# Moorlands Together
# Community Safety Partnership

# OVERVIEW REPORT

# DOMESTIC HOMICIDE REVIEW

**in respect of**

**Rachel**

**March 2018**

**Report Author: Bronwen Cooper**
**Independent Review Panel Chair: Kam Sandhu**
**December 2021**

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***Please note: The final stages of this Review were completed during the Coronavirus Pandemic, which has caused a delay throughout 2020 up until the Report being submitted to the Community Safety Partnership. We apologise to all concerned for this unavoidable delay.***

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The Review Panel, the Chair and Author, wish to offer our sincere condolences to the family and friends of Rachel. We are very grateful for their participation in this review, and we have valued their contributions to it.

## Introduction

1.1 In March 2018 an ambulance was called to the home address, as Rachel was said to have taken her own life. The Police also attended and established that in fact Rachel had been stabbed by her daughter, Catherine, who admitted to this. Catherine was arrested and was subsequently charged with the murder of Rachel.

1.2 The matter was reported by the Police in March, 2018 to the Commissioner for the County Council Safer Communities and The Community Safety Partnership, that a Domestic Homicide had occurred as defined by Section 9 (3) Domestic Violence, Crime and Victims Act 2004.

1.3 On 21st May 2018 a Domestic Homicide Review (DHR) Scoping Panel met to consider the circumstances of the death. The Scoping Panel agreed that the criteria for a Domestic Homicide Review had been met.

1.4 The recommendation to commission a DHR was endorsed by the Chair of The Community Safety Partnership and an Independent Chair and Overview Author were appointed.

1.5 It was agreed that the scoping period for the Review should be from January 2009 up until the date of the death of Rachel in March 2018.

1.6 It was further agreed that the focus of the review would be on the two main subjects: Rachel and Catherine.

### Grounds for Commissioning the Review

1.7 The Terms of Reference for this Domestic Homicide Review (DHR) have been drafted in accordance with the Statutory Guidance for the Conduct of Domestic Homicide Reviews (December 2016), which requires the relevant Community Safety Partnership (CSP) to conduct a DHR when a death meets the following criteria under the Domestic Violence, Crime and Victims Act (2004) Section 9, which states that a domestic homicide review is:

A review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse, or neglect by:

- a person to whom he was related or with whom he was or had been in an intimate personal relationship, or
- a member of the same household.

The purpose of undertaking a DHR is to:

- **Establish** what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.
- **Identify** clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.
- **Apply** these lessons to service responses including changes to policies and procedures as appropriate;

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- **Prevent** domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.
- **Contribute** to a better understanding of the nature of domestic violence and abuse; and
- **Highlight** good practice:

**Scope of DHR**

1.8 It was agreed that this Review should follow the key processes that are outlined in the Multi Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (2016).

The Review should consider in detail the period from January 2009, when Staffordshire Children's Social Care were involved with the perpetrator prior to her becoming an adult, until the date of the victim's death.

1.9 The focus of the DHR should be maintained on the following subjects:

| **Name** | RACHEL | CATHERINE |
|---|---|---|
| **Relationship** | Victim | Perpetrator |
| **Age** | 53 | 24 |
| **Ethnicity** | Identified as White | Identified as White |

The agencies involved were therefore asked to review their files (both paper and electronic) and to complete a detailed chronology of events that occurred within the scoping period, as well as a brief summary of any relevant background information that might assist the Review. They were asked to complete Individual Management Reviews (IMR's) of the work their own agency did with Rachel and Catherine. As part of this process the key staff who had first-hand contact with either Rachel or Catherine were interviewed by the agency Authors, and their views were incorporated into the IMR's. Agencies that did not have direct involvement or, had only very brief historic contact were asked to complete Summary Information Reports. A combined multi-agency Chronology was compiled, prior to the completion of this Overview Report.

1.10 The key issues, identified by the Chair and Review Panel, to be addressed within this review were as follows.

- *The victim's mental health issues and the provision of services in respect of this.*
- *The perpetrator's role as a (young) carer for the victim and provision of services in respect of this.*
- *The transition of the perpetrator from children to adult services provision*

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**Excluded matters**

1.11 The Review excluded consideration of how Rachel died or who was culpable- as that was a matter for the Coroner and Criminal Courts respectively to determine.

**Timescales**

1.12 The review commenced with effect from the date of the decision of the Chair of the Community Safety Partnership. The statutory Guidance indicates that the Review should be completed within six months of that date. Completion of the Review was not possible until conclusion of the criminal proceedings in September 2018.The Review Panel met on six occasions in addition to the scoping panel meeting and the Panel discussions and emerging themes have been reflected in this Overview Report. The final stages of this Review were completed during the Coronavirus Pandemic, which has caused a delay throughout 2020 up until the Report being submitted to the Community Safety Partnership. We apologise to all concerned for this unavoidable delay.

**Confidentiality**

1.13 The content and findings of this Domestic Homicide Review are held to be confidential, with information available only to those participating officers and professionals and, where necessary, their appropriate organisational management. It will remain confidential until such time as the DHR has been approved for publication by the Home Office Quality Assurance Panel. The Chair and Author met with family members in November 2019 to outline the aims of the Review and in October 2020 the Chair had a telephone conversation to clarify their wishes around anonymity of the victim within the report. The family requested that a European name be chosen for both the victim and the perpetrator, this was accepted by the Chair and their request honoured. The person responsible for the murder will be referred to as Catherine.

**Terms of Reference**

**See Appendix A**

1.14 Key issues to be addressed within this Domestic Homicide Review are outlined below as agreed by the Scoping Meeting. These issues should be considered in the context of the general areas for consideration listed at Section 4 of the Statutory Guidance.

- The victim’s mental ill health issues and the provision of services in respect of this.
- The perpetrator’s role as a (young) carer for the victim and provision of services in respect of this.
- The transition of the perpetrator from children to adult services provision.

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**Methodology**

1.15 The agencies involved were asked to complete Individual Management Reviews (IMRs) of the work their own agency did with both parties. As part of this process the key staff who had first-hand contact with either Catherine or Rachel were interviewed by the agency author, and their views were incorporated into the IMRs. Agencies that did not have direct involvement or had only very brief contact with either Catherine or Rachel were asked to complete Summary Reports.

There was a wide range of experience among the agency IMR authors; for some this was their first IMR, for other more experienced authors, the completion of IMR's was a regular task within their agency. However, experience is no guarantee of quality, and although all authors were given a briefing by the Overview Author as to the nature of the task, the requirements to adhere to the terms of reference, the need to interview staff who had direct involvement with the family, and a clear expectation that there would be significant analysis, this was very variable, and the reports varied greatly in length, substance and quality.

Several IMR's were reasonably comprehensive in terms of the facts of the case; for example, the number of incidents that the police or ambulance service were called to, and the brief record of their response was noted (where it was available – and several reports and logs were missing or destroyed) but were very scant in terms of any in-depth analysis or reflection on the service provided and its' impact on the family, or any deficits in it and any improvements that might be required.

Some authors were asked to do further work to improve the depth and quality of their IMR's in these aspects

The review panel met on six occasions and the discussions and emerging themes have been reflected in this Overview Report.

**Involvement of Family, Friends and Catherine**

1.16

Family members (Rachel's adoptive mother and sister) and Rachel's friend were sent a letter advising them of the DHR procedures at the outset, this was hand delivered and included a Staffordshire County Council leaflet named" *Domestic Homicide Review Information Leaflet"* as well as information relating to AFFDA. As part of the review the Chair invited discussions with Rachel's mother and sister as well as a family friend whom we shall refer to as Ann; meetings took place with Rachel's sister and Ann; their contributions are incorporated in this report. Rachel's adoptive mother declined involvement.

Catherine herself was invited to meet with the Chair and Overview Author, she agreed and the meeting was arranged via the Prison. These discussions are outlined later in the report at 4.2.

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One family friend (Ann) who wished to contribute to the Review met with the Author and the County Council Domestic Abuse Lead Officer at a local police station, and her views are also included.

At the conclusion of the Review, an invitation was extended to family members to meet with the Chair and the Overview Author to share the findings of the Review; however due to Covid19 this has been delayed.

**Contributors to the Review**

1.17 **Organisations that were required to complete Individual Management Reviews**

- Honeycomb Group; Staffs Housing (Formerly Staffordshire Housing Group)
- The Meadows School; Springfield School
- Staffordshire County Council Children's Services
- North Staffordshire Combined Healthcare NHS Trust
- West Midlands Ambulance Service NHS Foundation Trust
- Staffordshire Police
- University Hospitals of North Midlands NHS Trust
- North Staffordshire Clinical Commissioning Group

**Organisations that were required to complete Summary Report**

- Staffordshire Victim Gateway
- Challenge North Staffordshire
- National Probation Service
- Staffordshire County Council Families First
- Rethink Mental Illness

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## Review Panel Membership

1.18 **Panel Members consisted of:**

| **Name** | **Organisation/Agency** | **Job Title** |
|---|---|---|
| Kam Sandhu | N/A | Independent Chair |
| Bronwen Cooper | N/A | Independent Author |
| Nicola Albutt | West Midlands Ambulance Service NHS Foundation Trust | Safeguarding Manager & Prevent Lead |
| David Allcock | Honeycomb Group; Staffs Housing (*Formerly Staffordshire Housing Group*) | Housing Manager |

| | | |
|---|---|---|
| Laura Bosworth | Rethink Mental Illness | Service Manager |
| Michael Bowen | Staffordshire Moorlands District Council – Moorlands Together Partnership | Chair for Community Safety Partnership |
| Clive Cartman-Frost | Staffordshire County Council Children's Services | Head of Responsive Services |
| Amy Davidson | North Staffordshire Combined Healthcare NHS Trust | Head of Safeguarding |
| Kim Gunn | North Staffordshire Clinical Commissioning Group (GP Service) | Lead Nurse Adult Safeguarding |
| Cheryl Hannan | Staffordshire Police | Detective Inspector, Senior Investigating Officer |
| Jane Harding | North Staffs Carers Association | Chief Executive Officer |
| Janice Johnson | University Hospitals of North Midlands NHS Trust | Senior Nurse Safeguarding |
| John Maddox | Staffordshire County Council | Domestic Abuse Lead & MASH Principal Officer |
| David Mellor | Staffordshire Police | Policy and Development Team Manager |
| Sarah Rubanski | The Meadow School; Springfield School | Safeguarding and Enhanced Provision Lead |
| David Smith | Staffordshire Moorlands District Council – Moorlands Together Partnership | Community Safety and Enforcement Manager, |

Reports completed for this review, either IMR's or summary reports were prepared by persons independent of the actual case management issues and who hold key positions in their organisations and are cognisant of the need to be independent.

**Review Panel Chair and Overview Author**

1.19 The Partnership agreed to invite Ms Kam Sandhu to Chair the Review. Ms. Sandhu was known to be someone who had the requisite skills, knowledge, and experience to take on this responsibility (Set out in Section 4(39) of Multi Agency statutory guidance for the conduct of Domestic Homicide reviews 2016). Ms. Sandhu has completed several domestic homicide reviews within the East and West Midlands. An experienced non-executive director, with a strong commitment

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to understanding domestic abuse; she has worked with women's refuges and chaired an independent scrutiny committee into domestic abuse in Nottinghamshire. Having worked within the public sector for over twenty years she has a clear commitment to partnership working to provide the very best services to survivors and victims. She has produced academic research into forced marriage as part of her MSc in Criminology Ms. Sandhu is independent of the Moorlands Together Community Partnership and confirms she has no direct association with, nor is an employee of any of the agencies involved. There are no known conflicts of interest which would prevent her from taking responsibility for chairing the review panel.

1.20. Bronwen Cooper worked for over 30 years in local authority social care services. Her specialist area was safeguarding, in respect of both children and vulnerable adults. She became an Independent Author and Consultant in Social Care in 2009, and since that time has co-led and authored several (Children's) Serious Case Reviews and (Adult) Domestic Homicide Reviews. She has also conducted several Safeguarding Audits in various local authorities, contributed to national investigations, including Operation Yewtree (Savile) and given 'live' evidence to the National Child Sexual Abuse Inquiry (ICSA) She sits as a Tribunal Member on two national professional regulators, Social Work England and the General Medical Council. She has served on the management committee of a Women's Refuge and been a volunteer with Rape Crisis. She has lived experience as a deaf woman, and as a carer for a family member with long-term mental ill health.
Ms. Cooper is independent of the Moorlands Together Community Partnership and confirms she has no direct association with, nor is an employee of any of the agencies involved. There are no known conflicts of interest which would prevent her from being the author of this review.

**The Chair and Overview Author are very grateful for all of the contributions made to this Review, both from the agencies involved in the Review Panel and also from the family members themselves.**

**Parallel Investigations**

1.21

- North Staffordshire Combined Healthcare NHS Trust conducted a Serious Incident Investigation.
- Criminal Trial
- Post-mortem inquest

Equality and Diversity

1.22 Throughout this review process the Review Panel has considered the issues of equality in particular the nine protective characteristics under the Equality Act 2010. These are:

- Age

- Disability
- Gender reassignment
- Marriage or civil partnership (in employment only)
- Pregnancy and maternity
- Race
- Religion or belief
- Sex
- Sexual orientation

In terms of the consideration of her age, the majority of the scoping period for the review covered Catherine's young adult years – & even though the Chair & Author negotiated an extension of the scope from 2009 to 2018 (instead of the original scoping period starting from 2016) The information about her childhood & her early experience of being a young carer therefore relied on largely historical & anecdotal information. The very young age at which Catherine found herself taking on the caring responsibility for an extremely unwell mother is of course highly significant in terms of her development, but also in terms of her ability to access support and ask for help. The legacy of this continued into adulthood, when 'technically' Catherine would have been able to ask for help and support in her own right, but as she describes it, the pointlessness of her doing so was by then firmly established in her own mind

1.22.1 Within this review there were specific equalities considerations in respect of the heritage of both Rachel and Catherine. In addition, there were issues to consider in relation to Catherine's possible learning disability and Rachel's mental ill health.

1.22.2 Rachel's precise heritage in terms of her ethnic origin remained unclear throughout her life; both to herself and to her family, as she was adopted, and her precise birth-parent heritage was never known. Her birth mother was found at some point, and was identified as South Asian. Her birth father was never found. She was adopted into a white British family, and she identified as white British herself. The information found during the review established that this caused her problems over the years, as she was subjected to racist taunts. She appears to have presented as white British in order to 'fit in', both within her family and in the wider community and she showed a reluctance to identify as mixed heritage. At later stages when she accessed services, her ethnic origin was variously defined or reported by agencies, often on their monitoring or assessment forms, as European, mixed white/Asian and Pakistani/white, however, it was unclear how they had arrived at these various definitions.

1.22.3 Catherine's ethnic origin was similarly unclear; her birth father was known to be white British, but she obviously shared her mother's heritage, however she clearly identified as white British.The evidence is that the impact of both Rachel and Catherine's mixed heritage was never explored by agencies – both at the time they were in receipt of services, but also at any later stage, including in the agency gathering of the information for this review. It appears that agencies attached various definitions of the pair's racial identity as they saw fit, rather than exercising any professional curiosity in this respect. Had they sought the specific information about Rachel and Catherine's identity, it is possible that they may have been met with ambivalence – arising from Rachel's family's original stance that her origin was anything other than white/British. Any exploration of the impact that racial

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identity - and racism – had in this case, is consistently undermined by the complete absence of any professional curiosity, discussion or understanding of the two women's actual heritage.

1.22.4 Rachel's mental ill health was discussed at length in the review, as it dominated both hers and Catherine's lives throughout.

1.22.5 The full extent of Catherine's learning disability was never fully established, but the members of the panel from the Education Service were very helpful and knowledgeable in this regard. Their view was that Catherine may have had a mild learning disability, but her development and her social presentation may well have been compromised by the bizarre nature of her daily life, caring for a mother given to extremes of self-harming behaviour, and who kept her within the very tight boundaries of home for the majority of her childhood.

1.22.6 The panel membership was reasonably diverse in terms of ethnic origin, disability, gender, lived experience of using services and having carer responsibilities. There was also extensive expertise among the panel members of having worked in, or managed services for users of mental health services. The panel also drew on the expert input of a Carers Service. This expert input was highly relevant to Catherine, both as a carer and also as a young woman with a possible learning disability.

