Oxfordshire Safeguarding Adults Board
Safeguarding Adult Review
Overview Report

SUBJECTS: Adult F, born 1978 (son), Adult G, born 1951 (mother)

Author: Martin Bradshaw

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1.1 Circumstances

1.1.1 This Safeguarding Adults Review (SAR) concerns Adult F, a (then) 40-year-old man, and his mother Adult G, a woman aged around 70 years. Both lived in Oxford at the time of the trigger incident in July 2018.

1.1.2 Adult F and his mother are of Bangladeshi origin, and Adult F was born and raised in the UK. He is divorced, and his ex-wife and children live in Northampton. Adult F was diagnosed with schizophrenia in 2004, and has had at least five psychiatric in-patient admissions, all under the Mental Health Act.

1.1.3 On 19th July 2018, Adult F called an Ambulance, saying that he was James Bond and had attacked his mother. He had hit her over the head with a hammer. Police and Ambulance staff attended, and Adult G was found to have serious head injuries which were possibly life threatening. She subsequently made a good recovery.

1.1.4 Adult F was arrested and later convicted for attempted murder. He was held unfit to plead and was made subject of a S37 Hospital Order. Adult F now resides at Marlborough House Medium Secure Unit in Milton Keynes.

1.1.5 A referral was made to the Safeguarding Adults Review (SAR) Subgroup in January 2019, and the Subgroup resolved in February 2019 to commission a Safeguarding Adults Review.

1.1.6 Martin Bradshaw was invited to undertake an Overview report into the circumstances of the case. He is a retired Approved Mental Health Professional with extensive experience of management investigations.

1.2 Purpose of Safeguarding Adults Review

1.2.1 Safeguarding Adult Reviews are undertaken when a vulnerable adult dies or is seriously injured and abuse and/or neglect is known or suspected to be a factor.

1.2.2 The purpose of a SAR is neither to reinvestigate nor to apportion blame, but to establish if there are lessons to be learnt to prevent such an incident happening again. The Association of Directors of Social Services in their document '*Safeguarding Adults: Advice and Guidance to Directors of Adult Social Services*' described the overriding reasons for holding a review as being to learn from past experience, improve future practice and multi-agency working. Safeguarding Adults Reviews have become a Statutory Duty since the Care Act 2014 came into force on 1st April 2015.

1.2.3 In Oxfordshire the SAR Subgroup makes recommendations to the Oxfordshire Safeguarding Adults Board (OSAB) chair and manages the SAR process in accordance with the OSAB protocol for Safeguarding Adults Reviews in adult safeguarding. It considers whether a case meets the criteria for a SAR, applying the criteria as laid out in the Care Act 2014 and its accompanying guidance.

1.2.4 In relation to Adults F and G, the Subgroup reviewed the initial evidence and determined that this case did not meet the criteria for a statutory SAR. However, it recommended a 'discretionary SAR' looking at both son and mother, how services supported them and to see if more could have been done to prevent the incident.

1.3 Terms of Reference

1.3.1 The Review was required to include a summary of safeguarding issues and other key information relating to Adults F and G.

1.3.2 The period of detailed Review was to be from January 2015 to 19th July 2018 (date of trigger incident).

1.3.3 The following questions were specified by the Subgroup:

- Based on previous behaviour, was the incident predictable?
- Were assessments (e.g. risk, mental capacity, etc) carried out and were they shared between partner agencies?
- Was other information sharing done appropriately and in a timely fashion?
- Was information received by partners responded to appropriately?
- Were the mother's needs assessed and how were her needs met e.g. welfare and carer needs?

1.3.4 The Review was also required to consider generic questions asked for all SAR cases:

- What specific issues or questions does this case raise?
- Are there any unusual factors in this case, what are they?
- Are there any failings which appear obvious at this stage?
- Do there appear to be any other gaps in multi–agency working?

1.3.5 Exclusions

The Review is focussed on actions and events **prior to** the incident on 18.7.18. It does not consider the subsequent arrest, assessment and treatment of Adult F, or the treatment and support of Adult G following her injuries.

1.4 - Contributors to Review

1.4.1 The five agencies listed below were asked by the Subgroup to produce chronologies detailing their respective contact with Adults F and G. These chronologies were combined and used by the Author as the main factual basis for this report.

Contributing Agencies

1. GP Practice
2. Thames Valley Police
3. South Central Ambulance Service
4. Oxford Health NHS Foundation Trust
5. Oxford University Hospitals NHS Trust

1.4.2 The Subgroup did not consider that detailed Individual Management Reports (IMRs) were proportionate or necessary in the circumstances. Additional detailed information was obtained by the Author as required. There was apparently no significant involvement with Adult Social Care during the period under review in relation to Adults F and G.

1.4.3 OHFT supplied copies of their 'Initial Review Report' (24.7.18) and 'Comprehensive Root Cause Analysis Investigation Report' (24.10.18) which were used for background information. Various Mental Health Act documents were also supplied by the AMHP Service and used as background in this report.

