Domestic Homicide Review

Overview Report

Report into the death of Amy (pseudonym)

January 2021

Report Author and Domestic Homicide Review Chair: Stephen McGilvray

March 2024

Contents

Foreword

Amy was a warm hearted and kind person and was there for other people and the sympathies of the Panel go to all of Amy's friends and family.

Glossary

CMHT	Community Mental Health Team a co-located team of staff from Mersey Care mental health services and Adult Services.
DHR	Domestic Homicide Review.
G.P.	General Practitioner
GSF	Gold Standard Framework. GSF improves the quality, coordination and organisation of care leading to better patient outcomes in line with their needs and preferences
IMR	Independent Management Review
LivingWell	Is a free service with a focus on supporting people with issues that may be affecting their health and wellbeing. It is a collaboration of various Sefton organisations which have the expertise and knowledge to help people.
MDT	Multi-Disciplinary Teams comprising Adult Services and Mersey Care personnel.
NICE	National Institute for Clinical Excellence. Providing Evidence-based recommendations developed by independent committees, including professionals and lay members, and consulted on by stakeholders.
Non-CPA	Non-Care Program Approach used in support of people with mental illness but does not provide a single point of contact within treatment and support services for the individual.
RiO	Internal databased used within Mersey Care Services to record patient information.

1. Introduction

1.1 This report of a domestic homicide review (DHR) examines agency responses and the support given to Amy a resident of Sefton on Merseyside prior to the date of her murder in January 2021.

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

1.3 On an evening at the start of January 2021 Police officers investigating an incident on a nearby railway line discovered Amy lying on the floor of her home. She had been physically assaulted and was now dead.

1.4 Following a Home Office post-mortem examination, it was confirmed that Amy's cause of death was due to blunt force trauma.

1.5 Police Officers later arrested Amy's son Brian who was receiving treatment at hospital for injuries sustained in an attempt to take his own life.

1.6 Brian was initially detained under provisions of Section 2 Mental Health Act 1983 but in September 2021 was charged with the murder of Amy.

1.7 Brian appeared at Liverpool Crown Court in May 2022 charged with the manslaughter of Amy. Brian pleaded guilty to the manslaughter charge and in sentencing the Judge ordered that Brian be detained under two provisions of the Mental Health Act 1983, Section 37 Hospital Order and Section 41 Restriction Order.

1.8 The review will consider agencies contact/involvement with Amy, Brian, and Colin, who was Amy's husband and the father of Brian, from January 2018 until the point of her death in January 2021. This timescale was chosen because it includes the period of Colin's terminal illness diagnosis, "*he was the anchor for the family*", who later died from cancer in 2020.

2. Timescales

2.1 In January 2021 Merseyside Police notified Safer Sefton Together of the murder of Amy.

2.2 Members of the Safer Sefton Together agreed there was a requirement to complete a Domestic Homicide Review (DHR) in line with expectations contained within Multi-Agency Statutory Guidance for the Conduct of DHRs 2011 as amended in 2016.

2.3 In February 2021 the Home Office were notified of this decision.

2.4 An independent Chair for the Domestic Homicide Review was commissioned and appointed on 4th June, 2021.

2.5 The delay in completion of this report was at the request of the Police Senior Investigating Officer (SIO) following liaison with the Crown Prosecution Service (CPS) whilst decisions were made over whether or not Brian should face criminal charges and later over Brian's fitness to enter a plea to the charge of murder and the associated psychiatric reports that were required. The DHR Enquiries Team at the Home Office were informed of delays to this reports completion whilst awaiting conclusion of the criminal justice process.

3. Confidentiality.

3.1 Prior to Home Office approval for the publication of this Review its findings are confidential and information is available only to the Panel's participating professionals and their line managers.

3.2 The following pseudonyms were agreed by the Panel and by Amy's family and are used throughout this report to protect the identity of the individual(s) involved.

Amy	Deceased	Aged 81 years
Brian	Son perpetrator.	Aged 53 years
Colin	Husband of Amy and Father of Brian	Aged 85 years

3.3 All are white and their place of birth was the U.K.

4. Terms of Reference

4.1 In accordance with the statutory guidance for the conduct of Domestic Homicide Reviews (DHRs), the Panel agreed that the purpose of this DHR was to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations worked individually and together to safeguard victims.
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted upon, and what is expected to change as a result.
- Apply those lessons to service responses including changes to policies and procedures as appropriate.
- Prevent domestic violence and abuse homicide and improve service responses for all domestic violence and abuse victims and their children through improved intra and interagency working.

4.2 Following consultation with Amy's remaining family and the Panel's consideration of the chronology the following key lines of enquiry were agreed.

1. How effective was information sharing between agencies and information databases held by agencies and what impact did this level of effectiveness have upon the care of Brian.
2. Where this families risks and needs ever assessed in particular following Colin's diagnosis and subsequent death.
3. Was the appropriate level of support provided to Brian and his family and was the situation in which the family found themselves ever taken into account when making decisions regarding the level of support.
4. Could more mental health support and treatment have been provided to help Brian manage his illness?

5. Methodology

5.1 Having received notification of Amy's murder members of the Safer Sefton Together agreed there was a requirement to complete a Domestic Homicide Review (DHR) in line with expectations contained within Multi-Agency Statutory Guidance for the Conduct of DHRs 2011 as amended in 2016.

5.2 An independent Chair was appointed and a review Panel established.

5.3 Following the first meeting of the Panel, members were asked to secure all documents relating to their involvement with Amy and her family and to utilise those documents to complete chronologies of their involvement and contact with the family.

5.4 Panel members then completed independent management reviews (IMR) of their contacts with Amy and her family and during the course of this interviewed members of staff within their agency who had this contact.

5.5 Amy's family is a small and private family and the Chair of the review completed interviews with Amy's next of kin, her nephew.

5.6 After consideration of the IMR's Panel Members then produced a report based upon their Review which was shared with Amy's family prior to submission to the Home Office for quality assurance.

6 Involvement of Family, Friends Work Colleagues, neighbours and wider community

6.1 Amy and her family were a small and very private group. Amy had one sister who lived in Liverpool with her family.

6.2 Amy's only family were advised of the commissioning of this DHR and invited to meet Panel members which they declined. Information was provided to the family about advocacy provision which could represent them during the DHR but again declined this offer. The family did however, contribute information and their views to the DHR.

6.3 Brian was not interviewed during the course of this Review with clinicians declaring that he remained too unwell.

6.4 A copy of this overview report was shared with Amy's family and sufficient time permitted for them to review the document and make comment prior to the report being forwarded to the Home Office for quality assurance purposes.

6.5 Amy's family did share their views after reading the report and having initially felt that Brian had been "*let down*" by agencies the families overriding feeling now is that the greatest "*let down*" had been to Amy as they feel that services "*should have spotted the danger (presented by Brian) before it happened*" and should have provided higher levels of care and support to her.

7. Contributors to the Review

7.1 The following agencies submitted Individual Management Reviews (IMR) as part of the Review.

- Merseyside Police
- Southport and Ormskirk Hospital NHS Trust
- Living Well
- Mersey Care, NHS Foundation Trust

- Sefton MBC Adult Services
- Clinical Commissioning Group

7.2 The authors of the IMR's had no previous involvement with Amy or her family nor had they had direct supervisory responsibility for those engaged with the family.

8. Review Panel Members

8.1 The DHR Panel established by Safer Sefton Together comprised the following agency representatives:

- Neil Frackelton — Chief Executive Sefton Women and Children's Aid (SWACA).
- Natalie Hendry-Torrance — Designated Safeguarding Adults Manager, Sefton CCG
- Helen Smith — Head of Safeguarding Liverpool CCG
- Sarah Shaw; — Assistant Director for Safeguarding, Merseycare, NHS Foundation Trust.
- Gemma Kehoe — Named Nurse, Safeguarding Adults Southport and Ormskirk Hospital NHS Trust,
- Jan Herrity — Team Manager Adult Social Care, Sefton MBC.
- Paul Grounds — Detective Chief Inspector, Merseyside Police.
- Janette Maxwell — Locality Team Manager Sefton MBC.

8.2 The Panel also included Stephen McDermott who has over 10 years' experience working for a Sefton based mental health support group.

8.3 No member of the Panel had any contact with Amy and her family prior to this review nor did they have direct supervisory responsibility for staff within their agency who had contact with the family. The Panel met a total of 5 times

8.4 Contact was made with the carers who supported Colin in the final days of his life having been discharged from hospital and receiving palliative care in his home. Whilst their focus was critically upon the care and comfort of Colin none of the carers reported anything which caused them concern regarding Amy or Brian.

9. Chair of the Domestic Homicide Review Panel and Author of Report

9.1 Safer Sefton Together commissioned Stephen McGilvray to Chair the Review Panel and he was appointed in June, 2021. Stephen McGilvray is also the author of this Overview Report.

9.2 Prior to being commissioned to complete this Review Stephen had completed 30 years Police service with Merseyside Police. It was 17 years ago that Stephen retired from Merseyside Police.

9.3 On retirement from the Police Stephen was appointed as Head of Community Safety in a different Local Authority on Merseyside where he worked for nine years. Included within his area of management responsibility within that Authority was a multi-agency co-located team of professionals focussed on providing support to victims of domestic abuse and their families. This role included responsibility for the coordination and commissioning of services to meet the needs of domestic abuse victims and their children.

9.4 Whilst Head of Community Safety Stephen also had management responsibility for the Integrated Offender Management Unit a multi-agency collocated team of Police, Probation, and Substance Misuse workers whose role was to reduce the level of threat and risk posed by offenders, including perpetrators of domestic abuse.

9.5 Stephen has successfully completed the Home Office training course for Chairs of DHR's and has Chaired and authored Overview Reports for several Domestic Homicide Reviews as well as taking part in a number of Serious Case Reviews.

9.6 Before undertaking this Review Stephen McGilvray has not had any involvement with the individual's subject of this Review, nor is he employed by any of the participating agencies.

10 Parallel Reviews

10.1 The Coroner for Sefton was notified of the DHR commencing. The Coroner's investigation was later permanently suspended under schedule 1 of the Coroners and Justice Act 2009, due to a criminal prosecution being undertaken.

10.2 Mersey Care conducted a 72 hour Review and a Serious Incident Review following the death of Amy and some elements of those reports have with permission of the Review authors been included within this review.

10.3 A Mental Health Homicide Review was considered by NHS England, the CCG and Mersey Care. Their decision was that this case does not fit the criteria as it is felt there no concerns regarding care delivery that have been identified.

10.4 A referral was also made to Merseyside Safeguarding Adults Board for the consideration of a Safeguarding Adults Review. Once again it was felt that this case did not meet the necessary criteria.

