Waveney District Community Safety Partnership

Domestic Homicide Review Overview Report

A death in Lowestoft, Suffolk
November 2014

Report Author:
Mr Gary Goose MBE

Report completed: 2nd April 2016

Waveney District Community Safety Partnership
Domestic Homicide Review: Overview Report

Preface

Before formally introducing this Review, the Waveney District Council Domestic Homicide Review Panel would like to express their deepest sympathy to the family involved in this tragedy.

This Review could not have been completed without your challenge and support.

The Independent Chair and author of this Review would also like to thank all those staff from statutory and voluntary agencies who assisted in compiling and reviewing the information culminating in this report.

This Review was commissioned by the Waveney District Council Community Safety Partnership following the notification of the deaths in circumstances which appeared to fulfil the criteria of Section 9 (3)(a) of the Domestic Violence, Crime and Victims Act 2004.

This Review relates to the death of an elderly male victim who was killed by his daughter with whom he lived. This Review adopted the approach that the circumstances fall within the definition applied by the Home Office for Domestic Homicide Reviews as set out below:

"Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse: psychological, physical, sexual, financial and emotional.

Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim."

The key purpose for undertaking a DHR is to enable lessons to be learned from homicides where a person dies as a result of domestic violence or abuse. In order for these lessons to be learned as widely and as thoroughly as possible professionals need to be able to understand what happened in each case and most importantly what needs to change in order to reduce the risk of such tragedies happening in the future.

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Section 1. Introduction

1.1 Summary of circumstances leading to the review

.1 The deceased in this case is an elderly male who will be known for the purposes of this Review as The Victim. He was 89 years old at the time of his death. He was killed by his daughter on the evening of 19th November 2014 at the home they shared in Lowestoft, Suffolk.

.2 For the purposes of this Review the Victim's daughter will be known as The Pepetrator. The Victim's late wife (also the Perpetrator's mother) passed away in 2009. In 2013 the Perpetrator sold her own property, also in Lowestoft and moved in with her father.

.3 Whilst the Victim was beginning to suffer a range of age related issues, the Perpetrator had a long history of acute psychiatric illness and was under the care and support of the local mental health trust at the time of the incident, albeit living independently. Their living arrangement provided for a level of inter-dependent care for and by each other.

.4 There are no records of any previous domestic abuse incidents or other issues that would suggest a turbulent relationship history between the two at that address.

.5 On the evening of 19th November 2014 the Victim made an emergency telephone call and asked for police attendance saying his daughter was 'trying to hurt him'. Further calls were made by members of the public who found the Perpetrator outside the address in a distressed state. Police attended and found a number of people in the street struggling with the Perpetrator. Police were joined by a paramedic crew. Whilst in the street she had made, and continued to make, significant comments about killing her father. She was arrested initially for assault and subsequently for murder.

.6 Police and paramedics went into the property in order to check on the welfare of the Victim. They found him slumped in a chair in the living room. He was moved onto the floor in order to attempt resuscitation. Two other ambulance service colleagues attended in order to assist CPR but this was unsuccessful. At 10.03pm the Victim was pronounced dead.

.7 Several witnesses were seen by police and confirmed they heard the Perpetrator say "I've killed my dad".

.8 Following her arrest, she was taken to a police investigation centre where she was interviewed. However, it was clear that she had mental ill-health difficulties and was transferred to a mental health hospital.

.9 The post mortem examination of the Victim was carried out by a Home Office approved pathologist on the 20th November 2014. The cause of death was established as compression of the neck.

.10 In June of 2015 a decision was taken to instigate criminal proceedings against the Perpetrator for the murder of her father.

.11 On 16th December 2015, the Perpetrator pleaded guilty to the offence of manslaughter on the grounds of diminished responsibility. The Crown accepted this plea. The Judge issued an Order under Section 37 Mental Health 1983 (known as a Hospital Order). No separate criminal sentence was given.

.12 The Perpetrator had significant prior involvement with her GPs and the local mental health trust over a number of years both as an in-patient and one who was cared for within the community. There was active involvement with her by the trust up to the day of the incident.

.13 Local GPs, the local hospital and local adult social care staff had some minimal involvement with the Victim and he had been offered a range of support primarily in the form of 'signposting' to various support bodies and groups. It appears that he declined these offers.

.14 This Review will be concerned with the level of previous interactions across all agencies. Whether those interactions were reasonable and appropriate in the circumstances and whether lessons can be learned.

.15 Moreover, the review will concern itself with the totality of the situation. Whether those agencies involved took an overview of the whole situation or whether they worked in silo's. It is a fact that a vulnerable elderly man was living with a clearly vulnerable woman, albeit his daughter, both were in receipt of support from separate agencies. Did those agencies work together and were any opportunities to better assess risk missed?

1.2 Timescales

1.2.1 The Waveney District Council Community Safety Partnership was notified of the death by Suffolk Constabulary on 29th November 2014. There followed meetings of a Domestic Homicide Review Advisory Panel which took place on 17th December 2014 and 5th January 2015.

1.2.2 As a result of these meetings the Chair of the Community Safety Partnership made decision to undertake a Domestic Homicide Review. The Home Office was notified of the decision.

1.2.3 An Independent Chair was appointed on 29th January 2015; the review commenced immediately thereafter.

1.2.4 Three Domestic Homicide Review Panel meetings were held in this case: 5th March, 12th May 2015, and 4th March 2016.

1.2.4 The Review was completed in late April 2016.

1.2.5 It was not possible to complete the review within the six month timescales set out within the statutory guidance due to the commencement of criminal proceedings shortly after the second panel meeting. Following consultation between the Chair of the Review and the Police a decision was taken to place the Review on hold until the conclusion of those proceedings. This decision was taken due to the nature of the issues that had potential to arise within any future criminal trial. The Home Office were informed of the delay. The Review recommenced upon the conclusion of those proceedings.

1.3 Confidentiality

1.3.1 The content and findings of this Review are held to be confidential, with information available only to those participating officers and professionals and where necessary their appropriate organisational management. It will remain confidential until such time as the Review has been approved for publication by the Home Office Quality Assurance Panel.

1.3.2 In order to protect the identity of the victims and their family members, the following pseudonyms have been used hereafter within this report:

The Victim. A white British male who was 89 years old at the time of his death

The Perpetrator is the daughter of the deceased, she is a white British female and was 52 years old at the time of the incident.

1.4 Dissemination

1.4.1 The following individuals/organisations will receive copies of this report:

- Chair of the Waveney District Council Community Safety Panel
- Suffolk Police and Crime Commissioner

- Chief Constable, Suffolk Constabulary
- Chief Executive, Norfolk and Suffolk NHS Foundation Trust
- Chair, Great Yarmouth and Waveney Clinical Commissioning Group
- NHS England, Eastern Region
- Chief Executive, James Paget University Hospital NHS Foundation Trust
- Chair, Suffolk Health and Wellbeing Board
- Chair, Suffolk Adult Safeguarding Board
- Chief Executive, East of England Ambulance Service
- GP Practices involved in this review
- Family of the victim

1.5 Terms of Reference

1.5.1 Statutory Guidance states the purpose of the Review is to:

Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.

Identify clearly what those lessons are within and between agencies, 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 homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

To seek to establish whether the events leading up to the homicide could have been predicted or prevented.

1.5.2 Specific Terms of Reference for this Review.

Terms of Reference for the Domestic Homicide Review into the death of (The Victim)

1. Introduction

1.1 This Domestic Homicide Review (DHR) is commissioned by the Waveney Community Safety Partnership (CSP) in response to the death of the Victim on 19th November 2014.

1.2 The review is commissioned in accordance with Section 9, The Domestic Violence, Crime and Victims Act 2004.

1.3 The Chair of the CSP has appointed Mr Gary Goose MBE to undertake the role of Independent Chair and Overview Author for the purposes of this review. Mr Goose

is not employed by, or otherwise has any conflicting interest with, any of the statutory or voluntary agencies involved in the case.

2. Purpose of the review

The purpose of the review is to:

2.1 Establish the facts that led to the incident on 19th November 2014 and whether there are any lessons to be learned from the case about the way in which local professionals and agencies worked together to safeguard the family.

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

2.3 Establish whether the agencies or inter agency responses were appropriate leading up to and at the time of the incident on 19th November 2014; suggesting changes and/or identifying good practice where appropriate.

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

3. The review process

3.1 The review will follow the Statutory Guidance for Domestic Homicide Reviews under the Domestic Violence, Crime and Victims Act 2004 (revised 2013).

3.2 It will be cognisant of the process agreed by Suffolk Community Safety Partnerships and contained within the reference document. “Conducting a Domestic Homicide Review (DHR): Suffolk Protocol and Guidance, July 2012”.

3.3 This review will be cognisant of, and consult with, any on-going criminal justice investigation and the process of inquest held by HM Coroner.

3.4 The review will liaise with other parallel processes that are on-going or imminent in relation to this incident in order that there is appropriate sharing of learning.

3.5 Domestic Homicide Reviews are not inquiries into how the victim died or who is culpable; that is a matter for coroners and criminal courts.

4. Scope of the review

The review will:

4.1 Seek to establish whether the events of 19th November 2014 could have been reasonably predicted or prevented.

4.2 Consider the period of two calendar years prior to the events, subject to any information emerging that prompts a review of any earlier incidents or events that are relevant.

4.3 Request Individual Management Reviews by each of the agencies defined in Section 9 of The Act and invite responses from any other relevant agencies, groups or individuals identified through the process of the review.

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

4.5 Produce a report which summarises the chronology of the events, including the actions of involved agencies, analyses and comments on the actions taken and makes any required recommendations regarding safeguarding of families and children where domestic abuse is a feature.

4.6 Aim to produce the report within the timescales suggested by the Statutory Guidance subject to:

- guidance from the police as to any sub-judice issues,
- sensitivity in relation to the concerns of the family, particularly in relation to parallel enquiries, the inquest process, and any other emerging issues.

5. Family involvement

5.1 The review will seek to involve the family in the review process, taking account of who the family may wish to have involved as lead members and to identify other people they think relevant to the review process.

5.2 We will seek to agree a communication strategy that keeps the families informed, if they so wish, throughout the process. We will be sensitive to their wishes, their need for support and any existing arrangements that are in place to do this.

5.3 We will work with the police and coroner to ensure that the family are able to respond effectively to the various parallel enquiries and reviews avoiding duplication of effort and without increasing levels of anxiety and stress.

6. Legal advice and costs

6.1 Each statutory agency will be expected and reminded to inform their legal departments that the review is taking place. The costs of their legal advice and involvement of their legal teams is at their discretion.

6.2 Should the Independent Chair, Chair of the CSP or the Review Panel require legal advice then WCSP will be the first point of contact.

7. Media and communication

7.1 The management of all media and communication matters will be through the Review Panel.

1.6 Methodology

1.6.1 The Waveney District Community Safety Partnership was notified of the death by Suffolk Constabulary by way of report dated 29th November 2014. This was a timely

notification and showed a good knowledge of the need for early referral by the Constabulary.

1.6.2 As a result of that notification a Domestic Homicide Review Advisory Panel took place on 17th December 2014. This panel was convened by the Chair of the Community Safety Partnership and was an initial information sharing exercise by key professionals in order to fully inform a wider Domestic Homicide Review Advisory Panel which subsequently took place on 5th January 2014. Following the first meeting contact was made with a wider range of local statutory and voluntary agency to establish whether they had contact with the victim, perpetrator or family members. Instruction was also given that any records indicating contact should be secured. It was also explicitly confirmed at the meeting that all considerations would be taken in accordance with the Home Office Statutory Guidance for Domestic Homicide Reviews (revised 2013).

1.6.3 The Domestic Homicide Review Advisory Panel of 5th January 2015 was again convened by the Chair of the Community Safety Partnership and comprised of an appropriate range of senior professionals from across the statutory agency local network. As a result of the information provided to these two meetings the Chair of the Community Safety Partnership made decision to undertake a Domestic Homicide Review. The Home Office was subsequently notified of the decision on 5th January 2015.

1.6.4 At the time of these incidents Suffolk had in place its own county-wide procedure and protocol for Domestic Homicide Reviews: *Suffolk Community Safety Partnerships; Domestic Homicide Review. Suffolk Protocol and Guidance*.

1.6.5 The Chair of this Review found that guidance to be useful and fit for purpose. It provided a clear roadmap for all agencies to adhere to and set the framework for the Domestic Abuse Advisory Panels, as mentioned above. The Suffolk document refers directly to the Home Office Statutory Guidance as the overriding framework for reviews but provides local direction.

1.6.6 In the view of the Chair of this Review, that the use of a Domestic Homicide Review Advisory Panel is a sound mechanism that ensures timely and well-informed decision making. Both meetings were confidentially minuted and those minutes made available for the Chair of this Review.

Example of good practice: The use of a Domestic Homicide Review Advisory Panel to provide rigour around early decision making by the Chair of the Community Safety Partnership.

1.6.7 The Chair of the Review would also like to acknowledge that the Chair of the CSP's active and direct involvement in both Advisory Panels indicates a good knowledge of that role and responsibility;

1.6.8 At the initial meeting the Norfolk and Suffolk NHS Foundation Trust indicated their intention to conduct their own internal serious case inquiry. It was noted that linkage between the Trust's internal inquiry and this review would be desirable in order to ensure efficiency of resource and appropriate sharing of information.

1.6.9 The independent chair and overview author was appointed in on 29th January 2015 and the first full Domestic Homicide Review Panel was held on 5th March 2015. All statutory agencies were represented. The following were key outcomes:

- Contact with HM Coroner would be established
- Contact with the Chair of the Suffolk Adult Safeguarding Board would be established
- Draft terms of reference were agreed subject to the agreement of the deceased's family.
- The current status of the police murder investigation was disclosed in order that progress of the Review could be properly considered to ensure it did not affect the on-going criminal investigation
- A range of voluntary and charitable organisations were identified for contact to establish if any prior engagement with the deceased or offender was known.
- The Constabulary informed the panel that it had made a 'self-referral' to the Independent Police Complaints Commission as a result of its actions on the night of the incident. It was agreed that this Review would not seek to duplicate that inquiry as it would provide an in-depth overview of that particular aspect of the Review period.
- It was agreed that an IMR would be required from the following organisations:
    - Norfolk and Suffolk NHS Foundation Trust
    - The GP's for both deceased and offender
    - The James Paget Hospital
    - The East of England Ambulance Service
    - Adult Social Care Service, Suffolk County Council
    - Suffolk Constabulary

1.6.10 Information from records used in this Review were accessed in the public interest and under Section 115 of the Crime and Disorder Act 1998 which allows relevant authorities to share information where necessary and relevant for the purpose of the Act, namely the prevention of crime. In addition, Section 29 of the Data Protection Act 1998 enables information to be shared if it is necessary for the prevention or detection of crime, or the apprehension or prosecution of offenders. The purpose of a Domestic Homicide Review is to learn lessons in order to prevent similar crime.

