

**BOURNEMOUTH AND POOLE ADULT SAFEGUARDING BOARD**  
**AND**  
**DORSET HEALTH CARE NHS FOUNDATION TRUST**  
**FINAL**

**A Serious Case Review [SCR]**

Dr Paul Kingston and Edward Tolhurst

Gerontological Concerns Ltd

06.12.13

## **Table of Contents**

<b>1</b>	<b>Introduction</b>	
1.1	Semi-anonymisation of names	3
1.2	Circumstances leading to the Serious Case Review	3
1.3	Terms of Reference and Timeframe for the Review	4
<b>2</b>	<b>Methodology</b>	
2.1	Serious Case Review Commissioning Process	5
2.2	Individual Management Reviews and Chronologies	6
2.3	Individual Management Reviews and Chronologies Received and named focus	6
2.4	Report Structure	6
2.5	Referencing	7
<b>3</b>	<b>Facts and key events prior to SCR</b>	
3.1	Facts, key events and service interventions X	8
3.2	Short resume of previous facts related to X	16
3.3	Facts, key events and service interventions Y	18
3.4	Short resume of previous facts related to Y	24
3.5	Facts, key events and service interventions Z	26
3.6	Short resume of previous facts related to Z	29
<b>4</b>	<b>Findings and Analysis</b>	
4.1	X and Mental Health interventions	31
4.2	Addiction Services	36
4.3	General Practitioner	37
4.4	Y and mental Health interventions	39
4.5	Y's personal risk of domestic violence as a victim and perpetrator	40
4.6	Antisocial behaviour by X and threats to X by Y	41
<b>5</b>	<b>Conclusions</b>	45
5.1	X	45
5.2	Y	45
5.3	Z	45
5.4	Combined conclusions	46
<b>6</b>	<b>Recommendations</b>	47

## **1 INTRODUCTION**

This review has been undertaken jointly between the Bournemouth & Poole Safeguarding Adults Board having met the criteria for a Serious Case Review (SCR) and the Dorset HealthCare NHS Foundation Trust to meet the Trust's obligations under the Health Service Guidance and as agreed with the then responsible NHS South West Strategic Health Authority.

### **1.1 Semi-anonymisation of names**

The three individuals considered in this SCR Report are semi-anonymised as X (the victim), Y and Z (the alleged perpetrators).

### **1.2**

A draft of this report has been shared with the victim's younger brother. He offered different information about some early history than as described in the report from the information gleaned from professionals and this is placed in 4.3 at the bottom of page 37.

### **1.3 Circumstances leading to the Serious Case Review**

X was found stabbed in his flat [**Flat E, Anyplace Road**] Bournemouth on 27 July 2012 and despite treatment by paramedics pronounced dead a short time later. X was originally from Portugal, his father is deceased and his mother lives in Portugal. He has two brothers living in Bournemouth and Trowbridge. He was single and lived in rented accommodation. X was a registered sex offender and Level 1 MAPP. X was known to Bournemouth North Community Mental Health Team (CMHT) and had been previously known to the Bournemouth Community Addictions Team (BCAT).

Y and Z were both charged and subsequently convicted with his murder.

Y was known to Bournemouth West [CMHT] between 2001 and 2003 and subsequently between 2004 and 2005 prior to her transfer to Bournemouth North CMHT on the 25.2.2005. She remained under the Bournemouth North CMHT until her discharge in April 2012. She

had 6 previous admissions to St Ann's Hospital. Z was previously known to the Intensive Psychological Therapies Services within the Trust in 2008.

All 3 individuals were well known to Dorset Police for different reasons. In the case of Y and Z the majority of known incidents relate to Domestic Violence.

#### **1.4 Terms of Reference and Timeframe for the Review**

The SCR Panel consisting of members from Bournemouth and Poole Adult Safeguarding Board and Dorset HealthCare NHS Foundation Trust asked the IMR Authors to follow the agreed template and the guidance notes from Bournemouth and Poole Adult Safeguarding Board and also to give consideration to the following points:

- a) How far had agencies working with Y and Z considered the impact of their behaviours on immediate neighbours and community.
- b) To what extent did any cultural issues influence agencies responses both in terms of ethnicity (X) but also arising from the diagnostic "labels" carried by those involved specifically "borderline personality disorder" (Y) Substance Misuse (Y, X and Z) and the victim's status as a registered sex offender (MAPP A Level 1).

The time period to be reviewed was set from 01.01.1998 or from when the agency had initial contact.

## **2 METHODOLOGY**

### **2.1 Serious Case Review Commissioning Process**

A SCR was commissioned by Bournemouth and Poole Safeguarding Adults Board and Dorset HealthCare University NHS Foundation Trust on 14.8.2012. Agreement was reached with the Strategic Health Authority that the SCR would ‘serve as a “Serious Incident Review”, as the death involved 3 people known to Mental Health Services’ (Email JA to PK – 22.8.2012) and would also meet the Trust obligations under Health Service Guidance ( 94) 27.

### **2.1 Membership of the Serious Case Review Panel**

The following were acknowledged as members of the SCR panel:

Jane Ashman (Independent Chair)

Head of Specialist Adult Services, Adult & Community Services Directorate, Dorset County Council

Head of Adult Social Care – Services, Borough of Poole

Service Director, Adult & Community Support, Bournemouth Borough Council

Director of Quality & Lead Director of Safeguarding, NHS Bournemouth &Poole, NHS Dorset

Safeguarding Manager, South Western Ambulance Service NHS Foundation Trust

Detective Chief Inspector, Dorset Police

Patient Safety & Safeguarding Lead, Dorset HealthCare University NHS Foundation Trust

Policy and Performance Review Officer, Bournemouth & Poole Safeguarding Adults Board

For the purposes of the NHS Serious Incident Review the following additional members were co-opted

Director of Quality Dorset Healthcare University NHS Foundation Trust

A Doctor from Dorset Healthcare University NHS Foundation Trust

## **2.2 Individual Management Reviews and Chronologies**

IMRs were requested from:

South Western Ambulance Services NHS Foundation Trust covering Ambulance and GP Services Out of Hours.

Dorset HealthCare University NHS Foundation Trust (DHC) -( which included details of contact with its services which included Addictions, CMHTs, St Anns Hospital and the Intensive Psychological therapy service)

Primary Care Trust , NHS Dorset, Bournemouth & Poole Hospital, (to combine with DHC to assist triangulating of the information unless the need emerges for a separate GP/Primary Care IMR).

Bournemouth Borough Council (including Adult Social Care, Community Mental Health Team and Housing Department).

Dorset Police

Borough of Poole – Social Care, Out of Hours Service

## **2.3 Individual Management Reviews and Chronologies Received and named focus**

1 Borough of Poole Adult Social Care – Social Care, Out of Hours Service [X/Y/Z]

2 Bournemouth Borough Council, Housing landlord [X]

3. Dorset Police [X/Y/Z]

4. South Western Ambulance Services NHS Foundation Trust and Out of Hours [X/Y/Z]

5. PCT, NHS Dorset, Bournemouth & Poole Hospital, (to combine with DHC to assist triangulating of the information unless the need emerges for a separate GP/Primary Care IMR) [X]

6. PCT, NHS Dorset, Bournemouth & Poole Hospital, (to combine with DHC to assist triangulating of the information unless the need emerges for a separate GP/Primary Care IMR) [Y]

## **2.4 Report Structure**

Section 3 of this SCR report documents in chronological detail the known facts interconnected to the associations of X, Y and Z. The facts are presented as three separate

chronologies. Section 4 of this report brings together the key findings related to the interconnections of knowledge related to X, Y, and Z.

Section 4 of this report outlines the main conclusions of the SCR. The report concentrates on the main matters concerned with X and Y. This document reports only limited findings related to Z. The author suggests the facts relating to Z in this SCR are of peripheral interest to the Safeguarding Board and Strategic Health Authority.

## **2.5 Referencing**

Relevant documents are referenced in the main document using the short codings below:

**IMR 1:** Out of Hours Social Services Team

**IMR 2:** Housing Landlord, Bournemouth Borough Council

**IMR 3:** Dorset Police

**IMR 4:** South Western Ambulance Service

**IMR 5:** NHS Bournemouth and Poole/NHS Dorset/Dorset Healthcare University Foundation Trust (**Note this IMR relates only to X**)

**IMR 6:** NHS Bournemouth and Poole/NHS Dorset/Dorset Healthcare University Foundation Trust (**Note this IMR relates only to Y**)

**IMR 7:** NHS Bournemouth and Poole/NHS Dorset/Dorset Healthcare University Foundation Trust (**Note this IMR relates only to Z**)

**CC:** Combined Chronology

**Hemail:** Housing Email

**GPLett:** Letter from GP

**MHAP:** Mental Health Action Plan

**N.B.** IMR 2 [updated 27.11.2012] & 5 [updated 7.12.2012] were updated after the first meeting of the SCR Panel on the 1<sup>st</sup> November 2012. For clarity they have not been referenced separately, all references relate to the updated versions. Numerous further email communications were received as draft iterations of the report were considered by the Serious Case Review Panel: they are not individually referenced in this report.

Please also note that the author was made aware of a second transcribed interview with a staff member conducted as part of IMR 5/6/7 in May 2013. This staff member was subsequently telephone interviewed by the author.