11. Equality and Diversity

10.5 All aspects of equality and diversity Equality Act 2010 Protected Characteristics were considered throughout this review process.

10.6 Section 4 of the Equality Act 2010 defines protective characteristics as:

- **age** [for example an age group would include "over fifties" or twenty-one-year-olds. A person aged twenty-one does not share the same characteristic of age with "people in their forties". However, a person aged twenty-one and people in their forties can share the characteristic of being in the "under fifty" age range].

- **disability** [for example a man works in a warehouse, loading and unloading heavy stock. He develops a long-term heart condition and no longer can lift or move heavy items of stock at work. Lifting and moving such heavy items is not a normal day-to-day activity. However, he is also unable to lift, carry or move moderately heavy everyday objects such as chairs, at work or around the home. This is an adverse effect on a normal day-to-day activity. He is likely to be considered a disabled person for the purposes of the Act].
- **gender reassignment** [for example a person who was born physically female decides to spend the rest of her life as a man. He starts and continues to live as a man. He decides not to seek medical advice as he successfully 'passes' as a man without the need for any medical intervention. He would have the protected characteristic of gender reassignment for the purposes of the Act].
- **marriage and civil partnership** [for example a person who is engaged to be married is not married and therefore does not have this protected characteristic. A divorcee or a person whose civil partnership has been dissolved is not married or in a civil partnership and therefore does not have this protected characteristic].
- **pregnancy and maternity**
- **race** [for example colour includes being black or white. Nationality includes being a British, Australian, or Swiss citizen. Ethnic or national origins include being from a Roma background or of Chinese heritage. A racial group could be "black Britons" which would encompass those people who are both black and who are British citizens].
- **religion or belief** [for example the Baha'i faith, Buddhism, Christianity, Hinduism, Islam, Jainism, Judaism, Rastafarianism, Sikhism and Zoroastrianism are all religions for the purposes of this provision. Beliefs such as humanism and atheism would be beliefs for the purposes of this provision but adherence to a particular football team would not be].
- **sex**

- **sexual orientation** [for example a man who experiences sexual attraction towards both men and women is “bisexual” in terms of sexual orientation even if he has only had relationships with women. A man and a woman who are both attracted only to people of the opposite sex from them share a sexual orientation. A man who is attracted only to other men is a gay man. A woman who is attracted only to other women is a lesbian. So, a gay man and a lesbian share a sexual orientation].

11.3 Section 6 of the Act defines ‘disability’ as:

A person has a disability if;

[a] The person has a physical or mental impairment, and

[b] The impairment has a substantial and long-term adverse effect on their ability to carry out normal day-to-day activities

11.4 Amy, Colin and Brian were born in the United Kingdom and their ethnicity is White British. There is nothing in agency records that indicated that any of them lacked capacity in accordance with Mental Capacity Act 2005. Professionals applied the principle of Section 1 Care Act 2005:

‘*A person must be assumed to have capacity unless it is established that he lacks capacity*’

11.5 To ensure the review process considered issues around domestic abuse the panel included representatives from SWACA an organisation based in Sefton providing support to survivors of domestic abuse and their families.

11.6 Sex is relevant in this case since the victim was female and the perpetrator was male. The Office for National Statistics analysis of domestic abuse victims based upon findings from the crime survey for England and Wales revealed “*the victim was female in 73.5% of domestic abuse related crime*

recorded by the Police in the year ending March 2023 compared with 26.5% of domestic abuse related crimes where the victim was male" [1]

11.7 Brian had been diagnosed as suffering from a mental illness, treatment resistant schizophrenia, for which he was receiving ongoing medical treatment in the community. The Panel considered the influence this illness had upon the murder and additionally the impact the diagnosis and treatment had upon Amy, Brian's carer.

11.8 The Panel also considered the impact steps taken by H.M. Government to control the spread of the Covid 19 pandemic had upon the mental health of Brian and Amy.

11.9 During the work of the Panel no challenges had to be made by the Chair to any Panel member for a breach of equality standards.

12. Dissemination

12.1 In accordance with paragraph 79 of the Statutory Guidance for the conduct of Domestic Homicide Reviews following receipt of Home Office approval for publication, the Overview Report, Executive Summary and Home Office letter will be provided to Amy's next of kin and all other parties referenced in paragraph 79 of the Guidance who are listed within this report as Contributors to the Review.

13. Background Information

13.1 Amy was aged 81 years at the time of her death and had been married to her husband Colin, a former newsagent, for 60 years prior to Colin's death from

[1] https:www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/domesticabusevictimcharacteristicsenglandandwales/yearendingmarch2023.

cancer in 2020. No reports of domestic abuse were ever made involving Amy, Colin or Brian.

13.2 Amy along with her husband Colin was a former director of the Spiritual Assembly of the Baha'is of Sefton, before resigning in 2002.

13.3 Amy lived in her own home which she shared with her husband Colin and only child Brian in the Sefton area of Merseyside. Both Amy and Colin were retired.

13.4 Brian previously held a Directorship in a computer consultancy and supply business based in Liverpool. Financial reasons later forced the closure of that business.

13.5 In 1994 whilst working in Paris Brian attempted to take his own life. Due to this he ended his work in Paris and returned to live with his parents in Southport. Brian was in employment for a short while after a period in hospital but in 2007 Brian returned to his parents' home and had not worked since.

13.6 Brian was diagnosed as suffering from Treatment Resistant Schizophrenia which was managed in the community by means of medication, social exercise groups and monthly Clozaril monitoring appointments with Mersey Care Mental Health Services. Brian was managed using a non-Care Program Approach.

14. Chronology

Amy

14.1 Previously Amy had been a joint Company Director of a computer software consultancy and supply business with her son Brian which was established in 1992 and closed 4 years later in 1996.

14.2 Amy and Colin were both Directors of the Baha'is Faith in Southport but resigned those positions in 2002 and 2000 respectively. Friends from the Faith community describe Amy as a "*warm hearted"* and "*gentle"* person.

14.3 Colin who his G.P. described as "*very much the organiser of the family and the buffer between mother and son"* developed cancer and in February 2020 was diagnosed as being terminally ill.

14.4 Colin's G.P. defined the phrase that he was "*the buffer between mother and son".* Both Amy and Brian were described as *"hyper worriers"* and Colin was a much calmer individual who was able to manage down the hyper anxiety that Amy or Brian was feeling, restore calm for them and prevent transference of one person's hyper anxiety to the other person.

14.5 After being in hospital for two months at the end of July 2020 Colin was discharged from hospital to be cared for at his home by Amy and Brian with support from palliative nursing and care teams.

14.6 Both Amy and Brian at the request of Colin attended hospital to visit him during his inpatient stay and being in receipt of end-of-life care exceptions to the general visiting restrictions in place at that time were made for the family. Expected practice was followed by the hospital with Colin being GSF (Gold Standard Framework) registered, having an environmental risk assessment completed prior to discharge by the Therapy Team. Review of Colin's health records evidence that Colin's needs were fully assessed prior to discharge from hospital and that family were included in this assessment. There was however no carer's assessment's completed in respect of either Amy or Brian prior to Colin's discharge from hospital.

14.7 The Panel made contact with the District Nurses and Queenscourt Hospice staff supporting Colin and no concerns were identified regarding Brian's mental health or behaviour during their time supporting Colin.

14.8 In August 2020 less than three weeks after being discharged from hospital Colin died at home from his cancer.

14.9 Her husband's death had a significant effect upon Amy's mental health and family who travelled to Amy's home to support her describe how she was crying all the time. Amy's G.P. referred her to a social prescriber, LivingWell, for bereavement support but Amy didn't feel ready to engage with a bereavement service at that time and despite numerous attempts to engage with Amy she had little contact with the service at Livingwell.

14.10 As a service Livingwell work with clients for a 12-week period, but due to COVID this was relaxed and multiple attempts were made to engage 'Amy' with the service during the period September 2020 until shortly before her death in January 2021 but with limited success. LivingWell describe how Amy "*never initiated contact with our agency or asked for any additional support, this is uncommon within the Social Prescribing service, especially during Covid restrictions.*"

14.11 Amy's G.P. was appraised of the outcome of her referral by Livingwell at the conclusion of their involvement.

Brian

14.13 Brian was an only child and was living with his parents in Southport at the time of Amy's murder. He had no other family living in the immediate area. His hobbies and pastimes were largely solitary, visiting the cinema during the afternoon, going to the gym and for a meal alone in the pub on most Saturdays. Brian was however a keen member of a weekly walking group and cycling group both organised by the Community Mental Health Team (CMHT) in Southport which he began participating in during 2018.

14.14 With the outbreak of the Covid 19 pandemic and the country and services being placed into lockdown all the activities and pastimes supporting Brian's mental health were severely restricted. The stress these restrictions placed upon Brian was increased by his father's terminal diagnosis and eventual death which took place during this same period.

14.15 Colin's health condition worsened and during the height of the Covid pandemic Brian's father was admitted to hospital. Adjustments were made by the hospital to accommodate the family visiting Colin whilst he was receiving treatment as an inpatient despite Covid restrictions being in place restricting family visiting.

14.16 The impact of having his terminally ill father discharged from hospital and returned home and Colin's death very shortly after being discharged was that Brian is described by his family members as "*being lost*".

14.17 A family member describes how Brian had never shown violence to anyone else but that he had previously contacted him and told him that "*he wanted to kill himself."*

14.18 Acknowledging that the country was working to control the impact of the Covid 19 pandemic nevertheless the family member describes a feeling of Brian "*being let down*" after having all the support and activities especially the walking and cycling groups, which helped to moderate the impact of his schizophrenia, withdrawn from him.

15. Combined Chronology

15.1 Brian worked as an IT Consultant for a number of major companies throughout the UK and Europe, including in such places as Tunbridge Wells, Germany, Holland, and latterly in France. Whilst working in France he lived alone in an apartment in Paris. He became increasingly isolated, paranoid, and suicidal and in 1994, Brian left a suicide note for his parents after self-harming but he was discovered and formally detained in hospital in Paris. Brian returned to Southport that same year and lived with his parents where he reportedly remained depressed, paranoid and lacking interest, and was treated in a mental health unit of a Southport hospital as a day patient for a number of weeks.

15.2 After his return to England and at the end of his hospital treatment, Brian obtained employment in Blackpool where he stayed for just three weeks as he reportedly was not completely well at that point. He then worked at a car factory for a few months before finally moving to live in Holland in 1996 during which time he appeared to cope well for about a three-year period.

15.3 Over time, Brian had developed his own information technology company in which Amy became a Director, but was finally forced to sell it due to increasing financial losses. In 2004 Brian returned to Southport where he remained, living with his mother and father, and has not worked since.

15.4 Brian was admitted voluntarily to a mental health treatment facility at a local hospital in Southport in 2011 following a relapse in his schizophrenia. After a period of sustained stability he was discharged in March of that year.