1.6.11 Following the first review panel meeting the Chair of this Review met with the next of kin of the deceased. The terms of reference for the review were agreed and the process of review, its likely timescales and its relationship with other parallel reviews was outlined.

1.6.18 A second Review Panel meeting was held on 12th May 2015 at which draft IMRs and reports from all agencies were examined and discussed. All statutory agencies were represented as was the GPs practice. The following key issues arose:

- Three IMRs were complete.
- Further work was required in respect of the information provided by two of the organisations present.
- A number of other enquiries were identified as a result of the additional information learned through the IMR process.
- An update on the criminal investigation was provided by the police.

- It was agreed that a further panel meeting would be necessary but it was not possible to arrange a date at that time due to the nature of the progress of the criminal investigation.

1.6.20 Shortly after the second Review Panel meeting criminal proceedings were instigated in this case. the Perpetrator was charged with the murder of her father.

1.6.21 As a result of the instigation of criminal proceedings the Chair made contact with the police Senior Investigating Officer in accordance with the Statutory Guidance in order to ensure the Review did not interfere with, or have the capacity to interfere with, the course of justice. Following those discussions, the Chair made the decision to effectively place the Review on hold until the conclusion of those criminal proceedings.

1.6.22 The Chair wrote to all panel members outlining that decision and met with the victim's family to update them on the progress of the Review.

1.6.22 The Chair wrote to, and subsequently met with, the Police and Crime Commissioner for the Suffolk area in order to engage the Commissioner in the Review. In addtion, the Chair wrote to the lead officer for the County's Health and Wellbeing Board and subsequently met with the County Council's Head of Localities and Partnerships in order to understand the strategic oversight of Domestic Abuse services across the county.

1.6.23 On 16th December 2015, the Perpetrator pleaded guilty to the offence of Manslaughter on the grounds of diminished responsibility. The Crown accepted this plea. The Judge issued an Order under Section 37 Mental Health 1983 (known as a Hospital Order). No separate criminal sentence was given.

1.6.24 This Review was recommenced following the conclusion of those criminal proceedings.

1.6.25 On 4th March 2016 a final Review Panel meeting was held in relation to this case. At the meeting the Chair and Overview Author provided an updated chronology, a summary of the information gathered as a result of the Review and its draft findings. Full discussion followed and, subject to some minor points of detail, the information was agreed as sufficiently detailed to finalise the report and its findings agreed.

1.6.25 At the time of the final panel meeting the Independent Police Complaints Commission report had not been published.

1.6.25 In addition to the receipt of IMRs, reports and personal interviews and attendance at the Inquest, the Chair of this Review has read a number of documents to assist in compiling this report including:

- Understanding Domestic Abuse in Suffolk; A study of the experiences of survivors 2015. This was a research paper commissioned by the Suffolk Police and Crime Commissioner
- Domestic Violence and Abuse: A partnership strategy for Suffolk 2015-18
- Suffolk Constabulary Domestic Abuse Action Plan 2014
- Domestic Abuse, Local Action Plan for Suffolk 2014

- Suffolk Safeguarding Children Board: Responding to Domestic Abuse training programme September 2015 – December 2015

1.6.26 The Review's active inquiries concluded in March 2016. The report was completed thereafter.

1.7 Contributors to the Review

1.7.1 Those contributing to this Review do so under Section 2(4) of the statutory guidance for the conduct of DHRs and it is the duty of any person or body participating in the Review to have regard for the guidance.

1.7.2 All panel meetings included specific reference to the statutory guidance as the overriding source of reference for the Review. Any individual interviewed by the Chair, or other body with whom the Chair sought to consult, were made aware of the aims of the Domestic Homicide Review and referenced the statutory guidance.

1.7.3 However, it must be noted that whilst a person or organisational body can be directed to participate, the Chair and DHR Panel do not have the power or legal sanction to compel their cooperation or to attend the Panel for interview.

1.7.4 The following agencies contributed to the Review:

- The next-of-kin of the deceased by way of information to the Review.
- Norfolk and Suffolk Foundation NHS Foundation Trust (Mental Health Services): By way of IMR and Panel membership.
- GP Practice: By way of chronology and written peer review.
- James Padget University Hospital NHS Foundation Trust: By way of IMR and panel membership.
- Suffolk Constabulary: By way of IMR, provision additional information on the murder investigation, interaction with the IPCC and Panel membership.
- HM Coroner: By way of engagement with the review and attendance at panel.
- Suffolk County Council, Specialist Domestic Abuse Advisor: By way of general information, provision of policy and practice. Panel membership.
- Suffolk County Council Adult Social Care Services: By way of IMR and Panel membership.
- East of England Ambulance Service: By way of IMR and Panel membership.
- National Probation Service: By way of Panel membership
- Suffolk Family Carers: By way of information to the Review, personal interview and panel membership
- Suffolk Independent Living: By way of information to the Review and personal interview.
- Suffolk Police and Crime Commissioner: By way of personal interview by the Chair of the Review.
- Waveney Domestic Violence Forum: By way of panel membership
- Suffolk Adult Safeguarding Board: By way of panel membership.

1.7.6 No agencies declined to assist the Review.

1.8 The Review Panel

1.8.1 The members of the DHR Panel conducting this Review were:

Name of panel member	Role or job title	Organisation
Gary Goose MBE	Independent Chair and Overview Author	
Karen Hubbard	Community Development/Community Safety Manager	Waveney and Suffolk Coastal District Council
Julia Catterwell	Community Safety Officer	Waveney and Suffolk Coastal District Council
Jim Gooding	Chief Inspector	Suffolk Constabulary
Michael Lozano	Patient Safety and Complaints Lead	Norfolk and Suffolk NHS Foundation Trust
Kelly Boyce	Safeguarding Adults Lead	James Paget University Hospital NHS Foundation Trust
Shirley Osbourne	Domestic Abuse manager	Suffolk County Council
Caroline Sexby	Assistant General Manager	East of England Ambulance Service
Dreena Black		Waveney Domestic Violence Forum
Howard Stanley	Safeguarding Adults Lead	Great Yarmouth and Waveney CCG
Julie Baxter	Safeguarding Manager	Suffolk County Council Adult Social Care
Sarah Potter		Suffolk Family Carers

1.9 Author of the Overview Report and Chair

1.9.1 The Community Safety Partnership took the view that a combined role of Independent Chair and Overview Author was appropriate in this case. They appointed Mr Gary Goose MBE to that joint role.

1.9.2 Mr Goose is not employed by, nor otherwise has any conflicting interest with, any of the statutory or voluntary agencies involved in the review.

1.9.3 Mr Goose has significant criminal justice, local government and partnership working experience. He is an experienced police officer having served for thirty years, mostly as a detective, within Cambridgeshire Constabulary. He retired as a Detective Chief Inspector in 2011. He was awarded an MBE for Services to Policing in the 2006 New Year's Honours list. From 2011 onwards he has been involved in local government as Head of Community Safety Services with Peterborough Unitary Authority, has worked for the Cambridgeshire Police and Crime Commissioner and as a consultant providing Domestic Homicide Review services. He has previous experience of Domestic Homicide and Child Protection Reviews within both the police and local authority roles.

1.10 Parallel Reviews

1.10.1 At the time this Review began a police murder investigation was underway into the circumstances surrounding the death of the Victim. That investigation resulted in criminal proceedings set out in paragraph 1.6.21 above.

1.10.2 Following the incident that resulted in the death of the Victim, Suffolk Constabulary made a self-referral to the Independent Police Complaints Commission. The referral was in relation to the Constabulary's call-handling and deployment on the night of the incident. This Review has sought not to duplicate the work of the IPCC and has not therefore entered into enquiries relating to the police actions on the night. The Review has taken the view that irrespective of that call- handling and deployment; agencies prior involvement with the couple require appropriate scrutiny. The IPCC report will be published in due course; it does not affect the outcome of this Review.

1.10.5 The Norfolk and Suffolk NHS Trust undertook an internal serious case review following the death of the Victim as the Perpetrator was a patient under the care of their Home Treatment Team at the time of his death. That internal Review and the Trust's preparation of the IMR for this Review were undertaken concurrently. The Chair of this Review has seen the Trust's internal Review and is satisfied that its content is not materially different to the IMR the Trust prepared for this Review; they meet the requirements of their respective audience.

1.10.6 The Chair of this Review and the Independent Chair of the County's Adult Safeguarding Board (ASB) met at any early stage to determine whether this was a matter which should be subject of an ASB's Review as determined by the Care Act 2014. It was established that as a matter of legal fact such a Review was not required, however, in terms of good practice the ASB Board Manager was invited to attend this Review's Panel Meetings. This Review and its resultant action plan will be shared with the ASB upon completion and the agreement to publish by the Home Office.

Section 2. The Facts

2.1 Introduction

2.1.1 On 19th November 2014 an 89-year-old man, the Victim, was killed by his 52-year-old daughter (the Perpetrator), at the home they shared together in Lowestoft.

2.1.2 They had been living together since April 2013 after the Perpetrator had sold her own home to live with her father.

2.1.3 The Victim's wife (the Perpetrator's mother), had died in 2009 leaving him to live alone.

2.1.4 In addition to the Perpetrator, the couple had a son who lived in Bedfordshire.

2.1.5 The Perpetrator had a long history of acute mental ill health. She had been known to the Mental Health Trust since first presenting in 1989. At the time of the incident she was diagnosed as suffering 'Affective Disorder'. Affective Disorders is the name given to a set of psychiatric diseases also known as mood disorders, which include bipolar, depression and anxiety. Her illness consisted of a significant levels of depressive, psychotic and suicidal behaviours with accompanying psychotic symptoms of auditory and visual hallucinations. She was under the regular care of her GP and the local mental health trust. She was in receipt of an allowance which allowed her to employ a personal assistant (PA) for 4 hours a week. She also attended local Trust support groups twice a week.

2.1.6 The Perpetrator's illness manifested itself at times of heightened anxiety with episodes of paranoia of thoughts that her parents were going to harm and kill her. There were also several occasions when she expressed thoughts of harm towards them.

2.1.7 At the age of 89, the Victim was beginning to suffer a range of age related issues. Local GPs, the local hospital and local adult social care staff had been involved in offering a range of support; it appears that he declined these offers.

2.1.8 In the weeks and months leading up to the incident additional pressure was felt by the Perpetrator and the Victim as a result of the financial situation that had arisen following the sale of the Perpetrator's home. The equity she gained following the sale meant that she no longer qualified for the benefits that enabled her to employ her personal assistant. This had become a significant issue for the two and they had to make a decision whether to pay privately for the support or manage without.

2.1.9 On 14th November 2014, the Perpetrator contacted Suffolk Independent Living, and organisation who at the time managed the Perpetrator's account on her behalf, to say that she had decided not to continue to employ the PA. The Victim also confirmed this to them during the same telephone call.

2.1.10 On 16th November 2014, the Sunday prior to the incident the Victim's son and his wife visited them both and the issue of the personal assistant was a major point of discussion. It was the Victim's view that they could manage without the PA and in fact they had prepared the paperwork to dispense with the service. The son

persuaded them to reconsider and that he would telephone them again on the Wednesday evening, after the PA had next visited, to see how they had got on.

2.1.11 On 17th November 2014, the Perpetrator called Suffolk Independent Living again to say that they had changed their mind at that they would be keeping the PA and funding it themselves.

2.1.12 On the day prior to the incident, 18th November 2014, the Victim contacted the Mental Health Trust saying he was concerned about the Perpetrator and felt they needed some additional help. Arrangements were made for a visit in a couple of days' time.

2.1.13 On the evening of 18th November, the Perpetrator attended her local independent church group and at the end of the meeting became distressed, suggesting fear that someone might kill her when she went outside. She left of her own accord-and made her way home.

2.1.14 On the morning of 19th November the Victim called Suffolk Family Carers for the first time in many years and asked for assistance. Suffolk Family Carers provided support to the Victim and his wife in the years leading up to her death but he had largely disengaged from them in that interim period.

2.1.15 The PA also visited on the morning of the 19th November and took the Perpetrator shopping. She describes the situation as mainly normal although there was a conversation between her and the Victim about the Perpetrator having something on her mind. There was no conversation about the call made to Suffolk Family Carers or any other indication of more help being needed.

2.1.16 On the evening of the 19th November, the son called as had been arranged on the previous visit and the conversation confirmed that everything in relation to the PA had been sorted. He describes the conversation as being nothing out of the ordinary. This call was less than an hour or so before the incident.

2.1.17 At 8:52pm the Victim called the police asking for help, saying that his daughter was trying to hurt him. Police did not immediately attend.

2.1.18 Shortly after 9pm neighbours saw the Perpetrator in the street wearing just a nightdress and in a distressed state. They saw her stumble and fall to the ground and when they went to help she was agitated and began saying she had 'killed her dad'. The police and paramedics were called and attended.

2.1.19 They found the front door to the house open and the Victim deceased inside. The Perpetrator was in the street being restrained by neighbours. She was subsequently arrested.

2.1.20 Following her arrest, she was interviewed and then assessed under the Mental Health Act and conveyed to hospital where she was detained under Section 2 of the Act.

2.1.21 In her interview she spoke about how she had to 'kill the beast that was inside her father' after being told to do it by a face that she had seen in the sky.

2.2.22 It was not until June 2015 that a decision was taken that it was appropriate for her to stand trial in relation to the death of her father and a criminal process was embarked upon.

2.1.23 On 16th December 2015, the Perpetrator pleaded guilty to the offence of manslaughter on the grounds of diminished responsibility. The Crown accepted this plea. The Judge issued an Order under Section 37 Mental Health 1983 (known as a Hospital Order). No separate criminal sentence was given.