1.4.4 A Discussion Panel of professional staff with knowledge of the case was convened on 22.1.20. The circumstances of the case were reviewed, and notes of the meeting were used to inform the analysis and conclusions in this report.

1.4.5 The SAR conclusions and recommendations represent the collective view of the SAR Subgroup. There have been full discussions of all the significant issues arising from the review, and these have contributed to the drafting of the report.

1.5 - Responsibilities to Patients and Families

1.5.1 Good practice requires patients and families to be involved in the SAR process so that they can contribute as appropriate (SAR Protocol

para.10).

1.5.2 Adult F was seen by the NHS Investigation Team at HMP Bullingdon on 19.9.18. He was advised to contact the team if he had further questions.

1.5.3 The NHS Investigation Team made a number of attempts to contact Adult G, with no success. They were informed that she had stayed with family while recovering, and attempts were made to contact them. Adult G was then reported to have returned to Bangladesh indefinitely, but latest information suggests that she is living with her daughter-in-law (ex-wife of Adult F) and grandchildren in Northampton (January 2020). A letter was sent to Adult G by the SAR Board Manager inviting her to participate in the Review but there was no response.

2 Background, Events and Chronology

2.1 - Background summary and overview of information

Adult G up to December 2014

2.1.1 Little detailed information was available to the Author about Adult G, who is of Bangladeshi origin. There are conflicting reports of her age, and GP records vary (70-75 years). She arrived in UK in 1977. It appears that she was married to the father of Adult F, but her husband died soon after the birth of Adult F in 1978. Adult G has been known to the GP Practice in Oxford for some 40 years. She is described as an independent and strong-willed lady who attends the GP Surgery at least once a month for medical assistance. One of the partners has known her since 1990. She speaks Sylheti (a Bengali dialect), and has a very limited command of English, but is able to make her medical needs understood in an assertive manner. The only known family of Adult G (apart from her son, Adult F) are daughter-in-law and grandchildren living in Northampton. Adult G makes frequent trips back to visit family in Bangladesh.

2.1.2 Adult G owns her own property in Oxford, but frequently visited and supported her son. They may have lived together in the same property at various times, but the records are not clear.

2.1.3 Adult G was reportedly assaulted by her son on several occasions from 2004 to 2009, including a ‘domestic incident’ leading to a S136 arrest of Adult F in 2007. Adult G was assaulted by a ‘tenant’ in 2012, but this may have been her son. There are reports of Actual Bodily Harm by Adult F against both his mother and his (then) wife, and Adult G was the victim of a criminal damage incident, date and perpetrator unknown. There are no records of Adult G herself on PNC.

2.1.4 There are no records of Adult G being subject of formal Safeguarding process. AMHT notes indicate that Adult G provided regular and substantial support to her son over many years. There is no recorded formal Carer’s Assessment of Adult G.

2.1.5 In terms of physical health, Adult G suffers from (inter alia) sciatica, angina, dyspepsia, abdominal, back and knee pain, goitre, osteoporosis and diabetes. GP records and Panel comments indicate that some of the primary care assessments and interventions were difficult because of the language barrier.

General and Forensic Background of Adult F up to December 2014

2.1.6 Adult F was born and raised in the UK. His parents were of Bangladeshi origin. Father died when Adult F was about 2 months old, and he was subsequently raised by his mother as a single parent.

2.1.7 Adult F married his cousin in Bangladesh in 1998, and they had 3 children born in 2002, 2006 and 2007. The couple divorced around 2008/9, and his ex-wife and children live in Northampton. There has been intermittent contact with the children. Adult F has not reportedly had significant relationships since the divorce, and has not worked since 2008. He has not been registered with the local GP practice since 2007.

2.1.8 The first reported contact with criminal justice system was in 1996, when Adult F was 18 years old. He has a significant offending history up to 2014, but no custodial sentences. Police records list Cautions for: burglary and theft (1996), theft of vehicle (2008), Public Order Act (2008), possession of Cannabis and Class 3 drugs (2008). There were convictions for: handling stolen goods (2003), burglary and theft (1998/9) and shoplifting (2011). Adult F was arrested in 2011 for making a hoax bomb threat. In 2012 police had a report that Adult F was threatening his ex-wife with a knife, the first of three allegations of domestic violence.

2.1.9 Records indicate 23 Police intelligence reports on Adult F between 1997 and 2011, relating to low level drug use, approaching people for money and mental health issues.

Psychiatric History of Adult F up to December 2014

2.1.10 The first recorded contact with psychiatric services was in 2003 following an overdose, when Adult F was 25 years old. He was diagnosed with paranoid schizophrenia in 2004 and admitted to hospital under the Mental Health Act. His behaviour was agitated and aggressive. This was the first of five admissions in total prior to the trigger incident.