15.5 Brian had been diagnosed as suffering from Treatment Resistant Schizophrenia. Clinicians deemed Brian to be low risk and requiring low-level support and his clinical needs were met via a non-CPA framework approach administered by mental health services. Following two different courses of medication which did not control Brian's schizophrenia Brian was prescribed Clozaril medication which if not carefully managed could have serious impacts on a patient's physical health. To safeguard against this risk, regular white blood cell monitoring is mandatory and Brian would attend for monitoring of his blood count levels through blood tests every month with Mersey Care. This remained Brian's medicinal treatment until Amy's murder.

15.6 As a result of being assessed as non-CPA a detailed formal risk assessment was not required for Brian. For those non-CPA service users such as Brian a 'Statement of Care' is completed typically by a clinician which provides a broad overview of the person's care, treatment and progress and this is copied to the patients GP.

15.7 Mersey Care Trust policy to manage the care of non-CPA patient's states.

- *The statement of care will be reviewed as and when required, up to a minimum of annually.*

- *For Service Users on Non-CPA there should be on-going consideration of need for CPA if risk/safety issues or circumstances change.*

15.8 Despite this clear policy Brian had not been formally reviewed by the CMHT, in accordance with the Trusts published non-CPA policy, for two years until one month before the murder of Amy.

15.9 Brian's father Colin a retired newsagent was described by his G.P. as "*the organiser of the family and the buffer between mother and son*" and he was a "*protective factor*" in Brian's mental health. A role Colin filled by calming Brian when he became seriously anxious or worried about issues and being the protective factor in Brian's life by organising appointments on behalf of Brian and seeing that all his medical requirements were being met. The calming and reassuring word Colin also gave when required to his wife Amy.

15.10 Brian requested, through the CMHT, the opportunity to join groups where he could meet new people, and as a result he became involved in walking and cycling groups. Since 2018 Brian had taken part in weekly walking and cycling groups in Southport facilitated by a memorandum of understanding between Mersey Care and Adult Services as therapy to manage his schizophrenia. A Social Care Support Worker would attend the groups and offer support to Brian by way of asking him how he was feeling and encouraging him to keep active for the good of his mental health.

15.11 Engaging in these groups resulted in Brian feeling better about himself and his parents observed a noticeable difference in him. However, following the death of his father Brian withdrew from attending the cycling and walking groups.

15.12 In January 2020 Brian's G.P. asked Mersey Care to undertake a review of Brian's schizophrenia "*due to a worsening of his symptoms*". Brian had not been formally reviewed by a psychiatrist since 2018 and at the time his G.P. made the referral Brian was noted to be suffering no psychotic symptoms or suicidal thoughts. The review was requested because of a failure to review Brian's health annually in accordance with Trust policy and Brian's worsening depressive symptoms.

15.13 The G.P. referral would have been received by the Single Point Access Team at Mersey Care who triage all referrals. The G.P. referral was acknowledged by Mersey Care and a record made that the referral had been passed on to the CMHT. There is no evidence to indicate if any action was taken by the CMHT as a result of the referral. This referral was not discussed in any Multi-Disciplinary Team (MDT) meeting and there is no evidence of the referral having been received by the community mental health team on the local division clinical information system or within MDT minutes.

15.14 In February 2020 Colin "*the protective factor in Brian's mental health"* was diagnosed as being terminally ill.

15.15 On the 23rd March 2020 the Prime Minister announced the first Covid "lockdown" in England. Instructing people that they must stay at home, and should only leave for essential reasons such as buying food and exercising once per day. The weekly cycling and walking groups that supported and helped to manage Brian's schizophrenia immediately stopped together with his other social activities, visits to the gym and cinema and meals at the pub, in accordance with the Prime Ministers instruction.

15.16 With the suspension of the cycling group Brian did not have access to a cycle with which to continue exercising and efforts to loan a cycle to Brian by his Support Worker also failed. From 1st April in order to ameliorate the impact of the cessation of the walking and cycling groups the Social Care Support Workers who led the groups made weekly telephone contact call with clients who were in receipt of treatment from Mersey Care for their mental illness. Brian was part of the group now in receipt of the weekly telephone call. Whilst this may not have been the best means of communicating with clients in light of the Covid restrictions it was the only way staff could maintain their contact with individuals. During one of the first phone contacts to be made the Support Worker noted that Brian "*sounded quite low and reported that he felt anxious*".

15.17 It should be noted at this point that the Social Care Support Worker developed a good supportive relationship with Brian and throughout the time he provided

that support Brian felt confident enough to make several disclosures about his mental state.

15.18 During later phone calls Brian also disclosed that his father would need to be admitted to hospital and the worry this raised amongst Brian and Amy.

15.19 In May 2020 during the weekly telephone support it was noted that Brian "*felt very anxious"* over father's illness and in June the Social Care Support Worker spoke to Amy who disclosed that "*Brian is struggling with his dad being ill".*

15.20 During the weekly telephone contacts with Brian held between April and June 2020 the level of anxiety disclosure now became more regular as Brian disclosed seven times that he was feeling anxious. Throughout 2018 and 2019 when Brian had regular contact with the same Support Worker at the cycling group entries made on the RiO system showed that Brian had never raised issues with the Support Worker regarding anxiety or low mood.

15.21 A review of the RiO database shows that the disclosures being made by Brian during this time resulted in additional support being offered to help Brian manage his anxiety levels. On two occasions prior to Colin's death the Support Worker discussed with Brian some coping mechanisms to help with his low mood and anxiety.

15.22 This level of support continued following Colin's death. On two further occasions Brian was again offered advice on coping mechanisms by the Support Worker. On two occasions when attending the Clozaril Clinic Brian was told of the opportunity open to him to contact the duty worker within the CMHT should he feel anxious and both Brian and Amy were twice offered bereavement counselling which they both declined.

15.23 In June 2020 Covid restrictions eased and the Social Care Support Worker recommenced the weekly walking and bike rides with Brian on a one to one socially distanced basis. During these weekly sessions the Support Worker would ask how Brian was feeling and Brian would thank the Support Worker for setting up the walking session and disclosed that going on the walks made

him feel better. Brian did inform the Support Worker on a number of occasions that his mood was deteriorating, and he was upset over his father's diagnosis. During one of the rides Brian disclosed that his week is dominated by his dad being ill. "*The family are all under pressure."* One month later in compliance with the Covid restrictions the bike rides had to stop once more.

15.24 Amy's G.P. records that in July 2020 Amy was suffering panic attacks due to the stress of her husband terminal illness. It was later recorded that during the period July – October 2020 Amy was frequently attending surgery suffering from a reaction due to the grief she was feeling from Colin's illness and subsequent death. The G.P. records that "*He (Colin) arranged everything and without him she was lost*." At the same time in the absence of the walking and cycling group support for Brian the telephone support resumed with him and he continued to disclose his feelings of anxiety.

15.25 However, Mersey Care remained unaware of the impact that Colin's illness and death was having upon Amy and the potential impact this would have upon Brian's mental health and wellbeing.

15.26 Additionally due to excessive workload pressures no follow up enquires were made by the G.P. practice into the outcome of the referral made to Mersey Care regarding Brian.

15.27 On 1st July the Social Care Support Worker records that he advised Brian that the support he had been receiving through the walking and cycling groups and the weekly telephone calls was coming to an end. Whilst the Support Worker discussed strategies with Brian for keeping him well there is no record available to provide clarity on why this support was ending.

15.28 At the end of July 2020 Colin was discharged from hospital to be cared for in his own home. However, during a telephone contact by the Social Care Support Worker on the day before Colin sadly died Brian disclosed that he was "*feeling low having learnt that father instructed medical staff that he did not want to be resuscitated should that need arise*".

15.29 In mid-August 2020 Colin died.

15.30 Covid lockdown restrictions on services continued and the Social Care Support Worker's weekly telephone support to Brian continued after his father's death. In September 2020 during the telephone call, Amy answered the call and she described how his father's death was affecting Brian**.** An offer was then made for Amy and Brian to receive bereavement counselling support but this was declined at this stage. The same month Amy's G.P. referred her for support to a social prescriber, LivingWell to support her following Colin's death.

15.31 In September 2020 when attending the monthly Clozaril Clinic Brian reported feeling depressed and in a low mood due to recently losing his father. Face to face appointments continued to operate at the Clozaril Clinic throughout the Covid periods of lockdown and Brian was asked by clinicians at the Clinic if he would like to speak to someone from the duty mental health team regarding his low mood and depressive state. He declined this offer but stated that he would contact them if he feels the need to talk.

15.32 Brian disclosed during the weekly telephone call to support him in October 2020 that he was "*coping but it was hard*". He disclosed that he was feeling stressed about how Colin's death had impacted upon him and Amy he said he "*is coping but finding things a struggle."* The Support Worker ensured that Brian had the contact details of services if he needed support in a crisis.

15.33 Later in October 2020 during the support call with Brian he reported feeling stressed and described how Colin's death had affected his mother. Bereavement Counselling was again offered to support Brian and Amy but was declined at this time.

15.34 The Social Care Worker's contact with Brian in October 2020 was the 17th time since April 2020 during which Brian had disclosed that he was "*feeling stressed, anxious or suffering low mood*". These disclosures were not made at every meeting or contact Brian had with his Support Worker or staff at the Clozaril Clinic and during some contacts Brian reported no issues at all.

15.35 In October 2020 the weekly telephone support stopped and no contact, apart from an Out Patient appointment in December 2020 and his monthly Clozaril

Clinic appointments, was made by any services with Brian or Amy until Amy's murder.

15.36 During 2020 services made offers of support to Brian and Amy. Advice on coping strategies, access to the duty mental health team, bereavement counselling and a referral of Amy to a social prescribing service, Livingwell. Access to the duty mental health team and bereavement counselling were never acted upon by either Brian or Amy and contact with the social prescribing service by Amy was very limited. Whilst Brian was advised how to make contact with the Duty Mental Health worker by phone if at any stage he felt the need for additional support as already stated within this report Brian required proactive care requiring others to make the appointment for him, a role previously filled by his father. Therefore as Colin's terminal illness progressed and following Colin's death the likelihood that Brian would make contact with the Duty worker reduced. No formal risk or care assessments were undertaken with Brian or Amy during this time.

15.37 At the end of October 2020 a second national lockdown was announced by the Government and the outlets and support activities helping Brian to manage his illness again closed. Telephone contacts made by the Support Worker also ceased in October 2020. Records show that the ending of support was approved as mental health services deemed that "*Brian was at this time stable and actively engaging with community services"*.

15.38 Community Services were significantly reduced at the time that such a decision was made. There is no evidence that, in light of the restrictions accompanying measures to reduce the spread of the Covid virus and Colin's recent bereavement, this decision was reviewed.

