

Bath and North East Somerset Responsible Authorities Group

Domestic Homicide Review

Executive Summary Into the death of Mary (pseudonym)

David Warren QPM, LLB, BA. Dip.NEBSS
Independent Domestic Homicide Review Chair and Report Author

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Domestic Homicide Review Panel

David Warren	Accredited Independent Chair
Edward Yaxley	Avon and Somerset Constabulary
Claire Williamson	Avon and Wiltshire Partnership Mental Health NHS Trust
Val Janson	Bath and North East Somerset Clinical Commissioning Group
Lores Savine	Bath and North East Somerset Council
Helen Wakeling	Bath and North East Somerset Safeguarding Adults
Peter Brandt	BGSW Rehabilitation Service
Helen Dewbery	Knightstone Housing
John Trevains	NHS England South Central Team
Debra Harrison	Royal United Hospitals Bath NHS Foundation Trust
Geoff Watson	Sirona Care and Health
Debbie Sheppard	Southside

Review Administrator:

Mark Hayward Bath and North East Somerset Council

Section One: Introduction

1.1. This Review examines the contacts agencies in Bath and North East Somerset had with Mary (pseudonym) prior to her death in June 2015. Mary who was 55 years of age at the time of her death lived in Bath with her youngest son Zack (pseudonym).

1.2 The circumstances of Mary's death are:

Mary had bi-polar disorder and during 2013 spent some time as an inpatient in a mental health unit. Shortly after leaving the hospital in December 2013 she became friendly with Mark (pseudonym).

On 22nd May 2015 Mary contacted the Police to report that after ending her relationship with Mark, he found it difficult to accept and constantly made contact with her, which she found distressing and harassing. Although the police advised Mark not to contact Mary directly or indirectly, he continued to do so. Mary perceived his text messages as threatening.

On a date in June 2015 the mental health service Intensive Team made a welfare visit to Mary's home, but after she refused them entry, the police were contacted. On their arrival they found the front door was locked and whilst officers were talking to Mary through the door, she collapsed and it was apparent she had stabbed herself in the chest hitting the heart. Officers forced the door and first aid was administered. Air ambulance and other services responded and Mary was taken to hospital. On ■■■ June 2015 Mary's life support was switched off leading to her death.

1.3. The post mortem toxicology report revealed that the cause of death was likely to be hypoxic brain injury secondary to the blood loss suffered as a consequence of the stab wound to Mary's heart.

Section Two: The Review Process

2.1. This summary outlines the process undertaken by the Bath and North East Somerset Domestic Homicide Review Panel in reviewing the death of Mary.

2.2. On 24th November 2015 Bath and North East Somerset Responsible Authorities Group considered the background circumstances of Mary's death i.e. that she self-inflicted a fatal wound to her heart whilst anxious about perceived threats from a previous partner and took the decision to undertake a Domestic Homicide Review. The Home Office was notified of this decision on 2nd December 2015.

2.3. The process began on 25th January 2016, with an initial Review Panel meeting of agencies that potentially had contact with the victim Mary, her son Zack or her ex-partner Mark prior to Mary's death on the [REDACTED] June 2015. The Review was concluded on the 28th April 2016.

2.4. Mary's daughter was contacted at the commencement of the Review, the purpose of the Review was explained to her and she agreed to be the family liaison with the DHR. She provided the Review with pseudonyms for her mother and younger brother together with a consent form for access to her mother's medical records. She asked the Review to consider decisions made by the mental health trust in relation to her mother. She was provided with details of AAFDA and it was explained what help the family could receive from the Charity.

2.5. A letter was sent to Mark informing him about the Review and some time later he replied. The DHR Chair spoke to him about the Review. He denied that he ever threatened Mary or her son and had said there were no issues he wanted the Review to consider. He did however ask where Mary was buried as he wanted to pay his respects. This was passed on to the family. Mark did not wish to have any further engagement with the Review.

2.6. At the conclusion of the Review Mary's daughter and elder son read the Overview Report and Executive Summary prior to attending the Panel meeting on 28th April 2016. They stated there was mention in the Overview Report that their mother had on earlier occasions considered self-harming and taking her own life, they had never been made aware of these incidents. Whilst they acknowledged the need for patient confidentiality, as her carers, they strongly believe they should have been informed. It would have enabled them to introduce protective measures, including putting a key pad outside their mother's front door, so that emergency services could be given the code to gain entry of the flat if necessary. Panel members explained the difficulties that caring agencies are faced with in relation to balancing confidentiality against providing information to carers. Dr. [REDACTED] from AWP informed the family that this was currently being reviewed by AWP and she will feed in their comments to inform the decision making process. The victim's son and daughter thanked her. They also thanked the Chair for the opportunity offered to write a tribute to their mother, which they had declined, as they felt it would be too difficult emotionally. They thanked the Panel for inviting them to the meeting, which they found extremely helpful, they had not realised how thorough the Review would be and they were reassured that changes for the better may come from their mother's death. Mary's daughter thanked the Chair for keeping the family informed throughout the Review process and for the detail and obvious care take in the Report.

