Domestic Homicide Review

Executive Summary

Report into the death of Amy (pseudonym)

January 2021

Report Author and DHR Chair: Stephen McGilvray

March 2024

Contents.

Glossary

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

1. The Review Process

1.1. This summary outlines the process undertaken by Safer Sefton Together Domestic Homicide Review Panel in reviewing the homicide of Amy who was resident in their area. The following pseudonyms have been used in this Review to protect their identities and those of their family members.

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

- Amy Mother of perpetrator. Deceased Aged 81 years
- Brian Perpetrator. Aged 53 years
- Colin Father of perpetrator Aged 85 years

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

1.4. In February 2021 Merseyside Police notified Safer Sefton Together about the murder of Amy. Members of the Safer Sefton Together then met and agreed there was a requirement to complete a Domestic Homicide Review (DHR) in line with expectations contained within Multi-Agency Statutory Guidance for the Conduct of DHRs 2011 as amended in 2016. The Home Office were notified of this decision.

1.5. All agencies that potentially had contact with Amy, Brian, or Colin prior to the point of Amy's death were contacted and asked to confirm whether they had involvement with the family and were asked to secure their files relating to them.

1.6 A Serious Incident Review was completed following the murder of Amy and with the permission of that reviews authors elements of it are included within this report.

2. Contributors to the Review

2.1. The following agencies submitted Individual Management Reviews (IMR):

- Merseyside Police
- Southport and Ormskirk Hospital NHS Trust
- Living Well
- Mersey Care, NHS Foundation Trust
- Sefton MBC Adult Services
- Clinical Commissioning Group

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

2. The Review Panel Members

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

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

- Paul Grounds — Detective Chief Inspector, Merseyside Police.
- Janette Maxwell — Locality Team Manager Sefton MBC.

3.2 At a meeting of the DHR Panel it was agreed that the Review Panel would benefit from the knowledge and experience of Steven McDermott who has over 10 years' experience working for a Sefton based mental health support group.

3.3 The Panel met a total of 4 times.

3. Chair of the Review Panel and Author of the Overview Report

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

4.2 Prior to being commissioned to complete this Review Stephen had completed 30 years Police service with Merseyside Police. It was 16 years ago that Stephen retired from Merseyside Police.

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

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

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

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

5 Terms of Reference for the Review

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

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

5.2 Following a review of chronologies submitted by Panel members the following key lines of enquiry were agreed.

1. How effective was information sharing between agencies and information databases held by agencies and what impact did this level of effectiveness have upon the care of Brian.

2. Where this families risks and needs ever assessed in particular following Colin's diagnosis and subsequent death.
3. Was the appropriate level of support provided to Brian and his family and was the situation in which the family found themselves ever taken into account when making decisions regarding the level of support.
4. Could more mental health support and treatment have been provided to help Brian manage his illness?

6 Summary Chronology

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

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

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

6.4 Brian has an established diagnosis of Treatment Resistant Schizophrenia. Clinicians deemed Brian to be low risk and requiring low-level support and his clinical needs were met via a non-CPA framework approach administered by mental health services. Following two medicinal treatments which did not

control Brian's schizophrenia Brian was prescribed Clozaril medication which if not carefully managed could have serious impacts on a patient's health. To safeguard against this risk, regular white blood cell monitoring is mandatory and Brian would attend for monitoring of his blood count levels through blood tests every month with Mersey Care. This remained Brian's medication until Amy's murder.

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

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

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

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

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

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

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

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

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

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

6.13 The G.P. referral was acknowledged by Mersey Care and a record made that the referral had been passed on to the CMHT, there is no evidence to indicate what action was taken by the CMHT as a result of the referral. This referral was not discussed in any Multi-Disciplinary Team (MDT) meeting and there is no evidence of the referral having been received by the community mental health team on the local division clinical information system or within MDT minutes.

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

6.15 On the 23rd March 2020 the Prime Minister announced the first Covid 19 "lockdown" in England. The weekly cycling and walking groups that supported and helped to manage Brian's schizophrenia immediately stopped

together with his other social activities, visits to the gym and cinema and meals at the pub, in accordance with the Prime Ministers instruction.