**Dissemination**

1.3

The final version of this Overview report will initially be distributed to:

- Family
- Statutory partners of Moorlands Together partnership
- Organisations represented on the review panel
- The Police, Fire & Crime Commissioner for Staffordshire
- The Domestic Abuse Commissioner for England & Wales

## 2. The Facts

### Incident Giving Rise to the Review

2.1 Rachel and Catherine lived together in a small rural town in the Midlands area. There were no other members of the household. On a morning in March 2018 a call was made to West Midlands Ambulance Service from the home address. The caller reported that Rachel had cut her own throat. A total of three ambulances attended the address; the first arrived at 09.16. Catherine reported that she had come downstairs and found Rachel dead on the floor, apparently having cut her own throat. Catherine also told the ambulance crew that Rachel had been 'depressed' the previous evening. Rachel was confirmed dead at the scene.

2.2 Catherine was arrested on suspicion of the murder of Rachel and taken into police custody. When interviewed by the police, Catherine was reported as saying 'she drove me to it; I killed her'. She was subsequently charged with murder and

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appeared at Magistrates Court later in March 2018. She was remanded into custody until the time of her trial.

### Criminal Trial

2.3 Catherine was convicted of the murder of Rachel at Crown Court and in December 2019, she was sentenced to life imprisonment with a minimum term of 13 years. Her appeal against conviction was dismissed.

### Post-Mortem and inquest and/or Coroner's inquiry

2.4 The Post-mortem and Inquest have both been conducted and concluded. There is no intention for either to be re-opened.

### Background Information (Prior to Scoping Period)

2.5 Rachel had a birth name that indicates a mixed heritage, possibly of South Asian origin. She was adopted into a white/British family and her name was changed to their family name. Her adopted mother is still alive, her adopted father is deceased. She has two brothers, who are the birth children of her adopted parents, and one sister who is also adopted, but non-related and of white/British heritage.

2.6 Rachel married in 1989 and gave birth to Catherine in 1993. The couple divorced in 1995 and Catherine has had very little contact with her birth father.

2.7 Rachel had a history of mental health problems and violence, and she was well known to mental health services and to the police. She had a history of involvement with community psychiatric nursing services since 1994 having been on prescribed medication throughout this time. Rachel apparently believed that she had schizophrenia, but she had no formal or consistent diagnosis of this. She had self-harmed in the past, on one occasion setting her hair on fire.

2.8 Rachel had nine convictions between 1981 and 1987 for arson, wounding and causing a bomb hoax. She was imprisoned for nine months in 1986 and two months in 1987. The offences ceased after this.

2.9 Catherine lived with Rachel at the home address for her entire life up until the point of her arrest, apart from two or three nights spent in foster care when she was very young, and Rachel was in hospital. It was reported (by Rachel) that they had a good and supportive relationship for the majority of the time, although Rachel was significantly unwell with serious mental health issues.

Catherine appears to have become her mothers' carer from a very young age by default and remained the primary carer for her mother throughout her life, although it appears that this was never formally recognised or acknowledged by the agencies involved with Rachel. However, Catherine was in receipt of Carer's Allowance in addition to Income Support once she was 16 and had left school.

2.10 It is understood that Catherine has a learning disability but its exact nature and the impact of it on her are unclear. Catherine had a Statement of Special Education due to her assessed learning needs, but there was an ongoing debate about whether she was too bright for 'special' school. The evidence was that she struggled socially with the pressures in a mainstream primary school, and she was placed at a specialist school in 2007, but both she and her mother believed that she was academically more able than the majority of the school population.

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2.11 From the information drawn from the various agencies that became involved with Rachel and Catherine, their life together was characterised by an isolated co-dependent existence dominated by Rachel's problematic mental health. Agencies had very little information about any other significant family or friends, until they were spoken with as part of this Review. Rachel had a friend (Ann) who is referred to occasionally in agency records and appears to have accompanied her to appointments at times, and also offered Catherine some support, but the nature of this was unclear until this Review. Ann was able to contribute to this review and met with the review Author and and the County Council Domestic Abuse Lead Officer Rachel's adoptive mother lived nearby but had only occasional contact with them.

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## 3. Summary of Agency Involvement During the Scoping Period

**(January 2009 - March 2018)**

***The information in this section is primarily drawn from the Individual Management Review (IMR) Reports from agencies and includes the agency authors' own narrative where indicated. The Overview Author's comments are included in the text boxes in bold italic font.***

### Staffordshire Housing (Housing Association)

3.1 Rachel had been a tenant in the property she lived in with Catherine since at least 2009, when the property was acquired by Staffordshire Housing from a larger Housing Association. It is understood that Rachel and Catherine had lived at the address for some time prior to 2009. The Housing Association notes that although they were aware that Catherine lived at the property with her mother, they had no specific information about her and no indication that she was Rachel's main carer.

3.2 The Housing Association's involvement primarily focused on managing the neighbour disputes and anti-social behaviour, which were reportedly prevalent in the street between 2009-2011. However, there were some specific incidents noted in the chronology where there is evidence that the Housing Association were aware of and alert to Rachel's mental health issues. For example, in March 2010, there was contact between the agency, a senior staff nurse at the Mental Health Centre and a Community Safety Officer who advised that following a deterioration in her mental health, and pending a planned professionals meeting, in line with 'lone working' policies, Rachel should not be visited alone at home, as she was becoming increasingly aggressive towards the Housing Officer and the neighbours. There was no reference to Catherine in connection with this report, and no evidence of any consideration being given to the risk that Rachel might have posed to Catherine in this context. Further to this, the chronology noted that a meeting was held at the Mental Health Centre in April 2010, which the Housing Officer attended and there was an agreement from the Mental Health Team that they would monitor Rachel's mental health, with a planned further update in May 2010. Again, there was no reference within this record to Catherine.

3.3 After Rachel was arrested in June 2010 for threatening behaviour and brandishing a knife, Catherine had contacted the Housing Association to ask whether they provided temporary accommodation. Meanwhile the Housing Association had

applied for and obtained an injunction in respect of Rachel, aimed at restricting her threatening and aggressive behaviour towards her neighbours. The injunction was obtained due to the following anti-social behaviour by Rachel that had been observed by housing officers:

- Shouting, screaming and abusive language
- Banging of doors
- Gesticulating towards neighbours (V signs)
- Inappropriate comments made towards the family which could be interpreted as threats of violence
- Making false allegations to other agencies about neighbours (reports of illegal drug use and child protection issues to the Police and Social Services)

3.4 In July 2010, Catherine contacted the Housing Association to enquire about the court process and the action taken by the Housing Association on her mother's behalf – it was noted that Rachel was heard giving instructions about the questions that Catherine was to ask in the background.

The exact terms of the injunction against Rachel are as follows:

*"The Court ordered that the Defendant, Rachel, be forbidden (whether by herself or by instructing or encouraging or allowing any other person)*

*1) To engage in, or threaten to engage in, conduct capable of causing a nuisance or annoyance to any person who resides in, visits or engages in a lawful activity on (the street where Rachel and Catherine lived).*

*2) To use or threaten to use violence towards any person who resides in, visits or engages in a lawful activity on (the street where Rachel and Catherine lived)".*

3.5 At a second court hearing in September 2010, the injunction was extended for a further 12 months until September 2011, imposing restrictions on Rachel's behaviour towards her neighbours. Again, no reference was made to Catherine's situation in the records.

3.6 The agency indicates that this reduced the number of reports and incidents of anti-social behaviour considerably from the latter part of 2010 onward. In addition to this, a number of residents of the street moved away and the reported incidents became less frequent and also less serious in nature.

3.7 It was noted that officers of the Housing Association worked well with partner agencies, such as the Police and mental health services, particularly in the context of the MASH (Multi-Agency Safeguarding Hub, which was established in 2012), where it was noted there were regular discussions about the issues in respect of the family, and actions were agreed and followed up. Staffordshire Housing concludes that appropriate action was taken to prevent anti-social behaviour incidents escalating, in line with the policies and procedures of the Housing Association and partner agencies. There are no requirements for any future actions, changes in practice or recommendations have been identified for Staffordshire Housing.

***The absence of any reference to, or consideration of Catherine's position within this living situation has been identified during Panel discussions as***

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***a clear oversight and a missed opportunity for agency intervention to assess the risks of Catherine living with her mother. It is a matter of concern that a Housing officer could make an assessment that Rachel posed such a risk to staff that subsequent advice directed that she should not be visited alone – and yet the potential risks to her (then) 16 year old daughter were not recognised. There was no actual evidence in the Housing Association records of any reports of violence between Rachel and Catherine, but the evidence suggests that the agency simply did not 'see' Catherine, or took a rather blinkered approach that focused solely on the immediate anti-social behaviour issues and the perceived risks to neighbours and to professionals, but took no account of the wider picture in relation to the stresses and risks within the household.***

***The majority of Housing officers had received safeguarding training by this time, it is surprising therefore that none of the Housing officers in contact with the family identified the vulnerability of a young person who was exposed to the types of behaviours that gave rise to the need for an injunction against Rachel.***

***The alleged verbal abuse from Rachel, including the threat of physical violence towards a neighbour's child should have prompted a safeguarding referral to Children's services, which in turn should have given rise to an assessment of the risks to Catherine. Instead this was dealt with by way of an injunction – which served its' purpose in respect of the protection of the neighbours but offered no consideration of Catherine's needs for safety and protection.***

***There is some evidence of effective inter-agency communication and liaison in respect of Rachel and the challenges she presented as a tenant, but this dialogue unfortunately did not include any discussion of Catherine's needs as - in effect – a co-tenant and vulnerable dependant of Rachel, living in the same household.***

**Education Service**

3.8 2009 appears to have been a significant year for Catherine, as she turned 16 and moved into adulthood. The Education Service confirms that school became increasingly problematic for her, and her frustration at remaining in 'special' education was exacerbated by her mothers' assertion that she should be going to college and achieving qualifications, which appeared only to compound her difficulties and her isolation.

3.9 A CAF (Common Assessment Framework) approach had been put in place and there was regular contact between school and home, with Rachel often ringing the school with concerns – and frequent allegations – about Catherine's treatment by other pupils and also teachers. Her school attendance became increasingly erratic, and there were reports of bullying and racist taunts aimed primarily at her mother, but possibly also at Catherine herself. When the school moved site following a fire in 2009 and broadened its' remit to include more physically disabled children, Catherine's attendance dropped to only 45%.

3.10 The school made a referral to the First Response team at Children's Services in March 2009, when Catherine was not in school and had been seen out with her mother, shopping for cigarettes, alcohol, and scratch cards. The school were

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concerned that Rachel's mental health was declining. The school also contacted Staffordshire Police to carry out a 'safe and well' check on Catherine (this is also referenced by Staffordshire Police).

3.11 During May 2009, Rachel made a series of malicious and unfounded allegations against staff and pupils concerning their treatment of Catherine. She also made a call to another parent, posing as a teacher and making allegations against her child. In June, Rachel and Catherine attended a CAF meeting at school during which it was agreed that Catherine could attend the local (mainstream) high school for a trial placement to see how she got on. The evidence is that this plan did not materialise and during the latter part of 2009 up until the summer of 2010, Catherine was hardly in school.

3.12 In October 2009, there were reports of physical altercations between Catherine and some of the other girls in school, who had also allegedly been racially abusive about her mother, and Catherine told a member of staff that she wanted to 'end her life as she couldn't take it anymore'. It was agreed that the deputy head would talk to the other pupils and the matter would be discussed at a multi-agency meeting that was due to take place in November.

3.13 This meeting took place and was well attended, with representatives from the school, Children's Services, Connexions and the Adult Mental Health team (for Rachel), as well as Catherine and Rachel. The view of all present was that Catherine's attendance was improving, and that college and work experience placements were being explored. The pupils who had allegedly been abusive had been spoken to by the deputy head, and also by the police, who had been invited into school to talk to the students.

3.14 At a CIN (Child in Need) meeting in December 2009, also attended by the Education Welfare Officer, Catherine said that things had improved for her and that staff had responded to her concerns. The possibility of some input from CAMHS (Child and Adolescent Mental Health Service) for Catherine was also discussed, and a referral was made to the service.

3.15 There are indications that the communication between Rachel and the school became highly problematic, and in March 2010, the school had to write to her about the frequency and nature of her calls to the school. Rachel was advised that she needed to make appointments in order to have fuller discussions. The school also provided her with information about the complaint's procedure. Subsequent to this, the evidence from the school records is that Catherine was absent due to illness for a significant period and did not complete the school term or her exams.

3.16 Both Rachel and then Catherine contacted the school in May 2010, requesting copies of her school records, but when the school informed her that there would be a charge for this service, Catherine made her displeasure about this clear, as well as the fact that the school had apparently contacted social services to arrange a visit to her, and she informed the school that she wanted no further contact with them.

3.17 The comment in her final school report in 2010 is that it was 'a great shame that Catherine did not complete the school year as she would have achieved several qualifications'.

There are no further records from Education Services after 2010.

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***The evidence is that school life was difficult for Catherine, not least because of Rachel's fraught and fractious relationship with the staff, and her frequent telephone calls throughout the school day. The extent and nature of Catherine's actual learning ability or disability was never fully established. It may have been difficult to assess because of the complexities of her relationship with her mother, and was no doubt compounded by the level of trauma she was exposed to at home – much of which may have been unknown to the school at the time.***

***It is apparent that the school worked hard to maintain Catherine's attendance, but this was persistently undermined by Rachel; either because of her view that Catherine was too bright for 'special' school, or simply because she wanted Catherine at home to meet her own needs. It is of great concern that Catherine missed most of her final year in school and left without taking any exams – which the school were confident she would have passed – as this would have contributed both to her sense of self-worth and her independence.***

***The frequent allegations made by Rachel, that Catherine was the victim of assaults – both physical and verbal – by staff and pupils, served only to exacerbate the already fraught relationship between home and school. The evidence is that these allegations were appropriately investigated, and either found to be spurious or unsubstantiated.***

***It is evident that the school made strenuous efforts to maintain a constructive relationship with Rachel but that this was difficult in the context of her erratic mental health and complex behaviour. Several opportunities were offered to Catherine to undertake placements at high school and college but sadly, these were refused by Rachel.***

***It is evident that there was an ongoing dialogue between school and Children's Services – as is corroborated further in the information provided by Children's Services. This shows the repeated attempts to engage Rachel in robust discussions about her daughter and her educational and social needs; but this was highly problematic in the context of Rachel's apparent inability to subjugate her own needs and prioritise Catherine's for the majority of her school career.***

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**Staffordshire County Council Families First (Children's Services)**

3.18 Children's Services corroborate the view that 2009 was a significant year for Catherine, as she was subject to a CAF as well as a referral to CAMHS (Child and Adolescent Mental Health Service) There appeared to be an informal recognition of Catherine as a carer with the emotional responsibility of her mothers' poor mental health. In March 2009, there was involvement from the FASS (Family Assessment and Support Service) Team, who identified her needs as a 'young carer'. Support was offered to Catherine by way of a Connexions worker and Team Around the Child (TAC) meetings. This involvement appears to have been curtailed by Rachel, who informed agencies that it was not needed, and the case was closed to the FASS team in June 2009. However, Catherine's case was still open to Connexions and there is evidence that there were subsequent TAC meetings. There is also evidence to suggest that the Connexions worker was detailed to follow up the advice that Rachel should take Catherine to the GP, and the Nurse from the Mental Health Centre was advised by First Response to ensure that Rachel took Catherine to the GP. However, it is not known whether this actually happened.

3.19 An allegation made by Rachel in September 2009 that Catherine had been assaulted by the deputy head teacher at school was investigated by Children's Services but found to be malicious. The FASS Team became involved with Catherine again in October 2009, following an altercation at school when Catherine maintained that she did not have a learning disability and did not need to be at a special school. At a Children in Need (CIN) meeting in November 2009, it was agreed that Catherine could complete Year 11 at the local high school, and at a Review in December 2009, it was agreed that there should be further input from CAMHS.

3.20 The Children Service refers to some allegations made to the First Response team by Rachel and a 'family friend' in March 2010 that Catherine was being badly treated at school and therefore could not return there in the spring of 2010 to take her exams. Rachel was advised to speak to the Education Welfare Officer (EWO) and a recommendation was made that the TAC meetings should continue.

3.21 Subsequent to this, there was evidence from health professionals that Rachel's mental health was deteriorating in May 2010 and that she needed a hospital admission. There was a direct referral from a staff nurse at the Mental Health Unit to First Response, and the FASS team then assessed Catherine's ability to manage at home alone. This assessment concluded that Catherine was very different when Rachel was not present, and that Catherine was well able to care for herself and had insight into and awareness of her own needs.

