Executive Summary
Domestic Homicide Review into the death of Mrs CR

Introduction

1. This Domestic Homicide Review (DHR) examines the circumstances surrounding the sudden unexpected death of Mrs CR in Wandsworth. On 27th December 2012 police were called to the home of Mrs CR following an emergency call from her son, Mr AR, to report that he had killed his mother. He hit his mother 15 times with a saucepan and left her lying on the kitchen floor. He returned to the kitchen later and observed she was still alive and slit her throat. He was charged with murder and a plea of manslaughter with diminished responsibility was accepted. He is currently held in secure detention at Springfield Hospital.

The Review Process

2. This summary outlines the process undertaken by the Wandsworth Domestic Homicide Review Panel in reviewing the murder of Mrs CR.

3. The Metropolitan Police subsequently made a request that a Domestic Homicide Review take place, as it met the criteria of a review whereby the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by a person to whom he/she was related. The Wandsworth Partnership took responsibility for this review as prescribed by relevant legislation and guidance, Patrick Watson as independent chair and author of this report and instigated the forming of a panel consisting of suitably qualified members. At the request of the police the main parts of the review were stayed until after the trial which took place on 12th September 2013.

4. 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. DHRs 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.

5. The DHR involved the following agencies:, Metropolitan Police Service, Southwest London and St George's Mental Health Trust, , Wandsworth MIND, and Viridian Housing Wandsworth Borough Council Chelsea and Westminster Hospital NHS Foundation Trust St George's Healthcare Trust. Only the first four of these agencies were actively involved in this review and contributed an Individual Management Review (IMR) of their involvement with the victim and/or perpetrator. Invitations were also issued to the

General Practitioners (GP) of both the perpetrator and the victim, the local authority children's' services and housing departments to participate in the DHR panel but after representations it was agreed that they would make written submissions but not attend panel meetings. Relatives and family members of the deceased were contacted and given the opportunity to participate in this review. A full list of panel members is included in the full report.

6. Terms of Reference (ToR) were agreed by the panel and these will be set out in greater details below where they will be subjected to an analysis stage.

7. Where relevant each of the contributing agencies was required to:
   a) Provide a chronology of their involvement with Mrs CR and Mr AR during the time period of five years agreed by the panel.
   b) Search all their records outside the identified time periods to ensure no relevant information was omitted.
   c) 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.

8. The Serious Incident Governance Group (an NHS group covering Wandsworth) commissioned a Root Cause Analysis (RCA) Investigation and its purpose 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.

9. The Root Cause Analysis (RCA) Investigation undertaken by the Mental Health Trust (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. The recommendations and action plan are attached as appendix 1. Much of the detail used in this DHR review was obtained from the RCA investigation.

Background: The victim – Mrs CR

10. 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. Her husband died in 2001 following a stroke and other than her son she had no family in the UK.

11. Her only other remaining family (an elderly sister in poor health who was too ill to be told of her sister's death and a niece) were in Spain and do not speak English. All the DHR communication with the family was through the Spanish consulate who very kindly provided interpreting and translation services. The DHR panel expressed their condolences to her family in Spain through the Spanish consulate. Her family in Spain were aware that her son had a mental illness but had no knowledge of the British medical system and were not therefore in a position to offer any form of support or advice to her.

12. We were made aware from the family and friends of Mrs CR that ideally she would have liked to have returned to Spain when her husband died but concerns for her son kept her in the UK. She would not leave him and realised that he would not get the same level and quality of care if he relocated to Spain with her.

13. Her family in Spain 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. On one occasion when he could not make contact with her by telephone he reported her to the police as missing.

14. Mrs CR (as the mother of a mental health patient diagnosed as paranoid schizophrenic), under the National Institute for Health and Care Excellence (NICE) guidelines, should have had a carer's assessment which could have made her eligible for a range of support such as financial and psychological services but he (Mr AC) was allowed to decline this on her behalf without her being involved in any discussion. His mother knew him better that anyone else and was *de facto* his principal (or sole) carer. She was a valuable source of information about him (past and present) but her cooperation was never sought and in fact she was marginalised and her needs were not addressed.

15. Under the terms of the Mental Health Act (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. This consultation process would have also been an opportunity to engage with his mother and become aware of her views and insights to the benefit of both parties. 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 (since 1988 MR AR had 11 periods of hospitalisation).

16. Mrs CR was a patient of her GP 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. She was last seen at the surgery on 12th December 2012 (2 weeks before her killing) for a follow-up appointment for chest pains. She believed that these were connected to a recent fall. There was no evidence or information to suggest that the fall was related to an assault and she had no record of any previous injuries. 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.