6.16 From 1st April in order to ameliorate the impact of the cessation of the walking and cycling groups the Social Care Support Workers who led the groups made a weekly telephone contact call with clients who were in receipt of treatment from Mersey Care for their mental illness. Brian was part of the group now in receipt of the weekly telephone call. During one of the first phone contacts to be made the Support Worker noted that Brian "*sounded quite low and reported that he felt anxious*".

6.17 Brian had been supported since 2018 by the same Support Worker and it should be noted at this point that the Social Care Support Worker developed a good supportive relationship with Brian and throughout the time he provided that support Brian felt confident enough to make several disclosures about his mental state.

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

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

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

6.21 On two occasions prior to Colin's death the Support Worker discussed with Brian some coping mechanisms to help with his low mood and anxiety.

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

6.23 Amy's G.P. records that in July 2020 Amy was suffering panic attacks due to the stress of her husband terminal illness. It was later recorded that during the period July – October 2020 Amy was frequently attending surgery suffering from a reaction due to the grief she was feeling from Colin's illness and subsequent death. The G.P. records that "*He (Colin) arranged everything and without him she was lost*."

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

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

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

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

6.28 In mid-August 2020 Colin died.

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

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

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

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

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

6.34 In October 2020 the weekly telephone support stopped and no contact, apart from an Out Patient appointment in December 2020 and his monthly Clozaril Clinic appointments, was made by any services with Brian or Amy until Amy's murder.

6.35 During 2020 services made offers of support to Brian and Amy. Advice on coping strategies, access to the duty mental health team, bereavement counselling and a referral of Amy to a social prescribing service, Livingwell. Access to the duty mental health team and bereavement counselling were never acted upon by either Brian or Amy and contact with the social prescribing service by Amy was very limited. No formal risk or care assessments were undertaken with Brian or Amy at any point.

6.36 In December 2020 an outpatient's review was conducted with Brian via telephone. The review was completed by a qualified Doctor in clinical training with Mersey Care. In addition to their induction, robust training program and ongoing supervision by a Consultant provided by Mersey Care the Doctor will have already completed a medical degree and foundation training, and have anywhere up to eight years' experience working as a hospital doctor. At the end of the appointment Brian reported "*No concerns.*" However, it was noted by the Doctor that Brian had disclosed that three weeks earlier he had auditory hallucinations commanding him to kill himself but these hallucinations had now stopped and he confirmed he had no intention on acting on them. The clinician also recorded that Brian *"reported feeling "up and down", lacking motivation. He states that he feels that he has lost his energy sometimes. He mentions that he sleeps 11 hours on average".*

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

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

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

6.40 After discharge from hospital following treatment for the physical injuries sustained in the fall Brian was detained under Section 2 Mental Health Act 1983.

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

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

7. Key Issues Arising from the Review

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

Clozaril medication which had remained unchanged during the period of this review. Due to the possible physical effects of Clozaril Brian attended a monthly Clozaril Clinic where clinicians from Mersey Care obtained blood samples.

7.2 In January 2020 due to a worsening of his depressive illness, a symptom of his schizophrenia, and a two year gap since Brian had been last reviewed by a psychiatrist a request that a review of Brian's mental illness be undertaken was forwarded to Mersey Care by Brian's G.P. The request from the G.P. was recorded as being received by Mersey Care. Although the referral was acknowledged and an entry made that it had been passed on to the CMHT, there is no evidence to indicate that any action was taken by the CMHT, upon receipt of the referral letter.

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

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

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

7.6 The walking and cycling groups were a mixture of people. Those like Brian for whom exercise helped to moderate the symptoms of their illness and other members of the public seeking the benefit of a healthy lifestyle. During the periods of national lockdown to control the spread of the Covid virus the walking and cycling groups stopped completely and in Brian's case were

replaced by weekly telephone support calls which were made by the same Support Worker who accompanied Brian on the cycling and walking group activity.

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

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

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

7.10 Training records have been examined and it has been established that the Support Worker working with Brian had received no mental health, or risk assessment training, in preparation for this role and the likelihood of receiving such information.

