BIRMINGHAM COMMUNITY SAFETY PARTNERSHIP

WORKING TOGETHER FOR A SAFER CITY

Domestic Homicide Review

Executive Summary

In respect of the death of a woman

BDHR2011/12-03

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Introduction

This report of the Domestic Homicide Review (DHR) examines the circumstances leading up to the homicide of an elderly woman, by her son. During the evening of the homicide, the perpetrator called the police from his mother's address and reported that he had strangled her, beaten her about the head, and stated that she was dead. The perpetrator was known to mental health services and it appeared that he had relapsed and been psychotic for some time prior to the incident. At the time of the incident he was under the influence of alcohol and had not been taking his medication. The perpetrator had been seen at a mental health outpatient's appointment earlier that day and had moved in with his mother as he did not feel safe in his flat. It is clear from both the conclusions of the Serious Incident Review undertaken by the Mental Health Trust and from the criminal proceedings that the homicide was a direct result of the perpetrator being psychotic and responding to psychotic experiences.

Real names and dates have not been used in public documents including the terms of reference, the overview report and executive summary

Purpose of a Domestic Homicide Review

Domestic Homicide Reviews were established on a statutory basis under Section 9(3) of the Domestic Violence, Crime and Victims Act (2004). The Act requires a review to be undertaken in 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) a person to whom he was related or with whom he was or had been in an intimate personal relationship, or
(b) a member of the same household as himself, held with a view to identifying the lessons to be learnt from the death'

Domestic Homicide Reviews are not inquiries into how a victim died or who is to blame. These are matters for Coroners and criminal courts. Neither are they part of any disciplinary process. The purpose of a Domestic Homicide Review is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;
- Identify clearly what those lessons are 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; and
- Identify what needs to change in order to reduce the risk of such tragedies happening in the future to prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

The review serves to meet the requirements of Section 9 of the Domestic Violence, Crime and Victims Act (2004) and was delivered in accordance with the Home Office guidance - 'Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews' and followed the key processes that are outlined within the 'Governance and Procedural Arrangements for Domestic Homicide Reviews in Birmingham.'

The review process

This summary outlines the process undertaken by a Birmingham Domestic Homicide Review Panel in reviewing the homicide of the victim. Criminal proceedings have been completed. The outcome was that the perpetrator was found guilty of manslaughter due to diminished responsibility. He was unfit to plea and has been detained at a secure mental health facility under section 37/41 of the Mental Health Act.

Birmingham Community Safety Partnership (BCSP) was notified of the death three months after the homicide. The reason for the delay was because the case was not initially identified as meeting the domestic homicide definition. The homicide was perpetrated by the victim's son, who had temporarily moved in with her due to being unwell. During this time, a Serious Incident Review was being undertaken by Birmingham & Solihull Mental Health Foundation Trust (BSMHFT). BCSP sought advice from the Home Office to see whether this would satisfy the requirements of a DHR. Some months later, BCSP received Home Office guidance to undertake a full review. Department of Health statutory guidance[1] sets out (the former)Strategic Health Authority responsibilities for commissioning independent investigations against a set of criteria, including a homicide committed by a person under the care of specialist mental health services within 6 months preceding the homicide. The internal Serious Incident Review was completed as part of this process.

BCSP made the decision to commission a Domestic Homicide Review and notified the Home Office two weeks later. An independent chair was appointed and terms of reference drafted within the month. As the Serious Incident Root Cause Analysis was being concluded, a decision was taken to defer the first panel meeting for four months, when the report became available, to enable the Panel to consider the information within the report and to avoid duplicating requests for information.

A panel was formed with the following panel membership:

Agency	**Position**

[1] Independent investigations of adverse events in mental health services, Department of Health, June 2005

Independent Chair & Author	Independent social care consultant
Birmingham & Solihull Mental Health Foundation Trust	Lead for User Engagement
Birmingham Community Safety Partnership	Senior Service Manager, Violence Against Women
Birmingham MIND	Operations Manager
West Midlands Police	Detective Sergeant
Birmingham East & North Primary Care Trust	Senior Strategic Commissioning Manager
Birmingham City Council Adult Social Care	Head of Safeguarding
Solihull Clinical Commissioning Group	Designated Nurse- Safeguarding Adults and Children, Mental Capacity Act Lead and health advisor to the Panel

The independent chair/author was selected from a pool of chairs/authors who are fully independent of all agencies involved, and selected via a procurement process. The Panel members were selected by the respective agencies on the basis that they had no direct operational responsibility for the case. In addition the Panel included an independent person from a voluntary organisation and a health advisor from an independent NHS body.