2.1.11 Adult F was assessed under S136 following a domestic incident in 2007, but not admitted. In 2009 he was admitted under S2 for assessment after reportedly assaulting his mother. On this occasion he was delusional with agitated and aggressive behaviour. The admission continued under S3, and his diagnosis was changed to schizoaffective

disorder (manic type). During a Managers Hearing in 2009 Adult G reportedly assaulted Adult F and had to be removed.

2.1.12 The third compulsory admission of Adult F was under S3 in April 2012, after he seriously assaulted a member of the public, causing a leg fracture. He was subsequently charged with Grievous Bodily Harm. The following month he made verbal threats to rape the wife of a member of staff.

2.2 - Period of Review – January 2015 to 19th July 2018 Inclusive

NB: Adult G visited her GP many times during the period under review, at least monthly on average. These visits are recorded in the chronology but have not been included in this summary unless significant.
Events listed are illustrative, not an exhaustive account of this period.

2.2.1 Adult F called Police on 20.1.15 and was reported to be 'delusional, incoherent and rambling'. He was subsequently seen at home on 22.1.15 by staff from the Early Intervention Service (EIS), who found him to be delusional, thought disordered and confused. An appointment with GP for medication was arranged and the Adult Mental Health Team agreed to deliver medication if he did not attend.

2.2.2 On 26.1.15 Adult F attended A&E complaining of chest pain. Paramedics found him to be agitated, and worried about drugs paraphernalia. They discovered a kitchen knife in his front room, which was removed. On assessment, Adult F reported smoking Cannabis twice a week, denied any intent to harm self or others. Mood was good. There was no indication of need for psychiatric review, and he was advised to stop or reduce Cannabis use.

2.2.3 Adult F was reviewed at home on 3.2.15 by his Social Worker and found to be 'welcoming and engaging'. His flat was tidy and well-kept, and there were no concerns about self-care. Medication was arranged, to be collected by the patient.

2.2.4 Only a week later (10.2.15) Adult F was arrested for shoplifting. He was behaving 'irrationally', had not been taking his Olanzapine and had been drinking alcohol to excess (5 pints of beer that day). A Mental Health Act assessment was conducted in Abingdon Custody. Adult F said that he was a 'government detective' and had powers like 007. He was not fit to interview, was subsequently admitted to Vaughan Thomas Ward under S3 (Admission no. 4) and visited by his mother. Over the next two weeks he is described as thought-disordered and hyperactive, but with a gradual improvement in mental state. Mother visited him regularly.

2.2.5 On 28.2.15 nursing staff had to intervene in a physical dispute between Adult F and another patient, who were 'on the point of fighting'. Staff considered transfer of Adult F to a higher security setting due to his

behaviour. He remained unsettled for the next week, elated, intrusive and not sleeping well. Speech was pressured on 12.3.15.

2.2.6 During this seven-week admission, Adult G continued to visit her son. The OHFT chronology repeatedly states that no entry was made in the clinical notes about a Carer's Assessment being offered, declined or accepted.

2.2.7 Following a gradual improvement in mental state, Adult F was given increasing periods of leave away from the ward, and discharged home on S17 leave on 1.4.15. He failed to attend Day Hospital next day. Adult F's mother was about to go away for 3 weeks, had been cooking his meals and was not sure how he would cope without her. Adult F was then seen at Day Hospital on 7.4.15, with no recorded concerns. He was reviewed on 29.4.15 by a Consultant.

2.2.8 Adult F was taken to A&E by Ambulance on 9.5.15. He was 'acting strangely' and unable to follow conversation. He appeared psychotic, responding to external stimuli. Following review by on-call Psychiatrist, he was discharged home.

2.2.9 On 13.5.15, Adult F was again taken to A&E complaining of chest pain. He later absconded from the Emergency Assessment Unit (EAU) and was found at home by Police. EIS staff attempted to recall him to hospital on 14.5.15, but he refused to return. Several failed attempts were made to visit him over the following week, but no contact was made and he was not recalled that week as he could not be located.

2.2.10 Two AMHT staff made a domiciliary visit on 21.5.15. Adult F was not at home, but his mother was seen. Communication was difficult due to her strong accent and minimal English. She indicated that her son was very changeable, and aggressive at times. Adult G occasionally said "kill" using her hands in a stabbing motion. She reported that her son had assaulted his ex-wife, although date was not clear. Mother appeared to be providing substantial support with housework and cooking. She was worried about her high blood pressure and diabetes, and became distressed during the visit.

2.2.11 Following the visit on 21.5.15, AMHT staff planned to refer Adult F to Thames Valley Police (TVP) mental health liaison Inspector as presenting significant risk to others. It was also decided to consider referring Adult G for a Carer's Assessment.