3.22 In addition there were concerns that the CAF had broken down, as Rachel had been abusive to the Connexions worker, and Catherine had also witnessed her mum being involved in a violent incident with police officers. This was again referred to the FASS Team and a Core Assessment was recommended.

3.23 The record of this assessment states that Catherine was "in danger of her own needs being ignored by and lost within her mother's" and the recommended plan was that the focus should be on Catherine being able to achieve more education and training, with increased independence and "not to remain at home as her mothers' carer learning her behaviours from those mum exhibits because of her mental health needs".

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3.24 A decision was made in August 2010 by a team manager to seek legal advice as to Catherine's position and her options, as this manager clearly identified that when her mother was hospitalised "Catherine makes great improvements with her engagement, positive outlook, self-care skills, etc", but when her mother was at home, "Catherine reverts to a pattern of non-engagement and decline". A support plan was put in place for when Catherine was 'ready to engage'.

3.25 In October 2010, there appears to have been an update on the situation taken from the records; that Catherine was apparently attending college, that she appeared to be continuing to care for her mother, that 'pop in' visits had been carried out – the most recent in July 2010 – and a note that Catherine had the capacity to live independently, as evidenced when Rachel was in hospital. There was a recommendation that a home visit should be undertaken to obtain a further update on the current situation, with the explicit instruction that Catherine was to be spoken to alone. It was suggested that consideration should be given to a re-referral to Young Carers, and that there should be some discussion about Catherine moving toward independence.

3.26 A family support worker visited Catherine at home in November 2010, and Catherine told this worker that she did not want to engage with services any longer. The support worker subsequently checked with the college and found no record that Catherine had ever attended. A further home visit was made by a social worker in December 2010, with the stated intention of 'assessing Catherine's ongoing needs', but this worker concluded that there were 'no concerns evident' and Catherine's case was closed to Children's' Services.

3.27 After this home visit in 2010, there are no further records from Children's' Services.

***It is unclear whether Catherine was actually spoken to alone by either of these workers – as had been explicitly instructed in October 2010, and no 'view' was taken about the mistaken assumption that Catherine had been attending college. The statement that Catherine 'continued to care for her mother' went unquestioned. This update is concerning, when taken in the context of the assessment only a month previously by a different member of staff, that Catherine's needs were clearly being neglected alongside the burden of responsibility for her mother's complex demands, that Catherine had apparently thrived in her mother's absence, and the view that Catherine should be being assisted towards independent living.***

***This was a key decision and a key 'turning point' in the case; as Catherine at this point was discharged from Children's Services, meaning that no transitional services to support her into adulthood, to address her needs as a young carer, or to assist her to live an independent life – as had been clearly identified and recommended by Children's Services themselves - could possibly be accessed by Catherine.***

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***The matter of Catherine having declined or refused any ongoing involvement from services is worthy of further scrutiny. It is apparent that Catherine was much more amenable and able to engage with the services on offer, away from her mother's influence and demands. Had the workers concerned examined the record, they might have seen a clear pattern in relation to Catherine's ability to access services for herself - even as basic as her engagement and attendance at school – that was frequently undermined, even sabotaged by Rachel. This required more exploration and close questioning by the workers, in order to engage and secure Catherine's attention and understanding about her own needs. Of course, this is time-consuming and complex, but an approach of professional curiosity is always more likely to yield more positive outcomes when it is directed at those who struggle to recognise and prioritise their own needs. This could have made a significant difference for Catherine and was acknowledged as a missed opportunity. Catherine appears to have had no significant person in her network; either a teacher, adult friend or family member who could have offered support in terms of her social isolation. She seems to have had no significant trusted person that she could confide in at any point in her life, such as a particular teacher or adult family member. This is a feature that caused concern in Panel discussions, and is examined again in the later sections about the learning from this, particularly after the discussion that the Chair and Author had with Catherine. As Catherine had no access to a trusted adult figure that she could have confided in, the protective factors that would then have been in place, might have meant that opportunities for intervention would not have been missed.***

**North Staffs Carers Association**

3.28 The Carers Association representative told the Review that when Catherine was aged 12-14 years, she did receive some support from a Young Carers group. This included peer support and respite, and at times she attended a Saturday club. There are no formal records of this involvement but fortunately a long-serving staff member remembered Catherine and thought that it was most likely to have been Children's Social Care that referred Catherine to the Young Carers group. However, this staff member also recalled that it was "hit and miss" as to whether Catherine attended or was present when staff went to pick her up for sessions. Rachel reportedly gave various reasons and excuses as to why Catherine was unable to attend each time – anecdotally she recalled that 'there was always something wrong as far as Rachel was concerned'. However, apparently when this was looked into further, there were no good reasons for Catherine not to attend. Although Catherine engaged well, it was said that Rachel prevented her accessing the service. After Catherine reached 14 or 15 years of age, there was no further contact between the service and Catherine.

**North Staffordshire Combined Healthcare NHS Trust (Mental Health Services)**

The Mental Health Services Trust had some brief involvement with Catherine during 2010, but their primary involvement was with Rachel.

**Catherine**

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3.29 The Mental Health Services expands on the information from both Education and Children's Services about the referral that was made to Child and Adolescent Mental Health Services (CAMHS) for Catherine in January 2010, describing a timely and appropriate response to the referral, which raised concerns about the paranoid thoughts Catherine was experiencing regarding her peers. Commenting that this could have indicated the start of an episode of a psychotic type mental health disorder and although this proved not to be the case, if it had been it would have facilitated early intervention. It was also noted that CAMHS staff recognised and documented the influence of Rachel at this initial appointment.

3.30 There was then a joint visit between CAMHS and Children's Social Care to Catherine at her school, it was recorded that this was good practice as it gave Catherine an opportunity to talk openly away from the influence of Rachel. A meeting then took place in early February 2010 to share case histories with Children's Social Care, which again showed good interagency working and sharing of planned interventions from both agencies.

3.31 At a core group for Catherine shortly after this, the CAMHS nurse shared her finding that there was no evidence of Catherine having any acute mental illness and provided details to Rachel and Catherine of local youth services and children and young people's emotional wellbeing services.

3.32 In mid-March 2010, a further referral was made to the CAMHS service by Catherine's GP and an assessment appointment was offered to Catherine. Rachel declined this appointment on Catherine's behalf, stating they were both happy with primary care services meeting their needs. The GP Services records corroborate this, although the referral was dated April 2010, and that Rachel had written a letter to the GP to say it was not required.

3.33 Despite this, in July 2010 a further attempt was made to engage Catherine and Rachel in CAMHS services, when an appointment letter was sent offering another assessment. Catherine did not attend this appointment and was then discharged from the CAMHS service. This would have been in line with Trust policy at the time.

3.34 The author notes that throughout this episodic involvement with CAMHS there was evidence of good multiagency working and clear communication between the GP and the CAMHS service. Responses to referrals were timely and needs assessments were offered. There was clear evidence of the decision to discharge Catherine from the CAMHS service and the rationale for this having been shared with all other professionals involved with Catherine. However, in order to strengthen the discharge process, information could have been shared with Children's Social Care prior to the second discharge in July 2010.
This is now Trust policy as part of the CAMHS discharge pathway. In addition, the author's view is that consideration could have been given to whether Catherine was not attending because she didn't feel she required the support or 'was not brought' by Rachel. Additionally, a discussion with Rachel's care team may also have helped to inform the decision to discharge Catherine. The author confirmed that this is now included in the revised CAMHS pathway.

**Rachel**

3.35 The Mental Health Trust stated that Rachel's known history as a user of mental health services in the Trust dates back to 1980. It notes that over the total period of her involvement with the Trust, Rachel had received several diagnoses including schizophrenia and borderline personality disorder.

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3.36 The Mental Health Trust notes that during the scoping period, Rachel had significant input from mental health services. In addition to the medical management of the symptoms Rachel was experiencing, there was substantial input from the team in terms of trying to build meaningful occupation of time into Rachel's routine. She was given support with her physical health needs and with the development of alternative coping strategies such as swimming, spinning and accessing mental health third sector day services, including provision from Rethink. The author found evidence throughout Rachel's care of considerable efforts being made between health agencies to share information in order to offer Rachel a consistent and safe medication plan and to share information regarding risks.

3.37 It was recorded that numerous risk assessments were carried out with Rachel during the scoping period, in line with Trust policy, and at no point during any of these was Rachel ever recorded as being potentially at risk from Catherine. There is no evidence within the records of Rachel ever disclosing to staff she felt intimidated or at risk from Catherine, or vice versa.

3.38 The Mental Health Trust corroborates the incident previously described by the school and Children's Services, when in June 2009, Rachel made allegations against the deputy head and impersonated the head teacher. However, it also notes that there is no evidence of a report having been submitted or that any member of Rachel's care team attended the CAF meeting that was held in respect of this incident. However, it was recorded that there was good liaison by the mental health team with both Children's Services and Housing in respect of neighbour issues later in the same month.

3.39 In September 2009, Rachel disclosed feeling as though she wanted to stab someone, and on other occasions when she was experiencing poor mental health, Rachel voiced feelings of aggression towards others at times. However, there are records and subsequent interviews with staff showing that Rachel responded well to staff giving Rachel the opportunity to talk through her feelings and the perceived risks being effectively and swiftly reduced. As these were often telephone conversations it is not clear from the records if Catherine was present at these times or of the impact this may have had upon her.

3.40 In December 2009 there were concerns raised at a Child in Need meeting regarding Rachel's behaviour. The evidence recorded is that staff responded quickly to these concerns, providing transport and a face to face appointment with Rachel's care co-ordinator, as well as Crisis Team support being put in place over the weekend period for Rachel, while Catherine went to stay with her grandmother.

3.41 There were a number of documented interventions during 2010 aimed at practical support for Rachel to have planned bariatric surgery. The author comments that this demonstrated a real commitment from the staff team to support Rachel holistically rather than dealing with her mental health needs in isolation. The author also notes that neighbour conflict also remained a source of stress for Rachel during 2010.

3.42 During March 2010 Rachel reported feeling aggressive on several occasions, including one call when although Rachel stated Catherine was not in the house, Catherine could be heard shouting in the background. The Care Co-ordinator who took the call, documented discussing with Rachel the importance of calming this situation, however there was no evidence of any concerns about this being shared with Children's Services. However, following this incident there was some

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communication between Trust staff and Children's Services, as they had received a referral from an unknown source. This referral raised concerns that Rachel may have been under the influence of alcohol, as her speech was slurred. However, there was no known history of alcohol misuse; it was therefore understood to be over-use of medication by Rachel and a review of her care including medication was arranged.

3.43 In April 2010 following a decline in Rachel's mental health, the Care Co-ordinator attempted to discuss a referral to Children's Services with Rachel and Catherine by telephone. At this time Catherine would have been 16 years old. Catherine became argumentative, challenging the need for a referral. Catherine was offered a face-to-face appointment to discuss concerns alongside Rachel, and this offer appears not to have been taken up, Catherine clearly stated that she did not want a referral to go ahead. However, information was then received from the Connexions team, stating that they had made a referral, and discussions took place with the Trust Named Doctor for Child Safeguarding. The outcome of these discussions was that a professionals meeting was arranged with input from First Response (Children's Services).

3.44 As detailed by the Children's Services, the professional's meeting took place in early May 2010. It was noted that immediately prior to that meeting, a review of Rachel's care package was completed with Rachel and Catherine during which Young Carer's support was offered to Catherine. Catherine declined this service and reportedly told the meeting that she coped well and enjoyed helping to look after her mother.

3.45 At around this time, Catherine's needs and concerns regarding her care should Rachel require hospital admission were discussed in detail, and a plan was put in place for First Response to provide additional support to Catherine if this happened. Catherine had declined Young Carers and Children's Services involvement at this point. However, it appeared that all attendees at the meeting voiced concerns regarding the influence of an unknown friend of Rachel's who appeared to be a de-stabilising factor at this time, and may have influenced the decision by Catherine to refuse services.

3.46 With reference to the May 2010 injunction that was served on Rachel in relation to the ongoing conflict with her neighbours. At this time there was a review of Rachel's care package, this was organised by Rachel's Care Co-ordinator with both Rachel and Catherine present. The options of Catherine accessing additional support from Young Carers and Children's Services were discussed, and again Catherine declined. At a professionals meeting including housing, police, children's services and school, arranged by the Care Co-ordinator, the information was shared that Catherine had declined Young Carers' involvement.

3.47 On 21st of May 2010 a Mental Health Act assessment was carried out on Rachel following an altercation with her neighbours, during which the police had arrived to find her rolling on the ground and screaming. Following the assessment Rachel was relaxed and calm, and she was discharged home with a plan for community team-based care to continue.

3.48 As outlined by Staffordshire Police, in June 2010 Catherine telephoned to say that Rachel was brandishing a knife and she could no longer cope, and the police attended the home and Rachel was arrested. She was again assessed under the Mental Health Act and released with no further action. Following this incident

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Rachel's Care Co-ordinator discussed with her the negative impact this type of behaviour could have on Catherine.

3.49 There were several attempts by Rachel's care co-ordinator during June 2010 to contact Catherine to offer additional support, which Catherine declined stating that she was 'ok'. On the 15th June 2010 following another incident Rachel was admitted to hospital, and the Children's Services carried out daily visits to Catherine during the time Rachel was in hospital.

3.50 Rachel was discharged from this inpatient admission on 13th July 2010, there was evidence of continued discussion around the mother and daughter relationship, with Catherine at this stage voicing her wish for independence.

3.51 In March 2011 Rachel was admitted for gastric bypass surgery and appeared to recover well. Rachel appeared to be more settled until October when her self-harm appears to have escalated, resulting in burns to her wrists and an attendance at the Emergency Department, when Rachel threatened to stab herself with a knife. As a result of this incident she was admitted to hospital. During this admission Catherine was identified as the main carer, but there was no evidence of a carer's assessment being offered. Rachel was discharged on 1st November 2011 with input from the Home Treatment Team for a week post- discharge.

3.52 In December 2011, Rachel took an overdose of 15 paracetamol and contacted her care team, who called an ambulance to go to Rachel's home address. Rachel refused to attend hospital despite both police and ambulance crew requesting her to do so. A staff nurse from the care team spoke to Rachel and she agreed to see her GP the next day.

3.53 In February 2012 a post discharge three-month review was completed, which noted continued concerns regarding medicine management as well as an incident where Rachel had run out in front of a car. At this time, notes indicate that Catherine was identified as a 'protective factor' in relation to Rachel's risk of self-harm.

3.54 In July 2012 Rachel was referred to psychological services for counselling regarding her issues with food and feelings of guilt. However, Rachel did not engage in these sessions and was discharged in early 2013. There was an increase in Rachel self-harming during 2013 and more frequent reports of her having both visual and auditory hallucinations about the 'grim reaper'. Rachel was admitted to hospital as a voluntary patient in August 2013, but was discharged the same day, citing her relationship with Catherine as 'protective and supportive'.

3.55 Between September and December 2013, the escalation in hallucinations of the grim reaper and the incidents of self-harm continued. This escalation happened at times when significant changes occurred for Rachel, for example, the IMR cites three key changes at this stage; firstly, a change in lead medical professional for Rachel's care; secondly, a change in prescribing regime in order to reduce the amount of medication Rachel was on, and finally, a change in diagnosis from schizophrenia to borderline personality disorder. This diagnosis in itself can be controversial for patients as for some people there are negative connotations attached to the diagnosis. The use of the term borderline personality disorder has now been replaced by the diagnosis of emotionally unstable personality disorder in many cases.

3.56 During an interview with the Consultant Psychiatrist for this Review, it was established that the care team were aware that the change in medication may

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potentially lead to an increase in self-harm in the short term as Rachel struggled with the changes, however it was based upon Rachel's best interests as she could not continue to be prescribed such large amounts of medication long term.

3.57 In December 2013 Rachel was admitted to hospital as she felt she could not keep herself safe at home and Catherine felt she could not support her any longer. Catherine was identified as the main carer but there is no evidence of further support such as a formal carer's assessment or referral to any carers support being offered, and Rachel was discharged the next day to community-based services. It was also documented that Catherine should be offered support, although the context of this was unclear. As no referral to adult mental health services had been made for Catherine, it would be a reasonable presumption that this related to her role as carer for Rachel.