The process began with an initial scoping exercise prior to the first panel meeting. The scoping exercise was completed by the Birmingham Community Safety Partnership (BCSP) to identify agencies that had involvement with the victim and perpetrator prior to the homicide. Where there was no involvement or insignificant involvement, agencies advised accordingly. Birmingham Community Safety Partnership identified within its domestic homicide review procedures the importance and value of independent specialist voluntary sector representation on its panels. To this end it ensures that in cases of domestic violence that Birmingham and Solihull Women's Aid will be represented on the Panel and in cases of familial violence where no intimate relationship is featured but mental health issues are involved, then Birmingham MIND will be represented on the Panel. Birmingham MIND were represented on the panel for this review.

Agencies submitting information to this review include:

- Birmingham & Solihull Mental Health Foundation Trust
- The Primary Care Practice where both parties were registered, supported by Birmingham South Central Clinical Commissioning Group
- Birmingham City Council Adults & Communities Directorate
- West Midlands Ambulance Trust
- West Midlands Police

Agencies were asked to give chronological accounts and submit IMRs of their contact with the victim within the two years prior to her death. Agencies were also asked to provide any information prior to 2009 that was relevant or may be of interest to the panel. This was particularly pertinent to this case given the perpetrator's mental health history with previous acute psychotic episodes pre-dating the time period. Each agency's report was based on the terms of reference and key lines of enquiry as set out below, and covers the following:

- A chronology of interaction with the victim and the perpetrator
- What action was taken or agreed
- Whether internal procedures were followed
- Conclusions and recommendations from the agency's point of view.

Family and friends of the victim were identified from the police investigation and were contacted and invited to contribute to the review. The victim's only direct relative did not wish to be involved as she had no contact for many years. A further six friends and acquaintances were contacted, of which three responded.

In addition, the Panel contacted the Consultant Psychiatrist responsible for the perpetrator's care to seek his views on whether the perpetrator should be made aware of the review and be invited to contribute. This request was based on feedback from the Serious Incident Review, with which the perpetrator had been willing to be involved, and had made comments about his mother being unsupported by mental health services, which the panel wished to explore further. However, the Consultant Psychiatrist responsible for the perpetrator's care advised that it would potentially be detrimental to the perpetrator's mental health to engage with the DHR at the time of the review.

Terms of Reference for the Review

- To establish whether it was known, or could have been suspected, that the perpetrator posed a serious risk to his mother, The victim, and whether any action could have been taken to prevent the homicide. To establish whether the domestic homicide was predictable or preventable.
- To identify how effective agencies were in identifying the victim's vulnerability to domestic abuse and whether risks were identified and appropriately managed

- To identify how effective agencies were in identifying the risks that the perpetrator posed to the victim or others, and how effectively such risks were managed
- To establish how well agencies work together and to identify any gaps and/or changes that are required to strengthen inter-agency working, practice, policies or procedures to improve the identification of people subject to domestic abuse within Birmingham

Key Lines of Enquiry

- **History of events and relationships:** What was known about the perpetrator's relationship with his mother? What was the sequence of events leading up to the date of the homicide?
- **Information and assessments:** How was information about the perpetrator and the victim received and addressed by agencies? What assessments were completed and what was the outcome of these? Were there trigger points or missed opportunities for sharing information that would have made a difference? What are the thresholds for decision making?
- **Risk Assessments:** What risk assessments were completed to a) assess the risks to the victim and b) to assess the risks posed by the perpetrator? Did the perpetrator have a history of violence and, if so, how was this managed? What were the outcomes of any risk assessments? Were these completed on a single agency basis or jointly with other agencies? What actions were taken?
- **Contact with and support from agencies:** What contact did each agency have with the victim and the perpetrator? What support did each receive and from whom? What care and treatment did the perpetrator receive? What was the history of engagement and compliance with treatment including medication? What processes were followed and what were the key decision points and why? Was there any additional action that could have been taken and would it have made a difference?
- **Adult Safeguarding:** Were there were any safeguarding issues in respect of the victim and if so, were these appropriately managed?
- **Awareness of domestic abuse indicators:** To what extent were staff and agencies aware of the indicators of domestic abuse? Were these appropriately identified and what action was taken? Does the agency have policies and procedures in place for dealing with concerns about domestic abuse?