15.39 In December 2020 an outpatient's review was conducted with Brian via telephone. The review was completed by a qualified Doctor in clinical training with Mersey Care. In addition to their induction, robust training program and ongoing supervision by a Consultant provided by Mersey Care the Doctor will have already completed a medical degree and foundation training, and have anywhere up to eight years' experience working as a hospital doctor. At the

end of the appointment Brian reported "*No concerns.*" However, it was noted by the Doctor that Brian had disclosed that three weeks earlier he had auditory hallucinations commanding him to kill himself but these hallucinations had now stopped and he confirmed he had no intention on acting on them. The clinician also recorded that Brian *"reported feeling "up and down", lacking motivation. He states that he feels that he has lost his energy sometimes. He mentions that he sleeps 11 hours on average".*

15.40 There is no record to show that during the outpatient's consultation the impact of Brian's father's illness and subsequent death, or that the impact of Covid restrictions and national lockdown had upon Brian's health were considered. The Serious Incident Review records that *"it is not evident from the clinical information as to whether previous information reported by Brian was shared with the medic in advance or was shared by a member of the CMHT as part of the outpatient review process, or whether Brian was simply taken to be a reliable and open historian in the reporting of his own mental health*."

15.41 This outpatient's review is the first record of any formal reassessment of Brian's illness since 2018 and since his G.P. requested a further assessment be undertaken in January 2020 "*due to a worsening of his symptoms".*

15.42 At the start of January 2021 the Prime Minister announced the third national Covid related lockdown which again restricted the activities available to Brian to help manage the impact of his schizophrenia. Weekly contact by the Social Care Support Worker which had stopped in October 2020 did not recommence with the announcement of the latest lockdown. Neither is there evidence that Brian re-engaged with the walking and cycling groups during the period in between the second and third national lockdown.

15.43 In late January 2021 42 days after the Doctor carried out the telephone review Brian attempted to take his own life by falling from a bridge at a railway station in Liverpool. He survived the fall but required treatment for serious injuries he had sustained. Police Officers dealing with the incident went to Brian's home to inform his mother of the incident and her son's injuries. There they

discovered Amy lying on the floor in her home and, having suffered serious head injuries, was now dead.

15.44 After discharge from hospital following treatment for the physical injuries sustained in the fall Brian was detained under provisions of the Mental Health Act 1983. Clinicians concluded that Brian lacked the capacity to make decisions regarding a voluntary admission to hospital. He presented with a mental disorder of a nature and degree that warranted admission to hospital under Section 2 Mental Health Act 1983. At that time, he was also at risk of further mental health deterioration, risk to self, self-neglect and potentially a risk to others.

15.45 In June 2021 clinicians deemed Brian fit enough to be interviewed by Police Officers investigating his mother's death. When interviewed Brian made a full and frank admission to causing the death of his mother Amy telling officers that in the weeks before Amy's murder he had been "*hearing voices to end his mother's pain*" following the death of her husband. He believed his mother was shouting daily that she wanted to kill herself. He believed "*Satan*" was trying to harm him and his mother.

15.46 Brian continued to be detained in hospital under provisions of the Mental Health Act but following consultation with the Crown Prosecution Service in September 2021 Police Officers charged Brian with the murder of Amy.

15.47 During the first quarter of 2022 a number of Court hearings were held to decide upon the question of Brian's fitness to enter a plea to the charge of murder.

15.48 Following psychiatric reports requested by the Court it was agreed that Brian had been suffering from an abnormality of mental functioning at the time of the murder and the Crown Prosecution Service decided that it was not in the public interest to pursue the charge of murder against Brian on the grounds that there was not a realistic prospect of conviction on that charge. The charge was then reduced to one of manslaughter.

15.49 In March 2022 Brian pleaded guilty to the manslaughter of Amy. The criminal justice proceedings were concluded at Liverpool Crown Court in May 2022 when the Judge ordered Brian to be detained under a Hospital Order defined by Section 37 of the Mental Health Act and a Section 41 Mental Health Act Restriction Order. As a result Brian will only be discharged from the mental health unit were he is detained if his responsible clinician and the Ministry of Justice declare that he no longer poses a risk to the public.

16. Overview

16.1 Brian had been diagnosed as suffering from treatment resistant schizophrenia and a non-Care Programme Approach was taken towards his treatment which included medication, in recent years changed to Clozaril which was monitored monthly for its impact upon Brian's physical health, and participation in walking and cycling groups were he received support from a Social Care Support Worker.

16.2 Brian was an only child and lived with his parents both of whom were of retirement age at their home in Southport. In January 2020 Brian's G.P. requested a review be undertaken of Brian's schizophrenia "*due to a psychiatric review last being undertaken in 2018 and a worsening of his symptoms*" related to his feelings of depression. One month later Brian's father who played a pivotal role in the family and described by the G.P. as being "*the protective factor in Brian's mental health"* was diagnosed as being terminally ill.

16.3 Shortly after receiving this diagnosis concerning his father, weekly activities, cycling and walking groups, which Brian attended to assist in the management of his schizophrenia were affected by the national lockdown to prevent the spread of Covid 19 virus and all such activities stopped and replaced by weekly contact calls made to Brian by his Support Worker.

16.4 During the months leading to Colin's death in August 2020 Brian and his mother Amy frequently disclosed feelings of anxiety during the weekly

telephone support calls made to Brian by a Social Care Support Worker from Adult Services. These disclosures were recorded by the Social Care Support Worker on the Adult Services database and on the RiO system, a database operated by Mersey Care.

16.5 The referral sent to Mersey Care in January 2020 by Brian's G.P whilst recorded as being received by Mersey Care, was never acted upon and no review ever took place. The lack of action on the referral to Mersey Care was not followed up by Brian's G.P.

16.6 In response to the disclosures of low mood and anxiety being disclosed by Brian clinicians at the Clozaril monitoring clinic advised Brian to make contact with the Duty Support Worker in the CMHT when feeling anxious or of low mood. This advice to Brian from the Clozaril Clinic was however never communicated by the Clozaril Clinic to the CMHT and there is no record of Brian seeking help from the duty support worker within the CMHT.

16.7 Two months after Colin's death the telephone support calls, introduced in order to lessen the impact of the cancellation of the weekly cycling and walking groups caused by Covid restrictions, to Brian ceased. At a time when community services were significantly reduced and in Brian's case stopped completely due to the commencement of a third period of national lockdown it was deemed that Brian was at this time stable and actively engaging with community services. The decision to end this support was never reviewed in light of changing Covid restrictions and contact from the Social Care Support Worker who had worked and supported Brian since 2018 did not recommence at any time prior to Amy's murder.

16.8 In January 2021 Brian murdered his mother. In the weeks leading up to the murder Brian disclosed that he had been suffering from "*auditory hallucinations. He believed his mother was shouting daily that she wanted to kill herself. He believed "Satan" was trying to harm him and his mother".* Brian then tried to end his own life falling from a railway bridge nearby which he survived but suffered significant physical injuries from.

17. Analysis

17.1 Brian was diagnosed to be suffering from treatment resistant schizophrenia and in receipt of a non-CPA regime of continuing treatment at the time of Amy's murder. Following his diagnosis of schizophrenia Brian had been prescribed other medication but these had failed to prevent break though psychotic events and other side effects. Brian had therefore been prescribed Clozaril medication which had remained unchanged during the period of this review.

17.2 Schizophrenia affects the way a person thinks, feels and behaves. The most well-known symptoms of schizophrenia are hallucinations (hearing or seeing things that do not exist) and delusions (unusual beliefs that are not based on evidence). Other symptoms can also include problems with mood and a dulling of emotions. "Individuals diagnosed with schizophrenia are more likely to hurt themselves than those in the general population." [2]

17.3 Research has also found that *"it is the case that people living with schizophrenia are more at risk of dangerous behaviour such as suicide or violence while they are poorly. When a person with schizophrenia becomes violent the victim is usually someone from their own family or someone else close to them such as a carer*." [3]

17.4 A key line of enquiry considered how effective the level of information sharing between agencies was and what impact did this have upon the effectiveness of treatment provided to Brian.

17.5 In January 2020 due to a worsening of his depressive illness, a symptom of his schizophrenia, and a two year gap since Brian had been last reviewed by a psychiatrist a request that a review of Brian's mental illness be undertaken was forwarded to Mersey Care by Brian's G.P. The request from the G.P. was recorded as being received by Mersey Care. Although the referral was acknowledged and an entry made that it had been passed on to the CMHT,

[2] Vita A, Barlati S, De Peri L, Deste G, Sacchetti E Schizophrenia Lancet. 2016. BJP,vol180,issue 6 June 2002 pp490-495. Pubmed.ncbi.nlm.nih.gov

[3] Buchanan A, Fahy T, Walsh E, 2002, Violence and schizophrenia: examining the evidence, Published in the British Journal of Psychiatry.

there is no evidence to indicate that any action was taken by the CMHT, upon receipt of the referral letter. This referral was not discussed in any MDT meeting and there is no evidence of the referral having been received by the community mental health team on the local division clinical information system or within MDT minutes.

17.6 The G.P. referral was made and the receipt acknowledged by Mersey Care two months prior to any restrictions and changes to operating procedures including remote working resulting from Government Covid restrictions taking place. Mersey Care have no explanation to offer why this referral was not acted upon.

17.7 Due to excessive workload pressures no follow up enquires were made by the G.P. into the outcome of the referral made to Mersey Care regarding Brian.

17.8 Since 2018 Brian had received additional support in managing his illness through participation in the Active Sefton Teams walking and cycling groups. Facilitated by a memorandum of understanding between Mersey Care and Adult Services whilst Brian was not an open case with Adult Services the Support Worker and Adult Services were aware that Brian was receiving treatment for a mental illness from Mersey Care.

17.9 The walking and cycling groups were a mixture of people. Those like Brian for whom exercise helped to moderate the symptoms of their illness and other members of the public seeking the benefit of a healthy lifestyle. During the periods of national lockdown to control the spread of the Covid virus the walking and cycling groups stopped completely and in Brian's case were replaced by weekly telephone support calls which were made by the same Support Worker who accompanied Brian on the cycling and walking group activity.

17.10 Brian had the benefit of support from the same Social Care Support Worker who maintained weekly contact with Brian between 2018 until this weekly contact stopped in October 2020. Brian is recorded on a number of occasions to have expressed how valuable the Support Worker had been to him and

prior to ending his support to Brian the Support Worker did encourage Brian to reconnect with the cycling group which Brian said he was exploring doing and the Support Worker also provided contact telephone numbers for services should he need them in times of crisis.

17.11 Though Brian was not officially allocated to the support worker's caseload the Social Care Support Worker and Adult Services were aware that Brian was receiving treatment from Mersey Care Mental Health Services and the Support Worker did have access to and did record information on the Adult Services and Mersey Care information systems following each contact with Brian.