### **3      FACTS AND KEY EVENTS PRIOR TO THE DEATH OF X**

#### **3.1    Facts, key events and service interventions – X**

Dorset Police note that X has 24 convictions related to 42 offences. These 42 offences are broken down into 6 offences against the person, 2 sexual offences, 19 theft offences, 2 public order, 9 offences against police and the courts, 2 drug offences and 2 offensive weapon offences. He was first convicted in 1993.

On 16 June 2000, when X registered as an NHS patient, he was referred to addiction services by his GP. NHS Bournemouth and Poole/NHS Dorset/Dorset Healthcare University Foundation Trust note that X often failed to attend appointments with addiction services but was re-referred by GPs when he decided to re-engage.

X's involvement with primary care was regular and generally for repeat medication, diabetic management, and lumps on his chest.

There are no records held by the Out of Hours Social Services Team, in relation to X.

X's first arrest by Dorset Police on 24 February 2001 was for shoplifting. He received a conditional discharge.

On 29 April 2001, X was arrested for shoplifting. On 14 June 2001, PNC reports X sentenced to three months imprisonment.

On 9 October 2001, X was arrested for shoplifting. He received a term of imprisonment. A PNC record on 1 February 2002 notes that X was sentenced to 12 months in prison. Housing Landlord notes that X was released in August 2002.

X made a homelessness application on 9 September 2002 and was interviewed as homeless by the Housing Officer from the Housing Options team on 10 September 2002. X was placed into bed and breakfast accommodation in the Bournemouth area on the day of the interview.

Housing Landlord notes in its chronology that X was interviewed with regard to his housing situation on 3 October 2002.

On 20 January 2003, Housing Landlord notes in its chronology that a telephone call was made to X with regard to alleged thefts at a previous address.

Housing Options wrote to X on 21 January 2003 and advised that he had been accepted as homeless and was eligible for a rent deposit to help find accommodation. In the meantime X was to remain at his current accommodation .

On 13 March 2003, having received confirmation of X's drug use at his current accommodation, X was informed that the Council no longer owed a duty to provide X with temporary accommodation.

An interview with X and a further letter from Housing Options on 18 March 2003 confirmed why he was asked to leave his current accommodation.

X completed another homelessness application on 20 March 2003. X was advised of the right of appeal and an appointment was made for X to see Shelter for assistance.

Housing Options wrote to X on 23 April 2003 confirming that the Council no longer owed a duty to provide temporary accommodation and advised X of the rent deposit scheme to enable privately rented accommodation to be secured. X submitted an appeal against the decision: the appeal process concluded on 8 July 2003 and confirmed that X was no longer owed a duty to be provided with temporary accommodation.

Dorset Police note that on 6 June 2004, X was arrested for assault. He was charged with assaulting two police officers and charged with two assaults by beating offences. A PNC record on 4 February 2005 notes that he received four months imprisonment.

On 30 July 2004, X made a further homelessness application and was moved into temporary accommodation at a Hotel in Boscombe.

On 26 August 2004, Housing Options wrote to X to advise him that he had been accepted as homeless.

On 27 August 2004, X was accepted into Band A on the Housing Register. On 23 September 2004, Housing Landlord wrote to X to offer him the tenancy of **Flat E, Anyplace Road commencing on 04 October 2004.**<sup>1</sup>

Housing Landlord received a complaint [**COMPLAINT NUMBER 1**] about noise from X's flat from the stepfather of the tenant of the flat below (Y) on 2 December 2004. The Housing Office contacted X and X denied the allegation. X was sent a letter to advise him that a complaint had been made and to remind him of the terms of his tenancy.

On 10 April 2005, X was arrested for indecent exposure. On 17 October 2005 he received a three year community sentence order, a requirement to attend a Thames Valley Sex Offender Programme and became a registered sex offender for 5 years.

The Housing Landlord notes that when X was released from prison he was advised on 12 August 2005 to speak to Housing Benefits with regard to rent arrears. On 21 November 2005, a note on the file states that X had contacted the Housing Benefit team with regard to backdating housing benefit.

On 21 April 2006, X was arrested for provocation of violence. He received a term of imprisonment.

Y complained [**COMPLAINT NUMBER 2**] to Housing Landlord about X's behaviour again on 24 May 2006.

On 2 June 2006 X was arrested for indecent exposure after showing his genitals to children. On 19 July 2006, X was sentenced to 5 months imprisonment. His sex offender status was extended to 7 years and would expire in 2013. On 18 August 2006 X was released from prison.

---

<sup>1</sup> This is the address where he was eventually found murdered.

On 7 September 2006, X assaulted three police officers. He received a term of imprisonment and was released on 27 October 2006.

Y contacted Housing Landlord on 7 September 2006 complaining [**COMPLAINT NUMBER 3**] about X's behaviour. The Housing Landlord carried out a perpetrator interview with X on 27 November 2006. X was warned and on 6 December 2006 signed a written agreement with regard to his behaviour.

On 28 September 2006, the Team Manager from the Prison Mental Health Inreach Team recorded that X was suffering from a psychotic illness exacerbated by drug use.

On 29 September 2006 a referral was submitted by the Consultant Psychiatrist via the prison Mental Health in-reach team to North Bournemouth Community Mental Health Team. X had been remanded in the segregation unit of HMP Dorchester and it is reported that he had appeared acutely psychotic.

On 2 October 2006 the Community Consultant Psychiatrist following a conversation with the Consultant Psychiatrist who had seen X in prison, noted that X was 'a man on remand who appeared acutely psychotic', whilst the Consultant Psychiatrist noted on 16 October 2006 that X 'continues to show first rank symptoms of schizophrenia'.

On 30<sup>th</sup> October 2006 police received a call from Z [*recorded as Y in the chronology*] stating that X was banging on doors and was on their patio [**COMPLAINT NUMBER 4**]. When police attended X stated that he had lost his keys and was banging on doors hoping to gain entry. It is stated that X appeared calm.

From 25 September 2007 to 30 March 2012, twelve home visits were conducted by the police in line with his sex offender status. Dorset Police note that X was often incommunicative during these visits, and during a visit on 3 June 2011 was aggressive towards officers.

In January 2008 X was seen by a worker at the Department for Work and Pensions (DWP). Following a medical examination on 14 January 2008, there was a report of unexpected findings, as X had expressed concerns about voices constantly telling him to commit suicide,

rob others or kill others. The letter was not dated by the DWP, nor was it time-stamped by the GP practice.

On 20 November 2008 a GP referral was made to the CMHT. X had stated that he was hearing voices. The GP was concerned that there may be a psychotic element in his mental make-up. This was the first contact with the CMHT since X was released from prison in November 2006.

There was a home visit by the Housing Options team on 10 December 2008 regarding payment of rent.

On 24 April 2009, Y made a further complaint [**COMPLAINT NUMBER 5**] to Housing Landlord about X. Housing Landlord notes that X smashed up his flat and shouted abuse and threats.

X was seen by a psychiatrist employed by DHC, a letter dated 25 June 2009 states that X is hearing voices which tell him to harm himself and others. However, he described that he is not a danger to others. It is recorded that there does not seem to be any overt psychotic symptomatology.

On 17 December 2009, a referral made by the CMHT to the Drug and Alcohol team.

On 30 December 2009, the BCAT practitioner report that X described hearing voices in the clinic room. In the past they have told him to harm/kill others then kill himself. At that time he reported no suicidal ideation or desire to hurt/kill others. A risk of harm to others is noted, with reference to known violence in the past.

In January 2009, X was assessed by a doctor in the outpatient clinic of the CMHT. Ongoing drug and alcohol issues, possible psychosis and antisocial traits are identified. X was allocated a Community Mental Health Nurse (CMHN).

On 25 June 2009, X was assessed by a CMHT Doctor with X's CMHN present. 'No overt psychotic symptomatology' was noted and risks of violence, suicide and neglect were recorded as low.

In July 2009, the CMHN recorded that X had clear psychotic symptoms and many features of Borderline Personality Disorder (BPD), possibly related to stress induced from psychotic symptoms.

In December 2009, the CMHN records in relation to X that risks of harm to self, self-neglect and vulnerability are low; however, harm to others would remain potentially significant, particularly when X is experiencing excessive psychotic symptoms.

On 17 December 2009, X was referred to the Drug and Alcohol service. In December 2009, the BCAT service record X's diagnosis as heroin dependence, with a risk of harm to self, others and suicide.

On 19 March 2010, the CMHN reports that X is responding well to the Methadone programme and trial on Risperidone. X described a marked reduction in hearing voices, and reports a 50% conviction in them being real voices.

In May 2010 the BCAT service recorded a diagnosis of heroin dependence and schizophrenia.

At a CPA review on 2 February 2011 it is noted that X continues to report psychotic phenomena.

Following a clinic review at DHC on 20 May 2011, it is noted that X is not markedly depressed and that the clinic would link in with the Addiction Service.

At a BCAT review on 25 May 2011 X's risk of harm to and from others is listed as low; his risk of harm to himself is also recorded as low.