17. She was a very private person and did not tell even her closest friends that her son had a mental illness. She therefore had no one she could confide in or share confidences with. She was very protective towards her son and was reluctant to speak negatively about him.

18. Friends of Mrs CR told of comments she made on three or four occasions in the six months before her homicide on December 27th 2012 which seemed to distress her. She told them 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 this was going to happen. 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. They also told of an unusual event that occurred the week before Christmas (18th December) when Mrs CR arrived at their home unannounced in a distressed state. When she was leaving and they said their goodbyes they recollected that 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.

19. 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. The DHR panel accepted that there is no corroborative evidence that Mr AR did make these statements about dying before Christmas to his mother or 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.

Background : The perpetrator – Mr AR

20. Mr AR was an only child. His father, as stated earlier, died of a stroke in 2001. 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 abuse that he experienced as a child and the domestic violence that he may have witnessed between his parents may have impacted on his relationship and attachment with his mother. Mr AR had the same name as his father but changed it by deed poll as he felt odd seeing his name on his father's gravestone.

21. 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.

22. Mr AR was in a successful relationship with Ms FL over a 5-year period that ended when she 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 mental health nurse providing services to Mr AR reported that the stress of caring for the twins had caused him to have suicidal thoughts. 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. 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.

23. 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.

24. Mr AR has been in receipt of inpatient and community mental health services provided by South West London and St. George's Mental Health NHS Trust (SWLStG), since 1988. His diagnosis is paranoid schizophrenia. He had 11 periods of hospitalisation and five of the admissions were informal. The remaining six admissions were formal under the terms of the Mental Health Act.

25. His medication, while living in the community, was by three weekly depot injections. He accepted that he needed the medication to keep him stable but his history is one of constant complaints about the negative effect it was having on him and negotiations for the dosage to be reduced or changed to other forms of medication. 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.

26. When members of the DHR panel interviewed Mr AR in Springfield Hospital he attributed the killing of his mother to the reduction in his medication eight days before.

27. He was a reluctant or reticent patient. Those that knew him described him as a guarded enigmatic 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 lack of cooperation was perhaps accepted too readily and a more authoritative and assertive stance might have led to greater understanding about him and his life history. His care team were of the view that he could mask his symptoms. In large part he was a closed book.

28. The DHR panel took the perspective that optimisation of care was the most effective way to minimise risk and concluded that the focus solely on medication and the lack of other forms of treatment together with a very narrow insight into him as a person meant that care could not be seen as optimal. 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. The DHR were of the view that the care team over the years showed a lack of professional curiosity.

29. The lack of continuity in care co-ordinators, the frequent staff changes of those involved in his care and the high use of agency staff in the MHT appears to have worked negatively against maintaining a strong collective memory within the team and reduces knowledge of the patient's risk and social history. This also impacted negatively on consistency in the team and continuity of care. These shortfalls were consolidated by the lack of formal handover or briefing between care coordinators and by the fact that an overview of Mr AR's patient history was not easily obtainable by the staff caring for him.

30. The DHR accepts that Mr AR's clinical presentation did not change in the weeks prior to this incident and there were no warning signs that he was unwell. No external organisations or agencies had signalled any concerns about his mental state in the period immediately before the incident. Additionally, evidence from his visit to the GP on 24th December 2012, his attendance at the MIND centre on the same day, 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. 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.

31. 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 RCA 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.

32. Weaknesses were evident in the Care Programme Approach (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. There was a lack of engagement and communication with agencies dealing with him in the community. There was no attempt to capture the knowledge of him held by these external bodies and others in the community who saw more of him than his care team.

33. His case history contains a number of aggressive or violent incidents which were not of a serious nature and none resulted in criminal proceedings. Following complaints from his neighbours, his landlord instigated Anti-Social Behaviour (ASB) proceedings on two separate occasions but both were related to his mental illness and were cancelled following information from his care team that he was stable and receiving treatment. The humane approach was always given to him and therefore always had a "clean" record.

34. There were many references to him being paranoid about his mother when he was experiencing a relapse in his mental state. His psychiatrist had suspicions that he may have assaulted her in the past. His history of being paranoid about his mother and having assaulted others when unwell was given as a justification for the conclusion that it was not appropriate for him to return to the community in June 2011. His mother was never made aware of these concerns for her safety or given information on his relapse indicators and how to spot them. The family in Spain only saw him when he was well and described that they both had a caring relationship in respect of each other.