A full chronology of events and a summary of information known by family, friends, agencies and others will now follow within this report.

2.2 Chronology

(Please note this chronology does not include the totality of the Norfolk and Suffolk NHS Foundation Trust's (N&SMHT). Their service contact chronology is extensive and demonstrates at minimum weekly, at times several times a week, engagement with the Perpetrator)

1987	The Perpetrator first became known to N&SMHT after becoming disturbed by an encounter with a religious group. There are no electronic records to cover this period.
20/02/1989	The Perpetrator admitted to acute psychiatric hospital with depressive psychotic and suicidal behaviour. Left hospital on 22/03/1989
31/05/1998	The Perpetrator admitted to acute psychiatric hospital with psychotic symptoms, depressive disorder with thoughts of deliberate self-harm. Left on 29/07/98.
22/08/2001:	Assessment carried out by Suffolk County Council ACS looking at the Perpetrator's physical health, mental health, relationship issues and physical abilities at the time. Contact made with Community Mental Health Team.
05/05/2002	The Perpetrator admitted to acute psychiatric hospital with depressive episodes accompanied by suicidal ideation - Section 2 MHA. Left on 12/06/02.
20/05/2002:	The Victim and his wife in receipt of ad-hoc support from Suffolk Family Carers Mental Health Team
25/04/2003	The Perpetrator admitted to acute psychiatric hospital with psychotic depression. Left on 08/05/2003.
2003:	N&SFT electronic records commenced and provide the following background on the Perpetrator: A number of references to reports of psychotic symptoms which involve thoughts of harm to her parents, suspicion that her parents (and others) were out to harm/kill her and also that her parents were not her real parents and were imposters. (The Perpetrator) had many periods when her mood became low and several anti-depressants had been used over the years. It was documented in her record that she had 'psychotic depressive episodes'. When her mood was low it was accompanied by higher anxiety, poorer engagement with services, increased dependence on her parents and non-compliance with medication. As noted above she had been admitted on four occasions, following deterioration in her mood, with psychotic symptoms and suicidal behaviour. There were obsessional thoughts and behaviours recorded in her notes. The behaviours were related to 'counting in certain number sequences and washing her hands repeatedly'. There was a long recorded history of anxiety relating to the wellbeing of her parents and social situations.

25/04/2003: Police interaction with the Perpetrator who was found naked in the street clearly suffering psychiatric issue at the time. Conveyed to hospital.

15/05/2006: Noted in a letter to the Perpetrator's GP from her Psychiatrist that she reported voices:-

'telling her to be violent towards her parents and it seems that these may have an obsessional character. Given that she has experienced (sic) such voices for all her adult life they seem to be much more linked with her personality structure that part of her depression or psychosis as thought previously, this is difficult to tease out. Certainly today she was feeling low, upset because a friend had died recently, and asking again about her parents aging and being left alone without them' (N&SFT).

31/05/2007: The Victim, his wife and the Perpetrator, attend support groups and activity sessions offered by Suffolk Family Carers.

15/08/2008: The Perpetrator called Suffolk Family Carers to say she is taking on some of the caring as her mother is unwell (SFC) .

04/03/2009: (Between this date and December 2010) the Perpetrator attended JPH (Hospital) for routine gynaecological issues. It is also noted that between 2009 and December 2014 she attended regular ophthalmic clinic appointments due to a previous eye issue that had required an operation and that she suffered from Type 2 diabetes which resulted in regular screening.

13/03/2009: The Victim's wife (and the Perpetrator's mother) passed away.

19/03/2009: Suffolk Family Carers continue ad-hoc telephone contact with the Victim.

March 2009: Following her mother's death the Perpetrator entered the grieving process and was reported as spending more time at her father's home; they appear to support each other.

On one occasion the PA rang the Care Coordinator for advice with regards the Perpetrator thoughts of harm towards women in public place due to an incident in which the Perpetrator expressed thoughts whilst out in the community. This behaviour was attributed to social stressors at the time regarding her mother's illness.

At another time, the Perpetrator expresses anxiety regarding her father and "a feeling of dread" at his home although this is not explored further. At another time it is identified that they are worried about each other but do not communicate well with one another. No thoughts expressed to harm either parent by the Perpetrator. (N&SFT)

16/03/2010: The Victim had a discussion with Suffolk Family Carer support worker explaining that his own health is not good but that the Perpetrator is helping him and appears to have a new lease of life after slotting into the female role (SFC)

05/10/2010: Police interaction with the Victim. He approaches asking that a starting pistol he has be collected as part of amnesty. (Police)

17/04/2011: Police interaction with the Victim. He reports damage to a caravan parked at his property. (Police)

June 2011: Issue between the then engaged Personal Assistant to the Perpetrator which results in a change of worker. She expresses some anger regarding this situation but the Victim expresses no concern for her mental health and no risk of harm identified towards others at this time. (N&SFT)

16/09/2011: Ambulance service attended address with report of the Victim having fallen. (EASS)

The Perpetrator reports concern and stress of looking after father at various points during 2011 which result in crisis calls at the end of the year requesting care assessment for both. At another time, she expresses anxiety about father's health; she reports checking on him during the night and contacts the team with anxiety regarding his welfare after a fall. No identified risk of harm towards father from her at this time. (N&SFT)

30/12/2011: Ambulance service attends the Perpetrator; reported as confused and diabetic. Referral made to GP and community psychiatric nurse. (EASS)

07/02/2012: Record of Suffolk County Council's (SCC) Direct Payments Team intention to recoup excess funds from the Perpetrator's direct payments account. Direct Payments are paid to customers in lieu of care commissioned by Suffolk County Council; customers can then arrange care to suit their needs and pay for the care with Direct Payment funds. the Perpetrator opted to have a 'supported account' with Suffolk Independent Living, the funds were then paid to them and they held the money on her behalf.

24/02/2012: Ambulance service respond to report of the Perpetrator with possible stroke. Assessed at the scene and there were no physical issues apparent. It was noted that she had not been taking medication and was advised to see GP in the morning. Left in the care of her neighbour. (EASS)

08/06/2012: The Victim's GP requests Adult Care Services involvement with him. The GP reports that the Victim lived alone but spent a lot of time with his daughter who had a diagnosis of schizophrenia. GP reported that his daughter was going through a difficult stage. GP felt that the Victim would benefit from a package of care while he was going through this difficult time. (ASC)

08/06/2012: Initial Assessment completed at Suffolk County Council's call centre generating an initial contact record. Referred for further contact with the Victim (ASC)

12/06/2012: Telephone call made to the Victim by the ASC officer to follow up request received from GP on 08/06/2012. The Victim reported that he was managing with assistance from his daughter at that time but felt he might need some help in the future. He was given the telephone number for Suffolk County Council's Customer First call centre and advised him to ring as soon as he felt he needed assistance. (ASC)

22/06/2012: The Perpetrator admitted to Hospital to investigate possible stroke. All tests negative. Noted that she was not always compliant due to anxiety. Discharged on 26/06/2012 with a follow-up clinic appointment (JPH).

25/06/2012: Telephone call from the Victim to report that his daughter, normally visited him every evening but was in hospital and he did not know when she would be sent home. He stated that he had been told to contact ACS by his doctor and neighbours to request an assessment of his needs. Customer Services Assistant (CSA), recorded that he had told her that he was able to manage his own personal care, prepare his own meals and that his mobility was fine. It was recorded that he gave the impression that he was managing independently, did not need any social care support and had only rung because his GP and neighbours had told him to. (ASC)

25/06/2012: Further contact record created by the Customer call centre and referred as a previously. (ASC)

04/07/2012: Visit to the Victim by Adult Social Care officer. The Perpetrator was also present during the visit. Recorded that he had very poor mobility, angina and prostrate problems. The Victim declined any support from ACS and reported that he could manage with the support of the Perpetrator and a neighbour. He was provided with information to read through and advised to ring Customer First if he needed help or support in the future. (ASC)

04/07/2012: Adult Social Care assessment completed. (ASC)

July 2012: Trust record an update relating to the Perpetrator.

Living with father in a co-dependent relationship although she expresses significant concern that she is not able to offer care for father and is physically exhausted by it, as well as finding it emotionally challenging. She states that father is refusing to have carers. No thoughts expressed to harm her father but she expresses anxiety regarding his and her own welfare. Care Coordinator believes that father is main carer for both but Duty visit expresses concern that he is “frail”.

A carer’s assessment appears to have been offered to the Victim in July 2012, however, no evidence found of the outcome of this assessment. (N&SFT)

15/08/2012: The Perpetrator attended follow-up clinic at JPH re previous stroke query. Advised all clear and discharged. (JPH).

28/09/2012: The Victim attended a walk-in appointment at A&E following a referral from GP for possible minor stroke. Investigations and treatment planned and discharged same day. Social history notes accompanied referral stating he was supported by his daughter. The Perpetrator present at the appointment. (JPH)

01/10/2012: Ambulance service called to address. The Perpetrator saying she couldn’t cope with her unwell father. Notes record history as showing mental health/anxiety/panic. Community psychiatric team present at the time. No further action was required by the Ambulance service (EAAS)

02/10/2012: The Victim commenced monthly check-ups with the Hospital anti-coagulation nurses (JPH).

22/10/2012: The Victim attended Hospital for follow-up appointment re stroke investigation. (JPH)

23/10/2012: The Victim attended Hospital for further follow-up appointment re stroke investigation. (JPH)

31/10/2012: The Victim attended final appointment re stroke investigation and discharged from further consultant care. (JPH)

March 2013: Mental Health Trust record concerns expressed by The Victim for mental health of the Perpetrator. He requested a visit by Care coordinator; on arrival at the property the Perpetrator found to have a knife directed towards her abdomen expressing thoughts of self-harm. It appears that no risk of harm identified to others; father had not identified any risk to himself. The Perpetrator is non-concordant with medication and stability of mental health is not being maintained, therefore a brief intervention by the crisis team is requested to re-instate medication – the crisis team identified that the Perpetrator was confused by medication and needed a blister pack to manage, records state that she was advised to approach GP with this request. (N&SFT)

16/03/2013: Ambulance service attended the Perpetrator query stoke. Conveyed to Hospital. (EAAS)

16/03/2013: The Perpetrator attended A&E regarding tingling in her face. Noted as very anxious. She stated she was no longer taking her medication. Had a previous diagnosis for schizophrenia. All tests negative. Discharged into care of GP (JPH)

17/03/2013: Suffolk Family Carers note that contact is very sporadic consisting of invites to meetings and events. The Victim does not usually attend but thanks for the invites and sends donations. He then says he does not wish to be on the mailing list for Mental Health Family Carers Programme (SFC)

May 2013: In May 2013, the Perpetrator was referred to a community resource centre in mental health services and begins to engage in groups on a regular basis. This appears to become her main support from mental health services alongside her PA with over-arching care coordination managing the case. The Resource centre offers community support as well as emotional support when she is feeling anxious/needs someone to talk; something she expresses she does not have at home. Despite some low mood/ anxiety, the Perpetrator maintains relationship with the resource centre during the rest of the year. (N&SFT)

The Perpetrator reports co-dependent relationship with father and agitation regarding relationship and concerns for father. The Consultant Psychiatrist reports in May 2013 that “there are issues with her father that still need to be sorted out” which appears to be in relation to a GP letter stating that “she is angry with both dad and brother and the pressure she is under”. Care plan and Risk assessment dated April 2013 identify father both as a

being cared for as a vulnerable adult but also as a carer for the Perpetrator, however, no identified risk of harm towards him is recorded.

30/06/2013: Police interaction with the Perpetrator as she reported a burglary at her home. (Police)

11/07/2013: The Perpetrator moved in with the Victim

12/07/2013: ASC Benefits record: 'Telephone call from (the Victim). Sounded very muddled and advised that his daughter was moving in with him to care for him on 11/07/13. Unsure if he was in receipt of Attendance Allowance and would ask daughter to ring in that same day' (ASC Benefits)

12/07/2013: ASC Benefits note that the Perpetrator contacted the office to say she would be going in with details of income. (ASC Benefits)

20/07/2013: Ambulance service responded to the Victim with a possible stroke. Conveyed to Hospital (EAAS)

20/07/2013: The Victim attended A&E complaining of numbness in hand and a urinary issue. No stroke detected and discharged the same day. Documents show daughter as next-of-kin and living at the same address (JPH).

01/08/2013: The Perpetrator attended benefits payment office with details of income (ASC Benefits)

12/08/2013 The Victim contacted benefits team. Details: 'Letter advising that his daughter moved in with him 11/07/13 and that she comes under Mental Health' (ASC Benefits)

13/08/2013: Letter received from the Perpetrator to advise moving in to Father's property to care for him and advising that she was under the Mental Health Act (ASC Benefits)

26/06/2014: Record of Direct Payments team intention to recoup excess funds from the Perpetrator's direct payments account.

This entry refers to the Direct Payment team's 'intention' to recoup excess funds from the Perpetrator's 'supported account' at Suffolk Independent Living (SIL). In fact, SCC had already recouped the amount of £3,732.04 which the Perpetrator had authorised SIL to return. The result of the letter in February 2012 was the return of the excess funds to SCC, therefore no further action was required by the Direct Payment team. (ASC)

15/07/2014 Mental Health Trust record notes following visit from officer:
"I saw (The Perpetrator) at home as arranged. (The Perpetrator) says she hasn't been feeling so well and she is worried about a financial assessment form that has arrived and filling it in. I spent some time explaining it is to do with her direct payment for her support worker. I explained that as her financial situation has changed since selling her bungalow she may have to contribute towards it. (The Perpetrator) was worried about filling the form in so I tried to ring for somebody to come round and help her. The office was closed so I will try tomorrow and then let (The Perpetrator) know" (N&SFT).

16/07/2014: Referral to Suffolk County Council's Financial Inclusion and Advice Service by the Perpetrator's mental health support worker. (ASC)

Summer 2014: During summer 2014, the Perpetrator appears to begin to disengage from services and her anxiety increases so significantly that she finds it difficult to leave the house. (N&SFT)

August 2014: In August 2014 she expresses concern about her father dying or becoming ill but no thoughts of harm towards him are expressed. (N&SFT)

28/08/2014 Further notes recorded by Mental Health Trust following visit by staff:
"I saw (The Perpetrator) at home as arranged. (The Perpetrator's) PA S was also there as they had a little tea and cake as they have been working together for 2 years.