3.58 In March 2014 Rachel was discharged from Rethink due to her non-attendance for three months. Rachel had originally been referred to Rethink as part of a package of wider community-based support. During March and April 2014, Rachel's reports of hallucinations and also her self-harming behaviour increased, and professionals became aware that she had made a series of presentations to the Home Treatment team, the Emergency Department and also to her GP in order to achieve changes to her medication. This is also referenced by these agencies.

3.59 Ultimately, in May 2014, Rachel's consultant psychiatrist wrote to the GP explaining the rationale for changing Rachel's medication regime, based on the changed diagnosis, and the view that prescribing had been excessive and designed to meet Rachel's requests for additional sedation. Rachel's demands for increasing doses of sedative medication were historically often accompanied by intimations of future self-harm should medication not be prescribed in line with her wishes. Rachel also demonstrated a persistent inability to engage with any intervention other than pharmacological and her reliance on medical interventions had clearly become problematic.

3.60 Rachel's history of canvassing doctors in a variety of settings in the hope that she would be prescribed medication was also highlighted as a risk. Rachel had achieved some success with this in the past moving between mental health, the Emergency Department and the GP. The consultant psychiatrist felt that prescribing in respect of Rachel's mental health needs should be directed by secondary mental health services. In early June 2014 Rachel made the decision to remain with the current care team and consultant psychiatrist. Following this decision Rachel appears to have been more settled until December 2014, with no documented episodes of self-harm during this period.

3.61 Significantly, in mid-May 2015 Rachel disclosed her anxieties around Catherine's plans to leave home and how she would cope without her to her Care Co-ordinator. A referral to Housing was made by the Care Co-ordinator to explore alternative housing options. During July 2015 Rachel failed to attend review appointments with her Care Co-ordinator or her medical review with the Consultant Psychiatrist.

3.62 In early September 2015 Rachel attended the Emergency Department with cuts to her wrist that caused tendon damage. Rachel declined a mental health assessment and she discharged herself. The following day the Mental Health Team made contact with Rachel and with the acute hospital to ascertain what treatment was required. An appointment for the hand clinic was arranged for 2 weeks later and the community team arranged transport for this appointment. It was pointed out that this again demonstrated significant efforts being made by

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Rachel's mental health team to support her in addressing her physical health needs.

3.63 In October 2015 the police requested an 'Appropriate Adult' from the mental health team to support Rachel to make a statement regarding alleged racial abuse from a former friend. An 'Appropriate Adult' was identified, and the statement was completed. Rachel did not wish to press charges or go to court but wanted the former friend to have a police warning to stay away from her and Catherine. Rachel also alleged that this friend's son had 'forced himself' on Catherine when she was 17 years of age. The police officer agreed to follow this up with both Rachel and Catherine at a later date; however no more is known about this incident or the follow up.

3.64 During November and December 2015 Rachel continued to request additional sedative medication and declined extra support to access alternative activities to occupy her time and move her away from reliance on medication. It is documented that staff continued to try and promote these activities with Rachel. In December 2015 Rachel disclosed that Catherine's father had been in touch and this had upset her. Rachel was given the opportunity to talk through her feelings and was advised to call the police if she felt there was a threat from Catherine's father.

3.65 The evidence is that Rachel was back in contact with Rethink by early January 2016, as Rethink staff emailed Rachel's Care Co-ordinator to report that Rachel had told them she was not eating properly and if she ate, she was either feeling sick or vomiting. Rachel had told Rethink staff that she hadn't disclosed this to her care team as she was concerned that the Quetiapine she was prescribed would be stopped. It was noted that Rachel was engaging well at Rethink. Rachel's Care Co-ordinator made contact with Rachel and offered one to one support around eating; it was documented that Rachel was considering this.

3.66 In early 2016, Rachel raised concerns both at Rethink and with her mental health care team about her neighbours. She stated that she was unhappy where she was living due to the neighbours being noisy and using illicit drugs around the children. Rachel was supported by Rethink to contact the safeguarding children team and make a referral through appropriate channels. She told her care team that she wished to live somewhere rural in a bungalow and was looking to move once her daughter Catherine had left home.

3.67 During March 2016 Rachel made several requests of both her GP and mental health team to increase her medication, particularly Quetiapine, stating she was not sleeping well and not attending Rethink. It was noted that Rachel appeared to have been fixated on obtaining more medication rather than looking at other support mechanisms.

3.68 In late April 2016 Rachel contacted her Care Co-ordinator and stated that she had attended the Emergency Department the previous day following an overdose of prescribed medication. Rachel said she had an argument with Catherine, because Catherine's father had approached Catherine in the city centre the day before and had alleged that Rachel had an affair while they were married. Catherine had asked Rachel about it, resulting in an argument during which Rachel asked Catherine to leave the property. Rachel said she had been upset and, thinking that her relationship with Catherine was over, she took 6 days' allocation of prescribed medication and went to bed.

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3.69 Rachel woke the next morning but then collapsed, at which point Catherine called an ambulance, resulting in attendance at the Emergency Department, but she was subsequently discharged as medically fit.

3.70 During May 2016 there were concerns from others, and from Rachel herself, that her mental health was deteriorating, including irrational thoughts and mood swings. Rachel also reported further conflict with the neighbours during which the police had been involved. Over the following months, Rachel again made frequent requests for her medication to be reviewed and made threats to self-harm unless this happened. Even though her medication was reviewed and changed, Rachel's requests continued through to December 2016.

3.71 A fairly settled period is described between January and July 2017. Rachel reported that she was more settled in mood and no longer seeing the 'grim reaper'; that she was enjoying attending Rethink and was getting on with Catherine. Rachel was reviewed in medication management clinic in May 2017; no concerns were noted and no changes to medication suggested, the next review was agreed for 12 months later.

3.72 Later in May 2017, Rachel sought funding for abdominoplasty (also known as an 'apronectomy') In June 2017 the GP wrote requesting a review in clinic as soon as possible due to concerns about Rachel's low mood. later in July 2017 the Consultant Psychiatrist sent a letter to the North Staffordshire Clinical Commissioning Group requesting further consideration of their decision not to fund the abdominoplasty for Rachel.

3.73 In November 2017 Rachel's Care Programme Approach review took place, and no significant changes were identified. In January 2018 Rachel attended a face-to-face appointment with her Care Co-ordinator, when it was evident that Rachel had lost more weight and was inducing vomiting. A referral for psychological support was discussed and Rachel agreed to consider this, but she also stated that she got support from Rethink and her daughter Catherine.

3.74 In early March 2018 a telephone appointment took place between Rachel and her Care Co-ordinator. Rachel reported that her GP had concerns regarding her dietary intake and the induced vomiting, Rachel also reported she had stopped attending the mental health day centre and voiced some delusional beliefs regarding 'the devil and an angel being with her and being in charge of the end of the world'. Rachel was advised of the need for her to change Care Co-ordinator. No further contact is recorded between Rachel and the mental health team between 7th March 2018 and when she died.

3.75 The analysis is comprehensive, and bears repetition here;

*"Rachel received support and involvement from secondary mental health services covering the entire scope of the review. Rachel received significant ongoing support from her community care team, the access and home treatment teams and from Mental Health Liaison Team services when attending the Emergency Department.*

*There were, over the scope of the review, numerous examples of good communication between health agencies and a clear strategy in place for managing Rachel's attempts to obtain medication from different sources with her mental health prescribing led by the Consultant Psychiatrist.*

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*Rachel's contact with secondary mental health services reduced in the later parts of the review scope; this was felt by the professionals working with her to be as a result of her mental health being more settled. It is clear from the records and interviewing staff that Rachel knew the team well and was clear about how to make contact to access support. Significant efforts were made by the Mental Health care team to reduce Rachel's reliance on pharmaceutical interventions and to build on her recovery capital by engaging with local third sector services to access support and meaningful activities in her local area.*

*Catherine was identified as a carer for Rachel, several times during the chronology, on one occasion Catherine was asked if she wished to access carer's support, this was declined and there was no conclusive evidence that this was revisited with Catherine during future contacts. There is learning to be taken from this as the impact of caring responsibilities upon an individual is well documented.*

*Whilst there is good evidence of recognition of Catherine's needs whilst a child, appropriate consideration was given to making referrals to Children's Social Care and evidence of good multi-agency working around Catherine. The potential impact of her carer responsibilities upon Catherine's emotional health as an adult appears not to have been identified as part of Rachel's care package. Consideration may have been given to her needs had she engaged with services in a carer role".*

3.76 Since these events occurred there has been further recognition of the impact of caring and the need for all organisations to offer more proactive support to carers. The Mental Health Trust now includes questions regarding carers in all assessments and has an ongoing programme of work to embed the "Triangle of Care" model across the organisation in order to continue to improve the recognition of carers and the support offered to them.

***The IMR author's own analysis amplifies the fact that prior to 2015, there had been a consistent care team around Rachel for a period of time and she remained relatively stable. There had been a lot of input from mental health services, with a holistic package of care that addressed both her physical and mental health. It is apparent that Rachel also received significant support from Rethink mental health charity, which engaged her in activities outside of her home. However, the evidence is that Rachel's mental health declined during 2015, and this was exacerbated in 2016 when Catherine expressed her desire to move out, to become more independent, and also to make contact with her birth father. This caused Rachel to become unstable and resulted in her taking a serious overdose of medication in April 2016.***

***The records indicate a further deterioration in Rachel's mental health in 2017, whereby she increasingly isolated herself and stopped doing the activities she had previously enjoyed. In addition to this, there were increasing concerns about the amount of weight Rachel had lost, and evidence of some form of eating disorder. When Rachel was offered a referral to psychological services, she responded that she got the support that she needed from Catherine.***

***Whilst there were proactive attempts made to engage Catherine and offer psychological services to her as a child; once she was no longer in school, and moving into adulthood, these attempts to engage her were not***

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***sustained, and although she was often referred to as Rachel's carer, there was no evidence of any attempt to establish what this meant for Catherine, or to assess the psychological impact of this on her.***

***The IMR describes good liaison by the mental health team with both Children's Services and Housing in respect of the neighbour disputes but none of them identified Catherine specifically as being at risk or vulnerable.***

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**West Midlands Ambulance Service NHS Foundation Trust**

3.77 During the scoping period (2009-2018), the ambulance service notes that there were 52 calls made to the service relating to Rachel's mental health, self-harm and threats of suicide as well as actual suicide attempts, and that not only was Catherine the only other person present for the majority of these calls, she was frequently the person actually making the call. In 2009 Catherine she was still only a teenager. There appears little or no evidence that Catherine was ever recognised or acknowledged as Rachel's carer by the service.

3.78 The service acknowledges that records are either very limited or missing altogether. Specifically, the 'Patient Report Forms', which should be completed for each incident, have not been located for the majority of these callouts, there are therefore significant gaps in the ambulance service information.

3.79 It is evident that the ambulance service was usually Rachel or Catherine's first port of call in a crisis situation, often in conjunction with - or swiftly followed by – an additional police response.

3.80 During 2010, there were 6 calls and 7 in 2011. Following just one call-out in 2012, there was a huge 'spike' in 2013, with 25 calls to the service. These calls were frequently concerned with Rachel suffering a psychotic episode and self-harming by cutting her stomach or arms, using knives, tin lids, lighters or cigarettes. Rachel often described to ambulance staff and other health professionals that in her psychosis she was troubled by sightings of an 'incubus' that sought to hurt her, and of hearing voices that told her to harm herself. Rachel frequently described having suicidal thoughts and having a 'demon' in her stomach, which she was attempting to cut out, hence the cutting of her abdomen with tin lids.

3.81 Crew members regularly recorded that Catherine had removed dangerous items from her mother during the course of these incidents. Rachel was variously either admitted to the local Emergency Department or a Psychiatric hospital, or the situation was calmed; most often by Catherine. For example, an incident in June 2010 (when Catherine was 16 years old) a 999 call was received, reporting that Rachel was having a psychotic episode. When the ambulance crew arrived, they found Rachel shouting and being verbally aggressive, with Catherine having removed a knife from her as she had threatened to self-harm. The notes of this incident record that the crew were unable to assess Rachel due to the level of psychosis, and her refusal to go to hospital. The police subsequently attended, and Rachel was arrested for a breach of the peace, with a plan to have Rachel assessed by a police doctor.

3.82 A similar incident is described in October 2011, and when a crew attended, they learned that Catherine had removed a knife from Rachel who had been attempting to cut her stomach with it. On this occasion, Rachel was taken to hospital. No additional information was found about these incidents, and no Patient Report Forms.

3.83 In July and August 2013 there were further call-outs where it was recorded in the notes that Catherine had removed implements from her mother when she was cutting herself, and on one occasion had told the crew that the police would not be required as her mother was 'not violent'. In October 2013 when Catherine called stating that her mother was actively suicidal, threatening to starve herself and Catherine described feeling 'very concerned', Rachel remained at home with Catherine, with planned follow up from the mental health team. A succession of

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calls referred to Rachel being actively suicidal and Catherine being present in the home.

3.84 These calls became less frequent in 2014 (4 calls) although they were similar in nature, involving Rachel having suicidal thoughts or actively self-harming. There is little or no reference to Catherine during these incidents, apart from in May 2014, when it was noted that Catherine had contacted a CPN (Community Psychiatric Nurse), who had advised her that Rachel should attend the Emergency Department as the CPN was unable to help. This was the last reference to Catherine in the ambulance service records until the incident that led to Rachel's murder in March 2018.

3.85 In 2015 the ambulance service recorded only two callouts in respect of self-harming incidents in August and September. The incident in August 2015 appears to have been a particularly serious attempt by Rachel to cut her wrists, and she was taken to the Emergency Department.

3.86 In 2016, three 999 calls were logged, and the evidence was that Rachel was using medication to overdose; she took a large quantity of various tablets in April 2016 with the stated intention of taking her own life and was conveyed to hospital. Rachel had around this time requested additional medication from her GP in order to 'calm herself'.

3.87 In May 2016, there were two calls to the ambulance service three days apart; the first was made because Rachel had run out of her prescribed medication, and was reported to be throwing things, being verbally aggressive and wanted 'to kill something'. Staffordshire Police also attended this incident. The reason for the second call, three days later, was that Rachel was not sleeping, starving herself and 'having a battle with the devil and god'. Rachel refused to attend hospital on this occasion, and there was planned follow up by the mental health team.

3.88 There were no 999 calls to the ambulance service recorded at all for 2017 and the final call noted in the IMR was the call on the day Rachel died.

***What is striking about the information from the ambulance service and the description it provides of the records, is that the focus of all of the callouts to the home was exclusively on Rachel. Of course, the emergency calls were primarily concerned with Rachel, in often very serious and potentially life-threatening self-harming situations or extreme psychosis, but it was also frequently noted that the only other person present at the time was Catherine. The record clearly states that Catherine is Rachel's daughter, and it would have been apparent that Catherine was fairly young (16-17 years old in 2010-2011). It was also noted that 'it was apparent that she was undertaking the role of young carer'.***

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***During the initial assessment by 999 call operators, it was established that the situation was 'safe' for crews to attend; for example, when in October 2011, an ambulance was called when Rachel was cutting herself with a knife, the record states that Catherine had removed the knife from her 'so the scene is now safe'. Similarly, in August 2013, when Rachel was bleeding from a self-inflicted wound, the notes state that 'the patient's daughter had removed the weapon from her mum and the police would not be required'.***

***It is concerning that there was an unquestioning view of Catherine as a protective element in these crisis situations, rather than as a young person living alone with an extremely volatile and unwell mother, who could well have posed a risk to her. There are several occasions when it was assessed to be too high risk to allow an ambulance crew into the house until a police presence had arrived, but there is no evidence of any assessment of the possible risks that Rachel posed to her own child.***

***In addition to this, there appears to have been no consideration given to the levels of trauma that Catherine was being exposed to and having to manage on a regular basis. It is not always noted who made the 999 calls, but it is clear that more often than not, it was Catherine, as she was the only other person present and frequently recorded as having removed a knife or tin lid from her mother when she was cutting herself.***

***It was found that there are numerous records missing, most notably the Patient Report Forms, which would have been completed following every incident. This is a serious deficit and may have contained useful additional information. Without this, the records appear to catalogue an approach that failed to take account of the 'whole' situation, and also failed to address the almost constant risk and trauma that Catherine lived with.***

***This may be unfair in light of the missing records, however, there is no evidence from other agencies of any enquiries or safeguarding referrals in respect of Catherine having been made, which would have been expected had the ambulance service at any point alerted other agencies to the presenting concerns.***

***The ambulance service states that the service acted in accordance with all policies and procedures in effect at the time of the incidents. This is possibly true for Rachel, and there is certainly evidence of good practice in that her wishes and choices about treatments were explored with her, and alternatives to attendance at hospital were offered when the situation was not deemed life-threatening. There are also examples of effective inter-agency information exchange in respect of Rachel's follow up care and treatment.***

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***Acknowledgement that the deficits in respect of Catherine, and the author states that the attending clinicians 'could have demonstrated additional professional curiosity in terms of the daughter demonstrating the role of young carer and how she was managing this'.***

***Review Panel discussions have explored this further and emphasised the need for an approach that takes a wider view of the presenting situation and those impacted by it, particularly where there are concerns about risk and safeguarding of others in the same household as the patient. The safeguarding policies and procedures that were in place at the time should have been followed, and the situation in respect of Catherine should have been referred to the appropriate agencies***

**Staffordshire Police Service**

3.89 Staffordshire Police recorded that 106 calls were made to the service during the scoping period.

3.90 In 2009 there were 13 calls to the police.

In March 2009, the police were contacted by Catherine's school, as they were concerned for her safety after she had been absent for a week. The police carried out a 'safe and well' visit to the home and established that Catherine was unhappy at school, as she felt wrongly placed among children with more severe disabilities than she had. The police assessed that no further action was required, as a meeting had been arranged with the school and Rachel to discuss this.