2.7. The agencies taking part in the Review are:

- Avon and Somerset Constabulary
- Avon and Wiltshire Mental Health Partnership NHS Trust (AWP)
- Avon Fire and Rescue Service
- Bath and North East Somerset Clinical Commissioning Group,
- Bath and North East Somerset Council
- Bath and North East Somerset Council Children's Social Care
- Bath and North East Somerset Safeguarding Adults
- Bath Citizens Advice Bureau
- Bath Mind Advocacy Service
- Bristol, Gloucestershire, Somerset, Wiltshire Community Rehabilitation Service
- Developing Health and Independence (DHI)
- Great Western Hospital NHS Foundation Trust
- Knightstone Housing
- NHS England
- North Bristol NHS Trust
- Reach Housing Options and Advice
- Royal United Hospitals Bath NHS Foundation Trust
- Sirona Care and Health
- Southside
- South Western Ambulance Service NHS Foundation Trust
- Women's Aid
- Zack's School

2.8. The agencies were asked to secure all relevant documentation and to give chronological accounts of their contacts with Mary, her son Zack and Mark victim prior to her death. Where organisations had no involvement, or insignificant involvement, they informed the Review accordingly.

2.9. Of the twenty-two agencies contacted about this Review, ten responded that they had had no relevant contact with Mary, Zack or Mark. Twelve agencies completed an Independent Management Review (IMR) with information indicating some level of involvement.

2.10. The facts obtained from the IMRs, the Pathologist, Mary's family and Mark are summarised as follows:

2.10.1. As a child Mary was abused by her father and subsequently was taken under the care of the local authority. She married her first husband and had her first son at 19 years of age. Her husband, a drug user, introduced her to intravenous opiate use and she became infected with Hepatitis C. She later told agencies, her husband emotionally and physically abused her and she left him in 1988.

2.10.2. She married again in 1991 and had a daughter and son. She worked regularly as a medical secretary. At the end 2011, Mary and her second husband separated and subsequently divorced, Mary sought help from the Bath Citizens Advice Bureau with an employment grievance and while there confided that her husband had abused her. She was given details about Refuge provision and the help she could obtain from Southside, a domestic abuse support service. She never contacted either service. Her family has expressed surprise that Mary claimed her husband abused her as they were not aware of the abuse. Mary's daughter said that as the marriage was ending there were many arguments between her parents but not different to what one would expect at such a time.

2.10.3. Mary had suffered from mental health problems from 1998 and in 2013 it was diagnosed as bi-polar disorder. In January 2011 she was admitted to hospital under section 2 of the Mental Health Act (MHA) for a short period followed by outpatient treatment and medication. She was discharged in May 2011 but made contact again in November 2012 stating she felt suicidal as she had lost her job, after talking for a while she felt better and wanted to cope.

2.10.4. After her separation Mary had worries about finances, accommodation and employment and as her mental health deteriorated, she had unfounded fears about the safety of her children, on one occasion she was wrongly convinced that the house was on fire with her son and daughter in it. In June 2013 Mary contacted the police concerned that paedophiles were abusing her son Zack. She told the police she had mental health issues and felt she needed a psychiatric assessment as she felt unable to look after him properly. The police and Children's Social Care confirmed that Zack was not at risk. Mary was taken to hospital but later discharged into the care of the AWP Intensive Service.

2.10.5. During that time Mary's family became increasingly concerned about her vulnerability as she became preoccupied on the plight of homeless people. She was leaving the house in the middle of the night and giving away money she could not afford, on several occasions she went missing for days.

2.10.6. On 13th August 2013 Mary was taken to hospital and after assessment was detained under section 2 of the MHA. The psychiatrist reported: "She has a long history of mental health problems, but things seem to have been stable until recent months (lots of stressors - divorce, job pressures, and son getting married)".

2.10.7. Shortly after leaving the hospital in December 2013 Mary met Mark, she started to meet him socially and by August 2014 this had developed into a casual relationship. Nevertheless Mary would not stay over at Mark's flat because Zack was living with her and for that reason she would not let Mark into her home. Mary's daughter stated her mother would not let anyone into the flat for fear they would harm Zack.

2.10.8. Mark did not work but told Mary that if he could buy a van he could use it to get work. Mary felt pressured into offering him some money for a second hand van when her divorce settlement came through. However Mark and Mary went away for a few days for her birthday and she became suspicious that he was seeing someone else as he was constantly receiving telephone calls. She told him she did not want to see him again.

2.10.9. On 22nd May 2015 Mary contacted the Police to report that after ending her relationship with Mark, he found it difficult to accept and constantly made contact with her, which she found distressing and harassing. The police advised Mark not to contact Mary directly or indirectly. He claimed he had not realised she had wanted to finish their relationship.

2.10.10. Mary later told her Care Coordinator that when Mark was told she wanted to finish their relationship, he had assaulted her four or five times but she never reported this to the police. She did inform the police that he had been sending her threatening text messages but that she had deleted them.

2.10.11. On ■ June 2015 Mark turned up at Mary's address, he asked Mary for money for a van. She refused and asked him to leave which he did. Mary contacted the police, who attended her property a short time later. The officers recommended that Mary obtain an injunction preventing Mark from contacting her, they also arranged for a police and fire safety check to be conducted the next day as her door appeared to require more suitable security. A police officer later spoke with Mark and advised him to have no further contact. A "treat as urgent" marker was put on the premises and Mary's beat manager notified. That afternoon Mary attended a planned appointment with her Consultant Psychiatrist and the Care Coordinator. They discussed her current circumstances, mental health presentation and prescribed medication. The Consultant Psychiatrist noted that she appeared appropriately upset by recent events, but displayed no evidence of active mental illness.