(The Perpetrator) told me that she has felt more anxious recently and this was confirmed by her PA. (The Perpetrator) has found it more difficult to go out sometimes and go into shops etc. (The Perpetrator) spent some time giving an overall account of how she feels and we looked at what she finds helpful.

I discussed about the financial form that she is waiting to hear about somebody seeing her at home as this is worrying her. I advised I will ring tomorrow and let her know if they give me a date." (N&SFT)

29/08/2014 Further contact made by Trust LCP. Recorded as follows:
"I contacted (The Perpetrator) to let her know that I have heard from the financial assessment team. They will see her at home on Monday 8th September at 3pm. I will also attend to give her support as requested" (N&SFT)

08/09/2014 Further visit made by Trust LCP to The Perpetrator. Recorded as follows:
"I saw (The Perpetrator) at home with SG from Suffolk County Council to complete financial assessment form.

From this meeting (The Perpetrator) has too much money to have her PA paid for from the social services and the account will be closed.

I will contact the equal lives team to discuss about having them still involved and (The Perpetrator) finances her time with her PA and then get back to (The Perpetrator.)" (N&SFT)

11/09/2014 Notes from Trust records that LCP contact to Equal Lives
"I contacted the equal Lives team and he suggested that (The Perpetrator) has a visit from an advisor to look at her options. I have let (The Perpetrator) know that they will contact me with a time". (N&SFT)

19/09/2014: Letter sent to the Victim to report that as the Perpetrator had declared on her financial assessment form that she had in excess of £23,250 in capital, she would no longer be entitled to receive Direct Payments from Suffolk County Council. (ASC)

Autumn 2014: During autumn 2014, there is only sporadic attendance at groups at the Resource centre eventually less engagement by telephone also following non-attendance of groups. The Resource centre discussed these concerns with LCP who states that she feels the Perpetrator concerns regarding financial issues and her medication non-compliance have increased levels of anxiety. (N&SFT)

26/09/2014 Notes from Trust LCP visit to The Perpetrator records as follows:

"I saw (The Perpetrator) at home as arranged. (The Perpetrator) told me that she has been missing her morning risperidone for some time and this would help to explain why she was having some more difficulties getting about and attending xxxx
I have encouraged her to continue taking it regularly and I will review her on 9th October at 2 at her home when we are meeting an Equal lives advisor."
No clinical note exists re meeting on 09/10/14 with Equal Lives (N&SFT)

16/10/2014 Notes from Trust LCP visit to the Perpetrator recorded as follows:

"I saw (The Perpetrator) at home to try and give her some support while she decides about using equal lives and pay herself for a PA.
The Perpetrator has made a decision but will have the weekend to make sure before we start any paper work. I will follow up on Tuesday." (N&SFT)

21/10/2014 Notes from Trust LCP visit to the Perpetrator recorded as follows:

"I met again to discuss about funding her PA herself. (The Perpetrator) is now wanting to discuss this with xxxx (PA) before finally making a decision. She does appear a bit more settled at the moment and will contact me when she has discussed this with her."

No further clinical notes exist regarding financial concerns but this evidence shows that it may have been of concern to (The Perpetrator). It appears that LCP was involved in supporting (The Perpetrator) to reach a decision regarding the use of her money for her PA in the absence of direct payments for this purpose. No formal risk assessment undertaken at the time in regards to financial situation (N&SFT)

14/11/2014: Telephone call from the Perpetrator to Suffolk Independent Living. Notes as follows:

"Tc from (The Perpetrator) today, I spoke to her dad too with her permission. She has decided not to continue employing (x) and wants to end her employment and close the Payroll etc. I tried several times to find out what had led (The Perpetrator) to this decision, but all she and her father would say is that she had been worried and did not want to have to worry any more. I offered to visit her but she declined.

She would like to make xxxx redundant as of 28/11/14. xxxx was apparently there during the second call I took so they have made her aware of what is happening and she accepts. (The Perpetrator) is going to send a timesheet in soon (she has another week or so to go) so I talked her through the leaver details and explained that Payroll would write and let her know how much to pay. (SIL)

After this, we can send a close letter and also close the old Supported Account. It will then be up to the DP Team to pursue (The Perpetrator) for any funds they want returned.

*I asked (The Perpetrator) to call when she has heard from Payroll"(*SIL).

16/11/2014: The Victim's son and his wife visit both the victim and the perpetrator at their home in Lowestoft. He said that his father and sister were extremely stressed and agitated as they had been advised that their funding was being stopped, which was being used to provide support for his sister. His father had stated that they didn't need outside care – he could look after his daughter by himself, however the son stated that he had encouraged his father to apply for the funding, as they did need additional help, particularly as his father was 89 years old and becoming frail. The father had agreed to complete the forms, and as they were expecting a support worker to visit them on the following Wednesday (the day of the incident) they would discuss it with her. The son agreed a further call for that evening to discuss it. (GG)

17/11/2014: Telephone call from the Perpetrator to Suffolk Independent Living, she said she hadn't been well last week and has talked things through with some of her other family members who have explained things to her. She would like to keep xxxx on and self-fund as previously discussed.

Advised her to get rid of the timesheet with leaver details on and fill out a new one, following the dates list. The Perpetrator is going to speak to xxxx about continuing work but thinks she will be fine (SIL).

18/11/2014: No contact with father until November 2014; he calls Duty the day prior to and the actual day of the incident. He expressed concern for level of anxiety in the Perpetrator and that it was preventing her from leaving the house. He did not report any psychotic symptoms. It is not recorded that he expressed any concern of risk of harm towards himself from the Perpetrator. AS LCP was not available due to absence from work, duty workers offered advice to the Victim and the Perpetrator by phone and arranged duty visit for 22/12/14 as LCP was absent. No immediate risks identified to either the Victim or the Perpetrator or voiced by either party. (N&SFT)

19/11/2014: Contact to Suffolk Family Carers Information Line. From both the Victim and the Perpetrator asking for a home visit/carers assessment. Operator gave number for Customer First but also made a referral to SFC for a support

worker to visit. The note says both were struggling to look after each other (SFC)

19/11/2014: On Wednesday evening at approximately 8.15pm, the Victim's son phoned his father to see how the visit with the support worker had gone and whether the forms had been submitted for the funding. The son had a 15-minute conversation with both his sister and his father and everything appeared to be ok. He was reassured by his sister who had said 'it has all been sorted…' (GG)

19/11/2014: Ambulance respond to 999 call as woman may have killed her father. Police at scene on arrival. (EASS)

19/11/2014: Police respond to 999 call. On attendance murder investigation launched.

Section 3: The Overview

3.1 Summary of information known to agencies, family and friends.

1 The Victim and his wife moved from Bedfordshire to the east coast of England in around 1966 to provide a better, healthier environment. Their then young daughter, the Perpetrator, moved with them. Their son stayed in Bedfordshire as he had recently begun his working life.

.2 The Victim and his daughter had lived together since mid-2013. Prior to this the Victim had lived alone following his wife's death in 2009; the Perpetrator had lived in her own home nearby.

.3 The move to live together was done with mutually beneficial intent: The Victim was beginning to develop a range of age related issues and his daughter suffered acute mental ill-health for which the Victim (previously, together with his wife) had provided significant levels of care over many years.

.4 Whilst the Victim's wife was alive the couple sought support from a local charity; Suffolk Family Carers as they cared for their daughter. Following her death the Victim gradually withdrew from the using their resource.

.5 The Victim was described as a very private and proud man. At 89 years of age he had only given up cycling a year before his death and had been an active member of a local bowls club and the British Legion.

.6 Despite his advancing years, the Victim had little engagement with statutory services. It was only in the last couple of years of life that his age, and undoubtedly the levels of support he had to provide for his daughter, meant more frequent engagement with his GP. This resulted in June and July 2012 in a referral by his GP to the local social care services for an assessment of his needs and support available. Given the description of the Victim as a private and proud man it is perhaps not surprising that he declined any assistance from the social care offer.

.7 The Victim and the Perpetrator lived a structured life. Meals were always at a certain time and it helped both to follow routine.

.8 The Perpetrator had suffered from acute mental ill-health issues for many years and been subject to significant, consistent and on-going levels of care from her GPs and in particular local mental health services. At the time of the incident she was diagnosed with Affective Disorder; more specifically bi-polar affective, severe depression without psychotic symptoms. She did however, have a long history of 'psychotic' symptoms; these included auditory and visual hallucinations. She reported hearing derogatory voices, seeing 'monsters' around the television, faces at the window. She also reported 'thoughts' that she was being 'chased by demons'.

.9 The Perpetrator's thoughts were reported as being often negative about herself with paranoid ideas that she was going to be harmed, for example, that she was going to be killed in the night or that her medication was going to harm her. There are also references within the Perpetrator's medical history of voices telling her to harm her parents.

.10 All of the above contributed to periods of high anxiety and avoidant behaviour, when she relied heavily on the support of her parents (in later years this was her father).

.11 She benefited from financial assistance in the form of benefits enabling her to employ a personal assistant to help her manage day to day living. This financial assistance was due to end at around the time of the incident as a result of the Perpetrator selling her own home and thus being above the financial threshold that afforded her benefits. There is strong evidence that this was a source of increased anxiety in the Perpetrator, but equally evidence that this individual issue appears to have been resolved in the week leading up to the incident.

.12 The Perpetrator's life was supported greatly by the resources provided by mental health services including day centres and visits by her personal assistant who would take her shopping and for coffee. She also sought comfort with a local independent church mission, somewhere she used to attend with her mother. Religion was regularly referenced as a source of both comfort and agitation in her life and her mental ill-health condition.

.13 Whilst the information before this Review indicates significant levels of health service involvement, other agencies appear to have had very little involvement with either the the Victim or the Perpetrator.

.14 The County's social care services appear to have minimal involvement, confined to the short period following the GPs referral for the Victim in 2012.

.15 The police had minimal involvement prior to the incident with either the Victim or the Perpetrator although there is information of the police assisting health colleagues when the Perpetrator displayed acute mental ill-health episodes (for example being naked in the street in 2003).

.16 The police response on the night to the incident that resulted in the Victim's death has been subject to a separate inquiry by the Independent Police Complaints Commission in conjunction with Suffolk Constabulary. Suffolk Constabulary have provided an overview of the learning arising therefrom; this is dealt with later within this report.

3.2 Analysis of agency involvement

The chronology set out at Section 2 details how the information known to agencies evolved. Section 3.1 summaries the totality of the information known by those agencies and others with influence during the years leading up to the deaths. The detailed chronology will not be repeated here; rather this section will provide an analysis of agency involvement.

3.2.1 General Practitioner and General Hospital services.

.1 Both the Victim and the Perpetrator shared the same GP. This was of great benefit in their circumstances and provided a level of oversight across the totality of their situation that was perhaps not available to other statutory bodies or organisations.

.2 Given the volume of contact by both the Victim and the Perpetrator with the local health service providers, this Review has looked in depth at the three years immediately preceding the incident in order to gain a full and deep understanding of the issues that presented over that period. It has, however, also looked further for any relevant issues concerning both.

.3 The Review is grateful to both the GPs and the local area Hospital for their assistance in compiling the information and their assistance with the Review.

.4 In relation to the Hospital. There were a relatively small number of interactions between the Hospital and both the Victim and the Perpetrator. This Review is satisfied that those interactions were for physical presentations that are not connected with the issues that go towards this Review. There were no in-patient stays that necessitated home discharge planning and there were no triggers that could, or reasonably should, have prompted further enquiry.

.5 This section will now concentrate on GP engagement.

.6 A detailed analysis of the last three years of contact with the Victim provides a good insight to the increasingly challenging physical and mental issues that he was presented with as he progressed into older age.

.7 This Review will has chosen not to repeat much of its knowledge around his physical condition and treatment; it seems irrelevant for the purposes for which the Review is intended. However, it is clear that his health was beginning to deteriorate and required increasing levels of attention. Much of which would perhaps be considered normal for a man who was in his late 80's.

.8 It appears to this Review that the GPs and, when called upon to assist, the area's general hospital services, acted promptly and appropriately to assist him in treating some conditions whilst managing others.

.9 It is the issue of the combination of the role played by the Victim's physical and mental condition coupled with the challenges faced by the Perpetrator as a result of her mental ill-health with which this Review concerns itself.

.10 The historic levels of contact between the GPs and the Perpetrator are considerable. Again, this Review has chosen not to include all those issues that are of a physical nature, however, it does accept that the levels of reporting of physical issues by the Perpetrator is probably linked in many ways to her mental ill-health but it adds nothing to this Review to refer to them all.

.11 What is clear is that the GPs acknowledged the depth of the Perpetrator's illness and worked closely with the acute mental health trust to manage her condition. The GP had a good working knowledge of the Perpetrator and her condition. She was able to provide information in her statement to the police about the Perpetrator's history of psychotic episodes as far back as 2003; being aware of her diagnosis of schizophrenia and the paranoid feelings that existed in relation to harm occurring to her parents, or indeed her parents trying to kill her. The GP was also aware of several psychotic episodes which resulted stays in the local psychiatric hospital.

.12 The GP was also aware of enough of the family dynamic and history to know that when the Perpetrator's mother became ill the Perpetrator received support to live independently. She described how she went between her own home and that of her parents for support.

.13 In 2006, the GP was made aware by the Trust's psychiatric team of further issues with the Perpetrator, on this occasion she was hearing voices which included worries about her mother and father dying, but also that she should harm her parents and be violent towards them. The GP was aware of the work by the Trust to deal with this condition, including adjustments to her medication.

.14 In 2007, the GP was aware of an incident where the Perpetrator held a knife to her own stomach at home when she became particularly distressed. The GP made the appropriate further referrals to the Mental Health Trust in order for the necessary specialist treatment to be adjusted accordingly.

.15 Around 9 months after the death of Mrs N, the GP saw the Perpetrator again. She appeared to be doing well.

.16 There were continuing visits and contact by the Perpetrator to, and with, the GP from 2011 through to 2014. The GP was aware of the Perpetrator's mood swings and also aware of the on-going engagement of the Mental Health Trust's teams in supporting and treating the Perpetrator.