A clinical entry in the DHC record on 5 July 2011 states that, as a result of non-engagement, X will be discharged from enhanced care and that of the Community Care Coordinator (CCO) to the consultant, who will try to engage him through psycho-education and medication information. An appointment was made to see the consultant psychiatrist on 3 August 2011 but X did not attend.

On 10 August 2011 the Care-coordinator had a telephone conversation with X. X reported finding the voices difficult to manage.

On 27 September 2011, police were called to X's home address following a dispute between him and his brother.

On 30 September 2011 record notes that there was correspondence between the care coordinator and the police, following third party information relating to a domestic incident at the patient's flat on 27 September 2011.

On 14 October 2011 X was seen by the CCO at the CMHT and it is recorded that he remains more stable.

On 24 October 2011, X was seen by the CCO at the CMHT and reported hearing fewer voices.

The DHC record of CCO contact on 11 November 2011 states that X continues to hear voices, causing distress and blocking his routine.

On 24 November 2011, X was seen by the CCO at the CMHT, and it is stated that his mental health symptoms appeared manageable.

On 8 December 2011, X was seen by the CCO, and it is stated that some clarification was gained on X's main stressors.

On 22 December 2011, X was seen by the CCO and it is recorded that he presents less anger. Arrangements were being made for X's door to be repaired.

On 13 January 2012, X was seen by the CCO and it is recorded that his mental health state and mood remain stable. It is also noted that he continues to experience some sort of hallucinatory interference.

On 27 January 2012, X was seen by the CCO at CMHT base and it is noted that his paranoid beliefs seem settled.

Recorded contact between the CCO and X on 10 February 2012 states that X's mental state remains unchanged. It is noted that X's compliance with medication remains inconsistent.

On 9 March 2012, X was seen by the CCO at the CMHT. It is noted that X appeared mild in mood and that he reported more stability.

On 23 March 2012 X attended the CMHT base. It is reported that he became agitated at the unavailability of the CCO and became agitated and angry. It is noted that X remained agitated and throughout his meeting with the CCO, and questioned the CCO's involvement in his family's attempts to manipulate him.

On 4 May 2012, X was seen by the CCO at the CMHT. X stated that the psychosis had reduced.

A letter from BCAT to the GP dated 13 June 2012 notes that X has not expressed any ideation or intent to harm himself or others.

A letter from BCAT to the GP dated 13 June 2012 states that X presents with a diagnosis of opiate dependence, alongside schizophrenia.

On 29 June 2012 X was seen by the CCO at the CMHT. It is noted that his mood and mental state remain stable and that he continues to engage well with the addiction plan.

On 6 July 2012, X was seen by the CCO at the CMHT. X reported a stable mental state.

On 17 July 2012, X was assessed at a consultant review at the CMHT base. It is noted that he suffers from schizophrenia, opiate dependence and harmful use of alcohol. It is noted that X reported hearing voices almost constantly. It is also noted that there seems to be no problem with his activities of daily living.

On 26 July 2012, X was seen by the CCO at the CMHT. It is noted that his psychotic symptoms appeared very mild. It was acknowledged that due to sustained stability on-going monitoring should take place at 3-weekly intervals but the patient requested appointments with 2 weeks of each other.

On 28 July 2012, a DHC record notes that information obtained via Bournemouth Police highlights the death of a man reported to be X.

### **3.2 Short resume of previous Facts related to X**

X has 24 convictions related to 42 offences. These 42 offences are broken down into 6 offences against the person, 2 sexual offences, 19 theft offences, 2 public order, 9 offences against police and the courts, 2 drug offences and 2 offensive weapon offences. He was first convicted in 1993. X was also imprisoned on six occasions: from 2001 to 2006, he was imprisoned for shoplifting twice (29 April 2001 and 9 October 2001); for assault on two police officers and battery (4 February 2005); provocation of violence (21 April 2006); indecent exposure to children (2 June 2006); and attacking police officers (7 September 2006).

As a consequence of his arrest for indecent exposure in April 2005, for which he received a community sentence order, X was placed on the sex offender register for five years in October 2005. Following his arrest in June 2006, his sex offender status was extended to seven years from July 2006 and was set to expire in 2013. X received home visits from the police in relation to his sex offender status: twelve home visits were conducted from 2007 to 2012. It is noted by Dorset Police that X was uncommunicative during these visits and was aggressive towards officers during a visit in June 2011. X was required to register his address with the police on an annual basis.

X made a homelessness application to Housing Landlord in September 2002. In March 2003, following confirmation of X's drug use, X was notified that the Council no longer owed a duty to him to provide temporary accommodation. X made a further homelessness application in July 2004 and moved in to a flat at Anyplace Road in October 2004. The Housing Landlord received four complaints with regard to X's behaviour at Anyplace Road. These were a complaint about noise from Y's stepfather in December 2004, and three times

from Y - in May 2006, September 2006 and April 2009. The Housing Landlord carried out a perpetrator interview with X in November 2006. X was warned and on 6 December 2006 signed a written agreement with regard to his behaviour. Police also received a call from Y in October 2006 stating that X was banging on doors and was on her patio.

When X registered as an NHS patient in 2000, he was referred to addiction services by the GP. It is noted by the NHS that X often failed to attend appointments with addiction services but was re-referred by GPs when he decided to re-engage. It is noted that X's involvement with primary care was regular and generally for repeat medication, diabetic management, and lumps on his chest.

In September 2006 a referral was submitted by the prison Mental Health in-reach team to North Bournemouth Community Mental Health Team as X had presented symptoms of schizophrenia. In November 2008, a GP referral was made to the CMHT. X had stated that he was hearing voices and the GP was concerned that there may be a psychotic element in his mental make-up. In January 2008 X was seen by a worker at the Department for Work and Pensions: following a medical examination in January 2008, there was a report of unexpected findings, as X had expressed concerns about voices constantly telling him to commit suicide, rob others or kill others. On-going drug and alcohol issues were also identified and X was referred to drug and alcohol services in December 2011. X was in regular contact with the Care Coordinator at the CMHT from August 2011 until his death in July 2012. It is noted that X hears voices and experiences hallucinatory interference, but apart from presentation of anger and agitation in March 2012, his mood and mental state are generally recorded as stable. A consultant review at the CMHT in July 2012 noted that X suffered from schizophrenia, opiate dependence and harmful use of alcohol. It is also noted that there seems to be no problem with his activities of daily living.

### 3.3 Facts, key events and service interventions – Y

The first recorded contact within Housing for Y is a housing application dated 14 March 2001. It is noted on the application that Y suffered with depression and stress, was an ex-addict and had suffered sexual abuse.

Y was accepted on to the Housing Register on 19 July 2001. Y moved into **Flat A, 4 Anyplace Road on 14 April 2003.**<sup>2</sup>

On 2 December 2004, Housing Landlord received a complaint from the stepfather of Y, with regard to noise from X's flat.

On 13 May 2004, Housing Landlord received a report from the police about criminal damage caused by Z at Y's flat.

Y made further complaints to Housing Landlord about X's behaviour on 24 May 2006, and 7 September 2006. Following X's release from prison, Housing Landlord carried out a perpetrator interview with him and on 6 December 2012 he signed a written agreement regarding his behaviour. Housing Landlord also wrote to Y on 6 December 2012 to highlight the action that had been taken to deal with the complaint.

It is recorded in Dorset Police's agency chronology that Y called on 30 October 2006, to highlight that X was causing problems. He had lost his keys and was trying to gain access to the flats. [*Listed as Z making call in detailed factual report section*]

***It is recorded by Bournemouth CMHT that a letter was sent on 30 October 2006 to Bournemouth Borough Housing Department. This letter states that Y is suffering severe harassment from a neighbour and that it would be reasonable to assume if her housing situation is not resolved then her mental health will deteriorate further.*** [this communication is not noted in Housing Landlord record]

---

<sup>2</sup> The same block of flats where X was to reside 18 months later, and where he was murdered.

***Further information received from BBC (email from BO 17.3.2012) states from BBC: ‘We have not seen this letter’.***

A clinic letter from the DHC record dated 30 November 2006 states that Y continues to have stresses with a rowdy and abusive neighbour. It is noted that the outcome of any engagement with Bournemouth Borough Council, Advocacy or Police Services is unclear.

Housing Landlord wrote to Y in March 2007 to state that the case had been closed with regard to X, as there had been no further complaints.

A DHC record highlights that a letter was sent from Y’s care-coordinator to Bournemouth Housing Department on 11 September 2009. This letter supports Y’s request to move from her current address due to the extreme impact from a neighbour who lives directly above her. [No mention in Housing Landlord chronology] ***Further information received from BBC (email from BO 17.3.2012) states from BBC: ‘We did not receive this letter’.***

Dorset Police note that Y has 3 convictions for 7 offences, all drug related (possession and supply of cannabis and heroin). She was first convicted in 1991.

Between 8 July 2003 and 19 February 2011, police were contacted with regard to 12 incidents involving Y and Z, in relation to assault, domestic violence or criminal damage.

On 8 July 2003 police were called to a DV incident. It is noted that Z had thrown mugs against a wall and been aggressive towards Y.

On 14 October 2003, police were called to a DV incident between Y and Z.

On 4 December 2003, police were called to a DV incident between Y and Z. It is noted that a DV form was completed and a copy faxed to Bournemouth Social Services.