It was identified at the point of the DHR referral that Birmingham & Solihull Mental Health Trust had already undertaken a Serious Incident Review, led by an internal Homicide Review Team. The DHR start date was therefore deferred to allow the conclusion of this review by BSMHFT, so that the report could be shared with the panel at the first meeting, and so avoid duplication in the collection of information. Department of Health statutory guidance[2] sets out the former Strategic Health Authority responsibilities for commissioning independent investigations against a set of criteria, including a homicide committed by a person under the care of specialist mental

[2] Independent investigations of adverse events in mental health services, DH, June 2005

health services within six months preceding the homicide. The internal Serious Incident Review was completed as part of this process.

In addition to BSMHFT, thirty agencies were contacted in the initial scoping exercise. Twenty-five agencies responded as either having had no recorded contact with the victim and/or the perpetrator, or any contact was out of scope and was not of relevance to the review. These were:

- Allens Croft Centre
- Anawim
- Aquarius
- Birmingham City Council Homes and Neighbourhooods Directorate
- Birmingham MIND
- Birmingham and Solihull Women's Aid
- Birmingham Community Health Care Trust
- Birmingham Community Safety Partnership, Safer Communities Team
- Birmingham Crisis Centre
- Birmingham Drug and Alcohol Team
- Birmingham Women's Hospital
- Bournville Village Trust
- Breathe
- Freshwinds
- Gilgal
- Heart of England NHS Foundation Trust
- Jan Foundation
- Rape & Sexual Violence Project
- Royal Orthopaedic Hospital NHS Foundation Trust
- Sandwell and West Birmingham Hospitals NHS Trust
- Shelter
- Staffordshire and West Midlands Probation Service
- University Hospitals Birmingham NHS Foundation Trust
- WAITS

The following agencies had recorded contact with the victim and/or the perpetrator within the review timescale and/or held information that was relevant to the scope of the review:

- Birmingham City Council Adult Social Care
- Birmingham & Solihull Mental Health Foundation Trust
- The primary care practice - both the victim and the perpetrator were registered with the same GP practice
- West Midlands Ambulance Service
- West Midlands Police

Summary of Contact

The perpetrator was known to mental health services from 1999 and was seen earlier in the day of the homicide. During the two years prior to the homicide the perpetrator was well engaged with the mental health team and key clinicians had worked with him consistently for eight to ten years. Following a hospital admission in March 2009 under section 2 of the Mental Health Act, the perpetrator had been seen by health professionals every two to four weeks. There had historically been little contact between mental health services and the victim, and no contact was recorded between 26th March 2009 and the day before the homicide, though it was recorded that that she tended to be involved when her son was unwell, often having him to stay with her whilst he was mentally ill. The victim rang the duty worker the day before the homicide to say that she was worried about her son's mental state, and the victim attended the outpatient's appointment with her son on the day of the homicide. The victim did not usually accompany her son to clinic appointments and this rare contact from her is seen as significant.

West Midlands Police had little contact with the perpetrator and no contact with the victim. They were involved in relation to mental health episodes in March & September 2002, September 2005 and March 2009, prior to being called to the homicide. On each occasion, the perpetrator was considered to be a risk to himself rather than others, though his behaviour often caused anxiety to members of the public.

Birmingham City Council Adults & Communities had no contact with the perpetrator between 2008 and the homicide. However, the case was allocated to a social worker between 2005 and 2008.

The only contact with West Midlands Ambulance Trust was when called out to the homicide.

There had been no face to face contact between the GP Practice and the victim for three years prior to the homicide. There had been five face to face contacts with the perpetrator since 2009, the final two contacts being two months and one month prior to the homicide.