17.12 Each contact with Brian reported not only what was disclosed to the Social Care Support Worker but also details what action the Support Worker took following the contact with Brian. The majority of entries recorded by the Social Care Worker under the heading of Action Taken used the phrase, "*no issues reported*". What becomes clear is that the Social Care Support Worker was engaging well with Brian during the walking or cycling group and during the weekly telephone contacts introduced during periods of Covid lockdown.

17.13 During the period January – April, 2020 "*no concerns*" were recorded following the Support Workers contact with Brian. However, throughout the period April – October 2020 Brian was disclosing, more frequently, levels of low mood and anxiety surrounding the loss of access to the cycling and walking groups due to Covid restrictions and his father's terminal diagnosis. On no fewer than 17 occasions during this period Brian disclosed "*feeling anxious, suffering from low mood or feeling stressed."*

17.14 Mersey Care report that fluctuations in Brian's mood ranging between no issues to report to disclosing feelings of anxiety and low mood are a common feature of Brian's history with Mental Health Services. Additionally, the disclosures of low mood following Colin's death were seen by Mental Health Services as a grief reaction to his father's death and were not judged to be outside of "*normal*" parameters for Brian.

17.15 However, training records have been examined and it has been established that the Support Worker had received no mental health, or risk assessment training, in preparation for this role and the likelihood of receiving such information. It is acknowledged by the Panel that whilst forming part of the CMHT and working in a multi-agency co-located office the Social Care Support Worker would have gained some knowledge useful to his role in supporting Brian. The Support Worker recorded all the disclosures made by Brian onto the Mersey Care and Adult Services databases, thus both organisations were in receipt of an increasing body of evidence that Brian's incidents of low mood and anxiety were becoming more frequent.

17.16 Mersey Care reflect that the failure to respond to the disclosures Brian was making and which were included on the RiO system was also due to the fact that the change in levels of risk or needs were not brought to the attention of a Multi-Disciplinary Team meeting or raised in supervision meetings between the Support Worker and his manager.

17.17 During interviews with Adult Service staff who had supervisory responsibility for the Support Worker working with Brian the independent management review identified that those supervisors were not aware of the disclosures being made to the Support Worker during telephone calls or one – one socially distanced walks, with Brian during the period of Covid restrictions.

17.18 From 23rd March 2020 governmentally imposed restrictions to combat Covid, included restrictions on office-based working with staff from many service areas now working remotely from home. It is acknowledged that this may have contributed to less effective communication and information sharing and the withdrawal of normal interpersonal office interaction and contact with supervisors which in turn may have impacted upon a referral being made of Brian to MDT for assessment.

17.18 Notwithstanding this it is acknowledged that this case should have been discussed within the Support Workers supervision sessions. This did not occur and whilst the Support Worker made entries on the Adult Services

information system this system was not routinely monitored by the Support Workers supervisor. It should also be noted that whilst face to face appointments at the Clozaril Clinic continued throughout the Covid restrictions the normal practice of the validation of disclosures entered onto the RiO database by a qualified mental health practitioner were suspended during the periods of Covid restrictions. Therefore despite the diligent recording of disclosures by the Care Worker assessment of the disclosures being made by Brian did not take place.

17.19 In July 2020 for the first time the Support Worker informed his team manager that he had been supporting Brian in the community since April and detailed the disclosures Brian had made during that time. The team manager instructed the Support Worker to refer Brain to be assessed so that his needs could be identified and so that Brian may receive support from the re enablement team. Had this instruction been followed Brian would have undergone assessment to establish if there was a need for his treatment and support regime to change and potentially for Brian to be supported through a full CPA approach.

17.20 There is no documented evidence to indicate that this instruction was followed and a referral for assessment made. Nor is there any evidence that the supervisor instructing the Social Worker made any checks to establish if the instruction had been carried out. The Panel do recognise the strain that Covid restrictions placed upon effective communication between and amongst the Community Mental Health team members as team members were no longer co-located and staff within those service areas were working from their home which may have impacted upon the supervisors instructions being carried out.

17.21 It was not possible, due to the Support Worker who worked with Brian since 2018 being absent from work due to illness, for the Panel member completing their services IMR to interview him and obtain an explanation for omitting to make the referral.

17.22 What this period illustrates is that communication between the Support Worker, his supervisors and the CMHT during the period January 2020 until

Amy's murder in January 2021 could have been far more robust. Information was held which may have changed the level of support Brian was receiving but it was never recognised or acted upon.

17.23 There are currently no service standards in place for the joined-up sharing of information across the CMHT and the Clozaril clinic pathway. This includes information detailing the monitoring, flagging and reviewing those many service users such as Brian, who are deemed non-CPA but who may continue to be symptomatic. Those patients who despite functioning independently, are seen periodically as an outpatient, but may not have been formally reviewed and discussed within an MDT context for a significant period. In the case of Brian there had been a "*lack of clinical oversight since 2018."*

17.24 Mersey Care and Sefton Adult Services each have different operating systems on which they record client information and detail. Data is however, not automatically shared between these systems and gaps in information held by the two systems regarding Brian is present. The decision to end one-to-one cycling and walking support, so important to Brian in helping him to manage his schizophrenia a short time before Colin's death is not included as a potential risk on the Mersey Care RiO system.

17.25 A Public Health England report on the impact of Covid restrictions underlined the impact upon an already anxious Brian that the suspension of the cycling and walking groups for a second time may have had.

"*Individuals may be unable to access usual social networks that could provide support and may experience increased loneliness and isolation. Additionally, pressures on health services have led to disruptions to existing mental health services and reductions in use by individuals. All of these factors are linked with higher rates of self-harm, suicide and poor mental health outcomes."* [4]

17.26 Such omissions on key databases increases the risk that warning signs in the escalation of risk within Brian's family are missed and opportunities or the need for assessment and for intervention not taken.

[4] www.gov.uk/government/publicmentalhealth-uk.org

17.27 Brian did continue to attend his monthly Clozaril Clinic appointments, one of the few services which because of the nature of its work maintained face to face contact during the Covid pandemic. Records show that both the Clinicians at the Clozaril Clinic recorded that at the clinic on 3rd November 2020, and following the Out Patients appointment with a trainee G.P. (This clinician was already a qualified Doctor but was undertaking training to become a G.P.) in December 2020 Brian reported suicidal thoughts and some auditory hallucinations to harm himself. However, clinicians were reassured by Brian that he had no intentions of acting on them. Staff were significantly reassured by Brian's intentions and therefore did not refer the disclosures to the Multi-Disciplinary Team meeting for further exploration and consideration. Mersey Care acknowledge that these failures to act were missed opportunities for a Multi-Disciplinary Team review of Brian's health to be completed.

17.28 Much of the information concerning disclosures made by Brian regarding his anxiety and low mood during the period April – October 2020 was held on the Adult Services and Mersey Care database's which against such entries regarding a low mood or depression disclosure was included a result that "*No issues reported*" or "*arranged further appointment*." There is no record of this information being shared with Brian's G.P. by either Adult Services or Mersey Care.

17.29 A second key line of enquiry which the Panel reviewed was if the risks and needs of Brian and his family were ever assessed in particular following Colin's diagnosis and subsequent death.

17.30 No formal CMHT reviews were held, during the three year period the Panel reviewed, concerning the treatment of Brian's schizophrenia. The rationale given for this lack of formal review was that "*Brian deemed to have low level psychotic symptoms that were being managed via the Clozaril Clinic. Despite his frequent expression and acknowledgement of low mood and at times suicidal ideation, this was deemed to be 'the norm' for Brian."*

17.31 A review of records from the monthly Clozaril blood screening appointments showed that white blood cell levels had reduced in Brian's system when

testing was carried out in April 2020 which was recorded as being below the lower level of the recommended therapeutic range. Whilst monthly monitoring of Brian's white blood cell levels via the Clozaril Clinic continued up to the time of Amy's death records show that no additional action was taken following this result. The Serious Incident Review acknowledged that the administration of Clozapine in Brian's case was "*well managed and there were no significant breakthrough symptoms experienced*."

17.32 The reason given to the Serious Incident Review for the absence of any further action beyond continuing attendance at the Clozaril Clinic each month is that "*there was no mechanism for this test result to trigger a Multi-Disciplinary Team discussion since Brian was non-CPA."*

17.33 The Panel have been unable to find evidence to show that the physical risk to Brian that a reduction in white blood cell levels was reviewed in conjunction with other issues impacting Brian's health and wellbeing at this time. The terminal diagnosis of his father and the withdrawal of supportive walking and cycling groups and other social activity due to Covid restrictions being imposed.

17.34 Mersey Care acknowledge that "*there was no evidence that consideration of a different approach was needed especially in those combined circumstances and that there was a lack of enquiry into the cause and effect of changes in medication levels."*

17.35 Mental Health U.K. provide guidance on the treatment of schizophrenia including that "*You should review your medication with your doctor at least once a year*".[5] A review of information provided by Brian's G.P. and Mersey Care indicated that no formal review of medication had ever taken place since 2018. The Mental Health U.K. statement places the onus upon the patient to take action but we know from the G.P. notes that Brian required proactive

[5] Mental Health U.K. Treatment for Schizophrenia. Help-and-information/conditions/schizophrenia/treatment

care, requiring others to make the appointments for him thus making a self-referral by Brian unlikely.

17.36 Following Brian's arrest, a review his medication was undertaken and his medication was increased as a result.

17.37 NICE Guidelines on the treatment of schizophrenia published in 2014 recommends services *"routinely monitor for other coexisting conditions, including depression, anxiety and substance misuse particularly in the early phases of treatment."* [6]

17.38 Despite clear NICE Guidance and Brian's disclosures to services of anxiety and low mood there did not exist at any point during the period under review a care plan or any risk assessment for either of Brian's parents. Nor apart from a hospital outpatient's appointment in December 2020 was a formal review undertaken of Brian's health and wellbeing.

17.39 The Serious Incident Review includes a statement on the management of need and risk within Brian's family. "*There is no indication that a formal Carers Assessment had been offered, considered or carried out. This would have been particularly pertinent following the death of Brian's father, given the associated stressors and emotional grief reaction following this significant event for both Brian and his mother, who had openly expressed her struggle in adjusting to life following her husband's death.*"

17.40 There are no records of a formal assessment ever being completed examining the impact that various traumas were having upon the family. Brian's suicide attempt whilst living in Paris, his diagnosis of schizophrenia and the impact of Brian's return to living with his parents following that diagnosis and their help in managing Brian's illness. The impact that Covid restrictions had upon the management of Brian's illness and the terminal diagnosis and subsequent death of Colin. The family unit was never formally assessed for its needs in light of such traumas. Nor was the increased

[6] National clinical guidance number 178 national collaborating centre for mental health commissioned by the national institute for health and care excellence P40

frequency of disclosures of anxiety and low mood disclosed by Brian ever considered in the context of what was happening within the family unit.