.17 Of particular note is an issue which occurred on 29th December 2011. Doctors attended following a request from the Perpetrator for a home visit. She was feeling particular unwell with some physical presentations but also handed the GP who attended a letter in which she outlined how she was concerned about her father's health, how she felt un-supported by her brother and needed help to continue supporting herself and her father. She asked for social work involvement. The following day there was a further visit after she had telephoned 999 asking for paramedics as she couldn't cope. No physical issues were identified but she denied the symptoms could be linked to her depression. In the notes, however, the GP wrote;

"Concerned as lives with elderly father who doesn't seem to have any idea what is going on with the Perpetrator"

.18 These two visits prompted a flurry of intense GP interaction with the Perpetrator in the coming weeks in order to manage a number of physical issues she presented. There were comments recorded that she continued to be worried about her father and also good connection between the work of the Trust and the GP.

.19 What the visits do not appear to have specifically prompted is any immediate pro-active action in relation to the condition she describes her father as suffering from. This review does not criticise the GPs for this for the following reasons:

- The letter (The Perpetrator) handed to the GP was handled properly; scanned in to both her notes and that of the Victim,
- There were several interactions between the Victim and his GPs in the immediate weeks that followed and given the nature of the relationship that existed it is reasonable to conclude the GPs considered his situation during those interactions. There is certainly evidence of discussions about his concern for the Perpetrator and it follows that the situation was under consideration, and,
- In May 2012, after a further visit by the Victim to his GP they were concerned enough, taking all of the information together, to make a referral to the county's adult social care team for assessment of help for him.

.20 It seems to this Review that the GPs made an appropriate referral to social care services as they were concerned about the situation that presented itself. They were aware of the health of the Victim and the concerns he had for his daughter; they were also aware of the health of the Perpetrator and the concerns she had for her father. They acted upon those concerns.

.21 There is no evidence that the GPs received a specific response to their referral.

.22 As stated above, there were other regular visits to the GPs by both the Victim and the Perpetrator during 2012, 2013 and 2014 (the contact with the Perpetrator could be described as voluminous). On occasions the Victim was accompanied to the GP by the Perpetrator and the notes record (in June 2013) her improved health and the support that he was getting from both her and a neighbour. Later that year though the fragility of her mental health is evident when it is recorded in the notes after a visit by the Victim that the GP spoke with the Perpetrator outside:

"spoke to daughter who sat outside and needed reassurance that he was doing well as she worries about him dying. Encouraged to let him go into garden without her worrying something might happen."

.23 During 2014, the Victim suffered a fall at home, there were also issues with his eyes and urinary system but all appeared to be managed effectively by the GPs with the last contact being in October 2014. There is no evidence of any catastrophic turn for the worse that made his care at home impossible.

.24 The level of interaction between the GP and the Perpetrator remained very high. The GPs notes are comprehensive and record the general demeanour and feelings of the Perpetrator at each visit. They demonstrate good working between the GP and

the Mental Health Trust. Whilst there is clear evidence the Perpetrator's illness, the paranoia she felt, coupled with one occasion of potential self-harm when she held a knife to her stomach (2013), there are no indications of any threat towards the Victim from the Perpetrator; the utterances she made in 2006 (.10 above) were not repeated.

.25 It appears the GP played an important role in being able to persuade the Perpetrator to start re-taking medication on those occasions when she lapsed. This was the case in the last visit by the Perpetrator to her own GP who saw her in September 2014 for a health review where again it became apparent that she had stopped taking her medication.

.26 She visited the surgery again in the week before the incident as a result of a rash that had appeared but this appears to be an unconnected physical issue.

.27 Summary of GP engagement

.28 Given the extensive medical knowledge held by the GPs of both the Victim and the Perpetrator, this Review has considered whether the GPs properly recognised the risks that existed within the household and whether they could have done more to support either of the individuals involved.

.29 The Review concludes that on balance the GPs showed a high level of awareness and care for both the Victim and the Perpetrator. They made an appropriate and timely referral for the Victim when his situation demanded it. They also interacted properly with the local mental health trust in managing the complexities and difficulties presented by the Perpetrator's mental and physical health.

3.2.2 Norfolk and Suffolk NHS Foundation Trust

.1 The Norfolk and Suffolk NHS Foundation Trust are commissioned to provide acute and emergency mental health provision for patients within the geographic area covered by this review.

.2 This Review recognises the difficulties staff face in dealing on a day to day basis assessing risk of harm and self-harm. It is grateful to the Trust for their own internal rigour in examining their interactions with the Perpetrator.

.3 The Perpetrator had been known to mental health services for many years. At the time of the incident the service user had a diagnosis of 'Affective Disorder'.

.4 Affective Disorder is the name given to a set of psychiatric diseases also known as mood disorders, which include bipolar, depression and anxiety. Her illness consisted of a significant levels of depressive, psychotic and suicidal behaviours with accompanying psychotic symptoms of auditory and visual hallucinations.

.5 Given the in-depth level of engagement by the Trust with the Perpetrator. This review will analyse the Trusts involvement by addressing the following issues:

- **Was the risk assessment process in place in this case appropriate in all the circumstances?**
- **Was the level of Trust engagement with the Perpetrator appropriate for her level of illness and were care plans being adhered to?**
- **Did the Trust respond appropriately when the Victim and the Perpetrator called for assistance the day before the incident?**
- **Was information shared appropriately with other agencies in order that a whole view of the household could be obtained?**

.5 Background information.

The Perpetrator's first involvement with mental health services was in 1987. She displayed a long history of 'psychotic' symptoms; these included auditory and visual hallucinations. She reported hearing derogatory voices, seeing 'monsters' around the television, faces at the window. She also reported 'thoughts' that she was being 'chased by demons'. Her thoughts were often negative about herself and paranoid ideas that she was going to be harmed, for example, that she was going to be killed in the night or that her medication was going to harm her. All these contributed to periods of high anxiety and avoidant behaviour, when she relied heavily on the support of her parents (in later years this was her father as her mother died in 2009).

.6 In Apr/May 2003 prior to being admitted to hospital The Trust note that the service user told police that she:-
'trying to escape from her parents who will kill her otherwise'

A mental health assessment in Sept 2003 by the Crisis Team noted:-
'fears and anxieties about her parents – which leads to persecutory ideas about her parents. Fears her parents are out to hurt her'

.7 On 15th May 2006 it was noted in a letter to her GP from her Psychiatrist that she reported voices:-

'telling her to be violent towards her parents and it seems that these may have an obsessional character. Given that she has experiences (sic) such voices for all her adult life they seem to be much more linked with her personality structure that part of her depression or psychosis as thought previously, this is difficult to tease out. Certainly today she was feeling low, upset because a friend had died recently, and asking again about her parents aging and being left alone without them'.

.8 As part of their review the Trust further investigated records held before the electronic record began and found a number references to reports of psychotic symptoms which involve thoughts of harm to her parents, suspicion that her parents (and others) were out to harm/kill her and also that her parents were not her real parents and were imposters.

This is a clearly significant point and will be picked up later within this section.

.8 The Perpetrator had many periods when her mood became low and several anti-depressants had been used over the years. It was documented in her record that she had 'psychotic depressive episodes'. When her mood was low it was accompanied by higher anxiety, poorer engagement with services, increased dependence on her parents and non-compliance with medication. As noted above she had been admitted on four occasions, in following deterioration in her mood, with psychotic symptoms and suicidal behaviour.

.9 The Perpetrator was supported by a Lead Care Professional and attended a number of therapeutic groups at a Trust community facility. She also received support from a Personal Assistant 4hrs per week.

.10 Generally she engaged well with the support offered, but on a number of occasions she disengaged for brief periods following a stressful events and/or failing to take her medication.

.11 Prior to the incident of 19th November her last formal assessments were as follows:

- she had been last seen by Consultant Psychiatrist 13.05.2014,
- last full Risk Assessment dated 06.04.2013 (risk review 11.04.2013),
- latest Care Plan dated 05.04.2013,

.12 The latest full Risk Assessment (2013) was completed by the Crisis Resolution Home Treatment Team (CRHT) following referral to them for more intensive support. The Perpetrator's mental state had deteriorated, poor sleep, anxious and some paranoid thoughts – thinking she was going to 'burn up or be snuffed out'. At that time she was at risk of injury to self, owing to paranoid thoughts. She had held a knife to her stomach 'demanding to be told the truth'. Some religious content to these symptoms. There was no reported evidence of a risk to others.

A Risk Review was completed on 11.04.2013 at the point of discharge from the CRHT – no risks to others were noted at that time.

.13 Staff members who have been involved in the the Perpetrator's care noted that she experienced high levels of anxiety which often stopped her from attending groups and activities. She often worried about her father and his deteriorating health and was very anxious about how she would cope when he passed away.

.14 At the time of the incident the service user was under the care of a Community Mental Health Team. She also attended a local Trust day care facility for 2 sessions per week, where she undertook a number of creative and therapeutic activities. These interventions were delivered by a multidisciplinary team of health care professionals. The Trust day care facility offers group therapeutic interventions for service users. The groups are designed, monitored and delivered by an Occupational Therapy led team with support from the Lead Clinical Psychologist. All groups have specific aims; these are graded to reflect the complexity of the intervention delivered. Groups are reviewed regularly to ensure consistency and quality of service delivery. Groups offer specific evidence-based interventions designed to enable better management of mental health.

.15 The service user care was delivered on a Non-Care Programme Approach (CPA) basis with a Lead Care Professional (LCP).

.16 There is sufficient evidence of high engagement by the the Perpetrator with the services provided by the Trust and also appropriate levels of intervention by the Trust's staff when she began to disengage, for instance from group sessions.

.16 Outpatient appointments with her Consultant Psychiatrist were held regularly (at least annually) over the 5-year period up to the incident. Where indicated additional consultations were held. These appointments were usually combined with the Care Programme Approach or Non-CPA review meeting with the Lead Care Professional present. The Perpetrator's father was often present at these meetings.

.17 This Review is aware that on the morning of the incident the Victim took the unusual step of contacting the Trust asking for additional help with the Perpetrator. He very rarely made direct contact with the Trust and this Review will address whether the response was appropriate.

.18 Was the risk assessment process in place in this case appropriate in all the circumstances?

.19 The most recent risk assessment(s) in the service user's clinical record are electronic documents. They comprise of a full risk assessment and risk review (dated 06/04/2013 and 11/04/2013 respectively).

.20 It was nearly 1½ years since the last risk assessment and therefore there was no 'current' risk assessment documentation as per the Trust's policy. There was no documentation of any risk posed to others in the service user's clinical record, either current or historical, noted at that time.

.21 The Perpetrator had been referred to the Trust's Crisis Resolution Home Team (CRHT) by her Lead Care Professional following an episode where she held a 'knife to her stomach and threatened to harm herself'. The Perpetrator displayed paranoid thoughts, such as 'she is going to be burn up or be snuffed out' and there was evidence of non-concordance with medication. During this incident there were no explicit threats to harm others or psychotic symptoms which commanded her to harm her father or others.

.22 In the section for recording harm to others there is no indication of any current or historical risk noted. However, of note there is evidence that she was asked specifically about harm to others, this was documented in the 'Further Details Summary' section, and states 'No thoughts or plans to harm others'.

.23 The Review has examined whether the risk assessment available captured the risk and in particular the support and support networks available.

.24 The intervention by the CRHT concentrated on the Perpetrator's risk of self-neglect and non-concordance with medication. It had been noted that she had got in a mess with her medication and was not following the correct regime. This was being addressed by arranging medication to be dispensed in blister packs. The risk review noted her mental state had improved as had her concordance with her medication regime. The initial concern regarding risk to self in the context of the incident with the knife on the 03/04/2013 had subsided and no further action was required for this particular risk during the CRHT intervention.

.25 Based on the presentation at the time, the risk assessment appears to adequately capture and address the risks present at the time of the CRHT intervention. Both the Perpetrator and her father did not express any other concerns.

.26 The latest accompanying care plan in the clinical record was dated 05/04/2013. It was therefore out of date at the time of the incident. The plan that was put in place was though both proportionate and realistic in relation to the care needs and risks identified at the time.

.27 The latest care plan contained in the electronic clinical record does not refer specifically to a crisis or contingency plan. As it was completed by the CRHT it in effect was the crisis plan at that time. Previous care plans do have crisis and contingency plans; the most up to date of these was 28/05/2012 and was signed by the service user. Although this was not documented in the latest care plan it is evident that the service user and carer were aware of and used these contingencies as needed. These contingencies were:-

- Service user/carer to contact Care Co-ordinator/LCP
- Increased contact with care staff as indicated
- Service user/carer to contact Duty line as indicated
- Acute Service crisis contact number as indicated

.28 The latest risk assessment with documented evidence of a crisis plan and contingency plans was dated 13/03/2012. It was not signed. Crisis plans refer to increased risk to self only and the plans contained therein outline actions to ameliorate this risk only.

.29 **Summary of the appropriateness of risk assessments**

.30 It seems to this Review that the health care professionals involved with the Perpetrator in the days prior to the incident and in the months leading up to it, acted accordingly with the information they had and the clinical nature of her presentation. She was well known and to the best of their knowledge there were no incidences of harm to others that indicated a different course of action should have been taken. The service user's presentation was one of high anxiety levels, poor concordance with medication and psychotic symptoms which had previously resulted in the risk to self being increased.

.31 It is of note that the last risk assessment (dated 06/04/2013) did assess risk to others, although it is not evident that this was done because of any historical risk issues; there was no risk to others reported or observed at that time. However, the previous comments made in 2006 about voices telling her to harm her parents and documentation found from 2003 containing persecutory ideas about her parents and fears that they are out to hurt her were reported. These do not appear to have been documented anywhere else in the clinical record or handed over verbally.

.32 When the Trust further investigated the clinical record prior to 2003 (i.e. when the electronic record began) they revealed a number of references to reports of psychotic symptoms which involve thoughts of harm to her parents, suspicion that her parents (and others) were out to harm/kill her. Also that her parents were not her real parents and were imposters keeping her away from 'Jesus'. None of these references, which date from 1989 onwards, appeared in the most recent risk assessment or care plan documentation, or in any documents leading up to them. It would appear all these reports were in the context of psychotic episodes and resolved following a combination of inpatient admission and/or a review of and compliance with medication, as well as an increase in community support. Mostly these episodes were subsequent to a social stressor and heightened anxiety. It is also the case that during this period there were a number of occasions when the Perpetrator also clearly denied any risk to others.