2.10.12. In the early hours of ■ June 2015, Mary telephoned her daughter who was planning to travel from Manchester to visit her mother that evening. Mary sounded very distressed and told her not to travel to Bath as she was afraid Mark would harm her. Her daughters contacted the mental health service to express concerns about her mother. A mental health team work development support worker visited Mary that morning and tried to contact the Recovery team with her concerns about Mary's conversation and behaviour. Mary's Care Coordinator contacted her by telephone and later visited her with the Duty Officer to complete a review. Mary presented as preoccupied and fixed on the idea that her children would come to harm because of her mistakes in relation to Mark. Despite this, she was able to focus on the task of contacting her solicitor to discuss pursuing an injunction. While the duty practitioner remained with her, the Care Coordinator made a telephone contact with the Consultant Psychiatrist and agreed an updated medication regime as Mary had become confused as to the doses she was meant to take. The duty practitioner spent time organising the medication and writing down clear instructions for her to follow. She was encouraged several times to take Diazepam, while they were with her but refused. The staff noted that there was a quantity of unused medication at the property, which they subsequently removed. On returning to their office the Care Coordinator discussed Mary's situation with the team manager. Arrangements were made for the Intensive Team to visit Mary at 5.30pm and Mary was informed by telephone.

2.10.13. When the Intensive Team arrived at Mary's home she did not open the door to them. The police were contacted and on their arrival they found the front door was locked and whilst officers were talking to Mary through the door, she collapsed and it was apparent she had stabbed herself in the chest hitting the heart. Officers forced the door and first aid was administered. Air ambulance and other services responded and once stabilised Mary was taken to hospital. On ■ June 2015 Mary's life support was switched off leading to her death.

2.10.14. The post mortem toxicology report revealed that the cause of death was likely hypoxic brain injury secondary to the blood loss suffered as a consequence of the stab wound to Mary's heart.

Section Three: Terms of Reference.

3.1. The decision for Bath and North East Somerset to undertake a DHR was taken by the Bath and North East Somerset Responsible Authorities Group on the 24th November 2015 and the Home Office informed on 2 December 2015.

3.2. The Home Office Statutory Guidance advises where practically possible the DHR should be completed within 6 months of the decision made to proceed with the review.

3.3. This Review, which is committed, within the spirit of the Equality Act 2010, to an ethos of fairness, equality, openness and transparency, will be conducted in a thorough, accurate and meticulous manner.

3.4. The Review will consider:

3.4.1. Each agency's involvement with Mary, 55 years of age at time of her death in June 2015, her son Zack who was 17 years of age at the time of her death or with Mark with whom she had previously been in a casual relationship. Agencies involvement should include any contacts between 1st January 2011 and the date of Mary's death in June 2015; and any contacts relevant to stalking, harassment, domestic abuse, violence or mental health issues prior to that period.

3.4.2. Whether there was any previous history of abusive behaviour towards the deceased, her son or to any previous partner of Mark and whether these incidents were known to any agencies or multi agency forum?

3.4.3. Whether family, friends, work colleagues or neighbours want to participate in the review. If so, ascertain whether they were aware of any abusive behaviour to the deceased or health concerns prior to her death?

3.4.4. Whether, in relation to the family member's friends, neighbours or work colleagues; were there any barriers experienced in reporting domestic abuse?

3.4.5. Could improvement in any of the following have led to a different outcome for Mary?

- a) Communication and information sharing between services.
- b) Information sharing between services with regard to the safeguarding of adults and children.
- c) Communication within services.
- d) Communication to the general public and non-specialist services about available specialist services.

3.4.6. Whether the work undertaken by services in this case are consistent with each organisation's:

- a) Professional standards
- b) Domestic Abuse policy, procedures and protocols
- c) Policies for the safeguarding of adults and children

3.4.7. The response of the relevant agencies to any referrals relating to Mary, her son or Mark concerning stalking, harassment, domestic abuse, violence or mental health issues. It will seek to understand what decisions were taken and what actions were carried out, or not, and establish the reasons. In particular, the following areas will be explored:

- a) Identification of the key opportunities for assessment, decision making and effective intervention in this case from the point of any first contact onwards with the deceased, her son or Mark.
- b) Whether any actions taken were in accordance with assessments and decisions made and whether those interventions were timely and effective.
- c) Whether appropriate services were offered/provided and/or relevant enquiries made in the light of any assessments made.
- d) The quality of any risk assessments undertaken by each agency in respect of Mary, her son or Mark.

3.4.8. Whether organisational thresholds for levels of intervention were set appropriately and/or applied correctly in this case.

3.4.9. Whether practices by all agencies were sensitive to the ethnic, cultural, linguistic and religious identity of the respective family members and whether any specialist needs on the part of the subjects were explored, shared appropriately and recorded.

3.4.10. Whether issues were escalated to senior management or other organisations and professionals, if appropriate, and completed in a timely manner.

3.4.11. Whether, any training or awareness raising requirements are identified to ensure a greater knowledge and understanding of domestic abuse processes and/or services.

3.4.12. The review will consider any other information that is found to be relevant.

Section Four: Key Issues.

4.1. The Review Panel, having had the opportunity to analyse the information obtained from agencies, from Mary's family, Mark and from the Coroner's Inquest, consider the key issues in this Review to be;

4.2. Mary's long term mental health.

4.2.1. Mary first received treatment for mood-related problems in 1999, when she required treatment as an inpatient under the Mental Health Act (MHA) for an episode of psychotic depression. However it is not clear how long she had suffered from mental illness although it is noted that she had been abused as a child and childhood abuse has been associated

with a plethora of psychological and somatic symptoms, as well as psychiatric and medical diagnoses including depression, anxiety disorders.¹

4.2.2. Mary was discharged in 1999 on an antipsychotic medication and an antidepressant which she continued to take and was followed up intermittently as an out-patient until 2011. She was again admitted under the MHA in February 2011 following a further similar episode which resolved rapidly and she was discharged with similar medication and with outpatient follow up.