17.41 Furthermore Mersey Care remained unaware of the negative impact that Colin's illness and death was having upon Amy and were therefore unsighted on the potential impact this may have had upon Brian's mental health and wellbeing.

17.42 In addition to NICE guidance, policy within the Local Authority is that following a family member's terminal diagnosis Adult Services would offer the family a carer's assessment which in this case would be applicable to both Amy and Brian. There is no evidence in the Local Authority records to suggest that consideration was given to Brian and Amy receiving or being offered a carer's assessment.

17.43 To summarise the outcome of this key line of enquiry. Despite NICE guidelines for the treatment of schizophrenia and an increase in the frequency of disclosures regarding anxiety and low mood raised with services treating Brian the Panel could find no evidence of a formal review of care or treatment needs ever taking place for Brian and his family.

17.44 Part of this review was also to establish if the appropriate level of support was provided to Brian and his family and if the situation in which the family found themselves ever taken into account when making decisions regarding the level of services support.

17.45 Brian illness was managed within the community and he was afforded a non-CPA level of support. Treatment that Brian received was the prescribing of Clozaril which is an anti-psychotic treatment specifically designed for treatment resistant schizophrenia. Monthly monitoring of the physical impact of Clozaril, and support to engage in outdoor activities associated with a local walking and cycling group as an aid to the management of his schizophrenia.

17.46 Amy is described in G.P. notes as suffering an acute grief reaction: "*He (Colin) arranged everything and without him she was lost"* and that between July and October 2020 Amy was a frequent attender, contacting the surgery

every few days, often in tears. Both Brian and Amy were offered bereavement counselling on two occasions following Colin's death but felt unable at the time to take up those offers. On two occasions during Colin's illness and following his death Brian was provided details of the duty mental health worker within the Community Mental Health Team who he may contact for support at a time of crisis but the Panel could find no indication that a formal review was ever discussed or considered in respect of Amy or Brian's needs given the heightened levels of anxiety within the family and previous observations by Brian's G.P. That Colin was "*the buffer*" between Amy and Brian and the impact that the loss of that "*buffer*" may have had upon the escalation of anxiety levels within the family.

17.47 In July 2020 the Support Worker advised Brian that his support via the cycling or walking groups and the telephone calls would be ending. This support, with the same Support Worker, had been in place since 2018. There is no information available to the Panel to indicate why this support was being withdrawn but it is acknowledged that following Colin's death the next month the Support Worker continued working with Brian for a short time longer.

17.48 In October 2020 the support given to Brian by the Social Care Support Worker stopped. The rationale for ending this weekly support in October 2020 was *"that it was deemed that Brian was at this time stable and actively engaging with community services*" having been provided with contact details of services should he need to contact them in a time of crisis. The ending of this support took place two months after the death of Brian's father Colin and the only support that remained following this ending of Social Care Support Worker contact and engagement was the monthly Clozaril Clinic testing.

17.49 The only community services Brian had been engaged with was the weekly contact with the Social Care Support Worker and this had now stopped. During the weeks following his father's death Brian disclosed to the Social Care Support Worker who entered this information onto the RiO and Adult Service database's that he was feeling low about things. He reported feeling depressed at this time. He spoke of the passing of his Dad and said that he was coping but it was hard, Brian reported that he was feeling stressed at this

time, he discussed his feelings around the loss of his Dad and how it had affected him and his Mum, he said that he is coping but he is finding things a struggle.

17.50 Brian did not take part in a clinical review prior to this decision to withdraw support, nor was the decision made by the MDT. It is not clear what information was relied upon to adjudge that Brian was "*stable*" at this time nor which community services Brian was now actively engaging with since the Social Care Support Worker provision had been withdrawn. There was not a tapered approach to reducing support and no alternative means of direct support were provided for him. The decision was not reviewed following the Government decision to introduce another period of lockdown in England. Neither was a formal review completed as to how Brian was coping following the withdrawal of the Support Worker nor the acute grief reaction that Amy had to Colin's death in the weeks and months following the ending of that support.

17.51 In December 2020 Brian did receive an outpatient's appointment conducted via telephone with Mersey Care, 12 months after his own G.P. requested a review of Brian's schizophrenia, because of Brian's worsening depressive symptoms, and 42 days before the murder of Amy. At the conclusion of the outpatient's appointment the clinician recorded that Brian had "*no concerns*" regarding his health and there was nothing of concern highlighted by the Doctor in their recording of the outpatient appointment.

17.52 There is no record within the clinical notes from this outpatient appointment indicating that the review first requested by Brian's G.P.in January 2020 due to a worsening of Brian's schizophrenia was considered or discussed at this appointment. It is not evident from the clinical information as to whether previous information reported by Brian, disclosing feelings of low mood, anxiety and struggling to cope, which was held on the RiO database was shared with the trainee G.P. undertaking the review in advance or if it was shared by a member of the CMHT as part of the outpatient review process, or

whether Brian was simply taken to be a reliable and open historian in the reporting of his own mental health.

17.53 It is therefore not possible to establish if the situation that Brian and his mother found themselves in at the time of the outpatients review in December 2020 five months after the death of Colin and one month before Amy was murdered was ever considered as part of a holistic assessment of the support the family needed at this time. This outcome compounded the fact discussed earlier within this report that there is no indication that a formal Carers Assessment had ever been offered, considered or carried out for Colin and Amy

17.54 The National Institute for Health and Care Excellence published guidance entitled, "Psychosis and schizophrenia in adults: prevention and management**"** This guidance includes reference to the support for carers in which it states.

"Offer carers of people with psychosis or schizophrenia an assessment (provided by mental health services) of their own needs and discuss with them their strengths and views. Develop a care plan to address any identified needs, give a copy to the carer and their GP and ensure it is reviewed annually."

"Building trust and continuous dialogue with healthcare providers was important for both ensuring and facilitating care for the service users, as well as to ensure that their own needs as carers were recognised and met." [7]

17.55 Whilst the Panel acknowledge that if effective contact had been established between Livingwell and Amy many outcomes from a carers assessment, the provision of counselling, bereavement support, and other ongoing support may have been achieved the NICE guidance does not appear to have been

[7] National clinical guidance number 178 national collaborating centre for mental health commissioned by the national institute for health and care excellence P41

followed in this case and no explanation is recorded for the failure to offer, consider or carry out a formal Carers assessment.

17.56 The Serious Incident Review records that "*from 2017 onwards there is a noticeable absence of clinical oversight of Brian's care and treatment*." The rationale given by clinicians at Mersey Care Mental Health Services for this was that Brian "*was deemed to have low level psychotic symptoms that were being managed via the Clozaril Clinic. Despite his frequent expression and acknowledgement of low mood and at times suicidal ideation, this was deemed to be 'the norm' for Brian"*. It would appear that this rational was a fixed and never challenged, reviewed or considered for change by Mersey Care and makes no consideration of the events of 2020 that impacted upon Brian and his family.

17.57 Mersey Care Trust Policy relating to Brian and other patients being managed as non-CPA patients is that

- *The statement of care (replaces risk assessment in Non-CPA patients) will be reviewed as and when required, up to a minimum of annually.*

- *For Service Users on Non-CPA there should be on-going consideration of need for CPA if risk / safety issues or circumstances change.*

17.58 It is clear that Trust Policy was not followed in this case.

17.59 An absence of clinical oversight of Brian's care and treatment. The apparent failure to follow Trust policy for the management of non-CPA patients, and National Institute for Health and Care Excellence "Psychosis and schizophrenia in adults: prevention and management" published guidance. Taken together it is difficult to establish that the appropriate level of support was provided to Brian and his family for the trauma's that they as a family had and were suffering and if the situation in which the family found themselves was ever taken into account when making decisions regarding the level of services and support.

17.60 The Panel also considered if more mental health support and treatment could have been provided to help Brian manage his illness?

17.61 The Panel accept the restrictions imposed in trying to reduce and control the impact of the Covid pandemic and the challenges this presented to services in the community that supported Brian's management of his illness. Whilst also acknowledging the significant benefit Brian obtained from the Social Care Support Worker.

17.62 At several points throughout this review it appears that the conduit for more help and support to help Brian manage his illness was the MDT and the review they would have conducted. However, in the three years reviewed during this DHR Brian was never reviewed by a Multi-Disciplinary Team.

17.63 A view was formed amongst those charged with treating Brian's schizophrenia that Brian's low mood and suicidal ideation were *"the norm*" for him. Brian's case was formally reviewed by clinicians in 2018 and next at the out patient's appointment completed in December 2020. This was a view that remained unchallenged until the murder of Amy in 2021.

17.64 Trust policy regarding the treatment of patients who are non-CPA a failure to take a holistic approach to risk management and poor communication prevented a review of Brian's case and the need for further support via MDT.

17.65 In 2021 the National Institute for Clinical Excellence published research into factors that might contribute to relapse in people with psychosis or schizophrenia living in community settings, "*such as stressful life events and communication difficulties in families.*" [8]

17.66 This research was supported by the organisation Mind who published that *"restrictions on seeing people, being able to go outside and worries about the health of family and friends are the key factors driving poor mental health."* [9]

[8] National Clinical Guidance Number 178 National Collaborating Centre for Mental Health commissioned by the National Institute for Health and Care Excellence

[9] The mental health emergency How has the coronavirus pandemic impacted our mental health? June 2020 Mind P5

17.67 The Serious Incident Review noted. Colin's death "*appears to have been a milestone in Brian's mental health deteriorating, evidenced by an increase in low mood, poor concentration, memory, and auditory hallucinations. He believed his mother was shouting daily that she wanted to kill herself. He believed "Satan" was trying to harm him and his mother"*. This was not recognised by mental health services and at a time of clear need for Brian a service that Brian expressed his appreciation for, contact with the Social Care Support Worker, ended three months after this milestone event.

17.68 A decision by services on whether more treatment and support could have been provided to help Brian manage his illness was hindered by the fact that neither Amy nor Brian's risks and needs were ever formally assessed in particular following Colin's diagnosis and subsequent death.

18 Conclusions

18.1 The Panels work has primarily focussed upon the health and wellbeing of Brian being the perpetrator of Amy's death and, the risks to a worsening of his schizophrenia, which these key events posed to Brian. However, the Panel were always mindful of the impact the escalating level of risk and an absence of care assessment and support that Colin's illness and death and Brian's worsening condition had upon Amy and prior to his death Colin.

18.2 The foundations of Brian's family and the health and wellbeing of Brian and Amy were impacted by two key events which began almost simultaneously at the start of 2020 and extended through to the time of Amy's murder.

