BIRMINGHAM COMMUNITY
SAFETY PARTNERSHIP
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Domestic Homicide Review

Executive Summary of the report into the death of a woman

DHR2012/13-03

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Presented to Birmingham Community Safety Partnership on
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Introduction

The purpose of this Domestic Homicide Review (DHR) is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;
- Apply these lessons to service responses including changes to the policies and procedures as appropriate; and

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

A domestic homicide review is not an inquiry into how a victim dies or into who is culpable as those matters are for Coroners and criminal courts to determine. Domestic homicide reviews are not specifically part of any disciplinary enquiry or process. Where information emerges during the course of a domestic homicide review which indicates that disciplinary action should be initiated then the relevant agency disciplinary procedures should be undertaken separately to the domestic homicide review process.

In production of this report, agencies have collated sensitive and personal information under conditions of strict confidentiality. The Birmingham Community Safety Partnership has balanced the need to maintain the privacy of the family with the need for agencies to learn lessons relating to practice identified by the case..

A decision to undertake a domestic homicide review was made. The Birmingham Community Safety Partnership determined that agencies would secure and review their files from 2008 until the date of the victim's death. Agencies were required to compile an Individual Management Review (IMR) to provide an independent, open and critical analysis of individual and organisational practice. The Individual Management Reviews identify lessons learnt by the individual agencies, highlight any good practice and include recommendations for single agencies to improve practice.

For the purposes of this report and to protect the identity of those involved a key will be used throughout the report as follows:

- The victim: the deceased
- The alleged perpetrator: the son of the deceased

The victim had been married but was divorced from the alleged perpetrator's father. She had two other children who lived away from home. For some years she lived alone with her son although she did have a partner who had his own accommodation.

The alleged perpetrator was educated in Birmingham and had a job as a carpenter but he had given that job up some time before the death of his mother.

About 18 months before the death of the victim, it was recognised by the victim and the rest of her family that the alleged perpetrator was developing mental health problems. The victim sought assistance from her GP who referred her son to a Consultant Psychiatrist.

Her son was diagnosed as having depression but his behaviour deteriorated and he became aggressive and was paranoid that his mother was trying to harm him by poisoning his food. Attempts were made to admit the alleged perpetrator to hospital under the Mental Health Act 1983 but for various reasons as outlined later, it wasn't possible.

Police were called to the family home and on forcing entry found the victim dead. A murder investigation was launched and very quickly the alleged perpetrator was arrested near to the scene. He was charged with the murder of the victim and appeared at Birmingham Crown Court where he was found unfit to plead and was detained under the provisions of the Mental Health Act 1983.

The Domestic Violence Crimes and Victims Act 2004 Section 9 (3), which was implemented with due guidance[1] on 13th April 2011, establishes the statutory basis for a domestic homicide review. Under this section a 'domestic homicide review' means a review of the circumstances in which the death of a person age 16 or over has, or appears to have, resulted from violence, abuse or neglect by –

> (a) a person to whom he was related or with whom he was or had been in an intimate personal relationship, or
> (b) a member of the same household as himself, held with a view to identifying the lessons to be learnt from the death'

In compliance with the Home Office Guidance[2], West Midlands Police notified the circumstances of the death in writing to the Community Safety Partnership for Birmingham. The Community Safety Partnership accordingly notified the Home Office of their intention to undertake a Domestic Homicide Review.

The Domestic Homicide Review Panel

The review was carried out by a domestic homicide review panel made up of representatives of agencies who were involved in delivering services to the family of the victim. It included senior officers of agencies that were involved. The professional designations of the panel members were:

- Lead Nurse, Birmingham and Solihull Mental Health Foundation Trust
- Senior Strategic Commissioning Manager, NHS and Birmingham City Council
- Senior Service Manager, Face to Face Channel, Birmingham City Council
- Detective Sergeant, West Midlands Police
- Operations Manager, Birmingham Mind
- Designated Nurse, Safeguarding Adults and Children, Mental Capacity Act Lead, Solihull Clinical Commissioning Group

[1] Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews – Home Office 2011 *www.homeoffice.gov.uk/publications/crime/DHR-guidance*
[2] Home Office Guidance page 8

- Senior Service Manager, Violence Against Women, Birmingham Community Safety Partnership

The panel was supported by the Domestic Homicide Review Administration Officer.