4.2.3. Mary was admitted informally for several weeks in July 2013 and diagnosed as having had an episode of hypomania. Following discharge her mental health again deteriorated, becoming increasingly erratic, she was expressing paranoid beliefs and was detained under the MHA from August to December 2013. While in hospital she suffered self-inflicted lacerations to both wrists. During this admission her diagnosis was confirmed as that of bi-polar disorder. Antidepressants were discontinued and she was established on mood stabiliser drugs.

4.2.4. Mary had no other reported incidents of self-inflicted injuries although on one occasion in 2012, after she lost her job, she did telephone the mental health service to say she was thinking about ending her life, however after talking through her problems she changed her mind.

4.2.5. Mary knew that her mental health could very quickly deteriorate but she was aware of the stress factors that could cause this and when she recognised them she or her children sought help. Her divorce, financial situation, subsequent housing and work issues along with concerns for the welfare of her children were examples of stressors which triggered her bipolar disorder.

4.2.6. The Panel notes that 90% of suicides in the UK are related to forms of mental health problems² and that a history of sexual or physical abuse or a history of child neglect can increase an individual's vulnerability to suicidal behaviour. In addition a perceived stressful situation may push a person "over the edge" leading to suicidal thinking and action³.

4.3. **Mary's fear relating to the safety of her children.**

4.3.1. There were several occasions when Mary's mental illness manifested itself in her having unfounded concerns about her children's safety. In 2012 she believed that her two younger children were at home and the house was on fire, this was not the case. In 2013 there were instances, recounted in section 12 of this report, where she worried that Zack was being targeted by paedophiles; she contacted Children's Social Care to inform them her son was at risk from herself due to her illness and she contacted AWP with worries about her daughter coming home from holiday late at night. On 16th July 2013 she

¹ Childhood family violence and adult recurrent depression. Kessler RC, Magee WJ Health Soc Behav. 1994 Mar; 35(1):13-27. and Childhood sexual abuse as a risk factor for depression in women: psychosocial and neurobiological correlates. Weiss EL, Longhurst JG, Mazure CM

Am J Psychiatry. 1999 Jun; 156(6):816-28

²Mortality statistics in England and Wales by sex and age range (ONS) Dec 2015

³NHS - Choices <https://www.google.co.uk/url?>

contacted her elder son and a friend, stating her younger son and daughter were being abused, again this was not true. She told them she was leaving for Dubai to save her children from the Devil.

4.3.2. Mary's daughter has told the Review that her mother would not let people into the house because of her phobia about the safety of her children.

4.3.3. Mary recounted to her Care Coordinator that she would not let Mark into her home because of her fears for Zack. Mark knew of Mary's anxieties about Zack and whilst he has denied making threats regarding Zack or of sending threatening text messages, Mary believed that he had and she told both the police and her Care Coordinator that she felt she had put her children at risk because of Mark. Her text replies to Mark which were recovered by the police from her phone, confirm the depth of her fears.

4.3.4. Since the conclusion of the Review Avon and Somerset Constabulary have been able to recover all of the deleted text messages from Mary's mobile phone. Most were outgoing messages to Mark's phone. At least five of those outgoing messages imply or state directly that Mark was threatening either her or Zack. Those text messages did not outline the nature of the threatening behaviour, other than saying Mark intends to "hurt" Zack in a non-specific manner. Although there were text messages from Mark, only one could be construed to be possibly threatening; this was a message in which he offers the view that he "should have a word in [Zack's] ear to show his mother some respect".

4.4. The level of support Mary's children received.

4.4.1. After Mary separated from her second husband in 2011, Zack, her youngest son initially stayed with his father but later moved in with Mary for a short period in 2013 before moving to live with his 19 year old sister who was at University in Bath. In 2014, after his sister moved away from Bath with work, Zack went to live with Mary. Until the time of her death, her children often found themselves having to look out for her. As she became ill she would become fixated on particular issues. In 2013 this preoccupation was on homeless people. She would go out in the middle of the night, leaving Zack alone at home. She became vulnerable, giving homeless people money she could not afford. Too frequently her daughter and sons had to comb the streets of Bath looking for her. On more than one occasion they had to report her missing to the police and went as far as asking for her to be detained under the Mental Health Act for her own safety. Due to the age of the elder son and daughter at that time, no consideration was given to child welfare issues.

4.4.2. Agencies including the Police, AWP, GP, School and Sirona were aware that Zack was living with his mother and of her concerns in respect of him. Bath and North East Somerset Council (BaNES) Children's Social Care (CSC) never received any formal referral relating to Zack, although they did receive information regarding him. Mary herself contacted CSC on two occasions, when she spoke of her fears that she was abusing her son Zack. Enquiries were made with Zack's school and it was confirmed "he was a bright boy who does not present with any concerns about his home situation" no further action was taken. On 17th July 2013 a police intelligence report to CSC indicated that Mary's mental health was deteriorating. CSC again made contact with the school, where there were no concerns and no further action was taken. In October 2013 further contact was made with CSC by the school, confirming that Zack had moved in with his sister and they were receiving support from the School swimming instructor, who would make a referral if necessary. CSC had no further information until 26th May 2015 when Mary again

contacted them to state she was upset by contacts from Mark. CSC thought there was no role for them to play.

4.4.3. Mary's daughter and elder son have stressed to the DHR that they and Zack tried to ensure that Zack's education was not affected by their mother's illness and that Zack would not discuss family issues at school. If asked specific questions, he would play down the gravity of the situation and as he was doing well academically, at sport and socially there would have been no reason for the school or CSC to challenge him.