Key issues arising from the review

Circumstances

During the evening of the homicide, the perpetrator called the police from his mother's address and reported that he had strangled the victim, beaten her about the head, and stated that she was dead. Prior to the homicide the perpetrator had moved in with his mother whilst he was unwell, and had been showing signs of a relapse of his mental health condition for some time. He and his mother had attended a mental health outpatient's appointment earlier in the day of the homicide. The perpetrator had not been taking his medication for several weeks, though he had told health professionals that he had re-started it. He was also under the influence of alcohol, having been to the pub earlier in the evening. The internal Serious Incident Review undertaken by the Mental Health Trust concluded that the homicide was directly due to the perpetrator's psychotic illness and had been a response to his psychotic experiences – he stated after his arrest that he had killed the "she devil". He said that his mother had "shape changed" into a demon, and that his rage had come from the voices telling him to hurry and kill the devil. Forensic and post mortem evidence showed that the victim had been strangled and that her son had stamped repeatedly on her head in his bare feet.

Victim & Perpetrator

The perpetrator was well known to, and actively engaged with mental health services and came to the attention of police and other agencies as a direct result of mental health episodes. He suffered from an enduring mental illness and relapse was usually associated with failing to take his medication. He could become ill very quickly, and could mask the true extent of his illness, and didn't usually disclose that he was not taking medication. Increasing the use of alcohol was a recognised symptom of relapse, as was the onset of delusions relating to black magic and visual hallucinations. He often heard voices and these worsened during times of relapse. The perpetrator, when unwell, was considered a risk to himself rather than to others. Though his behaviour could cause anxiety with the public, and he could become aggressive with staff and with police officers detaining him, he had never posed a risk to others.

Though much is known about the perpetrator, the agencies involved with him had little contact with or knowledge about his mother despite her playing a significant supporting role when he was unwell. Agency records are contradictory, variously suggesting a close and positive relationship and a problematic one. The perpetrator had previously disclosed that he was abused by his mother during childhood and there was a suggestion that the voices were linked to controlling parent figures. However, the evidence suggests that they had regular contact – daily telephone calls and weekly or fortnightly visits. The perpetrator had his own flat close to his mother's address but had moved in with her prior to the homicide because he felt safe staying there. Interviews with friends identified that the victim was a private person who rarely socialised. She didn't often confide in friends about how she coped with her son, though it was clear to them that she was isolated and unsupported. There is clear evidence that the perpetrator had been unwell and had not been taking his medication for some time prior to the

homicide, and that the homicide was driven by acute and florid psychosis. There was no known history of domestic abuse within their relationship and the victim was not identified as a vulnerable adult – indeed, she appears to have been relatively fit and healthy for her age. Friends confirmed that the victim did not seem to be afraid of the perpetrator and that there was no evidence that he was physically violent towards her, though she told friends that he used to take money from her.

Timeline

The perpetrator's history of mental health episodes demonstrated that there was a clear pattern or cycle to his episodes, which occurred between one and two years apart – following in-patient treatment. The perpetrator would respond to treatment and was well after discharge. After a period of time he would reduce or stop his medication, his drinking would increase and his behaviour become increasingly bizarre, resulting in a further psychotic episode and in-patient treatment. This pattern is evidenced in agency records and also reflected the perception of friends interviewed, who were well aware of the link between his behaviour and non-compliance with medication, although they were sometimes unsure as to whether the behaviour was due to psychosis or the effects of drug abuse. Friends also felt that the victim understood this cycle.

The internal Serious Incident Review identifies that prior to the homicide there were clear signs of relapse and non-compliance with medication during the three months preceding the homicide, and that these were missed resulting in the perpetrator remaining in the care of his mother on the day of the homicide. In months leading up to the homicide, the perpetrator missed clinic appointments and reported hearing negative voices. During this period he self-reported that he was taking medication, but blood tests demonstrated sub-therapeutic drug levels. His CPN/Care Co-ordinator retired the month before the homicide. The day before the homicide, the victim rang the clinic to express concern about her son's mental state and the clinic contacted her son. The following day, the perpetrator and the victim were seen at outpatients and the decision was made that he remain in the care of his mother, with whom he had moved in. The homicide happened that evening.

Key findings

There was no evidence to suggest that the perpetrator posed a risk of violence towards his mother. When he became unwell he was usually a risk to himself, because of self-harm or suicide. There had been no history of domestic abuse, no reported incidents of assaults on his mother or on others and there is no evidence that his mother was frightened of him. It is the view of the panel therefore that the homicide could not have been predicted.

However, the lack of involvement with the victim by agencies makes it very difficult to be certain whether the homicide was preventable given the contradictions about their relationship and lack of an assessment of risks**.** Throughout the perpetrator's engagement with mental health services, there was little contact between the agencies and the victim and very little knowledge about their relationship. Evidence from friends suggests that the victim was a private person,

with few close friends. She was universally perceived to be isolated and unsupported and did not trust authority. Friends reported that it was the victim's perception that her confidence had been broken by a health professional when she discussed her concerns about her son's mental health on a previous occasion.