The panel chair and the overview report writer was Mr Malcolm Ross, a retired Senior Detective from West Midlands Police. He has considerable experience in conducting case reviews for local authorities in the United Kingdom and is independent of any agency involved in this case.

Terms of Reference

In addition to the generic terms of reference contained within the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (Home Office 2011), the following key lines of enquiry were sought to be addressed within the review:

- *What knowledge did your agency have that indicated that the alleged perpetrator might present a risk to others? What knowledge/information did your agency have that indicated that the victim might be vulnerable? To what extent had risks related to the victim been fully assessed and acted upon.*
- *What information and/or concerns did the victim or alleged perpetrator's family, friends or associates have about any indication of risk or abuse and what did they do? How did your organisation respond?*
- *Were there issues in relation to capacity or resources in your agency that impacted on the ability to provide services to the victim, the alleged perpetrator or any to other members of the family and also impacted on the agency's ability to work effectively with other agencies?*

In addition to the points above, individual agencies were asked to address specific points. Birmingham and Solihull Mental Health Trust were asked to address:

- *Whether changes in the service user's behaviour to clinicians and/or lack of contact with the mother on the day preceding should have been escalated and merited a more urgent response*
- *Whether risks assessed on the days immediately preceding the incident were fully reflected in treatment and actions*
- *Whether delays in accessing/prioritising a bed were appropriate in relation to the risk of the assessed service user. Whether appropriate procedures were followed to manage this and whether the procedures available were appropriate to meet the needs of the service user.*
- *In relation to bed management arrangements whether access to an Approved Mental Health Practitioner impacted on the ability to respond appropriately to the service user's needs and if so whether actions should have been taken to respond to this.*
- *Whether the risk history relating to the service user had been appropriately identified and recorded and whether these were appropriately reflected in actions taken and treatment provided.*
- *The extent to which risks relating to the mother had been fully assessed.*

In addition to the points above, Birmingham City Council was asked to address:

- *Whether the alleged perpetrator's approach to the City Council for assistance with homelessness addressed his needs and identified any risk to himself or others. This should include an analysis of how vulnerability is identified in young people who approach the City Council's customer service centres and homeless service and an analysis of the six day wait for an appointment in this case.*

Concerns over the alleged perpetrator's mental health were first raised eighteen months before the death. The DHR therefore focused on events during this period. However, the review also considered relevant information relating agencies contact with the victim and her son outside of this time frame as it impacted on the assessments in relation to this case.

Individual Management Reviews

The panel requested the following agencies to carry out Individual Management Reviews of their agencies involvement and produced reports. The aim[3] of Individual Management Review is to look openly and critically at individual and organisational practice to see whether the case indicates that changes could and should be made, and if so, how those changes will be brought about. It is also important to identify examples of good practice within agencies.

The following agencies were requested to prepare chronologies of their involvement with the victim and her family and produce Individual Management Review reports.

- Birmingham and Solihull Mental Health Trust
- Birmingham and Solihull NHS Safeguarding Team in respect of primary care
- Birmingham City Council Adults and Communities Directorate
- Birmingham City Council Neighbourhood Advice and Information Service

Information reports were requested from St Basils and West Midlands Ambulance Services.
Agencies were encouraged to make recommendations within their Individual Management Reviews, and these were accepted and adopted by the agencies that commissioned the reports. The recommendations are supported by the panel Chair / Overview Author and the other members of the panel.

The Individual Management Review reports were of a high standard providing a full and comprehensive review of the agencies involvement and the lessons to be learnt.