7.11 It is acknowledged by the Panel that whilst forming part of the CMHT, and prior to the implementation of Government restrictions to control the spread of the Covid virus which lead to the temporary closure of such offices and staff working from home, the Support Worker worked in a multi-agency co-located office and would have gained some knowledge useful to his role in supporting

Brian. Throughout the period he was working with Brian the Support Worker recorded all the disclosures made by Brian onto the Mersey Care and Adult Services databases. Thus both organisations were in receipt of an increasing body of evidence that Brian's incidents of low mood and anxiety were becoming more frequent.

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

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

7.14 From 23rd March 2020 governmentally imposed restrictions to combat Covid 19 included restrictions on office-based working with staff from many service areas now working remotely from home. It is acknowledged that this may have contributed to less effective communication and information sharing and the withdrawal of normal interpersonal office interaction and contact with supervisors which in turn may have impacted upon a referral being made of Brian to MDT for assessment.

7.15 In July 2020 for the first time the Support Worker informed his team manager that he had been supporting Brian in the community since April and detailed the disclosures Brian had made during that time. The team manager instructed the Support Worker to refer Brain to be assessed so that his needs could be identified and so that Brian may receive support from the re enablement team. Had this instruction been followed Brian would have

undergone assessment to establish if there was a need for his treatment and support regime to change and potentially for Brian to be supported through a full CPA approach.

7.16 There is no documented evidence to indicate that this instruction was followed and a referral for assessment made. Nor is there any evidence that the supervisor instructing the Social Worker made any checks to establish if the instruction had been carried out.

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

7.18 What this period illustrates is that communication between the Support Worker, his supervisors and the CMHT during the period January 2020 until Amy's murder in January 2021 could have been far more robust. Information was held which may have changed the level of support Brian was receiving but it was never recognised or acted upon.

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

7.20 Mersey Care and Sefton Adult Services each have different operating systems on which they record client information and detail. Data is however, not automatically shared between these systems and gaps in information held by the two systems regarding Brian is present. The decision to end one-to-one cycling and walking support, so important to Brian in helping him to

manage his schizophrenia a short time before Colin's death is not included as a potential risk on the Mersey Care RiO system.

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

7.22 Records show that the Clinicians at the Clozaril Clinic recorded that at the clinic in November 2020, and following the telephone appointment with a G.P. in December 2020 Brian reported suicidal thoughts and some auditory hallucinations to harm himself. However, clinicians were reassured by Brian that he had no intentions of acting on them. Staff were significantly reassured by Brian's intentions and therefore did not refer the disclosures to the Multi-Disciplinary Team meeting for further exploration and consideration. Mersey Care acknowledge that these failures to act were missed opportunities for a Multi-Disciplinary Team review of Brian's health to be completed.

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

7.24 The Panel have been unable to find evidence to show that the physical risk to Brian that a reduction in white blood cell levels below the therapeutic range recorded in April 2020 by the Clozaril Clinic was reviewed in conjunction with other issues impacting Brian's health and wellbeing at this time. The terminal diagnosis of his father and the withdrawal of supportive walking and cycling groups and other social activity due to Covid restrictions being imposed.

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

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

7.27 NICE Guidelines on the treatment of schizophrenia published in 2014 recommends services *"routinely monitor for other coexisting conditions, including depression, anxiety and substance misuse particularly in the early phases of treatment.*" [1]

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

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

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

[1] National Clinical Guideline Number 178 National Collaborating Centre for Mental Health Commissioned by the National Institute for Health and Care Excellence

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

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

7.33 Amy is described in G.P. notes as suffering an acute grief reaction: "*He (Colin) arranged everything and without him she was lost"* and that between July and October 2020 Amy was a frequent attender, contacting the surgery every few days, often in tears. Both Brian and Amy were offered bereavement counselling on two occasions following Colin's death but felt unable at the time to take up those offers. On two occasions during Colin's illness and following his death Brian was provided details of the duty mental health worker within the Community Mental Health Team who he may contact for support at a time of crisis but the Panel could find no indication that a formal review was ever discussed or considered in respect of Amy or Brian's needs given the heightened levels of anxiety within the family and previous observations by Brian's G.P. That Colin was "*the buffer*" between Amy and Brian and the impact that the loss of that "*buffer*" may have had upon the escalation of anxiety levels within the family.

