found. Two friends of the victim were interviewed and useful background information was gained. In addition the friends of Mrs CR were able to inform the DHR panel about her concerns during the last few months of her life.

**Lessons learned – a wide perspective**

405. In considering if lessons have been learnt it was considered appropriate to look at past cases of homicide involving mental health patients. A cursory analysis of many nationwide mental health homicide inquiries over the last 10 years show the same problems keep occurring. Typically these include a failure to communicate effectively between agencies, failure to involve family members, failure to look beyond the symptoms towards the underlying problems to name but a few. The impression we have gained from looking at other reports and from the working experience of panel members is that "learning" not identifying is the main problem.

406. Lessons clearly were identified at the time of these homicides and embedded into training and procedures but with the passage of time appear to not always being consistently followed. Lessons, both local and national, have clearly not been learnt. The same recommendations keep being made by successive reviews and inquiries. Without some change of approach it was our view they will continue to be routinely ignored or be subject to superficial compliance. Unless weaknesses and noncompliance are identified and rectified it is difficult for us to see how the care of patients can be improved and theses terrible tragedies reduced.

407. The lessons to be learnt have also become the subject of official national and professional guidance. Despite all the action plans and new policy initiatives there is little evidence that lessons are being effectively learned because the number of mental health homicides is not falling. We were of the view (as previously stated in paragraph 393) that the Home Office should explore this problem and attempt to identify why lessons are being "identified", implemented but not "learned". This would be a natural follow-up to their recent publication – "Common themes identified as lessons to be learned".

**Conclusions and key learning**

408. The events of 27th December 2012 could not, on the balance of probability, have been predicted or prevented. The DHR found that there was no evidence to indicate that the patient's clinical presentation had changed in the two weeks leading to the incident (paragraph 213). There is great pressure on mental health professionals to predict and minimise risk and we recognise and do not underestimate the difficulty of the decisions that must be made. Risks can never be eliminated and accurate prediction is never possible for individual patients. The comments made by Mrs CR to her friend that she had to die before Christmas as she had lived too long was never communicated to health professionals and therefore does not add weight to any suggestion that events on the 27th December 2012 could have been predicted or prevented.

409. We do not feel equipped or qualified to comment constructively on the clinical judgements and treatment he received but take the view that the apparent concentration solely on medication and the lack of any psychological therapies was sub-optimal. If NICE guidance on the care and treatment of paranoid schizophrenics had complied with then this medicinal focus would not have occurred.

410. The mental health professionals knew Mr AR from a restricted perspective and it seems obvious to us that must have had a detrimental effect on understanding him and his subsequent treatment. The clinical benefits of involving family and others in the external network must be an important lesson that must be learnt.

411. The communication between the agencies involved in this case was poor. All agencies accepted the need and the benefits of good information flows but still the problem occurred.

412. The failure to engage with and marginalisation of Mrs CR was a serious failure that should not be allowed to be repeated. Mental health professionals must learn to accept that where risk is concerned the patient is not their only client (professional Duty of Care to others, carers, public etc.).

413. Risk assessments on the risk to others posed by mental health patients would be enhanced and better informed by the involvement of others outside the hospital network such as the police and other agencies that have experience in determining risk to others.

414. Records should be organised so that it is relatively easy to absorb the full history of the patient so that historical events can be considered as part of risk assessments to avoid simply concentrating on the current situation. Historical events should be discounted if they are not relevant but not simply because they are historical.

415. Policies, procedures and action plans must be seen as a means to an end and not an end in themselves otherwise achievement will be seen as the ticking of boxes. We have stated elsewhere the view that these lessons will only be implemented and complied with when they become internalised and seen as synonymous with good practice.

416. In the mental health field there is a wide raft of guidance, policy and procedures that have the aim of optimising the care and treatment of patients. Most of these are complied with fully but it was clear during this review that many are omitted or ignored for reasons we were not aware of. Not all procedures will be relevant in every case and judgement will be exercised on whether compliance is necessary or not and this is acceptable provided the omission is for sound justifiable reasons. Some omissions or failure to comply will also be for less defensible reasons. One such reason could be because of a seemingly lack of concern or lack of checking by supervisors and managers that they are being complied with. If all these policies and procedure are truly to optimise care and treatment then an audit mechanism needs to be robust to ensure that high quality services are delivered as intended in a consistent and cost effective way.

**Recommendations**

417. Recommendations relating to specific service issues are detailed within each contributing organisation's individual management review and will be included in the action plan for these services. All contributing organisations and agencies have accepted their identified shortfalls and have made recommendations to correct and improve their service provision or organisational behaviour. Given that all the causes of concern highlighted in this review have been repeated innumerable times in other inquiries and reviews and set out as lessons to be learnt and absorbed into current policies and procedures, we have very little new to add. To repeat all the recommendations of other reviews would detract from and obscure what we see as the two issues we wish to highlight for further attention.

418. **Recommendation One** The MHT review their strategic and operational approach to risk assessments and report back to the Wandsworth Community Safety Partnership within 6 months on their progress and implementation plan.

419. **Recommendation Two** The MHT produce effective audit mechanism to ensure compliance with policy, procedures and guidance.

Patrick Watson
DHR Chairman and Author
4th June 2014