Agency intervention may not have prevented the homicide but would have impacted on the victim by reducing her isolation and supporting her better in her caring role. It was known by agencies since 2002 that the victim found it difficult to cope with his behaviours when he was unwell. However, it would appear that no attempts were made to engage with her at times of assessments or reviews, or to further explore the difficulties she referred to. The facts paint a picture from the victim's perspective of an elderly woman who was isolated and unsupported in the care of her only son.

The outcome of the internal Serious Incident Review clearly demonstrates that the perpetrator was unwell at the time of the incident and was under the influence of alcohol. The findings were that it was extremely likely that he had not been taking his medication for some time, and that this incident mirrors previous episodes when he did not disclose that he was not taking his medication. He had failed to recognise early warning signs of relapse and did not seek help and the evidence suggests that he was psychotic for some time before the incident. There was an over-reliance on self-reporting, particularly given his history of non-compliance and he was good at masking his symptoms. At the final appointment it was accepted that he had re-started his medication because he said that he had – there was no robust monitoring put in place for this.

It is impossible to say whether the homicide was targeted at his mother or whether his psychotic experiences meant that he could have targeted any individual who was in his presence when hallucinating. What is known is that the perpetrator's violence against another individual could not have been predicted given that he had no history of violence against others. Whether the homicide could have been prevented is debatable – Home Treatment may have presented an opportunity to pick up his deterioration and thus have prevented the homicide, but this is by no means certain as it would have been determined by staff visiting and assessing him at the right time, or by staff seeing his mother and identifying from information she provided that he had deteriorated.

Conclusions and lessons learnt

The review panel, after thorough consideration, believes that under the circumstances it is very difficult to state whether agency intervention potentially could have or would not have prevented the victim's death, given the information that has come to light through the review. The evidence suggests that there was no known history of violence by the perpetrator against the victim or others and it is conclusive that there were no recorded incidents of domestic abuse. However, different agency intervention would certainly have reduced the victim's isolation and provided her with better support as next of kin and sole carer.

The decision to leave the perpetrator in the care of his mother on the day of the homicide was made on the basis of the perpetrator and the victim's stated wishes when they attended the appointment that morning. However, no consideration had been given as to whether the victim was able to cope with him when he was unwell, and the opportunity to explore her concerns about his mental state had been missed. No risk assessment was completed and the decision was made based on accepting the perpetrator's word that he was re-starting his medication, and in isolation of information held about their relationship by other professionals. Furthermore, the Care Plan wasn't followed – had it been, then a referral to Home Treatment would have been pursued and it is possible that the perpetrator and the victim would have been seen again later that day or evening, as well as there being increased monitoring of his compliance with medication. It is difficult to judge with any confidence whether such intervention may have prevented the homicide – it would have provided an opportunity for further assessment through seeing the perpetrator and/or the victim. Staff may therefore have picked up his deterioration, and this could have resulted in action being taken that better protected the victim. However, it is also possible that staff may not have found him, or seen him at the point of deterioration, and it is important to remember that there was no predictor of violence against others.

The overarching lessons that have been learnt from the review include lessons regarding agency or multi-agency intervention that may have impacted on the outcome, as well as general lessons about how practice can be improved.

- The engagement and involvement of the victim, as mother and sole carer of the perpetrator when he was unwell, was inconsistent and inadequate.

- The victim's concerns about the perpetrator's mental state were not explored or fully understood. No-one checked with the victim that she was able to cope with her son whilst he was ill. Information about the victim's telephone call the day before the homicide was shared with the perpetrator without any further discussion with her or informing her that the information would be shared, or to consider the implications of disclosing her concerns.