Family Involvement

Home Office Guidance [4] requires that:

> 'Members of formal support networks, such as friends, family members and colleagues may have detailed knowledge about the victim's experience. The Review Panel should carefully consider the potential benefits gained by including such individuals from both the victim and

[3] Home Office Guidance page 17
[4] Home Office Guidance page 15

perpetrators networks in the review process. Members of these support networks should be given every opportunity to contribute unless there are exceptional circumstances',

and

'consideration should be given at an early stage to working with Family Liaison Officers and Senior Investigating Officers involved in any related police investigation to identify any existing advocates and the position of the family in relation to coming to terms with the homicide.'

In this case the Overview Report Author made contact with both the Senior Investigating Officer and the Family Liaison Officer from West Midlands Police at an early stage. The mother, sister, former husband and niece of the victim met the Overview Author and the Senior Service Manager and contact has been made on a number of occasions with the family since. All of the family were made aware of the DHR process and their views have been incorporated into the Overview Report. They have been visited again by the Overview Report Author and the Senior Service Manager prior to the Community Safety Partnership's acceptance of the report and emerging issues and themes discussed with them.

Independent Overview Report

Government Guidance requires than an Overview Report of the domestic homicide review should be written by a person involved from an early stage with appropriate qualifications, knowledge and experience. The Overview Report brings together and analyses the findings of the various reports from agencies and others and makes recommendations for future action.

This document is a summary of the Overview Report of the domestic homicide review prepared by Mr Ross on behalf of the panel and accepted by Birmingham Community Safety Partnership. The Overview Report comments that the business of the panel was conducted in an open and thorough manner. The meetings lacked defensiveness and sought to identify lessons and recommended appropriate actions to ensure that better outcomes for vulnerable people in these circumstances are more likely to occur as a result of this review having been undertaken. The Individual Management Reports contain recommendations that concern those agencies that are supported in the Overview Report. A list of the recommendations made in the Overview Report is set out at the end of this summary.

Summary of Background

The victim was a divorced woman who lived with her son, the alleged perpetrator. She had two other children who lived away from the family home.

The victim and her family noticed that the alleged perpetrator's behaviour had changed and he was demonstrating unusual habits. He increasingly became isolated from anyone else. He showed aggression towards his mother and listened to loud music, which was unusual for him. He spoke of things that did not make sense and he was concerned that people were trying to get into the house during the night.

Not being aware of the alleged perpetrator taking any drugs, the victim made an appointment with the family GP for advice. The GP recorded that he found no signs of paranoia, delusions or hallucinations, but the GP prescribed Quetiapine tablets, which are for the treatment of schizophrenia and bipolar disorder. The alleged perpetrator declined the invitation to see a psychiatrist. He admitted smoking 'weed' occasionally. A few days later, the alleged perpetrator was diagnosed as having 'drug induced psychosis.'

Within two months, the alleged perpetrator's condition had deteriorated. He was convinced that his mother was trying to poison him and he developed a mistrust of her regarding the food she prepared for him.

The alleged perpetrator was referred to the Home Treatment Team. The aim of the Home Treatment Team is to provide a flexible, responsive, proactive, coordinated and integrated service to individuals with severe and complex mental and behavioural disorder. The aim of the service is also to provide rapid assessment and robust support to individuals and their carers for episodes of psychiatric crisis. The teams are multidisciplinary and operate a 24 hour, 7 day a week service. Their aim is to support the individual in the least restrictive setting possible, usually their own home.

In the same month, the alleged perpetrator's father, became so concerned that he called the GP. The GP made arrangements for the alleged perpetrator to be seen later that day, where a Community Psychiatric Nurse (CPN) and two doctors saw him. He claimed to be possessed by demons and that he could also influence the weather. The medical professionals concluded that he was suffering from 'Prodromal Schizophrenia', the early stages of the illness, and if left untreated his condition would deteriorate. It was decided that the Home Treatment Team would supervise him taking his medication.