On 24 March 2004, Z was arrested for throwing a brick through a window of Y’s home.

On 17 May 2008, Y contacted police to state that she had been assaulted by Z.

On 9 December 2008, Z was arrested after he stabbed Y in the hand with a knife. Y was also arrested as she had stabbed Z in the leg with a fork. It is stated that neither assisted the police and no further action was taken.

On 24 April 2009, Y made a further complaint to Housing Landlord about X. Housing Landlord notes that X smashed up his flat and shouted abuse and threats. Y was asked to complete diary sheets to record any further incidents and to return these to Housing Landlord. These were not returned by Y and Housing Landlord wrote to Y on 10 July 2009 to inform her that the case was closed. [Not in Housing Landlord's report on X]

On 27 December 2009, police were called to a domestic violence incident between Y and Z.

On 27 February 2010, police were called to a domestic violence incident between Y and Z.

On 2 May 2010 police were called to a domestic violence incident between Y and Z. Z was arrested for assault but this was later discontinued at court.

On 23 October 2010 Z was arrested for assault after he struck Y.

On 19 February 2011, police were called to a domestic violence incident between Y and Z.

South Western Ambulance NHS Foundation Trust highlight that they were contacted 10 times from 2002 to 2012 when Y is listed as the subject; these comprised three Urgent Care Services calls, and seven 999 calls. The last of these calls was 31 August 2011, the call related to unconscious and fitting, with an overdose of various pills and lager. A 999 record also relates to an assault hand injury on 9 December 2012, but the subject is not identified.

On 26 March 2012, Y contacted the police with regard to X. She stated that she had been in a dispute with him for six years. She alleged that X had been throwing things on her balcony and shouting at her. As a consequence the Local Safer Neighbourhood Team asked the local council to send letters to residents with regard to their behaviour and to conduct an anti-social behaviour survey in the flats.

NHS Bournemouth and Pool/NHS Dorset/Dorset Healthcare Foundation Trust highlight that Y was first seen by specialist mental health services in 1998. Y had 6 informal admissions between 1998 and 2004 relating to misuse of alcohol and illicit substances, stress-adjustment reactions, depressive episodes and an emotionally unstable personality disorder of the borderline type.

Y had involvement with Bournemouth West CMHT between 2001 and 2003; and then between 2004 and 2005 prior to transfer to Bournemouth North CMHT on 25 February 2005. Y remained under Bournemouth North CMHT until her discharge in April 2012.

On 24 January 2004, Y attended a clinic appointment with a member of staff from the day hospital. It is noted that Y is vulnerable due to her diagnosis and current social circumstances. Risk factors are recorded as low.

On 24 November 2004 the CMHT carried out a mental health assessment following an urgent domiciliary visit request sent by Y's GP on 23 November 2004. It is noted that she appeared highly aroused and agitated. On questioning she brandished a knife, and also stated that she heard voices telling her to harm others, especially men. The police were called and a Dorset Police note that a knife was found in her sock. She was taken into custody but was later transferred to St Ann's Hospital, and was admitted informally and discharged on 2 December 2004.

On 22 June 2005 a letter from Bournemouth CMHT North sent by a Consultant to the GP, notes that the risk of violence to others is significant and this risk is embedded in Y's lifestyle. Risks noted as: Suicide – low to moderate; violence to others – moderate; neglect or abuse – low.

On 17 August 2005, a clinic letter from the Consultant Psychiatrist notes that Y's temper control continues to be poor.

On 27 July 2006, a clinic letter notes that Y still has problems losing her temper.

At an outpatient review on 11 January 2008 it is noted that Y has strong urges to self-harm. It is also recorded that the main risk factors relate to Y's impulsivity and need for care: there

have been times in the past when she has threatened to harm other people, and she has carried a knife.

On 23 October 2009, Y informed the Care Coordinator that she had experienced a difficult week, and had nearly stabbed a neighbour due to disputes.

On 31 August 2011, Y contacted the GP stating she had taken an overdose of Quetiapine. She was offered an appointment for the next day, but was subsequently admitted to PGH via ambulance.

On 1 September 2011, following the overdose on 31 August 2011 Y was reviewed by Psychiatric Liaison at Poole Hospital. Y reported feeling unhappy with her living arrangements due to her upstairs neighbour who is disruptive and noisy.

On 28 September 2011, duty contact with Y records that she is experiencing problems with her neighbour. It is noted that she is worried she will react with temper. CCO record at team discussion to consider discussions with the patient related to admission and a Mental Health Act assessment to be considered if no improvement in condition in the next few weeks.

On 19 February 2012 a telephone call was received by the Crisis and Home Treatment Service. Y stated that she was struggling with thoughts of harming herself.

On 12 April 2012, Y called the CMHT. It is recorded that Y stated that she was scared to say what was in her thoughts. She then stated that she had violent thoughts towards someone, the person who introduced her to heroin in the past and she has found out where he now lives. Y stated that she was having violent thoughts to slash him. This was known to be someone other than X .(please note this comment was added by JE, the author was not aware of the last sentence from the material in his possession).

On 13 April 2012, a DHC record of a CPA review states that Y did not attend this appointment and the clinical record states discharge.

On 5 July 2012, a clinical entry at Bournemouth North CMHT records that Y had called to state that she was at the GP surgery and that she was seeking a re-referral to the CMHT. Y

was advised to speak with the GP so he could update the CMHT on her mental health issues, so that the offer of another appointment could be considered. There was confusion about accessing the CMHT due to the lack of correspondence to the GP following the April 2012 decision to discharge Y.

Five incidents of domestic violence are recorded in the clinical record from 26 November 2002 to 10 February 2011.

On 27 December 2009 when in contact with the Crisis Home Treatment Team, Y reported that her partner had attacked her. She stated that she continues to fear him, and if he returned to her property, she would stab him and kill him.

On 24 July 2012 Housing Landlord received information from the police with regard to allegations of cannabis being smoked in Y's flat. It is noted that there was no time to take action on the matter as Y was subsequently arrested. [not in police chronology]

The Out of Hours Social Services Team report that the sum total of their records relate to the period after the incident that led to X's death. On 28 July 2012 a mental health assessment was requested by the Custody Nurse.

The Out of Hours Social Services Team state that a case note indicates the assessment was performed at 13:30, and an outcome note was posted at 15:46. The conclusion of the assessment was that Y demonstrated little evidence of acute mental disorder and that hospital admission was not required. As a result, Y was to remain under PACE in custody with a recommendation that she would need an Appropriate Adult present at the interview. No explanation is given for the request for an Appropriate Adult to be present at interview.

### **3.4 Short resume of previous Facts related to Y**

Y made a housing application in March 2001 and it is noted on the application that she suffered with depression and stress, was an ex-addict and had suffered sexual abuse. Y was accepted on to the Housing Register in July 2001 and moved in to Anyplace Road in April 2003. Y's stepfather made a complaint about X's behaviour in December 2004. Y also made two direct complaints to Housing Landlord about X's behaviour in 2006. Following the last of these complaints, in December 2006 Housing Landlord informed Y of the action that had been taken. They also wrote to Y in March 2007 to let her know that the case had been closed, as no further complaints had been received.

Y also contacted Dorset Police in October 2006 with regard to X's behaviour. A clinic letter from the DHC record in November 2006 states that Y continues to have stresses with a rowdy and abusive neighbour. It is also noted in this record that the outcome of any engagement with Bournemouth Borough Council, Advocacy or Police Services is unclear. In April 2009, Y made another complaint to Housing Landlord about X. Housing Landlord notes that X smashed up his flat and shouted abuse and threats. Y was asked to complete diary sheets to record future incidents. These were not returned to Housing Landlord, and Y was informed in July 2009 that the case has been closed. A further DHC record highlights that a letter was sent from Y's care-coordinator to Bournemouth Housing Department in September 2009. This letter supports Y's request to move from her current address due to the extreme impact from a neighbour who lives directly above her. Y made further contact with the police with regard to X in March 2012. She stated that she had been in a dispute with him for six years. She alleged that X had been throwing things on to her balcony and shouting at her. As a consequence the Local Safer Neighbourhood Team asked the local council to send letters to residents with regard to their behaviour and to conduct an anti-social behaviour survey in the flats.

Between 8 July 2003 and 19 February 2011, police were contacted with regard to 12 incidents involving Y and Z, in relation to assault, domestic violence or criminal damage. Dorset Police also note that Y has 3 convictions for 7 offences, all drug related (possession and supply of cannabis and heroin). She was first convicted in 1991.

NHS Bournemouth and Pool/NHS Dorset/Dorset Healthcare Foundation Trust highlight that Y was first seen by specialist mental health services in 1998. Y had 6 informal admissions between 1998 and 2004 relating to misuse of alcohol and illicit substances, stress-adjustment reactions, depressive episodes and an emotionally unstable personality disorder of the borderline type. Y had involvement with Bournemouth West CMHT between 2001 and 2003; and then between 2004 and 2005 prior to transfer to Bournemouth North CMHT on 25 February 2005. Y remained under Bournemouth North CMHT until her discharge in April 2012. In November 2004 the CMHT carried out a mental health assessment following an urgent domiciliary visit request sent by Y's GP. It is noted that she appeared highly aroused and agitated. On questioning she brandished a knife, and also stated that she heard voices telling her to harm others, especially men. The police were called and a Dorset Police note that a knife was found in her sock. Y made a further report to the NHS of difficulties with her neighbour in September 2011. Y's impulsivity and the risk of violence are noted in clinical records. Ideation relating to knife attacks is also referenced on – in October 2009, December 2009 and April 2012. Y was discharged from mental health services in April 2012. A telephone call from Y made to the CMHT in July 2012 suggested that she may be seeking a re-referral.