4.5. The rapid deterioration in Mary's mental health prior to her death.

4.5.1. The day before her death, Mary contacted the police after Mark had turned up at her home asking for money, Although he left when she told him she had no money to give him, the police attended and agreed a positive course of action with her. This included the placing of a "treat as Urgent marker" on the police commuter to ensure immediate responses to any further calls to her address; arranging for an urgent security survey of her address and for her to obtain an injunction to stop Mark contacting her. Later the same day she met with her Consultant Psychiatrist, who noted that she was reacting normally to the stresses she was faced with and that her mental health remained stable at that point.

4.5.2. However it appears that during the night Mary became increasingly anxious, becoming convinced that she had put her children at risk because of her relationship with Mark. In the early hours of the morning she made a number of telephone calls to her daughter, telling her not to come to visit her as Mark would harm her. Her daughter contacted AWP with her concerns and mental health workers visited Mary and spoke to her on the telephone several times during the day. Arrangements were also made for her to have visits from the AWP Intensive Support Team during the evening until her daughter arrived from Manchester.

4.5.3. Whilst the mental health workers who visited her, were concerned about her deterioration from the previous day, it was not thought that she was at such risk as to warrant initiating the process to consider her being detained under the Mental Health Act. During the early afternoon she had been able to rationally discuss contacting a solicitor about obtaining an injunction in relation to Mark. It was also known that she would be receiving extra support that evening from the Intensive Team until her daughter arrived later that night. The care coordinator left Mary 3.30pm and the Intensive Team spoke to her on the telephone at 4.32pm to confirm they would be with her at 5.30pm. When they arrived at her address at 5.30pm, her condition had declined to the extent that she was unable to or would not open the door to them.

4.5.4. Mary's mood swings from normality on ■ June 2015 when she saw her Consultant Psychiatrist, tone of intense depression, feeling uniquely guilty (in her case of believing she had introduced her children to danger from Mark) during the night and morning of ■ June 2015, to normality in the afternoon when she was able to rationally discuss security improvements with the Fire and Rescue Officer to telling the Care coordinator she was about to see her solicitor for an injunction, back into an intense depressive episode in the evening, is recognised behaviour for someone who suffered from Bipolar Disorder.⁴

⁴Goodwin, G.M. (2009) Evidence-based guidelines for treating Bipolar Disorder: revised second edition - recommendations from The British Association for Psychopharmacology. *Journal of Psychopharmacology*, 23(4); 346-388.

4.5.5. As the Police have now accessed the messages Mary had deleted from her mobile phone it is apparent that Mark had not made threatening text messages to her. Mary nevertheless perceived his messages as threatening towards her son and she became increasingly anxious, thinking she had put her son at risk. This possible delusional mood (the pervasive sense of foreboding that something bad is about to happen) was real to her.⁵ Research evidence shows a direct link between women's experiences of domestic abuse and fear of violence with heightened rates of depression, trauma symptoms, and self-harm.⁶

Section Five: Effective Practice/Lessons Learnt.

5.2. The following agencies that had contacts with Mary, Zack or Mark have identified effective practice or lessons they have learnt during the Review.

5.2. Avon and Somerset Constabulary

5.2.1. Identified good practice

- Evidence of steps taken to protect Mary, such as the use of Treat as Urgent markers
- Good liaison between two new teams: the Lighthouse and the Safeguarding Coordination Units

5.2.2. Issues of concern

- Officers did not routinely submit reports regarding vulnerable adult web storm logs, or routinely share this information with Adult Social Care. The information remained on a separate database (Storm) and was not linked to Mary's intelligence record held on the Constabulary's crime intelligence and incident management system Guardian. In order to overcome this gap, vulnerable adult information should require submission of an intelligence report documenting the details of the victim and circumstances. This information will then be recorded on the intelligence and incident management system database. This will be accessible to the Safeguarding Coordination Units or other relevant Police department should any future public protection or welfare concerns arise.
- On occasions, police officers did not recognise the risk to children living with a parent with deteriorating mental health.

Geddes, J. (2003) *Bipolar disorder*. Evidence Based Mental Health, 6 (4): 101-2.

Morriss, R. (2004). *The early warning symptom intervention for patients with bipolar affective disorder*. *Advances in Psychiatric Treatment*, 10: 18 - 26.

NICE CG185: Bipolar Disorder: the assessment and management of bipolar disorder in adults, children and adolescents, in primary and secondary care (2014)

⁵ Geddes, J. (2003) *Bipolar disorder*. Evidence Based Mental Health,

⁶ Mental Health and Domestic Violence: 'I Call it Symptoms of Abuse'

Cathy Humphreys Ravi Thiara Br J Soc Work (2003)

- In view of Mary's fears further efforts could have been made to obtain the deleted text messages from Mary's phone as they would either have provided evidence of harassment or have reassured Mary that her fears were groundless.

5.3. Avon and Wiltshire Mental Health Partnership NHS Trust

5.3.1. It was identified that the care and treatment was of a satisfactory to good standard, all core aspects of treatment and care were addressed, including risk assessment and management plans.

5.3.2. Following the information being shared by Mary that she had experienced domestic abuse it may have been appropriate to work with her on a referral to a local domestic abuse support service such as Southside, to help provide more specialist support and work on any issues that arose from this although given the short timescale between her disclosure and her death this may not have been practical.

5.4.3. There was no operating procedures or guidance within AWP for mental health staff to consider when requesting for the police to conduct a welfare check on a service user and what is required from AWP staff once a request has been made.