During that month the alleged perpetrator's condition worsened. He was sporadic regarding taking his medication, with periods where he did not take it at all. By the end of the month, the victim had become very concerned and the family thought the situation had gone too far. Arrangements that had been made to discuss his admission to hospital the following week were not soon enough. By the evening of that day the victim reported that the alleged perpetrator had calmed down and she was advised to call the Home Treatment Team if she had further concerns.

The following day the victim reported that the alleged perpetrator had had a settled night and the CPN suggested an assessment should be carried out the next day. This assessment did not take place.

The Home Treatment Team continued to persuade the alleged perpetrator to take his medication. Sometimes he did, other times he refused. He resented professionals coming to the house.

During the following month, after another period of sporadic medication taking, the victim suggested that she be allowed to supervise the administering of her son's tablets, which was agreed. This however was only days after the alleged perpetrator had claimed that the victim was putting poison in his food. This, the Overview Report suggests, was an extremely unwise move on behalf of the Home Treatment Team.

A few days later his general supervision and monitoring was changed from the Home Treatment Team to the Early Intervention Service. Unlike the Home Treatment Service which provides focus short-term intervention, the Early Intervention Services provides longer term support to young people who have experienced a first episode of psychotic illness. They provide support for the individual's recovery over a three year time span with a greater emphasis on engaging the individual in their recovery and promoting their self-esteem through social inclusion and goal setting.

Later in that year, after a short period of stability in the alleged perpetrator's condition, a CPN left 'a supply' of medication with the alleged perpetrator. It is not known how much medication was left with him. Again the Overview Report suggests that this was a unwise move.

For the remainder of that month, the alleged perpetrator declined to take his medication and his condition was worsening. A few weeks later, it was decided that his GP should be responsible for prescribing his medication. There was clearly the absence of a robust medication plan in place. This at a time when the alleged perpetrator did not consider he had a mental health problem.

Within months, the alleged perpetrator expressed a wish to be removed from any mental health services and became irritated with his mother when she tried to reason with him. He reluctantly agreed to see the Home Treatment Team who formed the impression that he was suffering from a relapse of illness and was experiencing delusions of persecution. He stated he wanted to move out of the house.

Later that day the alleged perpetrator went to a Birmingham City Council Neighbourhood Advice and Information Centre. He claimed that he had been made homeless as his mother had asked him to leave the house because he was smoking and he had been sleeping rough. None of this was true. He was referred to St. Basil's Youthhub during which he stated that he would be able to stay with his aunt. He completed a questionnaire over the telephone in which he stated he did not have any mental health issues, but had asthma. Because he stated he was able to stay temporarily with an aunt, an appointment was made for him to attend the following week. He failed to attend. There does not appear to have been any confirmation follow up enquires by either St. Basil's or the Centre to establish if what he was saying was correct.

He returned home and was seen later that evening by the Home Treatment Team. He stated that he did not want anyone else to come and see him and that he knew where the Home Treatment Team worked and he would send someone round to sort them out if they did return. The Home Treatment Team took this as a threat, but did not escalate their concerns. There is a note to indicate that the victim did not feel at risk at this time.

Later, contact was made with a mental hospital with a view to having the alleged perpetrator admitted for treatment under the Mental Health Act 1983, but there were no beds available. A plan was made for a mental health assessment to be carried out as soon as there was a bed made available. He was placed on the 'bed list'.

A few weeks later, the alleged perpetrator stopped taking his medication and a multi-disciplinary team meeting of mental health workers took place and it was decided that a Home Treatment Team worker should see him and arrange an admission. Two Community Psychiatric Nurses made a home visit but he alleged perpetrator refused to see them and walked form the house. The victim stated that she thought he ought to be admitted as he had not taken his medication for four days. No assessment took place but he was placed back on the bed list. There is no indication why he had been removed from the bed list within the previous 9 days.

By the end of that month, the alleged perpetrator had been without medication for ten days. He had isolated himself in his bedroom and had to be persuaded to see the Early Intervention Service together with an Approved Mental Health Professional (AMHP) and a Home Treatment Team consultant. He came from his bedroom, refused to speak to anyone present and left the house. Notwithstanding his condition, the alleged perpetrator was still not considered poorly enough to be detained, but it was decided to make daily visits for another week to supervise his medication. There were still no beds available.