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

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

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

7.37 Brian did not take part in a clinical review prior to this decision to withdraw support, nor was the decision made by the MDT. It is not clear what information was relied upon to adjudge that Brian was "*stable*" at this time nor which community services Brian was now actively engaging with since the Social Care Support Worker provision had been withdrawn. There was not a tapered approach to reducing support and no alternative means of direct support were provided for him. The decision was not reviewed following the Government decision to introduce another period of lockdown in England during the same month that support for Brian was stopped.

7.38 In December 2020 Brian did receive an outpatient's appointment conducted via telephone with Mersey Care, 12 months after his own G.P. requested a review of Brian's schizophrenia, because of Brian's worsening depressive symptoms, and 42 days before the murder of Amy. At the conclusion of the

outpatient's appointment the clinician recorded that Brian had "*no concerns*" regarding his health and there was nothing of concern highlighted by the Doctor in their recording of the outpatient appointment.

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

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

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

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

- *The statement of care (replaces risk assessment in Non-CPA patients) will be reviewed as and when required, up to a minimum of annually.*
- *For Service Users on Non-CPA there should be on-going consideration of need for CPA if risk / safety issues or circumstances change.*

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

7.44 An absence of clinical oversight of Brian's care and treatment and the apparent failure to follow Trust policy for the management of non-CPA patients. Taken together it is difficult to establish that the appropriate level of support was provided to Brian and his family for the trauma's that they as a family had and were suffering and if the situation in which the family found themselves was ever taken into account when making decisions regarding the level of services and support.

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

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

8 Conclusions

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

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

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

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

8.5 It was never recognised the pivotal role that the Social Care Support Worker might, and indeed did in Brian's case, play in identifying a deterioration in clients mental health. The Support Worker remained untrained in issues relating to mental health and risk assessment and records they made during contacts with Brian were never reviewed by his supervision or staff treating Brian at Mersey Care. Overlooking the value of the work that the Support

Worker undertook and the information they generated was a significant opportunity missed.

8.6 There are further signs of systemic weaknesses inhibiting the treatment and support of Brian. In spite of the fact that Brian had not been clinically reviewed for two years those treating him state that "*acknowledgement of low mood and at times suicidal ideation, this was deemed to be 'the norm' for Brian."* The Panel were unable to locate any clinical notes from a review which show that consideration was made of the changes that were taking place Brian's life, his father's terminal illness, the impact of Covid 19 lockdowns, the additional stress and its impact upon Amy, which justifies inaction and a lack of challenge to this categorisation.

8.7 Communication between services was poor. The information that the Support Worker was entering into RiO and the Adult Services databases of Brian's disclosures was never reviewed or considered. By the Support Workers supervisor or Mersey Care whose validation of disclosures entered onto the RiO database by a qualified mental health practitioner were suspended during the periods of Covid restrictions. Mersey Care were unaware of the acute grief reaction, being managed by her G.P. that Amy was suffering following Colin's death and did not consider the impact this may have had upon Brian.

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

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

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

9 Lessons Learnt

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

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

9.3 Consideration regarding the restrictions in place to control Covid and the impact these restrictions would have upon individual patients should have been discussed by management to establish how best to support Brian when

group cycling and walking sessions were stopped. These restrictions were given added significance in light of the additional stress of Brian's father's terminal diagnosis. Plans are required in future planning to ensure contingencies are in place to support patients impacted by future periods of lockdown or restrictions on services.

9.4 The Clozaril Clinics are staffed by mental health practitioners and whilst the primary focus of the clinic is to protect the physical health of the patient protecting them from potential serious side effects of the drug Clozaril this is also an opportunity to establish mental health needs. This does take place now but not in a planned way. Therefore following work with the Suicide Prevention Partnership in Sefton the clinicians have developed five questions that will now be asked of all patients attending the clinic enquiring of their level of suicidal ideation and enabling preventive support to be provided where appropriate.

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

- A named key worker for all service users with a clearer multidisciplinary team (MDT) approach
- Better support for and involvement of carers as a means to provide safer and more effective care [2]

10 Recommendations

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

10.2 Ensure all front line staff and all immediate supervisors of those staff supporting people with mental illness discuss ongoing cases in supervision

[2] NHS England. Care Programme Approach, NHS England position statement, 1 March 2022 Version 2.0

and/or in MDT meetings to gain other views and review possible interventions available to support people.

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

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

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

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

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

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