5.4. Bath and North East Somerset Adult Safeguarding

5.4.1. Mary's Care Coordinator should be commended on the relationship she appeared to have forged with Mary which enabled her to disclose the level of information that she did. Also of note is the degree of recording completed by the Coordinator on 22nd May 2015 outlining the risks and stating the safety plan that she had worked through with Mary.

5.4.2. Conversely, in considering the level of detail presented by the Care Coordinator there is an opportunity to question whether the Safeguarding Alert/Concern that was sent to the Adult Safeguarding Team required consolidating in order to focus on the relevant and most pressing issues, in this case the level of domestic abuse and the effects on Mary.

5.4.3. Consideration should be given to the level of support or training an individual worker requires following a disclosure of abuse being made to them.

5.4.4. Similarly, consideration needs to be given to how individuals both with mental health needs and without are supported through the process of disclosure of abuse.

5.4.5. The Care Coordinator clearly identified the need to progress to Safeguarding and as per the above protocol discussed with her supervisor. However, this assurance measure, the rationale for which is appropriate, led to a delay in the alert/concern being made and forwarded. The protocol needs to consider whether a degree of flexibility is required to enable professionals to act on their concerns as the need arises.

5.5. Bath and North East Somerset Clinical Commissioning Group

5.5.1. Blood results were not always actioned by Doctor viewing and filing results.

5.5.2. There is a need understand when and how to consider referrals to adult and child safeguarding.

5.5.3. All patients on a mental health register should have a documented assessment of any adult or child safeguarding issues.

5.5.4. Child safeguarding should be re-assessed if any mental health admissions or episodes of deliberate self-harm are apparent.

5.5.5. There is a need for increased awareness of domestic abuse.

5.6. Bath and North East Somerset Council Children's Social Care

5.6.1. The record of the telephone call from Mary on 26th May 2015 had insufficient detail to explain why the decision was made that there was no role for CSC and that there was to be no further action. There is a need to ensure that all Duty workers and Duty Managers record decisions in a detailed, clear manner which sets out succinctly the rationale for the decision/agreed actions .

5.6.2. There is a need to ensure that agencies are aware of the process of making a safeguarding referral.

5.7. Knightstone Housing

5.7.1. Letting interview questions and recommendation was not as comprehensive as it needed to be.

5.8. Reach Housing Options and Advice

5.8.1. The lack of a risk assessment was apparent.

5.8.2. There needs to be more clarity about information sharing.

6. Conclusions

6.1 In reaching their conclusions the Review Panel has focused on the questions:

6.2. Have the agencies involved in the joint Review used the opportunity to review their contacts with Mary, Zack and Mark in line with the Terms of Reference (ToR) of the Review and to openly identify and address lessons learnt?

6.2.1. The Review Panel acknowledges that the Individual Management Reviews and other reports have been thorough, open and questioning from the view point of Mary. The Panel is satisfied with the evidence provided by those organisations that have shown that their contacts, with Mary, Zack or Mark, were in accordance with their established policies and practice, have no lessons to learn. Other organisations have used their participation in the Review to properly identify and address lessons learnt from their contacts with Mary, Zack or Mark in line with the Terms of Reference.

6.3. Will the actions they take improve the safety of domestic abuse victims and individuals suffering from mental health issues in Bath and North East Somerset in the future?

6.3.1. The Panel, while satisfied that the implementation of the recommendations made within the Review will address the needs identified from the lessons learnt and make life

safer for victims of domestic abuse who are also suffering mental health disorders, wishes to emphasize the need for more timely referrals to appropriate Safeguarding bodies.

6.4. Was Mary's death predictable?

6.4.1. Although in 2012 there was one occasion when Mary was known to have spoken about being suicidal, and there were incidents in 2013, when on one occasion she had cut both her wrists and on a second put a plastic bag over her head, there had been no indication since that time that she intended to self-harm or take her own life.

6.4.2. On ■ June 2015 she was seen by her Consultant Psychiatrist who noted that: "Despite recent occurrences (*Mark calling at her house that morning*), she appeared appropriately upset by recent events, but displayed no evidence of active mental illness. She spoke in detail about events of the previous weeks and described how she had felt panicked. She reflected upon her abusive relationships and appeared determined to remain in control of her stresses and was clear in her intention to continue treatment. She stated that she had appreciated the support given to her and was clear that she was relieved that services had supported her at home rather than in hospital. We agreed that she would continue to receive frequent support as per her care plan and we made an appointment to meet again for review of her treatment in August 2015."

6.4.3. Mary's panic attacks during that night and following morning, which were followed by the episode of normality when she was able to rationally discuss home security and obtaining an injunction, before sinking into the later intense episode of depression were typical of bipolar disease mood swings as was the fact that she was unwilling or unable to accept the help on hand.⁷ The DHR Panel is therefore of the opinion that Mary's mood swings could have been predicted, but concluded that there were no grounds to foresee that Mary would inflict a fatal wound on herself.

6.5. Could Mary's death have been prevented?

6.5.1. After Mary separated from her husband, she had been subjected to a number of stressors including financial, accommodation and employment issues. However it was apparent to those people who spoke to her on ■ June 2015, particularly her daughter and her care coordinator, that on that day, the one issue which triggered her intense and rapid depression, was the fixation that she had put her children at risk of harm from Mark. The Panel therefore has focused on the following questions when considering if Mary's death could have been prevented:

- Could more have been done to allay Mary's fears that Mark would harm her son?
- Did the care offered by the mental health service appropriately address Mary's needs at that time?