The following day another home visit was made and again he refused to see anyone, slamming the door to his bedroom. He was still refusing to take his medication and his personal hygiene was deteriorating.

The following day the first medical recommendation for a mental health assessment was completed by a doctor and the alleged perpetrator was 'put back on the bed list'. Again no reference to him having been removed from the bed list, but clearly he had been. His admission was again thwarted due to the unavailability of an AMHP. It is necessary for an AMHP to be part of the assessment process and all available AMHPs were engaged elsewhere in Birmingham, albeit the senior manager on duty, who was a duly qualified AMHP and could have fulfilled that important role, did not. So again, the opportunity was missed for him to be admitted to hospital for treatment.

The victim was desperate to have her son admitted. His condition had worsened again and he was staying out on the streets until 4am. She was told that once a bed became available he would be admitted.

The following month, there was still no bed available despite the consultant and the community psychiatric nurse contacting the Bed Manager. However during the afternoon of that day a bed was made available and attempts were made to contact the victim and her son. There was no reply from the family home. A discussion was held about forcing entry under the powers of the Mental Health Act 1983, but it was decided that there was not sufficient evidence to justify such an entry and the likelihood of obtaining a warrant to enter by force was slim. Instead the police were called and under the provisions of the Police and Criminal Evidence Act, forced entry and found the body of the victim within the house. The alleged perpetrator, who was quickly traced to a nearby location, was arrested, charged with the murder of the victim but found unfit to plead Birmingham Crown Court. He was made subject of an indefinite hospital order.

Analysis and Conclusions

There are several areas of concern that the Overview Report has made comment upon.

Risk Assessments

There are instances where there are clear indications that the alleged perpetrator was a risk to himself and to his mother, the victim. His aggression was increasing and his own welfare was becoming seriously concerning. The victim should have been given the opportunity to be part of a risk assessment and there is guidance under Care Programme Approach (CPA) that makes it clear that carer's welfare, their caring capacity and their safety should be considered. There was an assumption by professionals that the victim was adequately equipped to take charge of the alleged perpetrator. They readily accepted she had the ability to administer his medication and that she could initially come to the correct decisions about him remaining at home rather than being admitted. However as time passed by, her views and those of the other family members changed and they were desperate for him to received treatment in hospital.

When one examines the circumstances of the alleged perpetrator it is clear that his deteriorating behaviour posed a risk to others. Whilst the BSMHFT Individual Management Review indicates there was no history of violence towards his mother, the evidence shows, that as time progressed and his mental condition worsened, his behaviour and verbal aggression towards his mother in particular should have been of concern, and the risk assessment as outlined above should have been completed.

This review echoes the recommendations made of BSMHFT in a recent Birmingham Domestic Homicide Review, DHR2011/12-03, which required a strengthening of assessments and management of risk for service users, their carers and significant others. In particular, BDHR2011/12-03 required that the Mental Health Trust put in place procedures and monitoring arrangements to ensure that the assessment for specialist mental health services involves and includes all significant others living with and involved in the life of the service user.

The administering of medication

Care Programme Approach guidance is clear that non-concordance with medicines is a high risk indicator and further that it is essential that everyone involved in the care of the service user understands who prescribes the medicine, where it is obtained from, the instructions for administering it and what other medicines are being prescribed at the same time. The mental health professionals involved in this case relied upon the victim to administer the correct amount of medication at the correct frequency, without any consideration of the relationship between the alleged perpetrator and the victim at that time. It was known that he was making his own choices about medication as was his attitude towards his mother. Again a previous domestic homicide review has identified similar issues. In particular, BDHR2011/12-03 required that BSMHFT ensure that all risk assessments consider whether poor compliance with medication is an indicator of risk and is incorporated into the Risk Identification and Management Plan (Recommendation 3.8 of Birmingham Domestic Homicide BDHR2011/12-03). Actions to implement this recommendation are being undertaken and will be monitored by Birmingham Community Safety Partnership against that review.