.33 This Review does not find it conclusive that had this information been handed over and was in the most recent clinical records, it would have resulted in different outcome.

.35 At the time leading up to the incident the service user reported high levels of anxiety and problems getting out of the house to attend groups. This had happened before and the approach taken was similar to these previous instances, whereby she was encouraged and supported to gradually return to her usual level of social activity. There were no observable signs of psychotic phenomena or reported symptoms which would lead to conclude that the service user posed a threat to others, generally or specifically.

.36 Examination of the full clinical record demonstrated that if there had been psychotic symptoms present, which indicated a risk to others, then the Perpetrator would have reported them if asked. It was also evident that if this had been of a nature and degree to represent a manifest risk to herself or others, her father would have contacted services. When this had happened previously her parents had contacted

the police to intervene when the service user had become violent and a risk to herself.

.37 Was the level of Trust engagement with the Perpetrator appropriate for her level of illness and were care plans being adhered to?

.38 The Perpetrator was very well known to the Trust and its staff. On occasions when she did not attend day care facilities attempts were made to contact to check why and encourage attendance. This was proportionate and appropriate in the context of the service user's history, as she had missed groups on numerous occasions previously and resumed attendance in a gradual manner as her anxiety and mental state settled.

.39 Six monthly reviews are required as a minimum for service users on the CPA, and annual reviews for service users on Non-CPA, unless there are clinical indications that additional reviews are required. In this case there were annual reviews and when indicated additional outpatient appointments were arranged. Over the five years prior to the incident there were bi-annual review in 2010 and 2012 (only one review documented in 2011), then annual reviews in 2013 and 2014.

.40 In the period leading up to the incident the Perpetrator had experienced a stress factor related to her financial situation and the funding of a PA. The support and interventions offered by her care team, in particular her LCP were appropriate and helped the service user through this stressful process. It is not evident that this stress factor contributed in any way to the incident. In fact, following the weekend immediately prior to the incident she had indicated that she was happy with the outcome and was looking forward to the continued support of the PA.

.41 The most recent care plan was out of date, not in accordance with Trust policy. However, this Review takes the view that the level of engagement by the Trust and its staff meant that appropriate levels of care were being provided at the time of the incident. The fact that staff had been consistent and that the Perpetrator was well known to the service means that any risk arising from lack of a current up to date care plan is mitigated. However, the organisational discipline in ensuring up to date care plans is something that should be revisited to ensure that such plans are up to date.

.42 This Review finds that that the level of engagement by the Trust and its staff with the Perpetrator was appropriate in all the circumstances.

.43 Did the Trust respond appropriately when the Victim and the Perpetrator called for assistance the day before the incident?

.44 The Review is aware that there was a call to the Trust by the Victim on the 17th November, 2 days before the incident where he asked for a home visit expressing concern about the Perpetrator's state of mind and that she wasn't leaving the house.

.45 We know that following the call the Trust's Duty worker made contact with staff at trust day care facility and tried to call the Perpetrator.

.46 The following day the duty worker called again and did speak to her. The duty worker explored ways to manage her anxiety as well as reengage the day care facility of other outside activities. They discussed her reasons for not leaving the house, established that she had visited her neighbour during that morning and agreed a plan - (i) To attend activities as discussed – this included attending via taxi, support from Personal Assistant and visit to local church. (ii) Duty worker to call again on 24/11/14 to offer support.

.47 It is not certain that a home visit, if arranged, would have made any difference to the outcome. For example, the duty phone conversation could have been a 'face to face' home visit and it is unlikely to have reached a different course of action based on the service user's presenting issues. In the days leading up to the incident there was no evidence or reports of any psychotic symptoms. The predominant issue reported was one of increased anxiety, which was hindering the service user's ability to get of the house. She did manage this on occasion e.g. to the GP's on the 13/11/2014 and to her neighbours on the 18/11/2014. From the Trust's interviews with staff who knew the Perpetrator there was considerable confidence that she would report any psychotic symptoms and their nature as she had done. This would also indicate that the duty response was proportionate. It was also concluded that if the service user's father had expressed any concerns other than anxiety and not being able to leave the house, the duty response would have been different as indicated.

.48 This Review comes to the conclusion that the Trust acted quickly and appropriately following the call from the Victim. The telephone call and the actions they took were appropriate in all the circumstances that prevailed at the time.

.49 Was information shared appropriately with other agencies in order that a whole view of the household could be obtained?

.50 There can be a temptation in Reviews such as this to always criticise levels of information sharing. The Review Panel considered and debated this aspect in depth.

.51 It is clear that there was good information sharing between the GPs and the Trust and vice versa. There is also strong evidence that the Trust worked with those others who were supporting, or could support the Perpetrator, with issues that were presented. This is evident by the contact between the Trust's staff, Suffolk Independent Living and the Local Authority's financial inclusion team when the financial issues arose during 2014.

.52 The one gap, however, that could be said to have existed in this case was the join-up between those supporting and caring for the Perpetrator and those who were asked to assess support for her father. It is clear that when the Adult Social Care staff were tasked with assessing the Victim's situation they were not fully aware of the level of mental ill-health suffered by the Perpetrator; that information being known to the Trust. The question in this case is whether the Trust could or should have made that information available to the Adult Social Care team to enable them to better asses the Victim's needs. This may have led to a more holistic view of the circumstances pertaining within the household rather than one organisation looking at the Victim and one looking at the Perpetrator.

.53 Having discussed this in depth, the Review Panel comes to the conclusion that whilst a professionals meeting may have helped provide a more rounded and holistic view of the household, the fact that one did not take place cannot and should not be subject of criticism in this case.

.54 An individual's medical condition and history is rightly protected in law; with exceptions made for specific reasons. In this case, as a result of professional levels of enquiry and care provided by both organisations (The Trust and the Adult Social Care staff) sufficient and appropriate levels of information were known by both to carry out detailed assessments. Where added layers of detail about the extent of the Perpetrator's mental illness made available to the Adult Social Care team it would have probably made minimal or no difference to the level of assessment and support offered. Such assessments were made on the basis of welfare need and not safeguarding need. There is no evidence that the Perpetrator provided such an immediate threat to anyone else, including her father, that would trigger this to have been considered a safeguarding issue by the Trust. Historic comments about harm to her parents were few and the most recent was six years old; the Trust had managed the issues that prompted those comments and nothing suggested they were being revisited.

.55 Information shared with carers - It is not evident that any risk posed by the Perpetrator to others was specifically shared with the individuals that were the subject of the risk, in particular, her father. The clinical record refers to a number of incidents which include some physical violence and/or references to persecutory thoughts that involved her parents, and suggest that they were aware of the risk. Unless there were clinical reasons for not sharing this information regarding risk, this should have been communicated and documented specifically. This may not have resulted in any material change in the outcome of the incident but good practice would suggest it should have happened.

.56 This Review therefore considers that appropriate levels of information were shared in this case by the Trust.

.57 Importantly, this Review is clear that had the Trust shared any of its information that it held about the Perpetrator's medical history with others, either as a result of consent or otherwise, there is no evidence to suggest that different decisions would have been made that would have prevented the tragedy.

.58 The Trust undertook a Serious Incident Review and Root Cause Analysis of its involvement in this case. That Review largely formed the IMR for this Review. The Chair of this Review has had sight of the Trusts SIR/RCA and can confirm that it contains no material information that is with-held from this Review. This Review confirms the conclusion of the Trust's own review, namely:

"No definite root cause of the incident could be identified by the review team. Risks could have been identified and potentially reduced by improved risk assessment documentation and a more proactive response from the Trust. However it is not evident that these would have prevented the incident because of its unpredictability based on the service user's clinical presentation at the time and leading up to the incident"

.59 Norfolk and Suffolk NHS Foundation Trust: Lessons Learned

The Trust identified several lessons from which it could learn arising from scrutiny of this case. These are set out below but it is the view of the Panel that these lessons are applicable for all agencies to consider when dealing with record keeping and the long-term engagement with service users.

Lesson Learned: That risks exist for organisations when migrating systems for recording risk assessments. Care should be taken to ensure that historical recorded risks are included on any new operating system.

Recommendation 1: Risk Assessments by agencies. Consideration and care should be given to the specific factor of historical risk. It should be convenient for all clinicians and staff to document such risks and for a summary to be electronically 'pulled through' and included in all subsequent risk assessments. Even if the risk not considered to be contemporary, a summary will allow future clinicians and staff ease of access to the information, prompt staff to ask about the risk and not allow staff to omit historical risk once it has been identified.

Lesson Learned: Where service users are well known and subject to intensive long-term support by the same staff a risk can exist that the discipline around maintaining regular documented reviews and updated care plans can lapse.

Recommendation 2.
That organisations ensure it is a key role of supervision to ensure the discipline of documenting regular reviews is maintained.

Lesson Learned: That risk assessments should pay particular attention to historic risk assessments in the context of an identified dynamic risk factor and an objective assessment of any signs and/or symptoms present. Highlighting the nature of dynamic risks and the need to monitor them will encourage/support clinicians to assess for these risks and improve the quality and effectiveness of risk assessments.

Recommendation 3.
Risk assessment training – should emphasise the importance of historical risk assessment, in the Timescale: This should be considered as part of the next review of the Trust's risk assessment training programme or within 3 months. Measure: Specific inclusion of the importance of assessing dynamic risks in risk assessment training.

3.2.3 Suffolk County Council Adult Social Care Services.

.1 This evidence before this Review shows minimal involvement by statutory social care services with both the Victim and the Perpetrator.

.2 There is no evidenced involvement of Adult Social Care with the Victim until the referral by his GP in June 2012. The records that followed that referral do say that he was 'known to the service' but that prior involvement is not considered relevant for the purposes of this review.

.3 The Perpetrator had been in receipt of statutory financial support for several years (known as Direct Payments). These payments were administered by the county's Adult Social Care Services whilst the commissioning of those payments, assessment and support was provided by the Community Mental Health Teams who formed part of the Norfolk and Suffolk NHS Trust.

.4 Direct Payments are paid to customers in lieu of care commissioned by Suffolk County Council; customers can then arrange care to suit their needs and pay for the care with Direct Payment funds. The Perpetrator opted to have a 'supported account' with Suffolk Independent Living, the funds were then paid to them and they held the money on her behalf.

.5 There is no evidence of direct involvement by the Adult Social Care teams with the Perpetrator between 2001 (reference to an initial assessment for undoubtedly for financial assessment purposes) and 2012 when there is record of the Authority issuing her with a letter intending to recoup excess money.

.6 This section will deal initially with the Adult Social Care teams involvement with the Victim before moving to that of the Perpetrator.

.7 The Adult Social Care records show that the referral from the Victim's GP was received on 8th June 2012 and requested adult social care's involvement as the GP reported that the Victim lived alone but spent a lot of time with his daughter (The Perpetrator) who had a diagnosis of schizophrenia. The GP reported that the daughter was going through a difficult stage and felt that he would benefit from a package of care while he was going through this difficult time.

.8 In 2012 the work of Adult Social Care Services was determined by Suffolk County Council's duties and responsibilities under the NHS and Community Care Act 1990 (NHSCCA 1990).

.9 The referral from the GP was received at Suffolk County Council's call centre, Customer First and is intended to be the first point of contact for social services in Suffolk. The member of staff taking the referral would firstly determine whether or not the subject person of the referral was known to the service and whether they appeared to have eligible needs. If the individual was not known to social care services then a record would be generated for them on which personal details, assessments, and work carried out with the individual would be recorded and securely held. They would then generate an Initial Contact record.

.10 The referral from the GP was recorded on an Initial Contact record and then passed to the Enhanced Customer First (ECF) team based in Lowestoft who would have been tasked with trawling any previous records and the current referral to decide whether the individual had needs that would eligible for services under the NHSCAA 1990. No specific risk assessment would have been carried out as routine as part of this initial assessment on the contact record but if any indicators of risk were identified from previous records or in the content of the referral, the expectation would have been to record these and highlight them on the customer's record in order to inform subsequent work. They would normally contact the referrer and the individual to do this. If necessary, a member of staff would visit the subject of the referral to establish their needs and if necessary pass them onto the appropriate social work team for longer term work to meet the individual's needs. Sometimes the individual's needs were able to be met quickly by ECF by providing information/signposting, by providing very short term care support. If the individual refused support the case would be closed at this point.

.11 The task of further exploration of the referral was passed to a named worker. A telephone call was made to the Victim in order to follow up request received from his GP that same day. The Victim said that he was managing with assistance from his daughter at that time but felt that he might need some help in the future. He was given the telephone number for Suffolk County Council's Customer First call centre and advised him to ring as soon as he felt he needed assistance.

.12 Unless exceptional safeguarding issues have arisen Adult Social Care staff can only intervene with the agreement and consent of the individual. The Victim stated that he was managing at the time and declined further support.

.13 This Review concludes that the actions of the social care team at this time were appropriate, proportionate and reasonable in the circumstances. They acted promptly on the GPs concerns and recorded the information correctly for future reference.

.14 Two weeks later, on 25th June 2012 the Victim contacted the number given by the social care team following the previous contact reporting that his daughter normally visited him every evening but was in hospital and he did not know when she would be sent home. He stated that he had been told to contact ACS by his doctor and neighbours to request an assessment of his needs. The Customer Services Assistant (CSA) who took the call, recorded that the Victim had told her that he was able to manage his own personal care, prepare his own meals and that his mobility was fine. It was recorded that he gave the impression that he was managing independently, did not need any social care support and had only rung because his GP and neighbours had told him to. This call confirms the effectiveness of the social care team's initial intervention.

.15 It is to the credit of the Customer First call centre staff and the county's adult social care team (and its systems) that the details of this call were recorded and despite the Victim's confirmation that he felt he could manage; the matter was passed on again to the same named worker who had previously made contact with him.

.16 After receiving details of the additional call the social care worker on this occasion visited the Victim at his home to discuss his situation further. This was an entirely

appropriate action and demonstrates good service user knowledge together with an ethos of care. It would have been easy to take the view that given the Victim's stance no visit was necessary or desired. The visit was timely, and was undertaken just over a week following the call.