2.2.12 Concerns were raised about Adult F on 22/3.6.15 after reports that he was acting strangely at a local school. He had also posted a letter to neighbours saying they would die within days. A decision was made the next day by a Consultant to recall Adult F from his S17 leave. There were initially some problems with locating him, but he went to the Warneford Hospital on 25.6.15 for his depot and was kept at the hospital until a bed

was available for his S3 recall admission to Vaughan Thomas Ward. Adult F went missing 3 days later from the Ward, but returned within an hour.

2.2.13 On 30.6.15 Adult F made threats of rape to staff after banging on a door and being asked to move away. He went missing from the ward the next day (1.7.15), but returned of his own accord a few hours later.

2.2.14 Adult G visited her son on the ward on 2.7.15, and staff observed a verbal dispute between them. Adult G threw her purse at her son, hitting him on the shoulder. She was then asked to leave by staff. Adult F was transferred to Phoenix Ward the next day (3.7.15) after absconding twice. Adult F attacked another patient without warning on 8.7.15, but later denied this.

2.2.15 During a Ward Round on 15.7.15, Adult F was noted to be having grandiose delusions, was paranoid about being strangled, and lacked insight. He went AWOL on 25.7.15, was found at home three days later by Police and returned to the Ward.

2.2.16 Adult F made a series of allegations in August 2015 that he was being sexually assaulted by another patient. This was investigated by Police, who concluded no crime had been committed.

2.2.17 On 2.9.15, Phoenix staff withheld leave for Adult F after he was verbally aggressive. A week later (9.9.15) Adult F was caught smoking in the toilets. When confronted, he repeatedly punched a nurse in the head. Police attended, but Adult F was too unwell to be interviewed.

2.2.18 Adult F went AWOL from Phoenix on 26.9.15. He was found at home by Police and returned to the Ward drunk and agitated. There were further unauthorised absences on 30.9.15 and 1.10.15.

2.2.19 During a Ward Review on 8.10.15, it was noted that Adult F had been having inappropriate conversations with his children during a visit, and a Safeguarding alert was made regarding family. On 15.10.15, Adult F made threats to kill his Consultant's wife, and to rape a woman he had seen on TV.

2.2.20 On 10.11.15 Adult F absconded from Phoenix Ward and was seen running in front of a bus with risk to his safety. He was returned to hospital by Police.

2.2.21 Adult G met with Doctors on 27.11.15 to discuss her son. She reported that when Adult G was on leave from the Ward, he usually took drugs and used alcohol. She also stated that she was looking after his three children.

2.2.22 In January 2016, Adult F failed twice to return from leave, and was brought back to hospital by Ward staff from home on 7.1.16 and 24.1.16. During a Ward round on 14.1.16 it was decided to arrange an Advocate

and interpreter for Adult G to discuss her concerns. There is no record of this happening. A few days later (1.2.16) Adult F attempted to set fire to toilet paper in order to leave the building during fire alarm.

2.2.23 AMHT staff contacted the ex-wife of Adult F on 4.2.16, as part of a Safeguarding enquiry. She stated that she did not have any concerns with regard to Adult F and his children, noting that he ‘loves his children very much’.

2.2.24 A multiagency risk-management and planning meeting was held on 5.2.16 in relation to Adult F. He was reported to be compliant with medication, and to have improved insight. Notes indicate that staff planned to talk with mother about serious concerns for her safety should she try to live with her son. It was agreed that a Forensic referral should be made for advice on management after assaults on staff, and a member of the public in the past.

2.2.25 A Forensic Review was conducted on 9.3.16, noting the high risk of low to moderate intensity violence to others, but low risk of severe violence. There is minimal information recorded in the chronology on this key assessment.

2.2.26 Adult F was discharged home 25.3.16, with planned attendance at Day Hospital and follow-up by Step-Up Team. The possibility of untreated ADHD was considered.

2.2.27 Some three weeks after discharge, Adult F called Police in a confused state, saying a friend had been forced onto a plane to Bangladesh (16.4.16). He was reviewed by Consultant on 26.5.16, and found to be compliant with medication and fairly stable in mental state. Mother reported that there was some tension with a lodger, and that her son was drinking alcohol to excess and using Cannabis.

2.2.28 Adult G reported to GP in June 2016 that her son was staying out late, using Cannabis and drinking to excess. A Community Treatment Order was started on 13.6.16. Adult F was reviewed by Consultant on 30.11.16, noted to be stable.

2.2.29 Concerns were raised on 15.2.17 about Adult F being exploited by drug users in his own home, and an Adult Protection referral was made to ASC.

2.2.30 On 28.3.17, Adult F failed to attend for his depot, thereby breaching his CTO. A Warrant was obtained for his recall, and Adult F was admitted to Ashurst PICU on 6.4.17 with a relapse in mental state. He was discharged home several days later. Several follow-up visits were attempted by AMHT, and there were some problems with depot compliance over the next few months.