### **3.5 Facts, key events and service interventions – Z**

Dorset Police state that Z has 10 convictions for 12 offences: one offence against property, 2 theft offences, 7 against police and courts, and 2 miscellaneous offences. He was first convicted in 1991.

Between 8 July 2003 and 19 February 2011, police were contacted with regard to 12 incidents involving Y and Z, in relation to assault, domestic violence or criminal damage.

On 8 July 2003, police were called to a domestic violence incident. It is reported that Z had thrown mugs against the wall and been aggressive towards Y.

On 14 October 2003, police were called to a domestic violence incident. Y had assaulted Z who had a swollen lip. It is noted that a copy of the DV form was faxed to Bournemouth Social Services.

On 4 December 2003, police were called to an incident that had occurred between Y and Z. It is noted that a copy of the DV form was faxed to Bournemouth Social Services.

On 24 March 2004, Z was arrested for throwing a brick through the window of Y's home.

On 29 April 2004, Z was arrested for assault on Y. It is noted that no evidence was subsequently offered and the case was dismissed.

Housing Landlord notes that on 13 May 2004 it received a report from police about criminal damage caused by Z on 24 March 2004. It is noted that this is the only mention of Z on the Housing file.

On 17 May 2008, Y contacted police to state that she had been assaulted earlier that day by Z.

On 9 December 2008, Z was arrested after he had stabbed Y in the hand with a knife. Y was also arrested as she had stabbed Z in the leg with a fork. The leg injury was treated on the

scene by the Ambulance service. It is stated that neither assisted the police and no further action was taken.

On 27 December 2009, police were called to a domestic violence incident. It is noted that Z was advised to leave the address.

On 27 February 2010, police were called to a domestic violence incident. It is noted that Z later left the address, while Y refused subsequent contact with the police.

On 2 May 2010, police were called to a domestic violence incident. It is noted that it appeared Z had thrown items around and slapped Y. Z was arrested for assault and charged with assault by beating, but this was subsequently discontinued at court.

On 23 October 2010, Z was arrested for assault. It is noted that after a verbal altercation, Z had struck Y causing no injury.

On 19 February 2011, police were called to a DV incident. Z had attended Y's flat but was refused access. It is noted that no violence was offered, and Z was taken home by police.

Dorset police also note that, on 16 March 2008, Z was *arrested* (please note term arrested is verbatim from IMR, it is not possible to arrest under the Mental Health Act) under the Mental Health Act after he threatened suicide. Z was at 4 Anyplace Road and was in possession of two knives. Z reported that he had had an argument with his girlfriend, but no one else was present. Z explained that he had been drinking and was depressed, he also stated that he was on medication but had not been taking it. [*Not recorded in NHS GP chronology*]

Dorset police note that Z contacted them on 30 October 2006 to inform them that X was banging on doors and was on the patio. (This is listed in the chronology at Y making the call).

South Western Ambulance NHS Foundation Trust highlight that they were contacted 8 times from 2004 to 2009 when Z is listed as the subject; these comprised 4 Urgent Care Services calls, and 4, 999 calls.

On 25 August 2008, a 999 call was made with Z as the subject with the information referring to a 'male fitting'.

On 30 August 2008 a 999 call was made as a 35 year old male had put his hand through a window.

On 9 September 2008, a 999 call was made referring to an injury with Z as the subject. Z was treated at the scene.

NHS Bournemouth and Poole/NHS Dorset/Dorset Healthcare University Foundation Trust note that Z first engaged with their services on 17 February 1998. A GP referral letter is sent as a result of Z's alcohol use. A referral is also sent to the consultant neurologist as a result of Z's epilepsy.

A GP referral letter is sent to Bournemouth CMHT on 20 March 2008, stating that Z is showing signs of symptoms of depression.

On 7 April 2008 an urgent referral is sent by the GP to Bournemouth West CMHT, enclosing the referral previously made on 20 March 2008. It is noted that Z had presented at surgery feeling increasingly depressed and was contemplating suicide.

An assessment of Z was undertaken on 8 April 2008. The assessment found that Z illustrated borderline personality disorder, and low degree obsessive compulsive symptoms. It is also stated that he had fleeting thoughts of self-harm but denied active thoughts to harm self or others.

Z made telephone contact with mental health services on 13 June 2008 and had been feeling angry and claimed to have shouted at his mother.

A referral was made to the Psychological Therapies Services on 2 July 2008. This document records Z's distress relating to childhood and sexual abuse; destructive behaviours including overdosing on five occasions; impulsive behaviours; and longstanding disabling interpersonal problems including a long-term but unstable relationship.

On 8 August 2008, clinical correspondence states that Z has been offered an appointment on 4 September 2008 at Branksome Clinic. It is acknowledged that, if therapy is offered after the initial the wait would be 10-12 months.

On 30 August 2008, Z was seen in Radiology at PHFT as he had punched through glass with his fist.

Z did not attend his outpatient appointment at the CMHT on 1 September 2008. Z also failed to attend appointments on 25 November 2008 and 20 January 2009. On 20 January 2009 clinical correspondence to the GP highlights that another appointment will not be offered immediately but the patient would remain open to the CMHT in case he needs additional support.

Z remained in touch with the GP and the last consultation he attended was on 6 June 2012 when he reported vomiting blood. Z failed to attend an appointment on 12 June 2012 and the GP record shows they were unable to contact Z by telephone on 9 July 2012 and 10 July 2012.

The final attempt to contact Z prior to the incident that led to X's death, was a letter on 24 July 2012 which requested Z make contact with the surgery.

### **3.6 Short resume of previous Facts related to Z**

Z has 10 convictions for 12 offences: one offence against property, 2 theft offences, 7 against police and courts, and 2 miscellaneous offences. He was first convicted in 1991. From July 2003 to February 2011, police were also contacted with regard to 12 incidents involving Y and Z, in relation to assault, domestic violence or criminal damage. Housing Landlord notes that in May 2004 it received a report from police about criminal damage caused by Z in March 2004.

In March 2008, Z was arrested under the Mental Health Act after he threatened suicide. Z was at 4 Anyplace Road and was in possession of two knives. Z reported that he had had an argument with his girlfriend, but no one else was present. Z explained that he had been

drinking and was depressed, he also stated that he was on medication but had not been taking it.

Z first engaged with NHS services in February 1998. A GP referral letter was sent as a result of Z's alcohol use. A referral was also sent to the consultant neurologist as a result of Z's epilepsy. A mental health assessment of Z was undertaken in April 2008 following an urgent GP referral, which followed up a previous referral made in March 2008: this assessment found that Z illustrated borderline personality disorder, and low degree obsessive compulsive symptoms. It is also stated that he had fleeting thoughts of self-harm but denied active thoughts to harm self or others. A record from a further intervention in July 2008 notes Z's distress relating to childhood and sexual abuse; destructive behaviours including overdosing on five occasions; impulsive behaviours; and longstanding disabling interpersonal problems including a long-term but unstable relationship.

As a result of Z not attending outpatient appointments, in January 2009 clinical correspondence to the GP highlights that another appointment would not be offered immediately, but the patient would remain open to the CMHT in case he needs additional support. Z remained in touch with the GP and the last consultation he attended was on 6 June 2012 when he reported vomiting blood. Z failed to attend an appointment on 12 June 2012 and the GP record shows they were unable to contact Z by telephone on 9 July 2012 and 10 July 2012.

## **4 FINDINGS AND ANALYSIS**

For clarity this report differentiates between services offered for X's addiction challenges and his mental health.

### **4.1 X and Mental Health interventions**

Within the time frame of this SCR, X had received sentences on 6 occasions [IMR 3]:

Offence date - April 2001 (Shoplifting)

Offence date – October 2001 (Shoplifting)

Offence date June 2004 (Assault)

Offence date April 2005 (Indecent exposure) 3 year community service order

Offence date April 2006 (Provocation of violence)

Offence date June 2006 (Indecent exposure)

Offence date September 2006 (Assaulting police)

The first Mental Health assessment appears to be related to custody in September 2006. The statements note while being remanded in the segregation unit of HMP Dorchester, 'He had appeared acutely psychotic' [IMR 5p.35]. X failed to attend an appointment with the Community Mental Health Team on release from prison. The Community Mental Health Team contacted both CRI Street Services and the registered GP requesting that they contact/inform the team should X make contact.

The second referral from X's GP was in November 2008. X was complaining of hearing voices and this is a fairly constant occurrence. Due to X's recent diagnosis of diabetes the GP 'needed to get a grasp of X's mental state' [IMR 5p.39].

Confirmation of a CMHT appointment for 20<sup>th</sup> January 2009 is then reported. In June 2009 X's mood is reported as well settled, however he is being troubled by the voices 'he has been experiencing almost all of his life' [IMR 5p.40].