6.5.2. Could more have been done to allay Mary's fear that Mark would harm her son?

6.5.2.1. Over the weeks before her death, both the police and Mary's Care Coordinator spent time with Mary, reassuring her and organising detailed safety plans which included advice about how to obtain an injunction, Officers warning Mark not to contact Mary, a "treat as urgent" marker was put in place, her beat manager was notified and her home

⁷ Improving Lives of people with mental illness: Bipolar Disorder: Royal College of Psychiatrists April 2015

was visited on ■ June 2015 for a security and fire risk assessment. The Police response was nevertheless limited as Mary never made any allegations to them that Mark had been physically violent to her. Also although she believed his text messages to her were threatening towards her and her son, she had deleted them prior to contacting the police and given her phone to her sister in Cornwall. If the police had been able to view Mark's messages at that time, they would have been able to reassure Mary that the messages were not threatening. It was not until after Mary died that the police were able to arrange for the phone to be checked and the deleted messages accessed.

6.5.2.2. During the Care Coordinator's and Duty Officer's visit to Mary on ■ June it was apparent that the stressor she was most anxious about was that belief that Mark was a threat to her children. They and the Fire and Rescue Officer who conducted a home security check on her home that day tried to reassure her and during the afternoon she was able to speak rationally about the process of seeing a solicitor about obtaining an injunction to prevent Mark from having contact with her and her family.

6.5.3. Did the care offered by the mental health service appropriately address Mary's needs at that time?

6.5.3.1. Whilst the Mental Health National Service Framework 1999 sets out service models for treating people with mental ill health, it is clear from the notes of Mary's consultant psychiatrist on ■ June 2015, that Mary's community based treatment was not as a result national policy⁸ but rather was based on Mary's wishes and what was considered to be the most appropriate treatment for her at that time. It was recorded in her Consultant Psychiatrist's notes that she preferred to be treated at home by her Care Coordinator supported by the Intensive Team when needed.

6.5.3.2. On ■ June 2015, Mary received an intense level of support from the mental health service. There were visits from the AWP Work Development Support Worker, followed by telephone support during the morning, visits from the Care Coordinator and Duty worker during the afternoon, her condition was discussed with a supervisor and her psychiatrist, her medication was sorted (although she refused to take her diazepam while the AWP staff were with her) and visits by the Intensive Team arranged for that evening.

6.5.3.3. While, during the morning of the ■ June 2015 there were visible warning signs: lack of eye contact, speech patterns and her failure to take her medication, which should have triggered a decision to having her detained under the Mental Health Act, this was discounted, when treatment options were being considered, due to her mood swing during the afternoon when she was positive and able to hold rational discussions. Once it was decided that there was insufficient grounds for Mary to be detained under the Mental

⁸ In 1999, the Mental Health National Service Framework set out the service models that mental health services should provide. The intention was that inpatient care should be used only when necessary and that intensive treatment in the community should be offered in its place. The Cochrane Review (which analyses existing research on a given subject) suggests that this service model provides equal or better outcomes for service users than inpatient treatment alone and results in higher service user satisfaction. Consequently, current guidance is that services should seek to provide people in mental health crisis with the 'least restrictive', appropriate treatment option. Essentially this means that home treatment, with input from an Intensive Team, is routinely considered as an alternative to admission to hospital. Hospital admission remains an option, but will normally only be considered if the assessment process indicates that treatment cannot be provided safely at home and/or if the service user does not agree to engage in home treatment.

Health Act the mental health service appeared to take action to maintain regular contact with Mary. Her Care Co-ordinator stayed with her until 3.30pm when Mary was going to contact her solicitor, She knew that support had been arranged for the Intensive Support Team to visit her and they telephoned her at 4.3pm to tell her they would be with her at 5.30pm. They arrived on time and spoke to her from the front door but although she told them she would open it in a moment she never did so. When they could not gain entry they contacted the police for a welfare visit and the police had arrived and were speaking to her through her locked flat door when she stabbed herself.

6.5.3.4. Mary's family has raised concerns that when the Intensive Team contacted the police on the evening of the ■ June 2015 requesting a welfare visit to Mary, it was not made sufficiently clear that Mary was very mentally ill and that the Police should attend with door opening equipment. The family believes that the time it took for the police to send for the equipment after they saw through the letter box that Mary had stabbed herself, resulted in Mary losing too much blood to be saved.

6.5.3.5. The Review Panel accepts that it is not police practice to carry door opening equipment to every welfare call.⁹ Emergency medical services were on hand to render assistance to Mary as soon as the door was opened and there is no medical evidence to indicate that if the police had been able to open the door more quickly, the medical assistance at the scene would have been more successful.

6.6.4. The Review Panel therefore believes that on the evidence available it is not possible to conclude that Mary's death was preventable.

⁹ Avon and Somerset Constabulary does not equip every patrol car with a door-ram because of the weight and bulk. The list of equipment that a frontline police officer may require, far exceeds the capacity of a typical car so some choices have to be made about the numerous items such as rams, fire extinguishers, shields, road signs, bollards, first aid equipment, tools, evidence bags etc., balancing the risk of not having the equipment with the likely frequency of its use. Rather than a national stance on how to approach this issue, Avon and Somerset Constabulary devolves the decision on how best to equip a police vehicle to local area commanders, as the typical requirements of a rural area are potentially very different from those in a city. Rams are always available to frontline staff but they may have to be brought by a colleague.