18.3 These events placed increasing levels of stress upon both Amy and Brian. The terminal diagnosis and death of Colin who his G.P. describes as the "*protective factor*" in Brian's illness and the "*buffer"* between Amy and Brian. Secondly the commencement of national lockdowns in order to control the spread of the Covid virus which had spread to levels reaching global pandemic. This halted all the non-medicinal measures in place to help Brian better control his schizophrenia.

18.4 The impact that these events had upon Brian's mental health was disclosed to services throughout the period of lockdown. This impact was never reviewed when lockdown temporarily ended nor treatment and support, in light of lessons learnt, changed for the onset of the period of the further lockdown restrictions. Had this been done it would not change the national restrictions but may have ameliorated the negative impact of the restrictions upon Brian's mental health.

18.5 It was never recognised the pivotal role that the Social Care Support Worker might, and indeed did in Brian's case, play in identifying a deterioration in clients mental health and more specifically during the periods of national lockdown when they were tasked with providing weekly telephone support calls to clients receiving treatment from Mersey Care. The Support Worker remained untrained in issues relating to mental health and risk assessment and records they made during contacts with clients were never reviewed by his supervision or staff treating Brian at Mersey Care. Overlooking the value of the work that the Support Worker undertook and the information they generated was a significant opportunity missed.

18.6 There are further signs of systemic weaknesses inhibiting the treatment and support of Brian. In spite of the fact that Brian had not been clinically reviewed for two years those treating him state that "*acknowledgement of low mood and at times suicidal ideation, this was deemed to be 'the norm' for Brian."* The Panel were unable to locate any clinical notes from a review which show that consideration was made of the changes that were taking place Brian's life that justifies inaction and a lack of challenge to this categorisation.

18.7 Communication between services was poor. The information that the Support Worker was entering into RiO and the Adult Services databases of Brian's disclosures was never reviewed or considered. By the Support Workers supervisor or Mersey Care whose validation of disclosures entered onto the RiO database by a qualified mental health practitioner were suspended during the periods of Covid restrictions. Mersey Care were unaware of the acute

grief reaction, being managed by Amy's G.P. that Amy was suffering following Colin's death and did not consider the impact this may have had upon Brian.

18.8 The Serious Incident Review expressed a view that "*had Brian been listed for MDT discussion and consideration, this may well have resulted in a more formal and comprehensive review of his health and social circumstances with arrangements put in place via CPA or other mechanism, to better determine his level of need and risk and ensure his support in the community was more formally overseen and co-ordinated*." The information which should/may have prompted a discussion of Brian's case at MDT was available it was just not acted upon.

18.9 Added to this at a single service level there was a total absence of the formal assessment of risk and care planning present throughout the period the Panel reviewed.

18.10 Services involved in this case do not appear to have followed guidance issued by NICE or their own organisations policies to protect carers of patients with schizophrenia and the patient themselves. The outcome of this is that the risk faced by Amy may have been reduced, notwithstanding the stress of lockdown to control the spread of Covid, had services acted upon information on Brian's worsening mental health and also followed guidance and policy.

19. Lessons Learnt

19.1 It was a key line of enquiry for this review to consider the effectiveness of information sharing between agencies and information databases held by agencies and what impact did this level of effectiveness have upon the care of Brian and safety of Amy. As highlighted in the conclusions of this report communications at inter and intra levels within agencies was poor and the effectiveness of care impacted as a result.

19.2 There is no system in place for monitoring and reviewing those many service users such as Brian, who are deemed non-CPA but who may continue to be

symptomatic, despite functioning independently, are seen periodically as an outpatient, but may not have been formally reviewed and discussed within an MDT context for a significant period. In the future this situation may be resolved with changes being implemented as a result of the Community Mental Health Framework which Sefton are soon to pilot in which non-CPA status will be removed and all patients will have a single point of contact. Plans are in place to commission third sector voluntary sector agencies to provide the key worker roles. Accompanying this will be an alert system when records show there to have been no contact with the client for a specified period of time.

19.3 When circumstances changed due to Covid restrictions, and the death of Colin, there was no clear consideration of whether Brian or Amy's levels of risk or needs had changed as a result of these traumas. There was no evidence that consideration of a different approach was needed especially in those combined circumstances. A whole family trauma informed approach may have resolved this requiring the whole family unit to be assessed together for the impact that the life changing events was having upon the individuals and the whole family unit. This will require a change in approach to the assessment of need and risk.

19.4 Consideration regarding the restrictions in place to control Covid and the impact these restrictions would have upon individual patients should have been discussed by management to establish how best to support Brian when group cycling and walking sessions were stopped. These restrictions were given added significance in light of the additional stress of Brian's father's terminal diagnosis. Plans are required in future planning to ensure contingencies are in place to support patients impacted by future periods of lockdown or restrictions on services.

19.5 The Clozaril Clinics are staffed by mental health practitioners and whilst the primary focus of the clinic is to protect the physical health of the patient protecting them from potential serious side effects of the drug Clozaril this is also an opportunity to establish mental health needs. This does take place now but not in a planned way. Therefore following work with the Suicide

Prevention Partnership in Sefton the clinicians have developed five questions that will now be asked of all patients attending the clinic enquiring of their level of suicidal ideation and enabling preventive support to be provided where appropriate.

19.6 The Panel also acknowledge the reforms and their relevance to this case, contained within the Community Mental Health Framework and note the relevance of two of the broad principles of the reform to this review.

- A named key worker for all service users with a clearer multidisciplinary team (MDT) approach
- Better support for and involvement of carers as a means to provide safer and more effective care [10]

20 Recommendations

20.1 Establish service standards for the joined-up sharing of information across the CMHT and the Clozaril clinic pathway and the creation of systems to facilitate joined up sharing.

20.2 Ensure all front line staff and all immediate supervisors of those staff supporting people with mental illness discuss ongoing cases in supervision and/or in MDT meetings to gain other views and review possible interventions available to support people.

20.3 Ensure training on mental health and suicide awareness is available for and is accessed by front line practitioners supporting Community Mental Teams (CMHT) and other community based support work/groups to include recognising symptoms, risk assessment and available support services and treatment pathways

[10] NHS England. Care Programme Approach, NHS England position statement, 1 March 2022 Version 2.0pp4-6

20.4 In all cases when undertaking Carers Assessments ensure that a trauma informed holistic assessment of the family unit's needs is also considered &completed, and that these are reviewed following any significant life events

20.5 Ensure that Carer's Assessments are being offered consistently in accordance with guidelines issued by NICE and in accordance with the emerging Community Mental Health Framework.

20.6 Complete a review by treatment providers of risk assessment tools to ensure significant events such as deaths of family members and the impact these may have on individuals suffering from schizophrenia are included.

20.7 When support services are suspended that are considered essential for optimum health and well-being, a review of the individual support plan must be undertaken and communicated to all involved in delivering care, the client and their families

20.8 Ensure robust risk assessments regarding an individual's risk to self and others are received by relevant services e.g. when patients are referred to A&E for mental health assessment by primary care.

Appendix A Action Plan

Recommendation	Scope	Action to Take	Lead Agency	Key milestone	Target date	Outcome
1.Establish service standards for the joined-up sharing of information across the CMHT and the Clozaril clinic pathway and the creation of systems to facilitate joined up sharing.	Local	Review current systems and opportunities for clinical oversight between teams.	Mersey Care	Evidence of joint entry recording on RiO system across Mental Health Division.	Feb 22	Completed Feb 2022 Review of RiO system completed: joint entries into the records are evidenced within this case during the timeframe of the review. All Trust staff record onto RiO within this division. Dairy entries are displayed as a combined Progress Note and is accessible for all staff to read.
2.Ensure training on mental health and suicide awareness is available for and is accessed by front line practitioners supporting Community	Local	Review current training offer available to Adult Social Care staff	Sefton Adult Social Care with support from Mersey Care	Outcomes of review and current uptake	April 2023.	ASC current training offer includes eLearning sessions on Suicide Awareness (delivered by Mersey Care) and Mental Health at Work -prerequisite

Recommendation	Scope	Action to Take	Lead Agency	Key milestone	Target date	Outcome
Mental Teams (CMHT) and other community based support work/groups to include recognising symptoms, risk assessment and available support services and treatment pathways		Review current uptake of training related to mental health and suicide awareness and consider whether this needs to be made mandatory training for frontline practitioners If needed, develop further resources and training options in conjunction with Mersey Care Relaunch of training offer and resources		New training/ resources available Numbers of Adult Social Care staff completing mental health and suicide awareness training Learning and completed actions shared with Sefton DA Board and Safeguarding Adults Board to inform and support future multi agency training development around mental		to completion of additional training modules. Mental Health First Aid and Social Isolation Awareness training sessions are now running with good attendance from across ASC. Learning outcomes include understanding issues associated to mental ill health, how to identify the signs of mental ill health and various personality disorders and techniques to help individuals by creating healthy environments. Key aim of the session is to gain the skills and confidence to help someone

Recommendation	Scope	Action to Take	Lead Agency	Key milestone	Target date	Outcome
				health and suicide awareness		who may be considering suicide. A two day MH First Aid course delivers learning outcomes based on recommendations of QA training providers, subject matter experts and in-depth research in mental health. Targeted at individuals who are required to raise awareness of the signs and symptoms associated with MH problems. Participation increases awareness of active listening skills and develops confidence to undertake conversation with people potentially experiencing an episode of

Recommendation	Scope	Action to Take	Lead Agency	Key milestone	Target date	Outcome
						mental ill-health. Skills in the ability to undertake risk assessment for a person's MH and information on support for individuals with potential mental health problems are also focused on. Course meets a Level 3 Award. Training is not currently mandatory but escalation to mandatory status is to be considered by SLT . The development and evaluation of learning and training across the SSAPB is the focus for the Learning Subgroup who report as a

Recommendation	Scope	Action to Take	Lead Agency	Key milestone	Target date	Outcome
						standing item on the SSAPB meetings
3.Ensure all front line staff and all immediate supervisors of those staff supporting people with mental illness discuss ongoing cases in supervision and/or in MDT meetings to gain other views and review possible interventions available to support people.	Local	Changes to MDT meeting process to be made highlighting open cases. Minutes of MDT to reflect discussion around each case.	Sefton Adult Social Care and Mersey Care.	Preparation of a briefing and delivery of same to staff.	May 2023	May 2023 - A 7 Minute Briefing focussing on the relationship between safeguarding and supervision has been produced and circulated across all operational Teams. This has been signed off by the Principal Social Worker. It reinforces the importance and relevance of discussion of cases in supervision and MDT meetings where the person is experiencing mental illness to optimise evaluation and project