IMR 5p.10 notes in 2009 documentation incorrectly reporting X as being at ‘low risk of violence, suicide and neglect’: the same documentation reported ‘command hallucinations telling him to harm himself and others’.

By 2010 it appears that mental health services tried to treat X for his psychotic symptoms. The Combined Chronology states X was on a trial of Risperidone<sup>3</sup> in March 2010: this appears the first reference to any treatment for psychosis/schizophrenia. Treatment appears to be effective with ‘X describing a marked reduction in his voices’ [IMR 5p.45].

It is not clear why 4 years had elapsed since the first assessment [In HMP Dorchester in 2006] before treatment for psychosis was commenced in 2010. One explanation may have been X’s refusal to engage with treatment. New information [from DHC 25.3.2012] states that ‘His first prescription for Risperidone was on 4.2.2010 (fax from Consultant Psychiatrist to GP to commence prescription).

The first reference to a CPA review appears in February 2011. This suggests that CPA had been commenced with X – although when such a plan commenced is not documented.

By May 2011 X appears to be making progress with treatment, he is reported as ‘looks calmer, less preoccupied’ [IMR 5p.48]. July 2011 reports non-engagement with services – with a plan to discharge from enhanced care and try and engage with psycho-education. If this new treatment is unsuccessful he is to be discharged to the care of GP.

Over the summer of 2011 X’s mental health appears to deteriorate:

‘He had reported that someone had sprayed a can of fake tan on him the night before and he reported that his voices are very difficult to manage; however, he does not wish to discuss this’ [IMR 5p.51]

The case notes do not report a consultation between the care coordinator and consultant psychiatrist or indeed an updated management plan in response to the apparent evidence of psychotic illness.

---

<sup>3</sup> **Risperidone** is an antipsychotic drug which is mainly used to treat schizophrenia (including adolescent schizophrenia), schizoaffective disorder, the mixed and manic states associated with bipolar disorder, and irritability in people with autism.

In September 2011 it is agreed to CCO reengagement, and concern related to X's mental health led to discussions with the patient related to hospital admission.

Later in September 2011 IMR 5 reports correspondence between the CCO and police relating to an incident between X and his brother (apparently due to legal papers related to their father's death). Discussions led the agencies to plan for admission under Section 136 should further disturbances take place.

IMR 5p.12 reports:

'Patient did not attend today's appointment. Plan to allow patient space as he will often pitch-up at the CMHT, which will reduce the risk of him becoming paranoid about me. If nil heard by end of Wednesday of next week, then a letter offering appointment as soon as possible'.

Consequently, DHC suggest a more 'assertive approach to determine the patients psychiatric presentation' may have been required.

This period during September/October offers conflicting plans for X's treatment. By late October discussions were again taking place for informal admission of X for treatment. On October 14<sup>th</sup> 2011 negotiations took place to persuade X to consider planned voluntary admission, to reduce Methadone, conduct a medication review and physical review: X agreed to consider this suggestion. Admission was again discussed on October 24<sup>th</sup>: X requested more time to consider this option.

By mid November 2011 it was decided NOT to pursue admission to hospital as symptoms remained manageable. However, it is noted that 'protection of mental health was of paramount importance', [IMR 5p.58]

By early January 2012 X's paranoid delusional beliefs appeared to be settled. Stability of mental state is also reported throughout February and early March 2012.

On the 23<sup>rd</sup> March X appears angry and delusional at the CMHT base with CCO contact. However X agrees to return for a consultation in 2 weeks time.

By early May 2012 X stated that the psychosis had reduced and agreed to a follow up appointment in 3 weeks.

IMR 5 appears to report a review of X's condition on 13<sup>th</sup> July 2012. X's diagnosis of opiate dependence is noted with schizophrenia. The medication regime at this point was:

Amitriptyline 50mgs daily<sup>4</sup>  
Omeprazole (is reported without a dose)<sup>5</sup>  
Amisulpride 200mgs daily<sup>6</sup>  
Diazepam 5mgs PRN<sup>7</sup>

The risk review noted:

Risk of harm to others – Low  
Risk of harm from others (Vulnerability) – Low  
Risk of harm to self or suicide - Low

X was seen in June/July and stated he had found medication helpful. A further review on July 17<sup>th</sup> 2012 IMR 5 reports:

Current Medication:

Amisulpride 400mg nocte  
Methadone 60mls daily

'The patient told me today that he continues to hear voices almost constantly. He still drinks alcohol, about 2 cans of beer daily; he then stops taking his medication whilst drinking. His CCo continues to see him every 2 weeks. Today, he was well-kempt. There was no evidence of depression. He maintained good eye contact. He was almost circumstantial at one point I thought. He was thought-disordered, but, eventually answered my questions. There seems to be no problem with his activities of daily living. He also exercises and walks daily.' [IMR 5p.69]

The 26<sup>th</sup> July 2012 was the last DHC record contact with X: X at this meeting had reported returning to Madeira for a short holiday. The file suggests:

---

<sup>4</sup> **Amitriptyline** is a tricyclic antidepressant (TCA). It is the most widely used TCA and has at least equal efficacy against depression as the newer class of SSRIs. As well as reducing depressive symptoms, these types of tricyclics also ease migraines, tension headaches, anxiety attacks and some schizophrenic symptoms. It is also known to reduce aggression and violent behaviour.

<sup>5</sup> **Omeprazole** is a proton pump inhibitor used in the treatment of dyspepsia, peptic ulcer disease (PUD), gastroesophageal reflux disease (GORD/GERD), laryngopharyngeal reflux (LPR) and Zollinger–Ellison syndrome.

<sup>6</sup> **Amisulpride** is an atypical antipsychotic used to treat psychosis in schizophrenia and episodes of mania in bipolar disorder. In small doses it is also used to treat depression.

<sup>7</sup> **Diazepam** first marketed as **Valium** is a benzodiazepine drug. It is commonly used for treating anxiety, panic attacks, insomnia, seizures including status epilepticus, muscle spasms (such as in cases of tetanus), restless legs syndrome, alcohol withdrawal, benzodiazepine withdrawal and Ménière's disease.

‘It was apparent that he retained some degree of longstanding delusional beliefs. His preoccupation remained in relation to his view of family. He denied any animosity and remained mentally stable and his psychotic symptoms appearing very mild. There again was acknowledgement of the detrimental influence that alcohol could have in exacerbating his symptoms. He described a continuing use of alcohol, up to 3 times per week.’

‘It was acknowledged that, due to the degree of sustained stability, ongoing monitoring should take place at 3-weekly intervals. The patient, however, requested appointments within 2 weeks, as he had found interactions to be helpful when in discussion.’ [IMR 5p.70]

These records catalogue the fluctuating mental state of X since first referral in 2006. The documents note frequent psychotic features and a diagnosis of schizophrenia since 2006. The documentation suggests that the substantive effort to treat X’s psychosis commenced after 2006. The offences noted by the police all occurred prior to 2006. However, X reports hearing voices for much of his lifetime. It is therefore not clear if the psychotic features commenced in 2006, or were of longstanding duration.

In the context of the police involvement with X, the author finds no police held information or intelligence to suggest or show that X had mental health issues or was a vulnerable adult. The author finds that no agency has shared with Dorset Police any information in relation to the mental health of X, any vulnerability of X or any concerns for the welfare of X. Without this information, Dorset Police had no reason to identify that X had mental health issues or was vulnerable. [IMR 3p.11]

It appears that CPA was commenced in (26/01/2009) however the evidence points to at best an interdisciplinary approach, with no confirmation of an interagency approach. Evidence [IMR’s] suggests mental health services appeared to rely on a reactive response, rather than a proactive response to episodes of both antisocial and psychotic behaviour. It is also not clear why a link was never made between X’s antisocial behaviour and the psychotic formulation. A more rigorous and substantial CPA may have assisted to make the above links.

The only communication noted between mental health services to the police occurred on September 30<sup>th</sup> 2011 following an altercation between X and his brother, during which the police were involved. This resulted in an unsatisfactory decision that further disturbances by X should be dealt with by the use of Section 136. This was clearly a deficient action plan. This reactive plan may suggest that the mental health agencies felt working proactively with X was not likely to achieve a positive treatment response.

Information related to MAPPA is also limited to dates of police surveillance meetings with X.

## 4.2 Addiction services

Running in parallel to X's psychotic episodes were addiction problems. X was originally referred to addiction Services by his GP in June 2000, with a further referral in December 2000: although it is reported that previously X had been referred to the Drug and Alcohol Team through the Probation Service [CC: p.14] . IMR 5p.7 states that ' ... X struggled to engage with addiction services and often DNA'd ... '.

IMR 5 notes frequent attendance at the addiction services beginning in 2005. It is not clear whether addiction services were at this point aware of X's criminal history, [IMR 5p.8] states:

'It is not routine practice for the Police National Computer checks to be requested by the Addiction Services: however CMHT's are encouraged to request additional information from the Police to assist in the completion of risk assessments in line with the Trust Clinical Risk Policy, particularly as X had been referred from the Prison in-reach team'.