Mental health assessments

The alleged perpetrator was subject to various mental health assessments throughout the period of this review. The assessments were conducted in isolation of each other, without coordination between the professionals who were conducting the various assessments.

At the time of the transfer from the Home Treatment Team to the Early Intervention Service, there was a missed opportunity to hold a formal 'handover' meeting which could have included all of the professionals involved, where information could have been shared and a multi-agency decision made about the alleged perpetrator's and the victim's future care needs. A recommendation has been made regarding the introduction of formal handover meetings in these circumstances.

During one home visit, when it was intended to have the alleged perpetrator admitted to hospital, he walked out of the house into the street. He had been showing aggression towards his mother, acting strangely and coming down the stairs on his back side. No-one thought to inform the police who, if the circumstances were found to be sufficient, could have detained him under the provisions of Sec 136 Mental Health Act 1983 and remove him to a place of safety.

Police powers could have been used on another occasion when mental health workers found there was no answer to the victim's family home. They had been called to the house by family members concerned for the welfare of both the victim and the alleged perpetrator. They stated that the victim was 'missing.' Finding no answer at the door they decided to call back later. Given all of the circumstances, a police officer could have justified forcing entry under Section 17 Police and Criminal Evidence Act 1984 where they have reason to believe that a person may be at risk of harm and in order to save life and limb.

The alleged perpetrator's admission to hospital and bed allocation

The Overview Report contains details of the Birmingham and Solihull Mental Health Foundation Trust Bed Management Policy which clearly sets out the procedure on the allocation of beds to those whose mental illness requires them to be admitted into hospital. The alleged perpetrator was placed on and off the 'bed list' on a number of occasions but each time there was an attempt to admit him, there were no beds available. He fitted the definition of a 'red referral' and under these conditions consultants and service managers should put considerable effort into finding an available bed, even if it means going outside the usual area for the patient. The escalation process when there are difficulties finding available beds was not followed, which frustrated his admission to hospital.

An aggravating feature in this case was that the victim often changed her mind about her son being admitted into hospital, which is understandable. However, the extended family who were not so emotionally involved were of the opinion that the alleged perpetrator was in need of admission. There was an over reliance on the information being supplied by the victim, when her capacity to make such decisions had not been assessed. The decisions to keep him out of hospital were not made with the best interests of either the alleged perpetrator or his mother.

Approved Mental Health Professionals (AMHPs)

When the Community Psychiatric Nurse was unable to obtain a reply from the family home, contact was made through Birmingham City Council for an AMHP. It was found that there were only 2 AMHPs on duty for the City of Birmingham, both of whom were committed elsewhere. The AMHP is an essential element in the admission process. Since this incident a new service has been introduced whereby twelve AMHPs will be available between 08.15 and 19.15 daily. In addition to that service that BSMHFT are currently training AMHPs to supplement the new system and cover should be available 24 hours per day.

The alleged perpetrator **declaring himself homeless**

Whilst there were no concerns with the manner in which the alleged perpetrator was dealt with when he sought a homeless service, the neighbourhood Advice and information Service have taken the opportunity to review processes especially in the way that young homeless people are signposted to assistance and to ensure that their duty to vulnerable people is effectively satisfied.

Views and opinions of the family

Family members expressed concerns that the mental health professionals could have done more to see the alleged perpetrator admitted into hospital. They described that at times the victim was desperate for her son to be taken into hospital for treatment. They also described how they felt that the alleged perpetrator had a controlling influence over his mother and that in turn, influenced the decision making by professionals against taking the steps to admit the alleged perpetrator. They were very concerned about the lack of AMHPs available on the evening that the alleged perpetrator was to be admitted and the lack of involvement with the wider family

Conclusions

This is a tragic case that has affected the lives of a large family Birmingham. The alleged perpetrator was mentally ill and needed positive treatment and ultimately, hospitalisation. His needs were complex. He did not acknowledge that he was ill and in need of support and treatment. He was inconsistent in taking his medication or co-operating with agencies. He did not understand his mental illness and therefore lacked insight for the need to take medication. He did not recognise that he had any mental illness that needed treatment. He did, however, reluctantly, take his medication and did engage, although this was poor at times.