2.2.31 Adult F called Police 18.5.17 saying he was in the CIA and that the hospital was trying to clone his family. After checks, no action was taken. There was some confusion between agencies about who Adult F was. There was a further paranoid call from Adult F on 12.7.17, saying he was 007, making allegations against Warneford staff. On 31.7.17, Adult F called Police asking to be escorted to Heathrow, and that Special Branch need to be informed.

2.2.32 Adult G visited GP on 29.8.17, who noted that it was 'hard to have a meaningful conversation' with her.

2.2.33 The mental state of Adult F deteriorated in September 2017, and he missed several depot appointments. A decision was taken on 25.9.17 to recall him, but he then went missing. Adult G was present at his home on 29.9.17. After much confusion with recall arrangements, Adult F was finally re-admitted to Vaughan Thomas Ward on 8.10.17.

2.2.34 An Online Safeguarding form from OHFT was received by ASC on 12.10.17, expressing concerns about Adult F being physically aggressive towards his mother when unwell prior to recall. She reported that he had pushed her, and she was scared of him. No safeguarding action was taken (16.10.17), with concerns to be reviewed as part of discharge planning. Records indicate that a Carer's Assessment was to be offered to Adult G, but it is not clear who was to do this.

2.2.35 Adult F was discharged from Vaughan Thomas on extended S17 leave on 23.10.17, and he was generally co-operative with follow-up and depot over the next two months.

2.2.36 Several attempts were made in October 2017 by the Fire and Rescue Service to visit Adult F's property for a safety check. They were unable to make contact with Adult G. On 31.10.17, ASC declined to attend a joint visit with Fire Service, as there was no evidence from available information that Adult G had any social care needs.

2.2.37 Adult F called Police in late December 2017, talked about the Queen dying, and wanted MI5 and the Pentagon to be contacted. The Crisis Team was informed.

2.2.38 On 17.1.18, Adult F refused his depot and a decision was made on 1.2.18 to recall him. He initially could not be located, but was found at home on 16.2.18, when he appeared calm with good concentration. After some difficulties with arrangements, he was admitted to Vaughan Thomas ward on 22.2.18. His mental state had deteriorated on 24.2.18, he was shouting in corridors and responding to unseen stimuli. Thought content was violent, and he was making threats of rape.

2.2.39 At a Ward Round on 1.3.18, Adult G was reported to have returned recently from Bangladesh, had been unwell (stroke) and had no money after spending £50k given to her by her son. It was noted that the

Care Co-ordinator (CC) had not responded to safeguarding issues re mother. An e-mail was sent to CC.

2.2.40 On 5.3.18, AMHT visited Adult G at home with an interpreter. Mother denied that Adult F was aggressive or abusive towards her, when well or ill. Sometimes his conversation did not make sense, she did not think that the AMHT could do anything to help her. She prays often and believed Allah would make it OK for her and son. She knew he had MH problems. She had to send his children away because he had threatened to kill them. Adult G was advised to contact the AMHT if she had any concerns.

2.2.41 The CPN called Adult F's ex-wife on 8.3.18. She said he had last visited the children several months previously, was alright with them although hearing voices. He was not there long, she was not concerned about him contacting her or children in future. Following this call Adult F was given extended S17 leave under S3. He had calmed down after being over-elated.

2.2.42 Adults F and G were seen at home on 12.3.18, he was calm. Mother was worried that he was taking heroin or cocaine. His sleep was disturbed, and he was wandering round at night.

2.2.43 Adult F was assessed for a CTO on 26.3.18. He was believed to be living alone at the time. The AMHP report describes him as agitated and thought-disordered on interview, with no insight into his mental illness. He was willing to continue with depot. Said that his mother was 80 years old. He lacked capacity to consent to CTO. The risk of verbal and physical aggression was noted, but not thought to have been 'prevalent' for over two years. Mother was thought to be vulnerable, but not willing to engage in safeguarding process. The CTO was duly completed.

2.2.44 On 22.5.18, City Housing reported to AMHT that Adult F was threatening to 'blow himself up and throw children in the river'. A recall letter was delivered the same day, but Adult F was not at home. He was then seen on 24.5.18, was willing to have depot, and appeared to be on good form. The recall was not implemented. Adult F made a series of rambling and incoherent calls to Police over the next ten days. He accepted depot at home on 5.6.18 and was 'pleasant and engaging'.

2.2.45 On 13.6.18, Police were called to Heathrow Terminal 3. Adult F had gone there by taxi, wanting to go to USA to speak at UN.

2.2.46 Adult F was seen at Warneford Hospital on 19.6.18 for help with benefits.

2.2.47 TVP received a 999 call from Adult F on 3.7.18. This was two weeks prior to the assault on his mother. The call was described as an 'incoherent ramble through various subjects' including the UN, CIA, Freemasonry, benefits and sexual issues. Adult F also made references

to chopping a woman's head off with a machete, stabbing and rape. There is a CHARM record of the call, but no URN was created and no further action taken. Adult F was not reportedly identified as the caller until later.