This referral coincided with queries from other agencies concerned about a decline in Rachel's mental health.

3.91 There was a 'spike' in calls in 2010 (48 calls), the majority of which were recorded as anti-social behaviour issues. Ten incidents were recorded as relating to the safety of an adult, three related to public safety, and one to the safety of a child. This was recorded as a call from Rachel in May 2010, when she alleged that her neighbours were smoking cannabis while having care of a baby. This was apparently one of many calls from Rachel that year when she was in conflict with her neighbours; most of these calls were simply recorded as 'administration'.

3.92 In May 2010 Rachel was served with the first of two injunctions obtained by the Housing Association (as outlined in the earlier section) with conditions attached aimed at forbidding her use of threatening behaviour toward her neighbours on the same street. The police noted that 'upon receiving the injunction, Rachel's mental health appears to have suffered', with the subsequent calls made by Rachel to the police that year being more in relation to her own needs than for anything that required an urgent police response.

3.93 Further neighbour disputes were reported to the police in 2011, when 13 calls were made in all, many of which referred to neighbour conflict. There is an example of this in October 2011, when Catherine called the police, to report that she and her mother were suffering abuse from their ex-neighbours. However, when the police attended, there was no evidence of such an incident and Catherine reported that she was in fact 'not coping' with her mother. The police noted, that in the officers' view, Catherine could possibly be suffering poor mental health herself. This was appropriately referred by them using an 'AS1', which would then have been referred to the Adult Contact Centre at Social Services. However, no trace of this referral has been found or reported by Adult Services.

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3.94 In December 2011, Rachel called the police stating that she felt suicidal. The police record stated that Catherine was 'normally Rachel's carer', but there was no additional information in respect of this contact.

3.95 In 2012 there were five contacts recorded with the police, including in April 2012, when Rachel again reported that she was feeling suicidal. During this contact it was noted that Catherine was asking for help for her mother, and it was recorded that Catherine would 'stay with her mother and care for her'.

3.96 In 2013 there were seventeen contacts with the police recorded, which appear to correlate directly with the fluctuations in Rachel's mental health, which deteriorated in 2013, as other agencies have noted.

3.97 In April 2013, police officers found Catherine sitting alone on the pavement, and were concerned for her safety, so transported her home. This was recorded at the time as 'concern for a child', but Catherine was 19 years old in 2013. The IMR author therefore notes that this should have been recorded as 'concern for an adult' and referred accordingly. However, the author's view is that this would have made no difference to the outcome. In September 2013, there was a call to the police from NHS Direct stating that Rachel was suffering hallucinations and hearing voices. Again, the records from the time state that Catherine was 'the carer for Rachel and would sit with her for a short while'.

3.98 Similarly to the pattern reflected by the Ambulance Service, the number of calls to the police decreased dramatically during the following four years; with only one call in 2014, three in 2015, four in 2016 and one in 2017. The only call in 2018 was the call related to the incident that resulted in Rachel's murder.

3.99 There was never any suspicion, or suggestion of violence or abuse between Rachel and Catherine, or anyone closely associated with them, prior to March 2018. The majority of the calls made to the police during the scoping period relate to neighbour disputes or Rachel's mental health. Several calls to the police originated with a call-out by Rachel for emergency assistance initially requiring an ambulance. The majority of the calls were made by Rachel herself, Catherine rarely called the police, but there were often joint attendances by police and ambulance crews.

3.100 As with the calls to the ambulance service, Catherine was often simply recorded as being the 'carer' for Rachel; there was no further information as to her status or any exploration of her capability within this assumed role.

***What is apparent is that there was a good and swift response to calls and incidents that necessitated police attendance. These primarily related to Rachel's poor mental health, the consequences of which appear to have caused frequent neighbour disputes as she became agitated and threatening. The evidence is that these calls and contacts in respect of Rachel were dealt with appropriately by the police and where necessary, there was good liaison with, or referral to other agencies. Other than the 'safe and well' check carried out in March 2009, the only other contact with the police that related directly to Catherine, was in 2013 when she was found alone sitting on a pavement outside in the street; which was mis-classified as 'concern for a child'. Had this been 'tagged' concern for adult, this may have warranted a referral to adult services.***

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***Similarly, when Catherine was known to have prised a knife or implement from Rachel when she was attempting to self-harm, this could have warranted a safeguarding referral by the police (or any other agency present) to the Safeguarding Adults Team. The threshold for any actual safeguarding activity may not have been met in respect of either Rachel or Catherine, but this would at least have triggered a discussion about the presenting risks.***

***As with other agencies, the deficits identified in the police response are in respect of a rather narrow, almost singular, focus on the sole presenting issue, as opposed to a fuller assessment and analysis of the total situation. The police had on record that Catherine had some form of learning disability and they would have observed that she was fairly young – 17 years old at that point - living alone with a very unwell and at times volatile, unstable mother. It is a matter of concern that at times this was simply accepted and noted, rather than acted upon by referring Catherine for more support. On the one occasion a referral was made specifically for Catherine, there is no evidence that this was followed up by the police, or other agencies, even though the police were called out again to a very similar situation only a few weeks later.***

***Staffordshire Police's IMR author's view is that there were no occasions where the police missed an opportunity to have intervened in any domestic abuse situations between Rachel and Catherine; indeed, no such events were ever witnessed or recorded by the police or other agencies. However, during Panel discussions it has been acknowledged that there were missed opportunities in terms of the police – and other agencies – failing to see the 'wider picture', and taking a more proactive response in respect of Catherine and the trauma and risks that she faced – as well as the possible risks that she posed to Rachel as the situation became increasingly stressful for her.***

**University Hospitals of North Midlands NHS Trust (UHNM)**

3.101 Rachel attended the UHNM Emergency Department on at least 27 occasions during the scoping period following incidents of deliberate self-harm. On one occasion in May 2009 when Rachel attended with a support worker for a duodenoscopy, it was recorded in the notes that 'a child of 15 is caring for Rachel when home'.

3.102 In May 2010 Rachel had three attendances at the Emergency Department; in the first, it was recorded that Catherine had made the 999 call as Rachel was having paranoid thoughts and that Catherine 'cannot cope with her mother'. It was further noted that they were having constant arguments, but Rachel denied having taken an overdose or made any attempts to self-harm and remained in the Department for only 5 minutes before discharging herself. It was noted that no reference was made to Catherine's age, who at that point would have been 16 years old.

3.103 The second attendance by Rachel in May 2010, was under a Section 136 (a police power to remove a person to a place of safety) following an 'altercation at home', and with an injury to her hand having apparently been caused by Rachel punching someone. There is no indication from the records as to who this altercation involved, but there was a further suspicion that Rachel might have taken an overdose. Rachel denied having overdosed and no evidence of this was found.

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The records give no indication as to whether Rachel was discharged or transferred to hospital. The author notes that the records for this incident make no reference to Catherine.

3.104 The third attendance at the end of May 2010, refers to Rachel again having psychotic episodes, and feeling depressed and suicidal. She reported having come very close to being arrested earlier on the same day during an ‘issue with her neighbours’. The records show that contact was made with the Crisis team, who arranged to visit Rachel later the same day. In the notes for this incident, it was recorded that ‘Rachel lives with her daughter, who is her main carer’.

3.105 In the notes for an October 2011 attendance, it was stated that Rachel had ‘attempted to stab herself but daughter intercepted and managed to persuade her mother to let go of the knife’. Catherine had just turned 18 at this point. In September 2013, Catherine was again mentioned in the notes following an attendance, when she had taken a tin lid from her mother, who was cutting herself with it.

3.106 These were the only specific references to Catherine, out of some 27 attendances, and that there was no further mention of her or any discussion of her situation or her needs.

3.107 In the notes, Rachel was referred to as a ‘regular A and E attender’ and a ‘Frequent Attenders’ meeting was triggered in 2013 as she had been treated in the Emergency Department more than three times per month in July, August, September and November of that year. This gave rise to contact with her GP to query whether there had been a change in her circumstances or her medication, particularly during September and November, when there was a noticeable increase in Rachel’s self-harming behaviour.

3.108 The UHNM author refers to these incidents having been appropriately followed up and referred on to the mental health liaison team. However, it also highlights the deficit in respect of Catherine, who is simply noted as being present, or even having intervened at times, but that there had been no probing or questioning of her or any assessment of her needs in the situation.

***It is evident that Rachel – like many people with mental health issues – used the Emergency Department as an additional resource in addition to her GP and the mental health team. She was frequently taken there after a call-out by the ambulance service, but most often returned home after receiving any necessary treatment to wounds, or simply after some calming discussions. It is evident that Catherine often made the initial call in an emergency, having intervened or found her mother in the act of self-harm.***

***It is clear from the records kept by the Emergency Department, that they were aware of Catherine, and staff had made a note of the fact that she was caring for Rachel on separate attendances. Some of these attendances arose because of serious acts of self-harm by Rachel, where Catherine had removed from her the implement she used to cut herself. This fact is simply documented in the notes, and this information was never ‘pulled together’ because previous recorded information was not available ‘at a glance’; this would have required a trawl of earlier records.***

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***This is another example of an agency acting procedurally appropriately and correctly in respect of Rachel, but not 'seeing' or hearing the 'voice of the child', Catherine, in the situation. The consequence of this is that Catherine's needs in these crisis events were overlooked, and the impact of the repeated trauma was not 'pooled' or considered at any stage.***

**North Staffordshire Clinical Commissioning Group - GP Service**

3.109 Rachel was in regular contact with the GP surgery during the scoping period – both in person and by telephone; in 2009, eight of the ten GP contacts were to do with her concerns about being morbidly obese and wanting gastric band surgery, but she was also preoccupied with not sleeping and making frequent requests for medication. Rachel frequently attended the surgery either with Catherine or a friend, both of whom also contacted the surgery by telephone at times when they were concerned about Rachel.

3.110 During April 2009 Rachel took Catherine to the Out of Hours Service requesting "something to calm her down", but the on-call GP provided information on "self-help" only and did not prescribe any medication.

3.111 A rise in incidents of Rachel self-harming and requiring hospital attendance during 2010 was noted. Rachel also contacted the GP Out of Hours service on five occasions during 2010, reporting that she was having hallucinations and suffering from psychosis, and she made repeated requests for more medication.

3.112 During 2010, there were also reports of several neighbour disputes, and Rachel's mental health deteriorated, resulting in a brief admission to a psychiatric unit.

3.113 Again in March 2010, Rachel took Catherine to the Out of Hours service requesting "something to calm her down", referring to her daughter as the "poor child". The on-call doctor noted Catherine had good rapport and eye contact, but low mood and made a diagnosis of depression. The GP subsequently made a referral to 'Young Minds' and prescribed Hydroxyzine (a sedating antihistamine) which was then extended for a further four weeks. In April 2010, the GP referred Catherine to the Child and Adolescent Mental Health Service (CAMHS) but – as evidenced by other agencies - Rachel wrote to CAMHS to say that Catherine did not need their support, as she was happy with the support provided by the GP. Catherine confirmed this when she next saw the GP and said that she didn't need psychological support but wanted to remain on the medication.

3.114 The GP records document the build up to and aftermath of the gastric band surgery, which took place in March 2011, after which Rachel lost nearly half of her body weight.

3.115 There was an ongoing dialogue in 2012 between Rachel and the GP practice with regard to her mental health and medication, and it was noted that she was persistent in finding mechanisms for seeking additional medication. The notes record that Catherine often accompanied Rachel to GP visits and the notes refer to Catherine as a 'vulnerable personality' who spoke articulately about problems. It was also noted that there were arguments between Rachel and Catherine, but the surgery gave increased responsibility to Catherine for Rachel's medication, while being aware that Rachel used manipulative behaviour to obtain more medication than was advised or prescribed.

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3.116 During 2013 there was a further 'spike' in incidents of self-harm by Rachel cutting her wrists and using sharp instruments to cut her abdomen. There were increased attendances at the GP surgery, to see both the doctors and the practice nurses; some 34 visits were recorded between August and December. Most of these consultations were concerned with follow-up to the self-harming events, but also Rachel's preoccupation with her inability to lose weight. There were indications in the notes at this stage that Catherine was considering moving out of the home they shared to live independently, and in 2014 Rachel asked the GP to write to the housing department on her behalf, as she feared that she would not cope if Catherine moved out of their home, as was her stated intent. During 2014 Rachel made frequent requests for more medication and this resulted in her being put on a daily prescription at times.

3.117 Rachel's fears about Catherine leaving home and her requests for more medication continued into 2015, alongside further self-harming incidents by Rachel, and the GP notes in September 2015 stated that "I feel powerless to help her, she is under the care of experts but does not want me to contact them". There is no mention at all of Catherine in the GP notes during 2016, but there is evidence of Rachel becoming very manipulative in her attempts to obtain higher and more frequent doses, particularly of Quetiapine – which on at least one occasion, she then used to overdose.

3.118 Rachel's preoccupation with losing weight continued into 2017, and the GP records show that she had dropped from 24.5 stone to 13 stone by May 2017, and was said to be 'delighted', had developed a more positive attitude and 'could not stop smiling' throughout one consultation. However, Rachel's subsequent request for funding for an apronectomy to deal with the loose skin that was a consequence of her weight loss was refused, and after that she was noted to be 'psychologically damaged, tearful and bulimic'. The evidence in the GP records shows that between April and June 2017, Rachel had been starving herself and vomiting. There is no mention of Catherine in the GP notes for 2017 until August, when Catherine enquired of the surgery how much it would cost to pay privately for an apronectomy for Rachel and was signposted to the Nuffield Hospital.

3.119 The records show that Rachel developed bulimia in the years before her murder, but she had also received various diagnoses over the preceding years, including personality disorder and schizophrenia. It is clear from the notes that she was frequently troubled by psychosis and hallucinations, and these returned during early 2018. A benefits review prompted contact between Rachel and the GP surgery in February 2018, and the GP response to the DWP (Department for Work and Pensions) was that Rachel was not fit to be assessed at that point. Rachel contacted the surgery in early March and said that 'the evil half was taking over her good half' and she requested Diazepam, which was prescribed. The last record in March 2018 noted that 'the mental health key worker is arranging a care worker for her'. There is no reference to Catherine at all during 2018.

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***The GP practice author describes good liaison between the GP practice and other teams and agencies, including the mental health team, the ambulance service and hospitals in relation to Rachel's medical needs. There are examples of good practice; for example, when Rachel was given daily prescriptions in 2014, in order to avoid the risk of her 'stock-piling' medication. However, there is little reference if any to Catherine in regard to her appearing to be her mother's sole carer and support for the majority of the time, and the GP practice highlights the fact that there were occasions when there were clearly missed opportunities to explore this further.***

***The possibility that Rachel at times sought to obtain medication for herself 'via' a prescription for Catherine was explored during Panel discussions. This would have been difficult to prove, but was highlighted by Rachel's presentation of Catherine at the GP surgery at times to request 'calming' medication for Catherine, at the same time as her reluctance or refusal to enable or encourage Catherine to access psychological services or 'talking therapies'. It was good practice by the GP surgery not to prescribe for Catherine on the basis of demands from Rachel and was also in accordance with clinical guidance. However, this could have raised concerns about safeguarding in respect of Catherine, as there was a risk that either Catherine could have taken unnecessary medication, or that Rachel was 'using' her inappropriately to obtain medication for herself***

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**Rethink Mental Illness**

**A Summary Report of involvement with Rachel has been provided to the Review by Rethink**

3.120 The report notes that Rachel accessed Rethink services from September 2012 to March 2018 and was supported by a worker on a one-to-one basis to build up her confidence in going out of the house. The Rethink Information System (RIS) entry in late November 2013 indicated that Rachel had decided to have a break over the Christmas period to consider what support she needed or whether she felt happy for her daughter to support her with this in future. It was recorded that she then disengaged from the service for some time.