.17 During the visit it is noted that the Perpetrator was present. The worker recorded that he had very poor mobility, angina and prostate (gland) problems. The Victim declined any support from ACS and reported that he was able to manage with the support of his daughter and a neighbour. He was provided with information to read through and advised to ring Customer First if he needed help or support in the future. There is no evidence of the offer of a carers assessment for the Perpetrator. Given that the Victim was clear in his refusal of services this is perhaps not surprising but with the value of hindsight such an assessment could have been useful as it may have alerted the ASC staff to the nature of the illness suffered by the Perpetrator; She may, of course, have refused such an assessment in any case. Such disclosure may have led to a professional's conversation or meeting to discuss the holistic picture of the household that existed at the time. This is previously discussed in detail at 3.2.2 points 52 to 54.

.18 The worker recorded an Adult Social Care assessment. The assessment was carried out in accordance with prescribed policies and procedures and looked at various aspects of his life including: Physical and Mental Health, Mobility, Accommodation, Daily Living and Finances, Employment, Education, Community and Social Activities, Family and Key Relationships and Personal Safety in order to gain a holistic view of the Victim's circumstances. The worker would have asked questions pertaining to each subject area to gain an overall picture of the Victim needs which could have then informed his eligibility for services provided by SCC ACS services.

.19 The assessment's summary and recommendations make no mention of perceived significant risk factors.

.20 All assessments are closed with an outcome. There is a selection of answers appropriate to the type of assessment being carried out available on a drop down menu at the conclusion of the assessment recording. The outcome of this assessment was 'new services offered but declined'.

.21 The named worker has been spoken to as part of this review process, she reported that she did not identify any obvious risk factors during the visit but if she had, she would have recorded them on the Victim's record to inform subsequent workers. She recalled that there was nothing remarkable about the situation. When she visited the property, both the Victim and the Perpetrator were present. They showed her around the property. She was told that the Perpetrator lived a few doors away but visited on a daily basis and that the couple appeared to be devoted to each other. She reported that the victim refused all offers of help so she left some leaflets and the contact number for Customer First.

.22 In the knowledge of what is now known she stated that she was unaware of the whole circumstances that prevailed in the household at the time (i.e. the level of the Perpetrator's mental ill-health) there being minimal information from CMHT's (Community Mental Health Team) work available on the ACS recording system. This issue will be revisited within the summary at the end of this section.

.23 The first indication of specific contact with the Perpetrator is in February 2012 when a record is created by the county's Direct Payments Team indicating their intention to recoup excess funds from the Perpetrator's direct payments account. She was only allocated to the Lowestoft Older Persons and Disability team (later called Adult and Community Services and now Adult Social Work Services) for 2 days. Otherwise she was allocated and supported by Lowestoft CMHT and it would have been that team who would have commissioned the direct payments based on their assessment of the Perpetrator's eligible needs and how to meet those needs. Only a minimal amount of information regarding the CMHT's work is held on the ASWS recording system.

.24 The entry on the record for the Perpetrator refers to the Direct Payment team's 'intention' to recoup excess funds from her 'supported account' at Suffolk Independent Living (SIL). In fact SCC had already recouped the amount of £357.66 which she had authorised SIL to return.

.25 Suffolk Independent Living is an organisation that was, at the time of the Victim's death, part funded by Suffolk County Council and was set up to provide a support service available to customers receiving Direct Payments. The support varied according to the customer's needs and included support with recruitment of personal assistants/carers and payroll duties. The arrangement between SIL and the County Council has now ceased.

.26 A condition of the Direct Payment Agreement that the Perpetrator signed states that every quarter she agreed to provide SCC with a summary of her income and expenditure in relation to the Direct Payment funds. SIL provides this information on her behalf. Based on this information if a customer has more than 8 weeks of Direct Payment funds in their account a letter is automatically sent from SIL (as agreed with SCC) asking the customer if there is any reason why they have excess funds, if there no specific reason then we ask for the funds to be returned to SCC. At that time she had no specific reason and signed the form agreeing for SIL to return the excess funds to SCC. There was no change in circumstance which led to the decision to recoup, this was (and still is) the policy followed.

.27 All Direct Payment customers are governed by the same rules and regulations whether they are funded through SCC or the Norfolk and Suffolk NHS Foundation Trust so this has no bearing on the decision to request a recoup of funds. Direct Payments then continue to be paid at the same weekly rate until the customer has a reassessment of their care needs.

.28 As far as the Direct Payment team were aware, the Direct Payments were paid so that she could employ a personal assistant.

.29 Direct Payments started on 3rd June 2006 and ceased 28th July 2014. During this period of time the total amount of Direct Payments paid is £27,187.96.

30 The result of the letter in February 2012 was the return of the excess funds to SCC, therefore no further action was required by the Direct Payment team.

.31 This Review is cognisant of the timing of this letter in relation to the visits to the GP which resulted in the Victim's circumstances being referred to ASC for assessment. This issue will be revisited within the summary of this section.

.32 On 26th June 2014 an identical note on the Perpetrator's record to that described above appears. This entry refers to the Direct Payment team's 'intention' to recoup excess funds from the Perpetrator's 'supported account' at Suffolk Independent Living (SIL). In fact, SCC had already recouped the amount of £3,732.04 which the Perpetrator had authorised SIL to return. Thus, there was no requirement for further action.

.33 In July 2014 a referral for the Perpetrator was made to Suffolk County Council's Financial Inclusion and Advice Service by her mental health support worker. This was due to the financial situation that had arisen as a result of the Perpetrator selling her own home and moving in with her father in July 2013. The equity received from the house sale meant that she no longer qualified for financial support.

.34 It must be noted that both the Victim and the Perpetrator notified the authorities of the house sale and their living arrangements in a timely manner when it occurred. It is likely that they anticipated a financial impact from these new arrangements.

.35 We are able to say from the records held that staff from both the mental health trust and the local authority's financial inclusion team spent time with the Perpetrator working through the financial assessment and signposting her to other organisations for additional advice. It is reasonable to assume that these discussions led to a letter being sent to the Victim in September 2014 also outlining the financial situation and that she would no longer be entitled to Direct Payments from Suffolk County Council.

.36 This letter would not have been sent to the Victim's as a result of him being the Perpetrator's carer. It would only have been sent to him if permission were received from the customer (The Perpetrator) to do so.

.37 During the early stages of this Review we were concerned that the process of recouping what were thought to be overpayments of the Direct Payment fund made to the Perpetrator may have contributed to increased levels of anxiety and stress and exacerbated her mental ill-health during that immediate time (February 2012 and June 2014). Having spoken with staff at Suffolk Independent Living, examined the process surrounding these payments and having had the benefit of information from the county's adult social care team those initial concerns have been allayed.

.38 The decision to stop the Direct Payments as a result of the Perpetrator's financial assessment following the sale of her home did clearly increase her levels of anxiety and became a significant issue of discussion and stress.

.39 This Review does not criticise that decision in any way; it was made in accordance with legislation and was communicated appropriately.

.40 It is also clear that staff from the mental health trust and the local authority and Suffolk Independent Living were all involved in supporting the Perpetrator and the Victim in working through its ramifications.

.41 The real issue that the decision prompted was whether the Perpetrator would pay privately to continue with her Personal Assistant support. It seems clear that the Victim's view was that they could manage without and didn't want to spend the money on that service. The conversations that appear to be recorded in the notes of others are that the Perpetrator didn't know what to do but prior to her brother visiting at the weekend immediately before the incident, had decided to stop the service. We know she changed her mind after that visit and had decided she would continue with the service. There is no indication that this caused any difficulties between the two in days that followed, in fact, those who visited felt things were as normal as they could be.

.42 Summary of Adult Social Care involvement

.43 The Review has looked at whether the referral in 2012 from the Victim's GP, followed by his telephone call a couple of weeks later, could or should have been dealt with differently. The Review comes to the conclusion that the Adult Social Care staff and the process by which it gathered and assessed the information were entirely appropriate. Their actions were timely and a personal visit was made to assess the situation which was a good positive intervention.

.44 The issue that requires further mention is whether that member of adult social care staff who carried out that assessment could or should have reasonably been made aware, or have been able to reasonably ascertain, the level of mental ill-health suffered by the Perpetrator. After all, one of the contributing factors for consideration was that the Victim was managing with the help of his daughter. Unfortunately, his daughter was prone to suffering bouts of acute mental ill-health and thus her capacity at times to help look after him was severely impaired. There is no evidence of a carers assessment being offered to her. Such an offer, if agreed to, could have led to the Adult Social Care team becoming aware of the level of her illness. However, that illness, at the time was being effectively managed by specialist staff and there were no concerns about her risk to others or her ability to manage in the household with her father in an increasingly caring role.

.45 On balance, this review comes to the conclusion that the involvement of the social care team in this instance was centred, rightly, around the Victims welfare needs, not a safeguarding need. In view of that, whilst a conversation between adult social care and the mental health trust about the Perpetrator's capacity to act as carer would have been preferable, it is not likely to have made any tangible difference to the outcome. The Victim was capable of making his own decisions to decline support and this was not such an acute case where care could be enforced.

.46 The Panel did consider whether a separate recommendation be made in order to ensure that professionals meetings were held in each case where service users were involved with more than one service. It felt on balance that this was unnecessary but rather that learning from this case should be passed through the Adult Safeguarding Board and that where service users are involved with more than one service then consideration should be given to a professionals meeting in order that and holistic view of the circumstances prevailing at the time is available.

3.2.4 Suffolk Constabulary

.1 Until the incident on 19th November 2014 police involvement had been limited to responding to crime reports and general enquires. There is no recorded history of violence between the Victim and the Perpetrator.

.2 There was one previous engagement by the police with the Perpetrator where they supported health service colleagues when she was suffering a severe mental ill-health episode. This occurred in April 2003 when she was found naked in the street following reports made by members of the public. Police officers and an ambulance attended the scene. The Perpetrator's welfare was considered by the staff in attendance, she was taken to hospital having fallen and hurt herself.

.3 This was an appropriate course of action; the Perpetrator had been identified as requiring medical assistance and was appropriately tended to by ambulance staff who took the lead. There was no necessity for the police to engage further in this incident as it was clearly a health related issue; the police supported accordingly.

.4 In June 2013 the Perpetrator reported that there had been a burglary at her house. When seen by a police officer she was accompanied by a neighbour, the police officer established that she suffered with mental ill-health issues and that she was upset by the burglary. Some weeks later the officer updated her with the outcome of the investigation. The Perpetrator said it was her intention to sell the property and move in with her father. Whilst the officer had established that she suffered with mental ill-health issues, there was no apparent cause for concern regarding her welfare and no requirement for any referral to be made.

.5 These two issues, over ten years apart were dealt with appropriately by police and this Review does not suggest that any further referrals or action was necessary in the circumstances that prevailed at the time.

.6 Prior police interaction with the Victim was confined to three instances over the previous thirteen years. All were routine police matters (theft of a ladder, an enquiry about a gun amnesty and damage to a caravan). Those incidents have been scrutinised and there is nothing that has emerged that could be relevant for the purposes of this Review.

.7 The issue of the police response to the emergency call made by the Victim at the time of the attack has been scrutinised by the Independent Police Complaints Commission (IPCC) in conjunction with the Police. This Review has therefore not concerned itself with that aspect as to do so could have the capacity to divert attention from the whole set of circumstances that preceded it and amount to duplication.

.8 The Chair of this Review has liaised with the Police to ensure that any issues arising from that investigation and relevant to this Review have been identified and incorporated within this report.

.9 As a result of the IPCC investigation it was clear that the call made by the Victim at 8:53pm on the night of the incident was not handled correctly by a police control room operator. Subsequent internal proceedings led to that operator's employment

in the police control room being terminated. Given the nature of the attack, in particular that it almost certainly happened at the time of the call made to the police, it is important to note that even had the call been handled differently then it is unlikely that officers would have been able to attend in time to save the victim. Whilst this cannot be said with absolute certainty, it appears to this Review that the victim is likely to have been dead immediately after the call terminated.

.10 The investigation did not find systemic or procedural failings by the police at the time. It did however ask that its findings were included in ongoing work of Suffolk and Norfolk Constabularies to align their call grading system. Since this incident the police have moved to a new method of dealing with each call based upon a more rigorous assessment of the threat, risk and harm posed by each incident.

.11 As a result of the scrutiny of the emergency call made on the night undertaken elsewhere, this Review concludes that that aspect is sufficiently exhausted. This Review has concentrated on the circumstances that prevailed in the months and years leading up to the incident and the appropriateness of agency response and action. The specific response to the incident on the night does not affect the analysis of those prior circumstances.

3.2.5 East of England Ambulance Service NHS Trust (EEAST)

.1 The East of England Ambulance Service Trust received three calls for assistance with issues relating to the victim between 2009 and the date of the incident (not including the incident resulting in his death).

.2 One was for a fall, one was a hospital transfer request and the other was a call after The victim suffered what was described as numbness in his hand. On each of these occasions it is clear the Ambulance service took direct action (in treatment and conveyance to hospital) or made appropriate referrals to others (GP and alternative transport services).

.3 During the course of the same period there were four calls associated with the Perpetrator.

.4 The first was in December 2011 when the ambulance service attended her home. On assessment the medical history was recorded as non-insulin controlled diabetic, anxiety, depression, query schizophrenic and query psychosis.

.5 Ambulance crews have no access to patient's medical history therefore rely on gaining this information from the patient, carers, others on scene or care notes held by the patient. Crews will also, if relevant, consider contacting the GP for further information. Baseline observations, in line with Trust protocol, were taken and a discussion took place with the GP who agreed to make arrangements for a nurse to attend that afternoon and also for attendance by the CPN team. It was noted that the patient became hostile at the mention of her symptoms being mental health related.

.6 In February 2012 the service was called to what was described as a possible stroke, (left side numb) for the same patient. The notes state that the patient admitted to not taking her medication since November 2011 and the GP was unaware of the noncompliance with the medication. The patient was advised to see her GP in the morning and left in the care of a neighbour.

.7 In October 2012 a call was received from the Perpetrator, crying, saying 'can't cope anymore'. The Community Psychiatric Nursing team were already at the scene. An appointment was made for the patient with the GP later in the day. It was also noted that '(The Perpetrator) has a good network of friends, one friend has taken a letter that she wrote to (the GP), explaining that she is unable to cope with her father, but it appears that her father is quite able and self- caring'. It is not clear if this was the opinion of the crew or information given by the friend. The previous medical history was listed as Mental Health: anxiety/panic.