Section Seven: Recommendations and Action plans

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date	Date of completion and Outcome
Avon and Somerset Constabulary to ensure that all operational staff-members are reminded of the importance of intelligence submissions for any relevant incident they attend.	Local	To form part of training and raising awareness which will, in turn, increase knowledge and understanding of our Domestic Abuse processes	Avon and Somerset Constabulary	A dip sample of intelligence system to be taken and remedial measures implemented as necessary.	To be conducted before the finalisation of the IMR report.	31/03/16
All operational staff to be reminded of the importance of recognising the risk to children living within a parent declining mental health. To be measured by an increase in referrals from the Safeguarding Coordination Units to Children's social care.	Local	Implement through briefings	Avon and Somerset Constabulary		completed	31/03/16

AWP to organise training to increase awareness of how vulnerability to domestic abuse can be linked to history of trauma and agencies available to support	Local-organisation al wide	Training session to be organised by Recovery Team Manager	AWP		31/07/16	31/07/16
The Operating Protocol in relation to Safeguarding decisions between AWP and Bath and North East Somerset Council needs to be reviewed particularly in relation to alerts having to be made by Team Managers or Senior Practitioners	Local to Bath and North East Somerset	To review protocols	AWP and Bath and North East Somerset Council Safeguarding Team	Protocol reviewed and agreed	1/05/16	Completed on target.
Awareness raising to be undertaken amongst AWP on CAADA DASH/Safe Lives tool and MARAC referrals, particularly the availability of option to refer to MARAC on professional judgement basis.	Local to Bath and North East Somerset		AWP and the Avon and Somerset Constabulary	training programme agreed delivery ongoing	31//16	training delivery ongoing

Explore IT solutions to reduce potential admin delays in reporting Safeguarding concerns	Local	Continue to implement Liquid Logic project	BANES Local Authority and AWP		30/09/16	30/09/16
During the Review it was identified that B&NES does not appear to have a clear multi-agency policy / procedure on Domestic Abuse and Violence or a multi-agency training programme.	Local to B&NES agencies	B&NES Council to publish a clear multi-agency policy / procedure on Domestic Abuse and Violence, along with a multi-agency training programme.	B&NES Responsible Authorities Group(Community Safety Partnership)		completed	31/11/2016
Review procedure on passing messages to advisers	Local	Quality Manager to review system and report to Director	Citizens advice B&NES		29/04/16	completed on target
Continue to implement the“ASK RE” information policy which highlights the need not just to signpost to services but t where appropriate to directly refer.	National Citizens Advice policy	Continued training for new advisers	Citizens advice B&NES		ongoing for new staff	All existing advisers trained continuous training for new advisers/volunteers
Referrals to Children's Social Care to ensure clarity on what constitutes a referral to CSC	Local	The issue about what constitutes a referral is clearly documented on CSC website. A C.2 is The form used for all agencies to request a service from CSC. This was not progressed by any agency and CSC saw no need to undertake an assessment. If an agency is not happy with the response from CSC they should refer to the LSCB escalation policy	Bath & NES Council Children's Social Care	All local agencies will be reminded by BATHNES RAG of referral routes into CSC		

Case notes Reminders to be given to Duty Team to ensure clarity and consistency in record keeping	Local	Duty Team manager will ensure records are recorded directly by the person who receives the information	Bath & NES Council Children's Social Care	This issue will be referred to at the duty workshop	05/05/16	Completed by 31/03/2016
That the Local Safeguarding Adults Board reviews the quality of referrals being made into safeguarding, particularly those made by statutory partners.	Local to Bath and North East Somerset	To review current referrals, identifying key issues/learning. Working across agencies, particularly statutory partners to agree a minimum set of data that should be provided by organisations when making safeguarding referrals. Consideration also to be given to how referrals for alternative forms of support such as social care assessments should be identified separately from safeguarding concerns, or where information only is being shared that there is an agreed process for how these should be actioned by the receiving agencies.	BANES Safeguarding Adults Board			31/12/16
DHI risk assessment for clients entering casework services to be reviewed and re-issued to all staff	Local (Reach service specific) and regional (all DHI services)	Review and revise service and organisational risk assessment processes	DHI	A revised and agreed risk assessment will be the measure of success	30/09/16	Reach risk assessment completed, organisational actions on track for target date
Relevant DHI policies and procedures to be reviewed to consider appropriateness of current thresholds for action	Regional (all DHI services)	Review and revise organisational policies and procedures (if appropriate)	DHI	DHI Board sign off of policy & procedure review will be the measure of success	30/09/16	Adult safeguarding policy & procedure currently under review, other actions on track for target date

Lettings procedures to be clear about specifically asking about DV and what support is or could be in place.	Local to Knightstone	To review lettings procedures	Knightstone	Procedures reviewed	01/04/16	29/03/16 Procedures amended to include DV
Audit of thyroid function test management as proxy for management of blood results	Local	Perform a search on all patients prescribed thyroxine within the past 12 months to ensure all have a TFT result within the past 12 months. Any who do not will be recalled for a TFT blood test. For all patients where TFT result is outside the normal range, a clinician will review the notes to ensure that the result has been actioned and any dose amendment or repeat test arranged	GP Practice	Completed	30/04/16	31/12/16
Baseline assessment of documentation of consideration of child and adult safeguarding issues for all patients on mental register	Local	Review of records	GP Practice	Completed	30/04/16	31/12/16
All patients on mental health register to have documentation of consideration of child and adult safeguarding issues	Local	Any not documented to have documentation of consideration of safeguarding issues	GP Practice	Completed	31/08/16	31/12/16
Staff are up to date with mandatory child and adult safeguarding training	Local	Training records to be checked	GP Practice	records checked by 15.3.16	30/05/16	31/12/16

IRIS training and advocacy package completed	Local	All staff to have the training	GP Practice	Admin staff have already been trained and clinicians training booked for 21.3.16 and 27.4.16	30/05/16	31/12/16
Specific DVA policy developed	local	Develop policy	GP Practice	Complete	30/05/16	31/12/16