3.121 In December 2015 the Community Mental Health Team referred Rachel back to Rethink and she attended "Open House" sessions at a Rethink resource on and off through 2016-2017. Towards the end of 2017 it is noted that Rachel attended less frequently, and it was reported that she felt uncomfortable in a large group. Instead she occasionally attended a craft group held at the library as this was a small group.

3.122 In the six months prior to her murder, Rethink staff provided welfare calls rather than Rachel attending group sessions. The last phone call received from Rachel was in March 2018, when Rachel said she was feeling a bit better having spoken to her GP and that she was waiting to speak to her Care Co-ordinator; it was noted that she expressed no concerns during the call.

3.123 In the Summary Report, the author has noted that no entries were ever made on the Rethink Information System relating to any perceived risk of harm or abuse to Rachel from her daughter. The risks that were 'flagged' included suicidal ideation and self-harm and issues around Rachel not getting on with her neighbours,

particularly Rachel's perception that people were shouting at her on the streets. The main concern observed by staff and voiced by Rachel was that she believed the 'Grim Reaper' was telling her to end her life and at times this was expressed by her purging after eating. This was discussed at Rachel's CPA (Care Programme Approach) review with the Mental Health team in February 2017. Rachel continued to purge throughout 2017 and lost a significant amount of weight. This was the main focus of concern and information about this was regularly shared by Rethink staff with members of her care team.

3.124 The report author notes that on the whole, Rachel portrayed a positive relationship with her daughter and always scored relationships highly on a scale that was used to assess the significant factors in her life. However, Rachel never described her daughter as her carer to Rethink staff but said that Catherine helped her with things such as prompting her to take her medication, helping her to bed and also to get up, as the medication made her tired. Rachel reported to the staff that she was protective of Catherine and would only get verbally aggressive if someone posed a threat to her daughter. She told them that she tried to spoil her daughter, particularly at Christmas, by buying her lots of presents and that she tried to win the Rethink Christmas competitions, so she could give the prizes to her daughter.

3.125 The author noted that Rachel had mentioned only a couple of occasions when she had fallen out with her daughter but described these as nothing more than a normal argument between family members, including shouting, but no physical abuse was ever disclosed. Rethink staff only met Catherine once when she came in person to let them know that Rachel could not attend a Christmas party. Afterwards Rachel had asked the staff if her daughter had been polite and staff reported that she had; Rachel told them she was pleased about this, as she had tried to bring her daughter up to be well mannered.

3.126 The author recalls that Rethink staff last physically saw Rachel at the Open House session Christmas party mid December 2017. After this date Rethink staff had been supporting Rachel on the telephone, up until the last time she made contact in March 2018.

***It appears that at times Rachel had a fairly high level of support from Rethink by way of 1:1 meetings, telephone and group support. She seemed to have preferred 1-1 support or telephone calls as she did not feel comfortable in a large group. The last call with her was in March when she had said she felt better after speaking with her GP. Rethink had very little knowledge of Catherine as they had only one contact with her. Again, it is apparent that Rachel was very much the focus of Rethink's involvement, which was appropriate, but although they were aware of Catherine, it never registered with the staff involved with Rachel that Catherine was Rachel's primary carer.***

## 4. Analysis

**In this section of the report the Author critically examines and evaluates the involvement of the agencies that came into contact with Rachel and Catherine, with regard to the terms of reference for this Review. The agencies own analysis contained within their IMR reports is referred to and examined, as well as the discussion and comment from Panel meetings. Views from the family, a friend and Catherine herself, shared during separate discussions with the Review Chair and Author, are also included.**

**The intention is to avoid the 'wisdom of hindsight', and rather to look openly, critically and constructively at the decisions and judgements that were made at the time, in the context of the time, with the emphasis on learning rather than on any sense of fault-finding or blame. The ultimate aim is to consider 'what might have made a difference' in this case, and what therefore is the learning from this Review that would make a difference in future.**

### 4.1 Key Themes from the Review

#### Rachel's Mental Health

The backdrop to this whole situation was Rachel's problematic mental health, which appears to have been an issue throughout most of her life and certainly was a permanent feature of Catherine's entire life with Rachel. From the anecdotal accounts given by Rachel's sister and her friend, Rachel's own childhood was difficult, being an adopted mixed heritage child in a white family, in what sounded quite an emotionally sterile environment. The evidence is that her mental health issues began in her late teens and became more complex over the years. Very little is known about Catherine's early childhood with her mother, or whether her mother was ever mentally 'well' when Catherine was younger. The evidence is that during the years they lived together that are covered by the scope of this Review (2009-2018) Rachel's mental health fluctuated greatly, with a marked deterioration at some significant times, and particularly when Catherine moved from childhood into adolescence and began to seek increased independence from Rachel.

Agencies may well be aware that statistically women are at far greater risk of domestic homicide, but this review has reinforced the fact that they are at even greater risk where mental ill-health is present. Research conducted by the UK Education Policy Institute into the impact on children of maternal mental illness has established a link to wide-ranging consequences for their physical and mental health throughout their childhood and adolescence. Children of mothers with mental illness are more likely to exhibit internalising and externalising behaviours, and there is some evidence that they perform poorly at school.

Research has found that a mother's mental ill health can affect her child's in both biological and social ways. There is likely to be a substantial genetic component to the development of mental illness, but there is more likely to be less engaged parenting, poor attachment, and worse early childhood development, which itself is critical for positive lifelong outcomes, including attainment, employment and adult health and wellbeing.

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From the agency IMR's, specifically those from health-based services, it is clear that Rachel's mental health condition was well-known, well documented and that she received extensive agency attention and support, as well as intensive treatment and care at times. This came from the GP surgery, community mental health teams and also hospital services, including Emergency Department resources and more specialist in-patient facilities. At times she also accessed services outside of the statutory sector, such as Rethink and MIND.

It is clear from the IMR's that health services responded frequently and promptly to Rachel's needs, particularly at points of crisis. There is evidence of some very good practice, where agencies tried to put together a package of care for Rachel, under a Care Programme Approach, with regular reviews, but this appeared to disband at times, when Rachel did not engage, or seemed to stabilise for a time, prior to a further incident or crisis event. This gives the impression of a rather reactive response to her situation, rather than an ongoing proactive 'holding' of her wellbeing through fluctuations in her state of mind. There is evidence of a reasonable level of dialogue and liaison between the GP practice and other health professionals, but no clear sense of any one agency taking responsibility for co-ordinating Rachel's care over an extended period of time. Good practice would indicate that inter-agency communication is always improved when there is a designated care co-ordinator holding this responsibility.

There is little, if any analysis of the effects of Rachel's dramatic fluctuations in weight on her state of mind. Although there is evidence of multi-disciplinary team meetings and reviews having been undertaken at the hospital where she had her procedure done which would have addressed her physical needs pre and post-surgery, there is no apparent evidence that the psychological impact of bariatric surgery was considered, and there is scant information about the emotional impact of both this, and the subsequent refusal to fund surgical abdominoplasty. The effects of problematic physical ill health on mental wellbeing (and vice versa) are well documented, but there appears to have been little or no consideration of the effects on Rachel of the apparently extreme variations in weight she experienced, both surgical and self-induced. The evidence suggests that she began deliberately vomiting in the last few years of her life, but there is little evidence that this - physically and emotionally self-harming activity – was ever addressed with her.

**Catherine becoming an Adult**

The evidence from both the school and Children's Services is that there were frequent and very real attempts to engage with Rachel in order to secure some supportive and therapeutic services for Catherine. The information in both IMR's demonstrates an ongoing and robust dialogue between the two agencies, and also between school and Adult Mental Health Services.

Children's Services refer to Catherine being quite difficult to reach, possibly because she was usually very much 'in the shadows' of her mother's presenting issues. She was viewed as high-functioning in relation to her peers at school, but the exact nature and impact of her learning disability was never fully established, and it remained unclear how much her perceived limitations were due to her disability or environmental factors, i.e. living in a very toxic and traumatic situation.

Education, Staffordshire Police and West Midlands Ambulance Service all record a common 'spike' in contacts and incidents during 2010, when Catherine – then aged 17 - was considering leaving school. She had been discharged from Children's

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Services and this meant that there had been no ‘transition’ planning as she moved into adulthood, as the fact that she had been ‘closed’ to Children’s Services meant that she would not even have been eligible for any assessment for transitional services. Of course, even if she had been referred for an assessment from Adult Services, she may not have met their threshold for services, but having not had her ‘voice’ clearly heard as a child, made any potential assessment as an adult even more remote.

There are numerous reported incidents of Rachel self-harming, requiring emergency callouts from the ambulance service and police, and Emergency Department attendances, particularly when Catherine indicated any desire or intention to move out of the home.

It is clear that once Catherine had left school, agencies access to her was far more limited, as she was not connected to any agency in her own right. Once she had left Education, Catherine became far less *visible,* as Rachel was seen as the primary ‘subject’ of agency contacts and interventions – appropriately in many instances of course. However, the unfortunate consequence of this was that Catherine was simply not *seen* by the agencies in contact with Rachel, or if she was seen, she was not viewed as part of their responsibility or ‘remit’.

There is a gap in information as to what happened to Catherine between 2010-2018 in terms of her lifestyle and social interaction. It appears that she spent the majority of her time dealing with her mother’s crises and hospital admissions, but there are also indications that she sought to leave the home they shared and become more independent. There is reference to her seeking contact with her birth father, and evidence that this caused her mother great distress, but the outcome of this search is not known.

**Catherine as Carer for Rachel**

Catherine appears to have been almost invisible to the agencies that were directly involved with her mother, Rachel. There appears to have been a very ‘blinkered’ approach by professionals whose focus was primarily, if not exclusively on Rachel. Catherine was frequently referred to as ‘Rachel’s carer’, and at the age of 16, she was paid a Carer’s Allowance in addition to her Income Support, but the reality of this assumed role as carer for her mother was never at any time fully explored with her, acknowledged with her or its’ consequences for her examined or understood.

For Catherine, the reality of her daily life appears to have been a potentially terrifying situation where she would never have known what was going to happen next, depending on how her mother was feeling and how stable her mental health was. The information gleaned from the IMR’s shows that Rachel was persistently troubled by psychosis, including recurring ‘sightings’ of a mythical creature (an incubus) and voices telling her to harm herself; which she frequently acted out by cutting herself and taking overdoses of her prescribed medication. Catherine was most often the person who sought help for Rachel in these crises, and also removed implements from her when she was self-harming by cutting herself. The possible level of trauma and distress that this may have caused Catherine, from a young age, can only be imagined. This however, was a situation that must have become commonplace for Catherine, and her ability and capacity to cope with these type of scenarios and to manage Rachel’s extreme behaviour appears to have been accepted without question by the agencies that came into contact with her. At no time was there any specific assessment of the distress that Catherine was regularly exposed to.

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The evidence from the agency reviews is of Rachel exhibiting a great deal of deeply disturbing and distressing behaviour, largely contained, and managed by Catherine, but in isolation from any consistent or formal mechanisms of support. Both Rachel and Catherine were vulnerable, but it is not clear that Catherine's vulnerability both as Rachel's child and her carer was ever fully understood. Catherine appears to have had no significant person in her network; either a teacher, adult friend or family member who could have offered support in terms of her social isolation. She seems to have had no significant trusted person that she could confide in at any point in her life, such as a particular teacher or adult family member. This is a feature that caused concern in Panel discussions and is examined again in the later sections about the learning from this, particularly after the discussion that the Chair and Author had with Catherine. As Catherine had no access to a trusted adult figure that she could have confided in, the protective factors that would then have been in place, might have meant that opportunities for intervention would not have been missed.

The agencies are unanimous in their view that Catherine fared much better when Rachel was absent, for example, when she spent brief spells in hospital. Even at a fairly young age – 16/17 years – Catherine was well able to manage in the house alone and became more able to articulate her own needs. It is apparent from the information held by agencies, as well as the family and Rachel's friend, that Catherine's needs were very much subsumed by Rachel's own, and Catherine was actually referred to by some agencies as a 'protective factor' in relation to Rachel's self-harming behaviour.

In the latter stages of the scoping period, between 2016 and early 2018, there is increasing evidence that Rachel actively prevented Catherine meeting her own needs by precipitating a crisis whenever she became aware of Catherine seeking to assert herself. For example, when Catherine talked about moving out to live independently, or sought to establish contact with her birth father; Rachel responded with deliberate incidents of self - harming behaviour. In addition to this behaviour, there is some evidence of Rachel presenting Catherine as being agitated and not sleeping and requiring medication for this – in her words 'to calm her down' - and the suspicion is that Rachel may have been using Catherine as a means of obtaining medication for herself.

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**Safeguarding Issues**

Some of the scenarios and behaviours that have been examined retrospectively within this Review and summarised above, could - and perhaps *should* – have warranted safeguarding activity around Catherine. Of course, it is easier to identify these issues when reviewing a situation, however, had the agencies involved with Rachel at the time taken a less blinkered approach and used a wider lens when viewing the situation, particularly the dynamic between Rachel and Catherine, they might have seen that Catherine needed safeguarding at times.

There were several occasions when a safeguarding referral might have been considered, for example in 2010, when the school reported that Catherine was said to be experiencing 'paranoid thoughts' and a referral was made to CAMHS. A social worker completed an initial assessment at Rachel and Catherine's home, and although no psychotic illness was identified, there were concerns about Catherine's support needs, but after some brief input this was rapidly closed down by Rachel, who informed them that Catherine was 'fine' and no support was needed. A further referral for services was made a few months later, but again this was sabotaged by Rachel who wrote to the CAMHS team stating that this was 'not needed'. At times there is evidence of an all too ready acceptance by agencies of Rachel having declined services & inputs for Catherine which could have been highly beneficial for her. Clearly, in this situation, the 'Voice of the Child' was not being heard.

There were several incidents when there were clearly safeguarding issues in the dynamic between Rachel and Catherine, but it was only the immediate injury or crisis that was dealt with; for example, when Catherine had removed knives or sharp implements from Rachel when Rachel was self-harming. The inherent dangers to both women must have been apparent to the professionals providing the emergency response – paramedics and police initially, but also Emergency Department staff – but it was only Rachel that received the direct input in these situations. It is clear that several of these recorded incidents warranted a safeguarding assessment, but the initiative to activate this was never seized by any agency.

**Vulnerability**

All of the agencies involved refer to Rachel being 'vulnerable', primarily because of her poor mental health, but also because of her social isolation. Had Catherine's position as a carer for Rachel been fully recognised and addressed, she too, should have been properly identified as vulnerable, particularly in light of her perceived learning disability. There are key points in this case where the vulnerabilities in this household were exposed, but no single agency was proactive in seeking ways of addressing this and offering support – which had they done so, may have prevented the situation escalating to crisis point at times.

Her Majesty's Inspection of Constabulary Report of 2015 (the Peel Inspection) into the local force states that.

> *"There are significant weaknesses in the force processes to identify repeat and vulnerable victims and there are unreliable and ineffective processes to assess the potential risks posed to victims with vulnerabilities. Some officers do not always recognise and respond appropriately to victims' vulnerability*." [1]

The Staffordshire Police and West Midlands Ambulance Service attended repeated crisis situations in relation to Rachel, and the UHNM Emergency Department and

[1] Peel 2015 page 8

GP surgery also referred to Rachel being a 'frequent attender'. A robust examination of these repeated contacts, and a thorough assessment of what they meant, in terms of the inherent threat of risk and harm in the situation would have been appropriate. All of these agencies clearly identified that Rachel was an adult with vulnerabilities, living with a daughter who was also vulnerable. This type of analysis of the frequent contacts could have been initiated by any one of the agencies that were concerned, but it required one of them to seize the initiative, and to cross-reference their assessment with other agencies, but this was not done.