In Early 2005 X has Methadone suspended for 1 month:

'X has not been able to stay within agreed safe prescribing boundaries therefore methadone script has been suspended for 1 month.  
Suicide – Current risk Low/Minimal Medium Term Risk Low/Minimal  
Harm to Others - Current risk Low/Minimal Medium Term Risk Low/Minimal  
Self neglect/Vulnerability current risk Low/Minimal'

The next report is February 2007 with a DNA. In early 2009 there is a major review outlining the use of illicit drugs and alcohol. By May 2011 stability of Methadone is reported. A report to X's GP in June 2012 states X has been treated on Methadone for 30 months and X reports feeling stable on this regime.

From 2000 X had intermittently been in contact with addiction services – latterly from around 2009 a Methadone regime appears to have been effective for opiate dependence. However, X continues to report the use of alcohol and cannabis. The relationship between illicit drug use

and X's psychosis is not clear. Furthermore, there are no reported attempts to assess this multiple dual diagnosis.

### 4.3 General Practitioner Services

X had a series of health problems related to Diabetes, Nephrology [IMR 5p.30 states his left Kidney had been removed], and Sebaceous Cysts. X was also admitted to Acute Care following a fight and a stabbing injury to his right shoulder in 5.4.2004.

X's GP(s) appear to have consistently operated to control his illicit drug habits and also refer X to Mental Health Services. However, to a degree they were not fully informed of his offending history.

IMR 5p.8 notes that 'GP's were unaware of X's offending history', and further :

'GP's have no access to Police National Computer checks and are therefore reliant on any relevant information being shared by the police or mental health services'.

Whilst at the same time X was considered ' ... at high risk of harming others, than being harmed'

X was receiving treatment for Diabetes management and 'lumps on his chest'. IMR 5p.30 – Agency chronology notes a referral for the removal of a Cystic lesion in March 2009. In 2010 a Sebaceous Cyst was removed from chest and scalp – analysis from the operation found the specimen benign.

IMR 5p.30 – Agency chronology notes that X's co-morbidities also included ' ... removal of left kidney, bullet wound in right leg, assault on right shoulder and self assault on left arm'. GP records [IMR5p.31] note 'X is ex-army<sup>8</sup> and has several bullet wounds. X is in pain and run out of medication, prescription needed. New information received from HM Coroner suggests bullet wounds relate to an armed robbery in Madeira in 1984 [Email from AC 18.1.2013]

---

<sup>8</sup> This reference to the armed forces is from GP notes 22.1.2005 – no further corroboration of this fact is evidenced.

A draft report was shared with X's brother who said that he had always been close to X at home in Madeira, then when X had joined him to work in the Channel Islands and more latterly when both moved to and lived in Bournemouth. He is very clear that his brother had never been in the Armed Forces, he also doubts the existence of bullet wounds that X had bad scarring following an emergency operation to remove a kidney whilst they were still living in Madeira.

It is not clear whether other agencies were aware of X's alleged past armed force history. Given the noted injuries further enquiries were justified. If this history had been shared with mental health services further enquiries linked to mental health status might well have been justified.

#### 4.6 Y and Mental Health interventions

Y's history of treatment for mental health reaches back to at least 1998. Treatment throughout this period included hospital admission, and "Dialectical Behaviour Therapy". The treatment regime is outlined as:

'Ys care and treatment was in line with Care Pathway for Service users with Borderline Personality Disorder. Her treatment included twice weekly therapy, weekly support group, and telephone coaching during the day as required. In line with the treatment of people with Borderline Personality disorder and the agreed care pathway, if Y declined the treatment plan offered treatment was suspended until she was ready to re-engage.'

Y was discharged from CMHT services on 16.2.2011. There were on-going communications with mental health services during 2011. By Late November 2011 Y was reconnected to the CMHT for DBT appointment. However, by March 2012 it was agreed to transfer Y back to standard care. On April 12<sup>th</sup> 2012 the CMHN notes violent ideation in a conversation with Y. The following day at a CPA review (at which Y does not attend), Y is discharged. Comments from IMR 6 chronology p.178 state:

'There is no progress note outlining decision making, risk assessment, team review. There is no correspondence on file to GP, Patient. There appears no recognition of the patient's violent ideation as recorded on 12<sup>th</sup> April 2012 or action plan. There is nothing in the GP records to state that this decision had been communicated.'

Y contacted her GP 5.7.2012 to ask for a re-referral – the GP was unaware of the discharge and reassured Y she had not been discharged. Furthermore Y:

'... attempted to re-refer herself to the CMHT but was told by administrative staff that 'she needed to get a re-referral from her GP'. This was wrong advice and not in keeping with the CMHT Operational Policy', [IMR 6p.16]

Y is then arrested on the 27<sup>th</sup> July and charged with murder.

Although Y is in frequent contact with the police, they had no record of Y's mental health condition or treatment (although Y had alerted the police herself):

‘Y had personally told the police that she had a personality disorder and Dorset Police had interacted with her CPN. However, no agency had shared information with the police to the effect that Y had mental health issues, that she was a vulnerable adult or that she was at risk from others including X and significantly that others, specifically X was at risk from Y.’ [IMR 3p.40]

#### **4.7 Y’s personal risk of domestic violence as a victim and perpetrator**

At least 12 incidents of DV, assault and criminal damage are reported in IMR’s from 2002 to 2011 between Y and Z. From the notes it is difficult to distinguish victim and perpetrator. On occasions Y claims to have been attacked (October 2009). On other occasions Y claims to have been involved in the fight. In November 2004 during a CMHT interview Y ‘brandishes a knife’, whereupon the police intervened and Y was placed in custody. There are references to Y threatening to stab her partner in 2009.

Domestic violence between Y and Z appears to be an enduring feature of the relationship. The IMR’s are not specific in relation to any DV service intervention and IMR 6p.12 states:

‘There is reference made to involvement of a MARAC process but limited information regarding actions/outcomes of this. At interview the staff reported that referrals for domestic violence support were discussed but Y had declined input. Staff reported that she had capacity to make this decision and in line with the DBT pathway Y was encouraged to help herself. Y was in receipt of services and was a victim of domestic violence however she often did not want services to intervene. The police were pursuing in 2010 despite Y refusing to give evidence.’

There were numerous opportunities to consider a MARAC referral. Such a referral would have brought a multi-agency group together including the police<sup>9</sup>. There is evidence of the effectiveness of the MARAC process in supporting victims of domestic violence. Moreover, such a referral may have also exposed concerns related to the level of potential violence from Y.

However, IMR 3p.14 clearly states that the threshold for MARAC was met in 2010. At this point a referral was not made, apparently on the grounds of resource:

---

<sup>9</sup> <http://www.homeoffice.gov.uk/publications/science-research-statistics/research-statistics/crime-research/horr55/horr55-summary?view=Binary>

‘During 2009 and 2010, there were 4 incidents of DV against Y graded as ‘High Risk’. They scored 9, 7, 6 and 11 on the risk assessments. During this time, the MARAC criteria was 12 or above and therefore based on the levels of each individual case they would not have been considered for MARAC.

‘Dorset Police do use the guidelines around escalation of violence and use a baseline of 5 incidents and 3 crimes (DV related) when considering putting a case forward to MARAC. Based upon this criteria Y would have met the threshold in 2010. However, the volume of cases that can be dealt with during each MARAC meeting is a factor and as a consequence, the DV Detective Sergeant has to make an assessment based on all factors as to which cases are presented at MARAC. Levels of risk, concerns and recent incident history are key factors. As a consequence, Y was not presented to MARAC.’ **BUI by SCR author**

Y and Z appear to have had a longstanding (over 12 years) turbulent and violent relationship. Both individuals suffered from consistent mental health problems, depression, alcohol and illicit drug use. Alongside these difficulties both individuals had been diagnosed with borderline personality disorders. Both individuals were known to have violent tendencies. It is therefore predictable that this relationship would continue to remain periodically abusive and potentially dangerous to both individuals and others.

#### **4.8 Antisocial Behaviour by X and threats to X by Y**

IMR 2 and 6 report consistent difficulties related to antisocial behaviour by X affecting Y.

In total 5 complaints were made:

Complaint 1: 2 December 2004

Complaint 2: 24 May 2006

Complaint 3: 7 September 2006

Complaint 4: 30<sup>th</sup> October 2006

Complaint 5: 24 April 2009

The first report was noted in December 2004: a complaint from Y’s father relating to noise from X’s flat. Y then complained herself in May 2006 (X was then imprisoned so no further action take). Y again complained in September 2006 (again X spent time in prison), and on his release was formally warned of his behaviour in November 2006. Y was asked to report further ASB – no further contact was made by Y, and the case was closed in March 2007. It

is noted other residents had also complained about X's behaviour at this time. Y again complained in 2009 – was asked to complete diary sheets by the Housing Landlords, having not done so the case was closed.