2.2.48 Adult F was next seen on 6.7.18 at home for his depot. Some paranoia in evidence, no hallucinations, he was worried about his finances. Eight days later (14.7.18) he arrived out of hours at Warneford Front Door, worried that he did not have enough money, not receiving DLA/PIP. Seen by CPN. He had delusional ideas about CIA, the queen and sick children. This presentation was consistent with his historic mental state. He was aware of how to contact AMHT in working hours, no action was taken.

2.2.49 On 19.7.18, the Care Co-ordinator attempted to visit Adult F, but he was not at home. Adult F was later seen at Warneford Front Door by a Social Worker a few hours before the assault. He was very worried about money, and his DLA had not arrived in his account. Adult F was advised to return the next day in office hours so that DLA could be contacted by telephone to check when funds would arrive.

Trigger Incident

2.2.50 At 20.26 hrs. on 19th July 2018, Police received a request for assistance from South Central Ambulance Service (SCAS). A man later identified as Adult F had called them saying he was James Bond and had hit his mother with a hammer. Another call was made from the same number about a cardiac arrest, saying this was his 'previous murder'.

2.2.51 Police and Ambulance staff attended the property. Adult G was found to be suffering from serious head injuries, believed at the time to be life threatening. She was removed to hospital, but Adult F escaped through a window. A walking stick was found covered in blood, and Adult F was believed to have taken a hammer with him. He was quickly located but did not have possession of the hammer. Adult F was arrested on suspicion of attempted murder and taken to Abingdon Custody Suite.

2.2.52 Adult F was assessed in Custody the next day (20.7.18) by a Consultant Forensic Psychiatrist and a Consultant General Adult Psychiatrist. There was no evidence of hallucinations or florid thought disorder. Adult F gave three different versions of the incident and was evasive at times. He was found to be fit to interview with an Appropriate Adult present, and there were no indications that he should be diverted to hospital at that stage.

2.2.53 The clinical notes of interview state that Adult F was potentially delusional, introducing unusual ideas at random times. He spoke of supercomputers, children's speed rape, CIA and MI6, sexual matters and the Queen. He said he co-existed happily with mother, did not feel threatened by her and did not demonstrate ill-will towards her. He denied

any intent to harm himself or others. His mental state 'did not seem markedly different from many occasions during his contact with MH professionals'.

2.2.54 The General Psychiatrist noted: 'I cannot see a clear association between mental state abnormalities and the apparent assault on his mother. His odd and potentially delusional ideas appear inconsequential and not obviously driving violent conduct'.

2.2.55 Adult G was later transferred to HMP Bullingdon, where he was interviewed by the NHS Investigation Team on 19.9.18. He was subsequently made subject of a Hospital Order under S37 of the MHA 1983 on 11.7.19, and was admitted to Marlborough House Regional Secure Unit in Milton Keynes.

3 Analysis

3.1 Case-Specific Questions

a) Based on previous behaviour, was the incident predictable?

3.1.1 Adult F had suffered from a severe and enduring schizoaffective illness for some fifteen years at the time of the incident. He had a long history of threats and violence towards staff, family and members of the public. When he is floridly unwell his behaviour is characterized by agitation and aggression. Even at his baseline when medicated in the community he is often delusional and paranoid. He often missed appointments for depot medication and was a heavy user of alcohol and cannabis. When not in hospital, he lived relatively unsupervised, often with his mother.

3.1.2 Given this history, it was always likely that Adult F would harm others again at some point. This was recognised in the Forensic Assessment in 2016, where a high risk of low to moderate violence was recorded. However, in terms of the specific assault on mother, there were no particularly strong indicators that she was at immediate risk. When last seen by AMHT staff (four months prior to incident), mother had no significant concerns for her welfare. When seen by AMHT staff, she often downplayed her son's behaviour, gave inconsistent accounts and was reluctant to engage with support.

3.1.3 Adult F was seen twice by AMHT in the five days prior to incident, including on the day of the assault. While he was anxious and thought-disordered, no specific risks or threats to mother were identified. The clinical team was clear on interview that they did not believe on 19.7.18 that Adult F posed an immediate risk to himself or others due to his mental state. The assault with a hammer was not specifically predictable.

b) Were assessments (e.g. risk, mental capacity etc) carried out and were they shared between partner agencies?

3.1.4 There were many formal and informal assessments of risk, mental capacity and overall mental state conducted in the review period, both in hospital and in the community. More assessments would have been done if Adult F had been more willing to engage and attend appointments. As he began to relapse, the assessment and recall process appears to have taken place as promptly as possible given his reluctance to engage. From the limited evidence in the chronology, it appears that assessment information was shared appropriately as necessary.