35. The other agencies and bodies involved this review painted a picture of the MHT as of having a "silo mentality". Communication flows were one way and there was little sharing of information and no attempts to gain broader insights into his background or life in the community. There was criticism of this approach for a variety of reasons but also because it potentially put the staff of other agencies at risk when information about his aggression or violent outbreaks and the relapse indicators were not shared. There were no multi agency meetings regarding Mr AR. There was no evidence of any external involvement in his care or discharge planning when leaving hospital. The DHR panel however took a balanced view and concluded that if the communication was considered insufficient then the other agencies involved could and should have taken the initiative and not simply accepted what they saw as an unsatisfactory situation.

36. The Police involvement with Mr AR related to a total of 7 issues and/or incidents and on 5 of these occasions there were concerns surrounding his medical health - none of which resulted in criminal proceedings. The execution of a mental health warrant in 2007 was the first record of him coming to the notice of police for mental health issues. The police complied with a request from Viridian Housing for full disclosure around Mr AR as they believed he had breached his tenancy agreement. The Police were of the view 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. 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.

37. 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 he attended the centre. MIND records had no updated risk assessment or information about the incidents that gave rise to concern during the period. 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. The flow of information between Wandsworth MIND and MHT staff both about Mr AR and other service users tended to be one way. In general, when attending MIND, his behaviour gave no cause for concern. There were the occasional incidents but nothing considered particularly significant. He was not demanding of staff time.

38. 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. Mr AR lived independently but received some additional support when required but all he wanted was support with moving house through mutual exchange and the floating support ended once this was achieved. Viridian related that although the risk assessments and support plans described Mr AR's psychological issues, he did not want to talk about or get support on these issues. Viridian had in place a vulnerability policy but it was not specifically triggered in this case. Mr AR's neighbours were concerned about his behaviour and there is no indication that Viridian was given any support from the CMHT in dealing with these concerns.

39. Viridian was 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 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 recounted a general pattern of one way communication which they considered 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 Community Mental Health Team (CMHT).

40. We interviewed and had written submissions from the GPs of both Mrs CR (GP1) and Mr AR (GP2).

41. 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. He last visited the surgery on 24th December 2012 (3 days before the incident on 27th December) to collect a prescription and the staff reported that they had no concerns about his presentation. They confirmed to the RCA 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. A decision was made by the practice in May 2010 that Mr AR would only be seen by a male doctor following an assault on a female doctor.

42. In terms of communication between the surgery and the CMHT there little documented communication attached to his medical records for the period July 2007 onwards. The surgery was not kept informed when the care co-ordinator changed and the information held on their records regarding his sectioning and discharge was incomplete. In terms of violent or acts of aggression there is no record of information being provided for the period 2007 onwards. The surgery saw the quality of the communication and information sharing as less than expected. They 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 patients file indicates a much better flow of information prior to July 2007. They were not involved in any Care Planning meetings concerning Mr AR and the outcome of care planning meetings that did take place were not shared with the practice.

43. 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 when a protocol was introduced which sought to ensure close working collaboration between the CMHT and GPs. The GP surgery could and should have taken the initiative to improve communications.

44. Although there were obviously shortfalls as outlined above, we could not identify anything that if done differently by the MHT (or any other agency or body) which would have made the incident more predictable or prevented the fatal outcome.

Analysis of the terms of reference

45. The three ToRs relating to communications and working together are taken together because of their interrelationship. *1) Communication and co-operation between different agencies involved with Mrs CR and/or Mr AR. 2) 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. 3) Identify what those lessons are, how they will be acted upon and what is expected to change as a result.*

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 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. 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. 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. 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.

46. **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.*

    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.

47. **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.*

    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.

48. **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.*

    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. 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. The transition from inpatient to life back in the community appears to have been poorly managed and this was a serious weakness.

The control exercised by Mr AR over some elements of his treatment (when he was not hospitalised) is detailed in the report. 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.

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.

His GP was not fully involved in his care planning. Communications with the surgery was poor from 2007 onwards. Collaboration between the surgery and the CMHT should have been better.

49. **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.*

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.

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.

50. **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.*

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. 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.

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

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

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

    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. 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 effectively 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.

    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 always 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. 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.

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

    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.

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

    Analysis We did not identify any incidents of failing to share information due to misplaced concerns over data protection rights. Lack of sharing to other agencies was not for

reasons of confidentiality but because they (MHT) did not see there was a need to.

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

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. 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. 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. 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.

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

Analysis We took the view that there were 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. The MHT used a preferred system of zoning based on a traffic light system to indicate the level of risk presented by patients and 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.

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

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.

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

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.

Conclusions and key learning

59. 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. 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.

60. 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 was complied with then this medicinal focus would not have occurred.

61. 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.

62. 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.

63. 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.).

64. 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.

65. 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.

66. 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.

67. 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. 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

68. 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 actively involved 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.

69. **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.

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

Patrick Watson
DHR Chairman
4th June 2014