Recommendation	Scope	Action to Take	Lead Agency	Key milestone	Target date	Outcome
						potential interventions for individuals in services. Adherence to supervision will be monitored through case file audit and will be a focus for discussion at the Professional Practice Forum Supervision and safeguarding are also highlighted within the refreshed Supervision policy that is to be relaunched across ASC imminently PDF Safeguarding and Supervision 7 Minute

Recommendation	Scope	Action to Take	Lead Agency	Key milestone	Target date	Outcome
4.Ensure that Carer's Assessments are being offered consistently in accordance with guidelines issued by NICE and in accordance with the emerging Community Mental Health Framework.	Local	Trust staff are made aware of their responsibilities to offer and record carers assessments as per the current Mersey Care policy Conduct an audit of cases with Schizophrenia as to numbers of families who provide a "caring role" are offered care assessments	Mersey Care	Audit completed. Review of Mersey Care Carer's Policy is completed. Learning from this review will be circulated in a 7 minute briefing regarding carers support – appropriate recording and signposting.		The Trust has a Carers Policy which is currently under review. The policy focuses on the support for carers as informed by the "Triangle of Care". The Policy directs staff to refer identified carers to the Local Authority for formal assessment. Guidelines in how to involve staff in care planning for service users is contained within the Policy. The Trust's Care Programme Approach Policy states: 7.7 All Carers should be advised that they are

Recommendation	Scope	Action to Take	Lead Agency	Key milestone	Target date	Outcome
						entitled to a Carer's assessment of their caring, physical and mental health needs and should be offered this. Following a Carer's assessment the Carer may require a Carer's support plan, which should be reviewed annually RiO patient record system records when carers assessments are offered: Carers Assessment record on RiO.docx

Recommendation	Scope	Action to Take	Lead Agency	Key milestone	Target date	Outcome
5.In all cases when undertaking Carers Assessments ensure that a trauma informed holistic assessment of the family unit's needs is also considered &completed, and that these are reviewed following any significant life events	Local	Review of the Carer Assessment process to ensure wider family needs and risks are considered within this process by agencies	Sefton Adult Social Care and Mersey Care	As part of the Carers Assessment process the Carer Support Team, guided by the Care Act complete the Carers Assessment in line with the 9 Principles of Wellbeing. Any issues identified as part of the assessment that require further support will be actioned by the Team signposting/referring the carer to		Trauma informed practice training for the Carers Centre staff and for frontline SW staff has been highlighted as an area for development Training in trauma informed practice for all staff is in the early stages of discussion and a programme will be developed over the coming months. A Quality Practice Alert, highlighting the Principles of Trauma Informed Practice will be distributed across all ASC Teams by June 2023

Recommendation	Scope	Action to Take	Lead Agency	Key milestone	Target date	Outcome
				appropriate in house/partner organisation support services.		
6.Complete a review by treatment providers of risk assessment tools to ensure significant events such as deaths of family members and the impact these may have on individuals suffering from schizophrenia are included.	Local	Risk assessment tools to be reviewed.	Sefton Adult Social Care and Mersey Care	All service users have a complete risk screen and/or assessment as per identified need under the CPA.	Feb 23	Completed Feb 2023 CPA risk assessment tools reviewed: The Trust uses evidenced based risk identification, assessment and management plans. This includes mandatory fields that include: ➢ Risk of losing essential services.

Recommendation	Scope	Action to Take	Lead Agency	Key milestone	Target date	Outcome
					May/June 2023	➢ Major life event. Sefton ASC have designed refreshed risk assessment and risk management tools into LAS during May/ June 2023
7.When support services are suspended that are considered essential for optimum health and well-being, a review of the individual support plan must be undertaken and communicated to all involved in delivering care, the client and their families	Local	To review business continuity plans for periods when services are suspended.	Sefton Adult Social Care and Mersey Care	All business continuity plans will have interim arrangements in place for the suspension of services.	March 23	Mersey Care services were not withdrawn during the pandemic however, the learning from this case will be shared with the emergency planning support in the Trust to ensure that business continuity plans of clinical services are cognisant of individual care reviews if services are suspended.

Recommendation	Scope	Action to Take	Lead Agency	Key milestone	Target date	Outcome
					March 23	In relation to Sefton ASC front line services continued to be delivered during Covid. In terms of oversight during suspension the Quality and Compliance Team work closely with the suspended service to ensure clear understanding for the provider and the individual Q&C Officer provides support. Where there are issues over the Continuity Plans or financial stability of a provider the Q&C Team immediately raise the concerns with an MDT approach or where appropriate an

Recommendation	Scope	Action to Take	Lead Agency	Key milestone	Target date	Outcome
						Organisational Safeguarding Episode All commissioned services in ASC must have an individual Business Continuity Plan. In the event of suspension of service all service user care plans are reviewed, and requirements rag rated and shared with Commissioners. Alternative services are accessed, or alternative means of support provided with minimal delay which may include the use of Direct Payments where appropriate.

Recommendation	Scope	Action to Take	Lead Agency	Key milestone	Target date	Outcome
8.Ensure robust risk assessments regarding an individual's risk to self and others are received by relevant services e.g. when patients are referred to A&E for mental health assessment by primary care.	Local	Agree process for achievement of recommendation between SDGH and Mersey Care.	Southport District General Hospital	Action complete as process establish: Staff at S&O will refer to Mersey Care to undertake the robust risk assessment of harm to self and others, and Mersey Care will be responsible for ensuring these are received by other services. Southport and Ormskirk will provide detail of the attendance to AED and maybe the		More robust client safeguarding system in place. Reduction in risk levels for clients and staff.

Recommendation	Scope	Action to Take	Lead Agency	Key milestone	Target date	Outcome
				outcome of the assessment, but not the assessment itself.		

Please note: the action plan is a live document and subject to change as outcomes are delivered

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15th January 2024

Dear Janette,

Thank you for submitting the Domestic Homicide Review (DHR) report (Amy) for Sefton Community Safety Partnership (CSP) to the Home Office Quality Assurance (QA) Panel. The report was considered at the QA Panel meeting on 13th December 2023. I apologise for the delay in responding to you.

The QA Panel felt this is a detailed review which includes input from family and friends, and the foreword is touching. Condolences were provided by the chair and CSP to the family of Amy, and the pseudonyms used were chosen by the panel. There is good reference to national mental health guidance and local mental health policies to back up the care and treatment that Brian the perpetrator should have received as part of his diagnosis of schizophrenia.

The QA Panel felt that there are some aspects of the report which may benefit from further revision, but the Home Office is content that on completion of these changes, the DHR may be published.

Areas for final development:

- Amy is somewhat unseen and unheard within the report, as she is overshadowed by the following things: the perpetrator and his mental health needs, her husband's rapid deterioration in health, and the impact his loss had on both Amy and the perpetrator as he was identified as a 'protective factor'.

- It may have been more appropriate to commission a Mental Health Homicide Review than a DHR or possibly consideration of a joint review.

- It might have been helpful to have an older age third sector representative, perhaps from Age UK, as a panel member. Amy was an older citizen and it would have been useful to have someone on the panel who understands the

experience of being frail in relationship to the perpetrator living with his older aged parents and being his carer.

- The Confidentiality section states that pseudonyms were chosen by the Panel. It is not confirmed that that these were discussed with the family to ensure they were appropriate. Please state whether this was done.

- 10.1 states the Coroner was informed of the DHR, but there is no outcome of an inquest or if it was adjourned. This should be added.

- Key lines of enquiry (5.4) would normally be found under the Terms of Reference rather than in the Methodology. Suggest moving them to section 4 where the reader can clearly ascertain the focus of the review.

- There was a lack of information sharing particularly between NHS/health and Adult Social Care (ASC).

- There was no carers assessment undertaken prior to Colin's discharge from hospital for terminal care following diagnosis of progressive cancer.

- There was no assessment of the perpetrator's mental health or medication review for two years despite the local policy stating that this was required annually.

- 11.2 rightly recognises sex as an issue with domestic abuse being a gendered crime. However, the quote in italics is from very old data. The referencing method is not standard format e.g. there is an (a) after the quote which one then finds an (A) in a References list at the end of the report. The reference for the quote used is from very old data (from 2001). There is a variety of crime data which could be used i.e. Domestic abuse victim characteristics, England and Wales - Office for National Statistics 2022. References should either be added as a footnote where they appear, or the author's name and publication date in brackets after the reference, then listed in the bibliography or references list.

- 17.65 cites a reference to NICE research which is followed by the letter (h), but in the reference list at the end of the report (H) is shown as 'Public Health England Covid 19 Mental Health and Wellbeing Surveillance report July 2021', therefore the incorrect source has been used.

- None of the references in the report contain page numbers from which the quote came within the document cited. When a direct quote is inserted a page number should be given. None of the references contain weblinks. If they are available on the internet, which most are i.e. the NICE guidance National Clinical Guideline Number 178, a weblink should be provided to enable the reader to follow them up.

- The equality and diversity section does not link to the protective characteristics specific to this review such as age, sex, religion, marriage (Amy had been married for many years and had a recent bereavement due to

her husband's death) and mental health and domestic abuse linked to suicide factors. The report would have benefited from further exploration/analysis.

- There is detail in the early paragraphs 14.6 and 14.7 of the chronology which include the victim's husband's treatment from his medical records. This is unnecessary. He was not the victim, and these details are irrelevant to the review and should remain confidential and be removed.

- There are no Lesson to be Learnt regarding the need for effective information sharing between services and between professionals. Given this was a considerable problem both in terms of supervision, data systems and checking records highlighting in the Review, this is a significant omission. It is appreciated that there is a recommendation around this area, but making it clear in Lessons Learnt would make it visible to the reader. Recommendations made should arise from the Lessons to be Learnt.

- For ease of reference, it would be helpful to have the recommendations numbered in the plan.

- Sefton Adult Social Care recommendation on page 59 has no actions recorded.

Once completed the Home Office would be grateful if you could provide us with a digital copy of the revised final version of the report with all finalised attachments and appendices and the weblink to the site where the report will be published. Please ensure this letter is published alongside the report.

Please send the digital copy and weblink to DHREnquiries@homeoffice.gov.uk. This is for our own records for future analysis to go towards highlighting best practice and to inform public policy.

The DHR report including the executive summary and action plan should be converted to a PDF document and be smaller than 20 MB in size; this final Home Office QA Panel feedback letter should be attached to the end of the report as an annex; and the DHR Action Plan should be added to the report as an annex. This should include all implementation updates and note that the action plan is a live document and subject to change as outcomes are delivered.

Please also send a digital copy to the Domestic Abuse Commissioner at DHR@domesticabusecommissioner.independent.gov.uk

On behalf of the QA Panel, I would like to thank you, the report chair and author, and other colleagues for the considerable work that you have put into this review.

Yours sincerely,

Home Office DHR Quality Assurance Panel