3.1.5 The evidence on assessment of safeguarding risks is inconclusive. There was discussion about formal safeguarding process in October 2017, but no specific proactive safeguarding action was taken. There is insufficient evidence in the chronology to form a judgement about this decision.

3.1.6 The CTO assessment of 26.3.18 may not have given sufficient weight to recent and historic incidents of violent behaviour and alcohol abuse by Adult F. His mother was noted to be '*vulnerable as an elderly individual'*. Adult F was recorded as having '*a history of verbal and physical aggression, however this has not been prevalent for over two years'.*

3.1.7 This assessment appears to understate the level of aggression by Adult F, particularly towards mother. His overall mental state had not changed significantly since the Forensic Review of 9.3.16 noted a high risk of violence. There had been a safeguarding referral on 12.10.17 reporting concern about physical aggression from Adult F towards his mother. He had pushed her and she was frightened of him. Prior to his last recall at the end of February 2018, Adult F had expressed thoughts of violence and made threats of rape. It is not clear how far the evidence of alcohol use, sudden relapse and risk of violence was considered in the CTO assessment. The views of Adult G as Nearest Relative on CTO are not recorded, and there is no mention in the AMHP report of Adult G being consulted about the care plan. The report apparently understates the risks to Adult G of having contact with her son, particularly in view of her poor health and previously reported concerns for her welfare.

c) Was other information sharing done appropriately and in a timely fashion?

3.1.8 The structure and content of the chronology does not give significant detail about information sharing. No evidence was found of poor practice in relation to sharing of information, apart from the 999 call

on 3.7.18 described below.

3.1.9 There appears to have been considerable confusion about where Adult G was actually living throughout the Review period, and she may have moved between her own property and the home of Adult F. This was not clear from the chronology, although she was often seen at the home of her son. It is not clear if more information sharing about Adult G's location would have affected the outcome.

d) Was information received by partners responded to appropriately?

3.1.10 Throughout the Review period there was a range of reports about Adult F relapsing, particularly from Police referring to AMHT. The chronology indicates that there was usually a prompt response to this information, although Adult F could not always be located quickly.

3.1.11 The 999 call made by Adult F on 3.7.18 was not dealt with according to expected standards. The call handler did not ask for sufficient additional information when key words like 'machete', 'rape' and 'stabbing' were used by Adult F. No URN was created to record concerns or build intelligence. If the call had been escalated and fully reported, it is likely that officers would have visited Adult F to check the situation, and a S136 arrest may have resulted, or a referral for further MHA assessment. An opportunity was missed for assessment, although Adult F was seen several times by AMHT in the two weeks after this call, with no immediate concerns about his welfare or risks to others.

e) Were the mother's needs assessed and how were her needs met e.g. welfare and carer needs?

3.1.12 The needs of Adult G were assessed in a number of ways during the review period. She was a regular attender at GP surgery, and her medical needs were assessed reactively by GP. Adult G was also seen regularly on the Ward and subsequently at home with an interpreter about four months prior to the assault.

3.1.13 The evidence on formal Carer's Assessment is contradictory. The 'Root Cause Analysis' notes that Adult G had received a 'relevant Carer's Assessment', but there is no other record in the chronology of such an assessment being made. The Discussion Panel could not establish if Adult G had declined a formal Carer's Assessment, or if it was never offered. There was a Safeguarding referral by OHFT in October 2017, and it was anticipated that a Carer's Assessment would be offered, but records are not clear how this was to happen.

3.1.14 Adult G was clearly at some considerable risk from her son. He had a history of significant violence when unwell, and was using alcohol

and illicit drugs to excess. Sudden relapse in his mental state was fairly frequent. Adult G was at least 70 years old with many health issues of her own. She should certainly have had a formal Carer's Assessment (with an interpreter) if at all possible. This process may have resulted in her having more support to keep an appropriate 'distance' from her son when unwell. However, the 'Root Cause' report notes that '*the team repeatedly tried to engage with Mother to address the risk posed to her by her son. In the team's opinion Mother was subservient in terms of her relationship with her son…and her willingness to engage in conversation with the team around her son and his illness was limited as a result'*.

3.1.15 The language issue was discussed by the Panel and covered in reports. The GP had repeatedly offered the use of interpreters to Adult G, but it had been difficult to find one who spoke Sylheti. It is likely that the language barrier made it difficult for mental health staff to develop significant rapport with Adult G. She would have been less likely to disclose abusive behaviour by her son, and less amenable to advice on 'distance' measures than a Carer without language issues.

3.2 Generic Questions for all Reviews (from TOR)

i) What specific issues or questions does this case raise?

3.2.1 There is no firm evidence of systemic or individual failure regarding the assessment, supervision and treatment of Adult F. The assault on his mother was held to be a 'criminal' act rather than directly resulting from his mental illness.