**Inter-Agency Issues**

It is clear from the agency reports - as outlined in the section summarising them – that where an agency had an identified responsibility for Rachel in terms of their specific remit there were examples of good practice, with evidence that agencies got to know Rachel well and were well engaged with her variations in coping abilities and her fluctuating needs. The same is true of the agencies that were primarily concerned with Catherine as a child; Education and Children's Services, both of whom were responsive and proactive in addressing concerns, seeking appropriate resources and assessments of her needs.

However, what a full reading across all the agency reports shows is that every 'frontline' agency that came into contact with Rachel and Catherine has recognised that there were times when they missed an opportunity to 'see the bigger picture', and to act upon information or an observation that might have led to a more holistic understanding of the whole situation, and of the impact that Rachel's poor mental health had on Catherine. There are situations which have been re-examined both within the IMR's and in Panel discussions, and all of the agencies have acknowledged that many of these situations required a great deal more professional curiosity about what was actually going on in the living situation.

**What Changes Agencies Have Made Since This Incident**

Within the Review Panel meetings, there was considerable discussion about whether there were any other mechanisms that could have been used at the time to retain an engagement with Catherine, particularly in light of the frequent sabotage of this by Rachel. There is some optimism that this type of engagement might be more feasible now, and that the likelihood is that the levels of both professional curiosity and also proactive engagement with someone in Catherine's situation would be more robust.

This view is endorsed by several sources and based on the provisions of new policies and approaches that have been developed across agencies, both nationally and locally. On a national basis, the 2015 revised version of 'Working Together to Safeguard Children' is key, as well as the provisions of the Carers (Equal Opportunities) Act of 2010.

One of the most significant changes in practice locally has been the creation of a 'Carers Hub', which was commissioned in October 2015, to deliver bespoke services to its Carers across the county, this includes adults and young carers as young as 5 years old. The Carers Hub has published a document entitled "Young Carers; Professionals Best Practice Guide" which states as follows.

*"It is everybody's responsibility to recognise Young Carers and support their needs. It is everybody's responsibility to identify and support Young Carers and their families. Even if your professional role centres on working with adults you are in a*

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*prime position to identify that a young person may have additional needs as a result of their parent's illness or disability, and to make sure they do not remain unnoticed."*

Following on from this, the local Safeguarding Children Board also produced a key document in 2017, "Safeguarding and Young Carers" which is intended to inform best practice in respect of safeguarding of young carers across all agencies.

In terms of the assessment of vulnerability, the Care Act 2014 gave greater scope for professionals to identify and address the needs of vulnerable adults they came into contact with. Locally the Panel heard that there had been a 'Vulnerability Forum' made up of managers from key agencies, where concerns about vulnerable adults – who may have fallen outside of the remit of statutory duties such as safeguarding – could be shared, discussed and monitored. It is possible that this type of forum would be highly appropriate for the discussion of situations like that of Rachel and Catherine with their combined vulnerabilities. It is unfortunate that this forum has recently been re-designated as a 'Partnership Forum', as this appears to shift the focus away from the specific emphasis on vulnerability and indicates a more generic brief.

The representative from the Carer's Association referred the Review Panel to the Care Act and the fact that Catherine should have received a carer's assessment. In 2010 Catherine's GP and other agencies recognised her as a carer but this was not formalised and therefore no assessment was carried out. The Carer's Recognition Act (2010) provided this formal framework, but there was scope prior to this for agencies to assess and identify carers within the terms and provisions of the Carer's Recognition and Services Act 1995. Had this been done when she was a 'young carer', the assessment would have travelled with her into adulthood and would have meant she could have accessed support services throughout. As it was, she had no contact at any stage with adult social care services. The Care Act (2014) added more 'teeth' to the 2010 Act and would have provided access via a formal assessment to resources for Catherine as a carer, had she, Rachel or any professional made a request on her behalf.

The 'Whole Family Approach' introduced in the locality approximately three years ago, encourages a holistic, whole family approach. Young Carers and Adult Services used to be separately funded, but now the funding is combined, giving a more consistent and 'joined up' service. Mental Health services in the locality have also introduced a mental health assessment form that includes specific reference to the safeguarding of children.

Recent NHS research[2] highlighted the following points (amongst others) concerning the impact of caring:

- 70 percent of carers come into contact with health professionals, yet health professionals only identify one in ten carers with GPs, more specifically, only identifying 7 percent (Macmillan Briefing on Carers Issues)
- 66 percent of carers feel that healthcare staff don't help to signpost them to relevant information or support, and when information is given, it comes from charities and support groups (Commitment for Carers: Report of the findings and outcomes)

[2] Source: NHS Commissioning – Carer Facts – Why Investing in Carers Matters, May 2014

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- The 2011 Census counted 166,363 young unpaid carers (5 to 17-years-old) in England. Evidence has shown that, providing unpaid care may have an adverse effect on young carers' general health. There is growing evidence pointing to the adverse impact on the health, future employment opportunities and social and leisure activities of those providing unpaid care, particularly in young carers (Providing unpaid care may have an adverse affect on young carers' general health)
- Many young carers remain hidden from sight for a host of reasons, including family loyalty, stigma, bullying, not knowing where to go for support. Carers may be as young as five years old (Hidden from view: the experience of young carers in England).

The introduction of the Carer's Hub means that young Carers referred in the locality should now have their needs assessed in line with the Children & Families Act 2014 by the Hub and a secondary support plan put in place if they are deemed to be undertaking an inappropriate caring role for someone they live with. The Hub has significantly strengthened the relationship and information triangulation process with the Children's Early Help and Safeguarding teams over the last 3-4 years and there is increased willingness to share information about young Carers they support and more awareness about 'hidden' issues in respect of young Carers.

In addition to this, the expectation is that current practice is now more informed by the extensive amount of research into ACE's (Adverse Childhood Experiences) and the profound and lasting impact that trauma during the early years can have into adulthood. The five specific traumatic events that ACE's refer to are; sexual, emotional and physical abuse, and emotional and physical neglect, and five chronic stressors; substance addiction, witnessing abuse, parental imprisonment, family member mental illness, and caregiver disappearance through abandonment or divorce.

Evidence shows that exposure to ACE's often has a negative impact on development and mental health. Supporting children with ACE's has been shown to reduce the potential impact on later life outcomes, and schools and educational psychologists have been identified as having an important role in providing this support.

## 4.2 Issues Raised for Consideration by Catherine, Family & Friend

The Chair and Author of this Review met with Catherine herself, with Rachel's sister, and with a family friend. Rachel's mother had made the decision not to participate at this stage, but the invitation was left open to her to be involved if she wished. Ms Sandhu and Ms Cooper outlined the process and purpose of the Review with each of the participants.

**The original and largest investigation of Adverse Childhood Experiences (ACE) is the CDC-Kaiser Permanente Study, conducted from 1995 to 1997 at Kaiser Permanente in Southern California. The study examined childhood abuse and neglect and household challenges, and later life health and well-being. In summary, the study found that the higher the number of ACE's, the higher the risk of negative outcomes later in life. The 1995-97 ACE study inspired many other studies that have expanded on the original research, including studies on epigenetics (the study of how your behaviours and environment can cause changes that affect the way your genes work), brain development and resilience".**

**Issues Raised by Catherine**

Catherine described a troubled childhood with "*only negative memories rather than positive memories*". She described feeling '*closed off within myself*', and that '*it was traumatic for a child'*. When she was a child she could not trust or confide in anyone as her mother was almost always present. She described calling ambulances frequently when her mother self-harmed, usually by cutting herself.

Catherine felt unable to talk to anyone at school because she had to focus on her mother. She described herself as a young carer, and that she could have no interests outside of school, no clubs or after school activities, and did no homework because she was too busy looking after her mum. Catherine could not go to college because she never finished school; her mother was always the priority.

Daily life involved doing the household chores, cleaning and cooking but said her mother "*just expected me to do it, it was my duty".* Catherine described feeling trapped from a very young age with no-one to confide in, she felt "*closed away & isolated*". She felt *"like there was no point…it was hard to explain all the past…mum's mental illness affected me emotionally...I couldn't open up*". Wider family relationships were strained and contact with the family was very limited.

She described feeling unable to ask anyone for help, like police or ambulance or the doctors, as they were busy seeing to her mother and she could not tell them that she was unable to cope. She came to believe that there was "*no point*" telling anyone how she felt. She spent time in her room and used social media as a way to talk to friends. She described her mother being upset that she spent time in her room and that she often insisted that Catherine sat with her watching TV.

Catherine felt that agencies "*shouldn't leave it to just happen*" when there is a parent with severe mental health problems who has a child: she wished she could have been fostered. She did recall going to a young carers group twice, but her mother had stopped it because she did not want her to go to outside activities. This restriction had continued into her twenties, as well as the very limited contact with family.

Catherine felt more despondent in later years about ever being able to achieve independence as her mother just wanted her to care for her all the time.

Catherine felt that there should be more support for young carers in similar situations, including groups, counselling, and one-to-one time.

As a child Catherine knew nothing else and the sense of despondency she described as an adult, about there having been 'no point' trying to tell anyone what was actually going on at home meant that Catherine in effect became paralysed by it all, and that no-one would believe the horror of what she was confronted by on a daily basis; she described feeling very trapped.

**Issues Raised by Family and Friend**

**Rachel**

Rachel was adopted at a young age and was said to have had a relatively happy childhood and became a keen sportswoman. However, she developed mental health issues as a teenager, which continued into adulthood. During the Review, further information about Rachel's mixed heritage came to light from the family, and Rachel was then identified as having mixed heritage, Pakistani/White and grew up in a predominantly white area, with white adoptive parents and siblings; this created

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more complex challenges for Rachel growing up in her local community; resulting in bullying and name-calling ‘*because she was mixed race and different*’. Rachel may have developed a perception of herself as not being part of the family and some resentment at being ‘different’. At 18 years old Rachel suffered an emotional setback when she decided to search for her birth family, and located her birth mother, who unfortunately rejected her approach for contact. Rachel had quite a volatile relationship with her husband until they separated, and then her family and friends throughout her life. Family members suggested that Rachel could change very quickly and become quite difficult and aggressive towards others, “*she could be like Jekyll and Hyde, and I was never sure which version I would get of her*”.

The participants believed that most of the time Rachel had good support from her GP, and received good NHS mental health services, with additional input from a local group she attended. The family suggest that they were *“totally taken aback”* to learn of the volume and nature of the emergency calls; several professionals had commented at the trial about the number of serious self-harm attempts that Rachel made in front of Catherine while she was still a child/young person, which Catherine then had to deal with. Rachel was deeply concerned that Catherine’s father might try to get back in touch with her and become involved in Catherine’s life and she was vehemently against this. The family believe strongly that Rachel would not have functioned without Catherine, to the extent that had Catherine moved out of the home there was only one likely outcome; they believe that Rachel would have taken her own life.

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**Catherine**

Catherine is reported to have struggled throughout her school life, as she had a learning disability. The family suggest that Rachel did not want her to go to a 'special school'. Catherine was a "*lovely little child, very sweet and loving". Rachel* and Catherine had appeared to have a good and close relationship; it was only during the trial that the family became more aware of the situation for Rachel and Catherine, as more information came to light. However, there was reference to Catherine reporting to a family member that she "*hated her mother, that she felt trapped by her and wanted to get away from her"*, but this was not pursued at the time.

Catherine was controlled and conditioned by Rachel, about who she could see and who she was allowed to let into the house. Catherine spent most of her time in her bedroom, which was very basic, with just a bed and a table with a laptop computer. She had very little money. Once she had stopped attending school, her main contact with others was through social media. There was some anecdotal evidence from the participants that when Catherine tried to form friendships with others they were quickly closed down.

The home was described as sparse and dirty, but with the help of friends some items were purchased to improve things, but there was no cooker, as Rachel was afraid that she would want to use it to self-harm.

**Themes identified/ issues from Participants for Consideration in the Review**

- Controlling behaviour, initially from Rachel but in later years the balance of power shifted to Catherine
- Rachel's poor mental health led to fractious relationships with others
- The true extent of the difficulties faced by Rachel and Catherine were concealed; the family and others had been presented with a 'front' by Rachel that "*everything was fine, and they socialised together and liked doing similar things"*
- Family and friends comment that "*agencies should not have taken the easy option of allowing Catherine to be a protective factor and the main carer for her mother*", although there is an acceptance that Rachel was difficult to deal with
- "*Agencies should have been more persistent in getting to the truth of the situation for Catherine".* When Rachel refused services for Catherine, agencies should have 'pushed' to get services to her
- It would have been easier for agencies to intervene when Catherine was a child; they had the power to do so and should not have been stopped by Rachel. They were too readily accepting of what Rachel reported when she told them *"they were fine and did not need help; Catherine clearly did"*
- Catherine must have had opportunities to reach out to the family, but she did not but *"someone without a voice should have been given a voice; she needed one"*
- In future agencies and professionals should have a broader and better understanding of domestic abuse in all its forms, including the type of 'coercive control' that can occur between family members. Rachel's interference with Catherine's education and behaviours which prevented her from becoming independent, could also be viewed through the lens of economic abuse, as

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Rachel prevented Catherine from acquiring economic resources and becoming financially independent.

- Professionals should be more assertive in 'pushing' for support services for carers, particularly young carers, who should also receive a formal assessment to identify the type of support they need
- For a young person like Catherine, who accessed social media, there should be online resources available that people can use to access support, especially when they appear to be isolated
- It appeared that Rachel got all the help she needed from the agencies and Catherine got nothing, but Rachel would say that Catherine did not need anything, that she was '*fine'*. It was felt that at times Catherine's childhood was terrible and Rachel was not capable of looking after her or meeting her needs – she could not look after herself and she felt that someone should have seen this and acted to separate them from this *'toxic'* situation.

## 4.3 Learning for Agencies

The information obtained from the family, the friend and Catherine herself, of course has to be considered within the context of the evidence about their lives together which only emerged and was made public during the trial of Catherine. The anecdotal information provided by these participants in the review must also be treated with a degree of caution because of the range of complex and extreme emotions that follow such an event, including anger, grief, guilt and confusion. A great deal of what is now known of this family's daily living situation may not have been known at the time by the agencies that came into contact with them.

However, most of the agencies that were involved with this family and have participated in this Review have acknowledged that there were opportunities missed at times to engage more proactively with Rachel, and to 'get alongside' Catherine at key points when she was quite obviously struggling. These 'key points' were generally at times when Rachel was in crisis and unsurprisingly, the immediate and primary focus was on her, as she required urgent care. However, these were also the key times when Catherine probably most needed emotional support and attention herself, but the agencies had reached a view that she was able to care for herself and that she coped effectively in the absence of Rachel. In effect, not only was Catherine apparently 'invisible' to agencies at these key times; her voice was also clearly not heard.

Had the relationship that had been established with her teachers during her years at school, and the additional involvement of support services, such as Children's Services and CAMHS been able to continue until the end of fulltime education, this might have been a positive and protective factor. Had the connection continued with these external support services there could have been some transitional activity from Children's to Adult Services, and the available supportive and protective elements may have continued, had she met the threshold for adult care at any stage, although the likelihood of this threshold being met at that time was low.

The key learning for the agencies from this review is that there needs to be an improvement in the skill level of professionals to be able to identify and understand both the 'Voice of the Child' and the role, impact and risks of being a carer and to enable professionals to make referrals through appropriate pathways to access support. The absence of this approach may mean that vulnerable people similar to Rachel and Catherine could quite easily remain in a very dangerous and toxic

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situation, when professionals provide what is essentially a reactive response to crises, rather than using a proactive, questioning and curious approach that not only draws together all of the information held within their own agency, but also cross-references it with that held by other agencies whose staff are involved in simultaneous and frequent contacts with the same service user. The essence of this is to avoid 'silo working' both within own agencies and alongside other agencies. To this end, several of the agencies represented on the Review Panel have made a commitment to incorporating the principles within the document published by the local Carers Hub referred to earlier in this report, entitled "Young Carers; Professionals Best Practice Guide" (2015)

Finally, a lesson that bears re-stating in this review concerns the assessment of a child's needs, which not only takes account of, but actually *hears* the voice of the child, and travels with them into adulthood. Any assessment that follows carefully the welfare principles of the Children Act, particularly where that child is a young carer, may well move through a child protection process to become a Child in Need, with a plan that addresses both their safety and their welfare. Where a child remains a carer into adulthood, this assessment, and the accompanying plan, should go with them as they reach their late teens and beyond. When a child is identified as a carer for a parent with serious illness, agencies need to adopt a more flexible approach, using the lens of child abuse – particularly that of emotional abuse – rather than the outdated approach of relying upon 'thresholds' for transitional services from child to adult carers.