.8 In March 2013 the service attended a call from the Perpetrator when she reported feeling unwell. Upon attendance the crew conveyed her to the local hospital for checks to be made as there were concerns about a possible stroke.

.9 All the calls received by EEAST were responded to within the target times. All calls received an appropriate response and there were no noted instances of back up for intervention or treatment.

.10 The varied previous medical histories provided to crews by the Perpetrator highlight a concern that information shared with clinicians may not always be accurate or complete. EEAST can only consider the information shared by the patient, carer and others on scene unless contact is made with the GP. It would prove challenging to GPs if all attendances by ambulance staff resulted in a telephone call for further information.

.11 This Review is confident that the actions taken by the staff of the East of England Ambulance Service Trust were appropriate in all the circumstances scrutinised by this Review. Good communication was made with GPs and other specialist services.

3.2.6 The voluntary and third-sector organisations involvement.

.1 The information provided to this review paints a picture of the victim being a private and proud man. It appears that before the death of the victim's wife in 2009 the couple were quite consistently involved with a small number of organisations from whom they gained support and social interaction. That engagement diminished following her passing. Amongst these was a Suffolk-wide charity known as Suffolk Family Carers.

.2 Suffolk Family Carers have a long history within Suffolk and provide information, advice and guidance to family carers of all ages.

.3 They provide a range of services to support adult, young and young adult carers across the county including visits in rural locations to provide information and advice to those who are isolated due to their caring role.

.4 Suffolk Family Carers were invited to participate in this Review. They did so fully and the Review would like to formally thank the organisation for its positive contribution to the Review and its findings.

.5 The organisation was involved with the Victim and his wife in their role as carers for the Perpetrator. The available records indicate this was from the mid-2000's onwards. The couple, and The Perpetrator were well known to staff and following her death they attempted to continue engagement with the victim. He declined to engage, however he always did respond when being invited to events and often sent a donation following with his decline. At some point between 2010 and 2013 he asked to be taken off the mailing list. There was no further contact between the organisation and him until the morning of the incident.

.6 On that morning a call was made by the Victim's to Suffolk Family Carers general telephone number. The call taker spoke to both the Victim and the Perpetrator and the general nature of the call was that they were 'struggling a bit' and could do with some support. Neither the Victim nor the Perpetrator put their issues at any higher than that and the call taker had no reason to consider it as any other. Procedures were in place at the time for any issues of urgent note to be forwarded to the County's Adult Social Care team or any of the other urgent referral routes that exist within the County. This call did not reach that threshold and thus there was no onward referral. The caller did pass on the number for Customer First (the county's adult social care first contact point) as a way of obtaining additional statutory support and also made arrangements for a Suffolk Family Carer's support worker to visit. This arrangement was made the following day, by that time of course it was too late.

.7 This Review considers that Suffolk Family Carers did all that it could reasonably have been expected to do given the information it held at the time of the call on the morning of 19th November. They recognised that support was needed and made arrangements for that support. There was no reason at that stage for them to realise the urgency of that support. In fact, it could be argued that given the circumstances that prevailed leading right to the incident that night that no one could reasonably have foreseen the urgency of the situation, perhaps that urgency did not exist.

.8 Suffolk Family Carers have shown themselves to be a learning organisation and have taken on a number of single agency changes since this incident.

3.3 Other issues considered

.1 Throughout the process of this Review it has considered the services provided within Suffolk and the operational effective, operation effectiveness and the strategic governance thereof.

.2 The Review considers there to be a good understanding of domestic abuse, its signs, how to signpost and where to go for advice and support at an operational level. The development of a multi-agency safeguarding hub (MASH) is a positive example of good partnership working at an operational level. Its development has been noticeable by positive comment at each of the Panel's meetings. The MASH is widely publicised and is explained as follows on the Constabulary (but also other statutory agencies) website:

"A range of organisations in Suffolk with responsibility for safeguarding both adults and children such as Suffolk County Council, Suffolk Police, Health Services, District and Borough Council Housing Services, Education, Probation and the Youth Offending Service have come together to create a Multi-Agency Safeguarding Hub (MASH).

The Suffolk MASH, has been developed as a result of learning from previous experiences, especially from lessons highlighted by reviews of serious safeguarding incidents across the country. A recurring theme of these reviews is the importance of information sharing and close working arrangements between relevant agencies. The MASH model has been strongly endorsed in the OFSTED report 'Good Practice by Local Safeguarding Boards' and 'The Munro Review of Child Protection'. The Care Act 2014 draft guidance also highlights a MASH which includes adult safeguarding as best practice.

The MASH is being implemented in stages to make sure that the high standards of safeguarding already in Suffolk don't suffer during the transition from current arrangements to a fully functioning MASH by the end of the summer. Once fully operational the MASH will be made up of approximately 60 professionals from the county council Children and Adult Services, Suffolk Police, Health and Mental Health Services, Youth Offending Services, Housing and Probation. The majority of these staff will be located at Landmark House in Ipswich.

The main advantage of the MASH is that officers can share the information their agency may have on a child or adult immediately to ensure the decisions taken about how to help an individual are done so, taking into account all available information."

.3 A revised County-wide Domestic Abuse Strategy was produced in 2015 by the Suffolk Domestic Abuse Partnership. Entitled 'Domestic Violence and Abuse: A Partnership Strategy for Suffolk. 2015-2018'. This is a comprehensive document and should drive Domestic Abuse strategy, thinking and delivery for the next three years.

.4 The County's Police and Crime Commissioner has helpfully made tackling Domestic Abuse one of his top priorities and took a lead in commissioning a research paper: "Understanding Domestic Abuse: A study of the experience of survivors". This could

be a catalyst for providing a new and fresh structure. It is well referenced within the new County Strategy document outlined above.

.5 The Chair was pleased that one theme within the County's Health and Wellbeing Boards' work programme will look to lead on domestic abuse. However, the Police and Crime Commissioner is not a statutory member of the Health and Wellbeing Board with the resultant risk that areas for which the Police and Crime Commissioner has primacy are not necessarily linked with those that the Health and Wellbeing Board have primacy.

Lesson Learned: The two-tier structure of the Local Authority, the independent nature of Community Safety Partnerships with no direct county-wide oversight, the emergence of the Police and Crime Commissioner and Health and Wellbeing Boards has the potential for making a clear governance structure difficult to achieve. However, it also provides great opportunity for strong partnership arrangements that drive down to a local level. The Chair of this Review has been struck by how many individuals truly want to make a difference. It is therefore essential that organisations agree a clear governance structure for Domestic Abuse in order to harness everyone's undoubted passion for making a difference.

Recommendation 4: That a clear County-wide partnership governance structure be established for the strategic leadership of domestic abuse within Suffolk

3.4 Equality and Diversity

Throughout the conduct of this Review the Chair and Panel have been cognisant of all aspects around equality and diversity issues. As new material arose, those aspects were considered as part of the ongoing Review process. In particular, in this case, the Panel was aware that attitudes, policies and processes relating age and mental health required particular scrutiny.

The Review does find that all agencies paid particular attention to the issues that presented themselves and we do not find that there was any direct or indirect discrimination in any of the organisations policies or practices, or indeed displayed by any of the staff working with or for them.

The Chair and Panel considered very carefully the issue of information sharing, in particular the level of mental ill-health being suffered by the perpetrator in so much as knowledge of it may have assisted the social care assessment of the Victim. We have considered, for instance whether the level of information sharing would have been different had that illness been a physical condition. Whilst it would have been obvious to an assessor at the time of assessment if the perpetrator (and as such, carer) had, for instance, a broken leg, it may affected the assessment. However, any less visible but equally debilitating physical injury may not have been disclosed. Therefore the non-disclosure of the level of her mental ill-health, whilst certainly not helpful in the circumstances, was not directly or indirectly the result of any prejudice.

The current national debate about parity of esteem and awareness around mental ill health is helpful in this respect. The NHS England paper on parity of esteem can be found at:

(https://www.england.nhs.uk/mentalhealth/parity/)

Section 4: Conclusions

.1 This was a truly tragic case where a loving and caring father was killed by his very ill daughter.

.2 Our thoughts are with the family left behind in such difficult circumstances.

.3 The issue of the police response to the emergency call made by the Victim at the time of the attack has been scrutinised by the Independent Police Complaints Commission. This Review has therefore not concerned itself with that aspect as to do so could have the capacity to divert attention from the whole set of circumstances that preceded it. This Review has concentrated on the circumstances that prevailed in the months and years leading up to the incident and the appropriateness of agency response and action.

.4 The issues that comprise this case demonstrate the very real difficulties that exist in managing the risk posed by those people suffering the type of illness as suffered by the Perpetrator.

.5 Whilst properly trained professionals should be expected wherever possible to recognise and mitigate that risk this case exemplifies how it is impossible to completely eradicate it.

.6 This Review concludes that those caring for the Victim and the Perpetrator did what they thought was appropriate in all the circumstances. They used professional knowledge and judgement to make referrals, provide support and reduce the risk that existed from the Perpetrator of self-harm and harm to others.

.7 Whilst there is evidence that the Perpetrator had made previous comments about thoughts of harm to her parents, and that these comments were not available to those who had completed the most recent risk assessments and care plans, the Review does not conclude that if that information had been known any other course of action would have been taken that would have prevented the death of the Victim. Those comments were historic and a symptom of her illness which had been managed effectively in difficult circumstances for many years.

.8 Services were involved with both the Victim and the Perpetrator and each dealt with their respective client. A conversation between professionals to ensure that an holistic view of the household was available would have been helpful, however, given the assessed low level of risk that existed at the time in relation to the Victim's age and the Perpetrator's illness it is unlikely that it would have made any difference to the services provided.

.8 The Norfolk and Suffolk NHS Foundation Trust and the GPs in this case had significant knowledge of the Perpetrator, her illness, the symptoms that manifested themselves in times of high anxiety and had successfully managed those symptoms for many years. There was nothing in the days immediately preceding the death that was at variance with previous issues of high anxiety and depression. In fact, the work done with her over the preceding weeks and the visit by her brother over the previous weekend seemed to have reduced the anxiety over the immediate financial

pressure in the days leading up to the incident. In fact, on the very day of the incident itself there do not appear to have been any signs of what was to come.

.9 One can only come to the conclusion that in the minutes immediately preceding the Perpetrators attack on her father, thoughts had come to her that prompted the attack.

.10 This Review does not consider this could have been reasonably predicted or prevented.

Examples of good practice

The use of a Domestic Homicide Review Advisory Panel to provide rigour around early decision making by the Chair of the Community Safety Partnership.

Lessons learnt

Lesson Learned: That risks exist for organisations when migrating systems for recording risk assessments. Care should be taken to ensure that historical recorded risks are included on any new operating system.

Recommendation 1: Risk Assessments by agencies. Consideration and care should be given to the specific factor of historical risk. It should be convenient for all clinicians and staff to document such risks and for a summary to be electronically 'pulled through' and included in all subsequent risk assessments. Even if the risk not considered to be contemporary, a summary will allow future clinicians and staff ease of access to the information, prompt staff to ask about the risk and not allow staff to omit historical risk once it has been identified.

Lesson Learned: That where service users are well known and subject to intensive long-term support by the same staff a risk can exist that the discipline around maintaining regular documented reviews and updated care plans can lapse.

Recommendation 2.
That organisations ensure it is a key role of supervision to ensure the discipline of documenting regular reviews is maintained.

Lesson Learned: That risk assessments should pay particular attention to historic risk assessments in the context of an identified dynamic risk factor and an objective assessment of any signs and/or symptoms present. Highlighting the nature of dynamic risks and the need to monitor them will encourage/support clinicians to assess for these risks and improve the quality and effectiveness of risk assessments.

Recommendation 3.
Risk assessment training – should emphasise the importance of historical risk assessment, in the Timescale: This should be considered as part of the next review of the Trust's risk assessment training programme or within 3 months. Measure: Specific inclusion of the importance of assessing dynamic risks in risk assessment training.

Lesson Learned: The two-tier structure of the Local Authority, the independent nature of Community Safety Partnerships with no direct county-wide oversight, the emergence of the Police and Crime Commissioner and Health and Wellbeing Boards has the potential for making a clear governance structure difficult to achieve. However, it also provides great opportunity for strong partnership arrangements that drive down to a local level. The Chair of this Review has been struck by how many individuals truly want to make a difference. It is therefore essential that organisations agree a clear governance structure for Domestic Abuse in order to harness everyone's undoubted passion for making a difference.

Recommendation 4. That a clear County-wide partnership governance structure be established for the strategic leadership of domestic abuse within Suffolk.

Action Plan

RECOMMENDATION	Scope of Recommendation	Action to be taken	Key milestones to enact recommendations	Target date	Progress indicator	Date of completion and outcome
What is the over-arching recommendation?	Local, regional or national level?	How relevant agency will make this recommendation happen? What actions need to occur?			Red Amber Green	
Recommendation 1: **Risk Assessments by agencies. Consideration and care should be given to the specific factor of historical risk. It should be convenient for all clinicians and staff to document such risks and for a summary to be electronically 'pulled through' and included in all subsequent risk assessments. Even if the risk not considered to be contemporary, a summary will allow future clinicians and staff ease of access to the information, prompt staff to ask about the risk and not allow staff to omit historical risk once it has been identified.**	Local	Affects all agencies undergoing change. Ensure clear and effective processes are in place to ensure that organisations are aware of the risk of historic information not being transferred when recording or assessment systems change.				

Recommendation 2: **That organisations ensure it is a key role of supervision to ensure the discipline of documenting regular case reviews is maintained.**	Local	Affects all agencies whether that be care plans, investigation notes, medical reviews etc.				
Recommendation 3: **That a clear County-wide partnership governance structure be established for the strategic leadership of domestic abuse within Suffolk**	Local	Identify and gain agreement of key organisation required to develop a county wide strategic leadership approach Develop a governance arrangement for strategic leadership for domestic abuse across Suffolk Identify leads for domestic abuse within each organisation Develop clear terms of reference for strategic roles to enable each organisation to understand their role and function within the county in preventing and reducing harm caused by domestic abuse				