3.2.2 The primary safeguarding issue in this situation was the predictable risk of harm to Adult G. With some degree of hindsight, Adult G was excessively vulnerable when caring alone for her son and his severe mental illness. She was clearly loyal and supportive of him during some extremely difficult periods of relapse, and there were significant tensions in their relationship. While there was no firm evidence of Adult F 'targeting' his mother, or having specific harmful delusions about her, there was significant risk to her health and wellbeing when they lived together or had regular contact.

ii) Are there any unusual factors in this case, what are they?

3.2.3 The principal unusual factor is the language barrier referred to in para [3.1.15] above. Adult G was able to make her medical needs understood to her GP (with some difficulty), but was reluctant to use interpreters when offered, and they were usually not available when she visited the Wards.

iii) Are there any failings which appear obvious at this stage?

3.2.4 There was an individual failure by TVP Call Handler, described in para [2.2.47] above. However, this was probably not significant in terms of the assault on Adult G.

3.2.5 It appears that Adult G was not given a formal Carer's Assessment, for reasons that are not clear. If she declined to have an assessment, that was her right. If she was not offered an assessment, that is a failure of the safeguarding process, given the expectation that she would be assessed by OHFT as part of discharge planning for Adult F.

iv) Do there appear to be any gaps in multi-agency working?

3.2.6 Information about Adult F's potentially deteriorating mental state was not communicated to OHFT by TVP following the 999 call on 3.7.18, as described in para [2.2.47] above.

3.2.7 On available evidence, a formal referral for Carer's Assessment of Adult G was not made by OHFT to OCC, as set out in para [3.1.13] above.

v) Good Practice

3.2.8 The Panel noted the diligent and comprehensive medical care given to Adult G by her GP Practice over many years.

3.2.9 The Care Coordinator completed multiple interventions in the context of Adult F's chaotic lifestyle and serious mental illness. The Coordinator was persistent and assertive when faced with frequent lack of engagement by Adult F.

4 Conclusions and Lessons Learned

4.1 Adult G has made a reasonable recovery from serious injuries that could well have been fatal if not treated promptly. She is a vulnerable individual with multiple health deficits, who had sole care responsibility for her schizophrenic son at the time of the incident.

4.2 Adult F has a severe and enduring mental illness, exacerbated by the regular use of alcohol and illicit drugs. '*This led to limited insight and poor lifestyle choices, which at times affected his ability to engage with treatment… Meaningful engagement with the team in the context of recovery was largely not achievable, which led to a lifestyle of chaotic living and propensity for offending behaviour'.* [Root Cause Analysis]

4.3 Adults F and G received a good overall standard of professional service during the period under review. Adult F was recalled appropriately

to hospital when he relapsed.

4.4 Adult G may have derived some benefit from a formal Carer's Assessment with an Independent Advocate and interpreter present. However, the Panel noted that there was no direct causal link established between Adult F's mental state and the attack on his mother. Even if Adult G had been better supported following a Carer's Assessment, the attack may well have still taken place.

4.5 Given his history, it was always likely that Adult F would commit further acts of violence in the community. There are inherent risks in managing chronic schizophrenic patients outside hospital with inevitably lower levels of supervision. However, Adult F also presented a significant risk to staff when in hospital.

4.6 There was no one individual professional who was taking an overview of Adult G's wellbeing and how she was coping with her son's illness. The support offered to Adult G was primarily reactive, and it may have been helpful for her to have some form of named advocate to provide regular advice and guidance in the care of her son. Adult G was very positive about her GP Practice, had good rapport with Doctors, and it may have been beneficial for additional support to have been accessed via the GP in some way.

4.7 Adult G had a very limited command of English and was reluctant to use professional interpreting services. This may have prevented her receiving a full range of support in relation to caring for her son.

4.8 The formal OHFT investigation did not identify any root cause to this incident. It concluded that '*this appears to be a case of criminal behaviour not relating to any deterioration in mental state*'. The Panel was in agreement with this finding.

4.9 The decision of 26.3.18 to discharge Adult F under CTO may not have taken full account of the documented risks presented to Adult G, or have given sufficient weight to her concerns and wishes.

4.10 Although safeguarding concerns were repeatedly expressed about Adult G, there does not appear to have been any formal action taken to protect her wellbeing. The chronology does not provide sufficient information or comment for the Author to make conclusive comments on safeguarding in this case.

4.11 The Author would like to offer his best wishes to Adult G for her continued recovery.

4.12 The Author wishes to extend his appreciation to the Discussion Panel and partner Agencies for their contributions to this Review.

5 Recommendations

5.1 OFHT to review guidance and training on Carer's Assessments to ensure that they are offered to patients and Carers when appropriate.

5.2 AMHP Service and AMHT to consider reviewing the CTO completed in March 2018 against practice guidance and taking action as appropriate.

5.3 OHFT and OCC to review the availability of Sylheti interpretation and ensure that patients and families are pro-actively offered accessible interpretation as necessary.