## 5. Conclusions

After an incident at their home in March 2018 resulting in the death of Rachel, and following a police investigation and criminal trial, Catherine was found guilty of her murder, for which she is now serving a prison sentence. The primary task of this Review was not to re-investigate what happened in March 2018, but to examine what had happened *up until that point* in the life of this family, and to consider what services and supports were available to the family, what use they made of them, and whether there were any deficits or barriers to them receiving appropriate support when it was required. The second main task of this Review was to examine what learning there is for agencies from this situation, and to identify what factors might lessen the likelihood of such an event happening within another family in the future.

To this end, the main conclusion of this Review is that had the professionals in the agencies that came into contact with this family over the years preceding Rachel's murder routinely exercised more curiosity and adopted a more questioning approach to what was actually going on in the household, the isolation and intensity of the situation was more likely to have been exposed. Had professionals taken a truly 'Think Family' approach, asked more questions, and shared information with each other about what they observed, and listened more to the 'Voice of the Child', Catherine could have been more clearly and formally identified as the sole carer for her mother from a young age and services might have responded more appropriately and consistently, even in the face of Rachel's apparent attempts to divert them.

This Review has identified several very timely and responsive interventions to Rachel at points of extreme crisis in her mental health, and many positive and

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targeted supportive services for her that followed. There were many examples of good practice in this respect. However, this Review has also identified that very frequently, the person who sought help for Rachel in these crises – Catherine – was simply not 'seen' during these incidents, and her needs were overlooked. In addition, the Review has learned from Catherine herself, that this was compounded by Rachel keeping Catherine isolated in their home and away from external contacts, including family, friends or access to support for herself.

It is clear to see how this long-term isolation and intensity could lead to a situation of extreme stress and pressure, particularly when from a very young age, Catherine was exposed to Rachel's bizarre behaviour and her self-harm by cutting with implements on an almost daily basis at times. The full impact of this on Catherine would be difficult to establish, but it is not unreasonable to conclude that Catherine must have been deeply affected by these events. In the 3- or 4-years preceding Rachel's murder, this family situation was allowed to go 'off the radar' when there were far fewer contacts with agencies, and their isolated and toxic relationship appears to have become more intense.

## 6. Recommendations

The Review has concluded that there are several recommendations for practice that can be made in this case, some of which are not 'new' but are intended specifically to encourage and support the use by professionals of the Carers Hub. What is required – and is largely driven by learning from other DHR's and serious case reviews nationally – is an 'attitudinal shift' in the approach of professionals working in the frontline agencies, so that they are equipped with the knowledge and skills to identify carers, and familiarise themselves with the correct pathways to access support for them.

1 *Professionals should adopt the Think Family (or similar) approach, in place in the locality since 2016, a model which encompasses a more holistic approach to problem solving; this will encourage staff to take a 'wide-angle' view of all members of a family or household as well as any significant others, and assess their particular needs alongside the person who is the key recipient of their service or support.*
*Each assessment must be fully recorded and documented, and any needs identified, with services offered or 'sign-posted' wherever possible. This type of approach should be embraced and embedded in practice and any barriers to access must be explored and addressed.*

2 *Within the Partnership the role of Carer (Children and Adults) needs to be better understood and promoted by agencies; support and clarification on identifying carers, understanding some of the challenges and risks associated with being a carer and identifying pathways for access to appropriate support services; ensuring that mechanisms for referral to services are fit for purpose and streamlined. The information and documentation which has been produced by the local Carers Hub will assist agencies in this regard.*

3 *The profile of carers within communities needs to be raised in order for families and communities to access support; promoting and encouraging better knowledge, understanding and support (practical and emotional).*

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4. *Where a person in a family or household is identified as a carer, they should be offered a carers assessment. Each assessment must be fully recorded and documented, and any needs identified, with services offered or 'sign-posted' wherever possible.*
5. *All agencies must ensure that policies and procedures for reporting and investigation of safeguarding events are relevant and robust, and that all staff have received up-to-date safeguarding training, specifically in relation to carers*

There is good evidence to suggest that this attitudinal shift has already been made to varying degrees in the local agencies, but this Review has found – and this has been acknowledged in Panel discussions – that there is more to be done locally to embed the understanding about carers in practice, in order for the agencies to satisfy themselves that the likelihood of an event such as this is minimised in future.

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## 7. Appendix A - Terms of Reference

# TERMS OF REFERENCE

## DOMESTIC HOMICIDE REVIEW

## STAFFORDSHIRE MOORLANDS COMMUNITY SAFETY PARTNERSHIP

## June 2019

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## DOMESTIC HOMICIDE REVIEW TERMS OF REFERENCE

### 1 Introduction

1.1 The Terms of Reference for this Domestic Homicide Review (DHR) have been drafted in accordance with the Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews[3], hereafter referred to as "the Guidance".

1.2 The relevant Community Safety Partnership (CSP) must always conduct a DHR when a death meets the following criterion under the Domestic Violence, Crime and Victims Act (2004) section 9, which states that a domestic homicide review is:
A review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by:

- a person to whom he was related or with whom he was or had been in an intimate personal relationship, or
- a member of the same household as himself,

held with a view to identifying the lessons to be learnt from the death.

1.3 An 'intimate personal relationship' includes relationships between adults who are or have been intimate partners or family members, regardless of gender or sexuality.

1.4 A member of the same household is defined in section 5(4) of the Domestic Violence, Crime and Victims Act [2004] as:

- a person is to be regarded as a "member" of a particular household, even if he does not live in that household, if he visits it so often and for such periods of time that it is reasonable to regard him as a member of it;
- where a victim (V) lived in different households at different times, "the same household as V" refers to the household in which V was living at the time of the act that caused V's death.

1.5 The purpose of a DHR is to:

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

[3] Home Office – last updated December 2016.

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developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;

- **Contribute** to a better understanding of the nature of domestic violence and abuse; and
- **Highlight** good practice.

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## 2 Background

2.1 The victim is the mother of the perpetrator. They lived together in North Staffordshire. On a morning in March 2018 the perpetrator called for an ambulance in relation to an injury to the victim's throat. The police attended and the victim was found deceased with significant injuries to her throat, apparently caused by use of a knife. The perpetrator was arrested and stated, "She drove me to it, I killed her." The perpetrator is charged with murder of the victim and a trial is currently planned to commence in September 2018.

## 3 Grounds for Commissioning a DHR:

3.1 A DHR Scoping Panel met on 21 May 2018 to consider the circumstances. The Panel agreed that the following criteria for commissioning a Domestic Homicide Review had been met:

| **CRITERIA:** | |
|---|---|
| There is a death of a person aged 16 or over which has, or appears to have, resulted from violence, abuse or neglect. | **X** |
| The perpetrator was related to the victim or was, or had been, in an intimate personal relationship with the victim. | **X** |
| The perpetrator was a member of the same household as the victim. | **X** |

3.2 The recommendation to commission this Review was endorsed by the Chair of the Staffordshire Moorlands Partnership who was present at the meeting.

## 4 Scope of the DHR

4.1 The Review should consider in detail the period from January 2009, when Staffordshire Children's Social Care were involved with the perpetrator prior to her becoming an adult, until the date of the victim's death.

4.2 The focus of the DHR should be maintained on the following subjects:

| **Name** | RACHEL | CATHERINE |
|---|---|---|
| **Relationship** | Victim | Perpetrator |
| **Age** | 53 | 24 |
| **Ethnicity** | Identified as White | Identified as White |

4.3 A review of agency files should be completed (both paper and electronic records); and a detailed chronology of events that fall within the scope of the Domestic Homicide Review should be produced.

4.4 An Overview Report will be prepared in accordance with the Guidance.

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4.5 Key issues to be addressed within this Domestic Homicide Review are outlined below as agreed by the Chair and Review Panel. These issues should be considered in the context of the general areas for consideration listed at Section 4 of the Statutory Guidance.

- The victim's mental ill health issues and the provision of services in respect of this;
- The perpetrator's role as a (young) carer for the victim and provision of services in respect of this;
- The transition of the perpetrator from children to adult services provision.

## 5 Individual Management Reviews (IMR)

5.1 Individual Management Reviews are required from the following agencies:

- Staffordshire Police
- Staffordshire Housing Group
- North Staffordshire Combined Healthcare NHS Trust
- North Staffordshire Clinical Commissioning Group
- West Midlands Ambulance Service
- University Hospitals of North Midlands NHS Trust
- The Meadows School

5.2 IMR Authors should have no line management responsibility for either the service or the staff who had immediate contact with either the subject of the DHR or their family members. IMRs and Summary Reports should confirm the independence of the author, along with their experience and qualifications.

5.3 Where an agency has had involvement with the victim and perpetrator and/ or other subject of this Review, a single Individual Management Report should be produced.

5.4 In the event an agency identifies another organisation that had involvement with either the victim or perpetrator, during the scope of the Review; this should be notified immediately to Julie Long, Staffordshire County Council, to facilitate the prompt commissioning of an IMR.

5.5 Third Party information: Information held in relation to members of the victim's immediate family, should be disclosed where this is in the public interest, and record keepers should ensure that any information disclosed is both necessary and proportionate. All disclosures of information about third parties need to be considered on a case by case basis, and the reasoning for either disclosure or non-disclosure should be fully documented. This applies to all records of NHS-commissioned care, whether provided under the NHS or in the independent or voluntary sector.

5.6 Staff Interviews: All staff who have had direct involvement with the subjects within the scope of this Review, should be interviewed for the purposes of the DHR. Interviews should not take place until the agency Commissioning

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Manager has received written consent from the Police Senior Investigating Officer. Participating agencies are asked to provide the names of staff they would like to interview to Julie Long, Staffordshire County Council, who will facilitate this process. This is to prevent compromise of evidence for any criminal proceedings. Interviews with staff should be conducted in accordance with the Guidance.

5.7 Where staff are the subject of other parallel investigations (Disciplinary, SI, etc) consideration should be given as to how interviews with staff should be managed. This will be agreed on a case by case basis with the Independent Review Panel Chair, supported by Julie Long, Staffordshire County Council.

5.8 Individual Management Review reports should be quality assured and authorised by the agency commissioning manager.

## 6 Summary Reports

6.1 Where an agency or independent professional has had no direct contact with the identified subjects within the period under review, but has had historic involvement with them, involvement with their extended family or is able to provide information regarding the provision of local services, a Summary Report should be prepared.

6.2 Summary Reports are required from the following agencies:

- Staffordshire Victim Gateway
- Challenge North Staffordshire
- National Probation Service
- Staffordshire County Council Families First
- Rethink Mental Illness

6.3 Summary Report Authors should have no line management responsibility for either the service or the staff who had immediate contact with either the subject of the DHR or their family members. Summary Reports should confirm the independence of the author, along with their experience and qualifications.

6.4 The Summary Report should commence from the point at which the agency first became involved with the subjects until that involvement ceased. A chronology of **significant** events relating to family members should be attached to the report.

6.5 The purpose of the Summary Report is to provide the Independent Overview Report Author with relevant information which places each subject and the events leading to this review into context.

6.6 Summary Reports should be quality assured and authorised prior to submission.

6.7 In the event an agency identifies another organisation that had involvement with either the victim or perpetrator, during the scope of the Review; this should be

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notified immediately to Julie Long, Staffordshire County Council, to facilitate the prompt commissioning of an IMR.

## 7 Parallel Investigations:

7.1 North Staffordshire Combined Healthcare NHS Trust is conducting a Serious Incident Investigation.

7.2 Where it is identified during the course of the Review that policies and procedures have not been complied with agencies should consider whether they should initiate an internal disciplinary process. Should they do so this should be included in the agency's Individual Management Review.

7.3 The IMR report need only identify that consideration has been given to disciplinary issues and if identified have been acted upon accordingly. IMR reports should not include details which would breach the confidentiality of staff.

7.4 The Police Senior Investigating Officer (SIO) should attend all Review Panel meetings during the course of the Review.

7.5 The SIO will act in the capacity of a professional advisor to the Panel, and ensure effective liaison is maintained with both the Coroner and Crown Prosecution Service.

## 8 Independent Chair and Overview Report Author

8.1 The Partnership agreed to invite Ms Kam Sandhu to Chair the Review. Ms. Sandhu was known to be someone who had the requisite skills, knowledge, and experience to take on this responsibility (set out in paragraph 5.10 of the National Guidance 2013). Ms. Sandhu has completed a number of domestic homicide reviews within the East and West Midlands. An experienced non-executive director, with a strong commitment to understanding domestic abuse; she has worked with women's refuges and Chaired an independent scrutiny committee into domestic abuse in Nottinghamshire. Having worked within the public sector for over twenty years she has a clear commitment to partnership working to provide the very best services to survivors and victims. She has produced academic research into forced marriage as part of her MSc in Criminology Ms. Sandhu is independent of the Moorlands Together Community Partnership and confirms she has no direct association with, nor is an employee of any of the agencies involved. There are no known conflicts of interest which would prevent her from taking responsibility for chairing the review panel.

8.2 Bronwen Cooper worked for over 30 years in local authority social care services. Her specialist area was safeguarding, in respect of both children and vulnerable adults. She became an Independent Author and Consultant in Social Care in 2009, and since that time has co-led and authored several (Children's) Serious Case Reviews and (Adult) Domestic Homicide Reviews. She has also conducted several Safeguarding Audits in various local authorities, contributed to national investigations, including Operation Yewtree (Savile) and given 'live' evidence to the National Child Sexual Abuse Inquiry (ICSA) She sits as a Tribunal Member

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on two national professional regulators; Social Work England and the General Medical Council. She has served on the management committee of a Women's Refuge and been a volunteer with Rape Crisis. She has lived experience as a deaf woman, and as a carer for a family member with long-term mental ill health. Ms. Cooper is independent of the Moorlands Together Community Partnership and confirms she has no direct association with, nor is an employee of any of the agencies involved. There are no known conflicts of interest which would prevent her from being the author of this review.

**Domestic Homicide Review Panel**

8.3 The Review Panel will comprise senior representatives of the following organisations:

- Staffordshire Police
- Staffordshire Housing Group
- North Staffordshire Combined Healthcare NHS Trust
- North Staffordshire Clinical Commissioning Group
- West Midlands Ambulance Service
- University Hospitals of North Midlands NHS Trust
- The Meadows School
- Staffordshire County Council
- Moorlands Together Community Safety Partnership
- North Staffs Carers Association

## 9 Communication

9.1 All communication between meetings will be in confirmed in writing and copied to Julie Long, Staffordshire County Council, to maintain a clear audit trail and accuracy of information shared. Email communication will utilise the dedicated Staffordshire County Council DHR email account.

## 10 General Data Protection Regulations (GDPR)

10.1 All participating agencies must be compliant with GDPR and all other relevant data protection regulations and legislation.

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## 11 Legal and/or Expert Advice

11.1 Individual Management Review Authors should ensure appropriate research relevant to their agency and the circumstances of the case is included within their report.

11.2 The Overview Author will include relevant lessons learnt from research, including making reference to any relevant learning from any previous DHRs and Learning Reviews conducted locally and nationally.

## 12 Family Engagement

12.1 The Review Panel will keep under consideration arrangements for involving family and social network members in the review process in accordance with the Guidance. Any such engagement will be arranged in consultation with the Police Senior Investigating Officer and, where relevant, Family Liaison Officer.

12.2 The Review Panel will ensure that at the conclusion of the review the victim's family will be informed of the findings of the review and have sight of the Overview Report. The Review Panel will also give consideration to the support needs of family members in connection with publication of the Overview Report.

## 13 Media Issues

13.1 Whilst the Review is ongoing the Police Media Department will coordinate all requests for information/comment from the media in respect to this case. Press enquiries to partner agencies should be referred to the Police Media Department for comment.

## 14 Timescales

14.1 The review commenced with effect from the date of the decision of the Chair of the Community Safety Partnership. The statutory Guidance indicates that the Review should be completed within six months of that date. Completion of the Review will not be possible until conclusion of the criminal proceedings, anticipated to be in September 2018.

14.2 Chronologies should be submitted by 10 August 2018 and earlier if feasible. Agency Management Review and Summary reports should be submitted by 10 September, 2018 at the latest.

14.3 The first Review Panel meeting has yet to be arranged but is likely to take place the first week in October 2018. Further meetings will be agreed at that time.

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