- Recording systems and working practices that were in place at the time were inadequate and resulted in information not being shared with the multi-disciplinary team

- Health & Social Care Assessments and Risk Assessments were not regularly reviewed and up-dated

- There was an over-reliance on self-reporting on compliance with medication with signs of relapse being missed
- There was a failure to follow the Care Plan and refer to Home Treatment when there were clear signs of relapse

- There was a lack of a transitional process to introduce the new Care Co-ordinator

- The Primary Care Practice were not fully aware of the relapse signs and the significance of non-compliance with medication

- There are good working relationships between West Midlands Police and mental health services; these can be strengthened by enhancing police records on people known to have mental health conditions who are in contact with the police

Recommendations

Key stakeholders, local Clinical Commissioning Groups and NHS England Area Team work jointly to promote best practice in safeguarding and supporting carers

Birmingham & Solihull Mental Health Foundation Trust (BSMHFT) and Birmingham City Council (BCC) Adult Social Care*:*

1. BSMHFT and BCC put in place procedures and monitoring arrangements to ensure that the assessment for specialist mental health services involves and includes all significant others living with and involved in the life of the service user.

It should be clearly stated in the records of both agencies, or any integrated records, that this discussion has taken place and if the service user does not want someone specifically involved in their care this needs to be documented with the reasons why clearly stated. This should be part of a multi-disciplinary discussion and reviewed especially if the specific person does have an active role in the service user's life when they are ill.

2. BSMHFT and BCC put in place procedures and monitoring arrangements to ensure that all health and social care assessments, risk assessments and carer's assessments are regularly reviewed and up-dated as directed by the CPA process, and at a minimum annually.

As set out in the previous recommendation, it must be

- Ensured that significant others living with and involved in the life of the service user are involved at each review, unless it has been clearly documented that the service user does not want someone specifically involved.
- In the case of the latter, this decision must be reviewed as part of the Care Plan.
- Risk Assessments must record the risks to self and others and describe the rationale for the judgement

3. BSMHFT and BCC put in place procedures and monitoring arrangements to ensure that a carer's assessment is always offered where a significant other is offering a caring role, even if this is at specific times only.

They do not have to live with the service user or consider themselves to be a carer, but

- Must be supported to and encouraged to have an assessment.
- This should be recorded and included in the care plan and any relapse plan.
- If a carer's assessment is declined, this must be clearly recorded, and the records must still record details of significant relationships.
- A copy of the Carer's Assessment must be retained on both social care file and the health file, or the integrated file if available.

4. BSMHFT and BCC jointly review the information sharing and record sharing protocol to ensure that records are integrated to enable effective sharing of records across the two agencies when both are involved in supporting a service user and their carer.

If separate files are held, BCC must also follow Council procedures in every case ensuring that

- Carers have their own file if assessed as requiring services
- The carer's assessment is opened as an event
- The Council file contains a copy of the current CPA Care Plan and Risk Assessment

Birmingham & Solihull Mental Health Foundation Trust

5. BSMHFT put in place processes that ensure that relatives or significant others contacting services to express concerns about a patient's mental state are given the opportunity to share their concerns with the care co-ordinator or responsible clinician.

Relevant information elicited from significant others

- Must be shared with the clinical team
- The process for sharing of information/concerns with the service user is discussed with the carers/relatives
- The implications of sharing information with the service user is taken into consideration and discussed with the carer

6. BSMHFT put in place processes to ensure that Care Plans are followed

7. BSMHFT implement a clear protocol for monitoring medication compliance for people who are considered to require sustained (long-term) treatment with antipsychotic medication.

Whilst it is appropriate and commendable that patient choice and autonomy are recognised in the context of long term treatment with medication and patients given responsibility to manage their own medication

- Such arrangements must be subject to regular and formal reviews

- A proactive approach must be taken when patients with severe mental illness are showing signs of relapse and there is indication that compliance with medication may be poor.
- There should be a systematic method for evaluating medication compliance in such instances as part of the CPA.

8. BSMHFT implements a procedure for the transfer of care from one practitioner to another.

There is already a clear process if the transfer is to another team. This needs to be extended to transfers within teams to enable all aspects of attachment to be considered and addressed.

9. BSMHFT should improve record keeping procedures to ensure that information is available to all members of the team.

This should include the following actions:

- Continue to implement the formal audit process of CPA and further develop the audit process to improve the quality of documentation and that this reflects actual practice.
- Audit the new RIO record database to ensure that it is capturing all information from services and practitioners that are involved with patients.
- Put in place a protocol that ensures that GPs are provided with information regarding signs of relapse.

West Midlands Police

10. West Midlands Police ensure that on each occasion a mentally vulnerable individual is moved by police to a place of safety under section 136 Mental Health Act, officers complete a WC392 in line with Force Policy