His mother, for the vast majority of the time, wanted to care for her son herself. She did not want him admitted to hospital until his behaviour, threats and aggression became intolerable. The alleged perpetrator controlled his mother and she tolerated him as most caring mothers would. But there came a point in time when she clearly had had enough and was unable to cope. She requested assistance to have her son admitted and cared for in hospital. It was at that time that the assistance she called for faltered. Assessments were carried out on her son over a period of time particularly when his mental state was deteriorating but the assessments failed to identify him as meeting the criteria for admission.

When at last, it was decided to make arrangements to provide a bed for admission, his behaviour and mental state improved and he lost his place on the 'bed list'. He was placed on and off the bed list many times and each time he was removed it appears that he started at the bottom again.

Issues around the victim as a carer have been raised in this review. Health agencies assumed the victim was in charge of the alleged perpetrator with regard to his care and for some of the time, his medication. The fact was that the victim was not in charge of the alleged perpetrator. He was in charge of his mother. It is clear that he was using his mother to keep services at bay and in doing so there was lost opportunities for agencies to share information about his condition with the wider family members and obtain their opinion about his circumstances.

The death of the victim was not predictable. There was nothing to indicate that the alleged perpetrator was such a danger to his mother to raise concerns about him killing her. However, on the basis that the BSMHFT Individual Management Review stated it is difficult to understand why the alleged perpetrator was not detained, the conclusion must be that had the alleged perpetrator been recognised earlier as a patient requiring admission, the attack would not have occurred and therefore the death of the victim was potentially preventable.

LIST OF OVERVIEW REPORT RECOMMENDATIONS

Recommendation No 1

Birmingham and Solihull Mental Health Foundation Trust Care Coordinators must ensure (as part of their organisation of care) that all carers are advised of their right to a carer's assessment. The offer must be clearly documented. If the offer is not accepted the reasons should also be clearly documented and a date set to revisit this with the carer

Recommendation No 2

Birmingham and Solihull Mental Health Foundation Trust to ensure that its staff recognise poor compliance with medication as an indicator of risk and that non-compliance is incorporated into the Risk Management Plan of Care Programme Approach.

Recommendation No 3

Birmingham and Solihull Mental Health Foundation Trust to ensure that teams are complying with the BSMHFT transfer and transition policy and there is a detailed handover meeting for a service user transferring to another team for longer term care, it should involve relevant agencies and engage with as wide a range of family members as reasonable.

Recommendation No 4

Each assessment needs to include all relevant information from family, friends, carers and others but must include meaningful contact with the patient in order to establish their mental state and degree of risk before being considered complete.

Recommendation No 5

Birmingham and Solihull Mental Health Foundation Trust to ensure that all staff are complying with clinical and management supervision policies ensuring that the management of clinical risk is imbedded in multi-disciplinary meetings, with emphasis on the role of the carer and family members.

4.6 Recommendation No 6

West Midlands Police to provide practice guidance for mental health practitioners about police officers power of entry and search of premises without a warrant, to save life and limb or prevent serious damage to property as per Section 17 Police and Criminal Evidence Act 1984

4.7 Recommendation No 7

The Medical Director of Birmingham and Solihull Mental Health Trust assures the Birmingham Community Safety Partnership that the bed management policy is sufficiently robust, understood by clinicians and senior managers and its implementation is understood by clinicians and senior managers in a way that keeps people safe

4.8 Recommendation No 8

Birmingham City Council Adults and Communities Service (Adult Social Care), to ensure that the new service to be introduced regarding Approved Mental Health Professionals be implemented as soon as possible and enshrined in training and policy with the guidance**.**