Y also informed the CMHT in October 2009:

‘she had experienced a difficult week “nearly stabbed neighbour due to disputes”. Y was encouraged to focus on listening in groups (Dialectical Behavioural Therapy sessions) and she was provided with a 14-day supply of sedative medication.’ [IMR 6p.14] **BUI by SCR author.**

and

‘On 28.09.11 Y's contact with the CMHT revealed further difficulty with neighbour problems. Police had been in attendance the previous day. Y had been worried she will react with temper. Wanted to know how to fix the problem and repeating that it's not fair having this stress when she is trying to recover.’ [IMR 6p.14]

Requests for rehousing were consistently made by Y and supported by agencies:

1. Request from Bournemouth CMHT dated 30 October 2006 [*letter not seen by Housing Department*]
2. Request from Y's care co-ordinator dated 11 September 2009 [*letter not received by BBC*]
3. Request from Y's GP dated 20 June 2011 [*Further information received from BBC (email from BO 17.3.2012) states: ‘This letter was not received by HLS. Housing options did see this and reassessed the application. No additional priority was awarded’.*]

There were three formal requests from agencies supporting re-housing for Y due to antisocial behaviour by X. In October 2006 Bournemouth CMHT wrote

‘Y is supported by the North Bournemouth CMHT. As you are aware, she is currently suffering severe harassment from a neighbour. This is having a detrimental effect on her mental health, and it would be reasonable to assume that, if her housing situation was not urgently resolved, her mental health will deteriorate further. We would urge you to assist in whatever way you can.’

This letter suggests Bournemouth Borough Council Housing Department were already aware of the ASB by X.

In September 2009 a CMHN wrote to support a housing relocation for Y – the letter states that the behaviour of the neighbour above is having an extreme impact on her health:

“I would like to support this lady’s request to be moved from her current address due to the extreme impact from a neighbour who lives directly above her. Y is currently undergoing intensive DBT preparation therapy at the Turbary Park Centre with myself acting as care co-ordinator. She suffers quite profoundly from a borderline personality disorder, which in itself is both very difficult to treat and, obviously, very difficult to cope with. Y has informed me that, over the last number of months, she has been subjected to high-levels of anti-social behaviour; extreme noise that often goes on through the night. This has, as I am sure you can appreciate, affected her treatment greatly and I feel has quite possibly influenced a number of setbacks during treatment. I am not sure if a resolution for this situation would be possible, but I understand that Y has expressed her concerns regarding the above neighbour over a long period of time, but that it has not been possible to resolve this. I understand that, currently, she is requesting to be moved and I would appreciate it if this could be considered on medical grounds based on her condition.

I have discussed this with the Doctor, who agrees that the *risk to herself and to others, related to Y’s condition, would undoubtedly be greatly worsened due to her environment.* BUI by author of SCR

I appreciate that scenarios like this are undoubtedly very difficult to solve, but would welcome your support in helping this lady.”

In June 2011 Y’s GP also supported rehousing due to ASB. The GP’s letter also states:

‘I am writing as this ladies General Practitioner to confirm that she suffers from significant mental health problems. These have been aggravated recently by on-going problems with the antisocial behaviour of one of her neighbours. I would therefore support her request for re-housing. I understand her psychiatrist has also written to you in the past’.

IMR 6p. 13 reports:

‘There were missed opportunities to fully record the assessment and decision making around threats to neighbours in response to stresses and conflicts.’

and

‘Y was assessed as being significant risk of suicide/self harm and domestic violence. Insufficient attention was paid by the CMHT with regard to safeguarding X in light of the threats made by Y. Although consideration of a MARAC is made in the case notes there is no evidence that a MARAC was requested or occurred. Y was encouraged to contact the police independently in line with evidence based treatment of borderline personality disorder. [IMR 6p.16]’

There is sufficient evidence to suggest that given X’s mental health status, episodes of antisocial behaviour were likely to continue for the foreseeable future. This risk factor placed

geographically close to Y with a history of violent threats towards X, alcohol and drug misuse and unstable personality disorder of the borderline type should have prompted a more serious attempt to relocate Y before July 2012.

## 5 CONCLUSIONS

### 5.1 X

X had a history of psychotic illness acknowledged during a prison sentence in 2006. X was referred to North Bournemouth Community Mental Health Team, a treatment plan was in place however, the plan appears not to have been taken forward. Whilst there were further attempts to treat this illness, the consistency of the treatment plan is unclear. X also had consistently been referred and treated for alcohol and illicit drug addiction. There is **no evidence** of a seamless service between addiction services and mental health services.

**Only one communication relating to X was forthcoming between the Mental Health and Addiction Services, the Police and housing. All four organisations appeared to be functioning in total isolation in relation to X.**

### 5.2 Y

Y had a history of borderline personality disorder, alcohol misuse and illicit drug use. Y also had a history of threats of violence and had, on several occasions threatened X. Y had also been found in possession of a knife on at least two occasions.

**No communication relating to Y was forthcoming between the Mental Health Services and the Police. Both organisations appeared to be functioning in total isolation in relation to Y.**

**There were serious failures in communicating requests for Y to be relocated. Three communications from the health agencies appear not to have reached housing authorities.**

### 5.3 Z

Z had a history of alcohol abuse, illicit drug use and borderline personality disorder. Z was violent towards Y on a regular basis, often at Flat A, 4 Anyplace Road.

## 5.4 Combined conclusions

Y and Z had a violent, dysfunctional, relationship of over 12 years duration.

X resided at Flat E, 4 Anyplace Road since October 2004. Y had resided at Flat A, 4 Anyplace Road since April 2003. Flat E appeared to be directly above Flat A.

X frequently exhibited antisocial behaviour in his flat. This included excessive noise and damage. Y's complaints relating to X's ASB go back to 2004: she had complained on 5 known occasions to agencies.

Given the consistency of the Antisocial Behaviour by X, the close proximity of Y in the flat below [Z as a frequent visitor and perhaps even spending prolonged periods in this flat with Y], further disturbances, altercations and violence may have been predicted.

Y's attempts to be rehoused had consistently failed, even with substantial support from various agencies who **were** involved in Y's care.

**ALL agencies**, Mental Health Services, Addiction Services, Police and the Housing Agencies ought to have been aware of:

- 1. X's psychotic behaviour and alcohol/drug habits;**
- 2. X's antisocial behaviour;**
- 3. Y's violent history;**
- 4. Y's consistent threats to X;**
- 5. Z's frequent violence to Y and the,**
- 6. Close proximity of Y/Z to X together in the same block of flats;**
- 7. The Housing relocation requests and their urgency.**

Inevitably a further altercation developed between X/Y and Z on the 27<sup>th</sup> July 2012 with disastrous results.

## **6 Recommendations**

### Risk assessment and management

1. Partner agencies should review and improve the effectiveness of the process of CPA in the areas of information sharing, communication, multi-disciplinary work and risk assessment, especially in situations where violence is a known risk factor. (Multi-Agency Action)
2. All staff in CMHTs should receive management supervision on a minimum of a bi-monthly basis to include a sampling of case notes for those on CPA to ensure up to date risk assessments and management plans, CPA reviews and Care Plans.
3. All CMHTs should ensure that they are fully implementing the principles of CPA including multi-disciplinary/ agency CPA reviews involving all relevant agencies engaged in the patients health, social, housing and offender care and informed by up to date risk assessments.
4. The Policy and Guidance on working with Adults at Risk who do not wish to engage with services and are at serious risk of harm, should be reviewed, updated, disseminated and action taken to ensure it is understood and followed. (Multi-Agency Action)
5. CMHTs receiving referrals from the Prison In-reach Team, should ensure that an assertive approach to follow up takes place in line with the Trust Policy & Guidance on working with Adults at Risk who do not wish to engage with services and are at serious risk of harm.
6. Where a patient presents with both substance misuse and psychotic symptoms the CMHT should ensure that a focus on the treatment of psychotic symptoms occurs simultaneously to working in partnership with the Addiction services regarding substance misuse issues.
7. All staff should be reminded of the need to consider the effect of domestic violence in

all aspects of risk management and to initiate the Multi-Agency Risk Assessment Conference (MARAC) process when indicated (Multi-Agency Action). The Borderline Personality Disorder Care pathway should be updated to include referral to MARAC where appropriate.

#### Data sharing

8. Partner agencies, especially Mental Health and Police should review their information sharing protocols and ensure they are fit for purpose in relation to safeguarding adults at risk. This should include how data is stored and accessed in line with the Data Protection Act. Where information sharing protocols do not exist (for example Level 1 MAPPAs), the possibility of sharing should be speedily explored. (Multi-Agency Action)

#### Intra-agency and Inter-agency communication

9. All agencies should revisit their internal communication processes and evaluate their effectiveness.
10. All agencies should urgently consider how inter-agency communications can be enhanced. This is especially important in situations where violence by or to other individuals is assessed as a potential risk.
11. When the Prison In-reach Team refer prisoners for follow up by local services this should include confirming and communicating their MAPPAs status to the local team so that they can ensure that relevant agencies are engaged in CPA reviews. This should be incorporated into the annual audit of patients under the MH In-reach team being referred on to local services for follow up.

#### Training and insight management

12. All agencies should consider how they might develop training strategies to enhance the understanding of working styles, appropriate interventions and best practice models across and between agencies. For example, 'Is effective training in place for

police forces to understand and manage mental illness?'; 'Do all agencies fully understand CPA and have effective mechanisms to contribute to this care approach?'; 'Is safeguarding training offered in multi-disciplinary, multi-agency forums?.

13. Other forms of cross agency/discipline training and staff awareness if noted to be less than optimal should be quickly addressed with appropriate training.