Domestic Violence Homicide Review

Executive Summary Report

Death of Maria[1]

Aged 59

Died: February 2021

Independent Panel Chair and Author Steve Hassall

Date DHR completed: - November 2024

[1] A pseudonym chosen by Maria's daughter Grace to protect the identity of the victim

A tribute to Maria by Grace, daughter of Maria and sister of Christopher

A lot of people were impressed by the determination that mum had in taking care of us. She went to work, took care of the house and took care of us. She did sports and was a great person to other people. She helped others a lot and never expected anything from others in return. Making other people happy made mum happy and she was well-liked by people who knew her.

People enjoyed her company and serenity. She was loyal, honest, hard-working, conscientious and sensitive without any self-interest. For me, she was my everything, my sunshine, my best friend. There are no such words to describe my love for her, she was my soulmate, we understood each other without having to speak the words to one another. I don't know if anyone would be able to understand my feelings, because for me, my mum was so much more than just my mum.

Mum making the decision to move to England was hard for all of us. As the years went by, we saw each other very rarely and we missed each other very much. Mum missed her grandchildren, not seeing them grow up. She always said that nothing would bring back those lost years of separation, but we talked every day. It is incomprehensible and very hard for me that in the year when my mother was to return to Poland permanently, God took my mother to himself.

A tribute to Maria by her close friend Rebecca: -

Maria was positive, warm and always smiling. She always said what she thought, she loved animals; her lifelong dream was having a farm, because that's where she would feel truly happy and at home. She was very active, she went running, hiking and boxing. She even had a punching bag at home to train. She wasn't afraid of challenges and her life wasn't easy. She was very caring, always. She always wanted to help everyone and defend people. She also stood behind the truth; she was a very honest person. She was a loving mother and grandmother. She was one of the most righteous, loyal and hardworking people I have ever known.

Preface

At the outset of this report, the Huntingdonshire Community Safety Partnership (HCSP) and the Review Panel want to express their deepest sympathy to all of those affected by this awful tragedy. In particular, the Panel notes the terrible impact on, and the contributions of, Maria's family and friends and the exacerbated trauma they have suffered as a consequence of Christopher's[2] connection to her untimely passing. This was an appalling and shocking tragedy for Maria's children, her friends and colleagues and we offer heartfelt condolences to them all.

[2] A pseudonym chosen by Maria's daughter Grace to protect the identity of the perpetrator

This review has been undertaken in order that lessons can learned from Maria's murder; we are grateful for the support, the input and the challenge from Maria's family and friends throughout the process. This review has been carried out in an open and constructive manner with all the agencies, both voluntary and statutory, engaging positively. This has ensured that the circumstances culminating in Maria's homicide have been thoroughly explored and considered to candidly address the issues that it has raised.

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1. The Review Process

1.1. This summary outlines the process undertaken by HCSP domestic homicide review (DHR) panel in reviewing the homicide of Maria who was a resident in their area.

1.2. The following pseudonyms[3] have been used in this review for the victim, her children and other witnesses in order to protect their identities, and those of their family members.

Table 1.

Pseudonyms:	**Relationship to Lucy**	Age at time of incident	Source material for this report Accounts[4] / Agency Records / Police interviews / Maria's diary entries / Transcripts of recordings of telephone calls made by Maria
Maria	Victim	59 years	Agency Records Accounts from family/friends Maria's diary entries Transcripts of recordings of telephone calls made by Maria
Christopher	Son/Perpetrator	40 years	Agency Records Police Interviews Accounts from family/friends Maria's diary entries

[3] A ***pseudonym*** is a name which is used to disguise the identity of an individual, instead of his or her real name.
[4] The interviewees were contacted and spoken to by the author

			Transcripts of recordings of telephone calls made by Maria
Grace	Maria's Daughter	N/A	Account
Stephen	Maria's son	N/A	Agency Records Accounts from family/friends
Rebecca	Close friend of Maria	UK	Account Agency Records Maria's diary entries Transcripts of recordings of telephone calls made by Maria
Susan	Daughter of Rebecca	U/K	Accounts from family/friends Maria's diary entries
Margaret	Christopher's landlady	U/K	Account Agency Records Maria's diary entries
David	Boyfriend of Maria	U/K	Agency Records Maria's diary entries
Jane	Ex- Daughter in Law	U/K	Agency Records
Sean	Grandson of Maria	UK	Agency Records
Peter	Christopher's housemate	U/K	Account
Mark	Christopher's employer	U/K	Account Transcripts of recordings of telephone calls made by Maria

1.3. Maria was discovered deceased in the flat where she had lived since 2014. The week before her homicide, she had periodically accommodated her son Christopher, the perpetrator in this case, at her home due to him being evicted from his tenancy the previous week for non-payment of rent and concerns his landlady harboured for her own safety. Christopher was arrested at the scene of the homicide and a murder investigation was launched. Christopher was subsequently charged with Mara's murder. At

trial, he was found not guilty by reason of insanity. He was made subject of a Section 41 Hospital Order with restrictions.

1.4. This review process began when the police notified the CSP of the circumstances of Maria's homicide in February 2021. An initial meeting of the CSP on 24.02.21 agreed to hold a DHR. The Independent Chair and Overview Author was appointed on 12.01.22 and the first panel meeting was held in May 2022. Prior to the initial panel meeting, seventeen (17) agencies and services were contacted to establish any record of contact with Maria and/or Christopher prior to the point of Maria's death. Nine (9) agencies confirmed they had been in contact with Maria and/or Christopher. These agencies were asked to secure their files.

1.5. The panel met 7 times by video conference with further work being conducted by telephone, video conferencing and the exchange of documents. At the start of the review process, the panel members each confirmed their independence.

1.6. The review report was concluded in November 2024 following final consultation with the panel.

2. Contributors to the Review

2.1. There was considerable contact with agencies by both Maria and Christopher during the review period. There was no historical tension or acrimony between them noted from any agency records, or any account from those who were close to them, prior to the 22.01.21 when Maria first noted her concerns regarding Christopher's mental health in her diary entry for that day.

2.2. The following were all 'contributors' to this review. Individuals with sufficient seniority are drawn from the following organisations:

Agency	**Contribution**
Cambridgeshire Constabulary	IMR[5] / Chronology / Police Statements
Cambridgeshire and Peterborough Integrated Care Board (ICB)	IMR / Chronology
North West Anglia Foundation Trust (NWAFT)	IMR / Chronology

[5] The aim of the individual management review (IMR) is to: allow agencies to look openly and critically at individual and organisational practice and the context within which people were working to see whether the homicide indicates that changes could and should be made

East of England Ambulance Service (NHS) Trust (EEAST)	IMR / Chronology
Places for People Homes, previously known as Chorus Homes and Luminous	IMR / Chronology
Cambridgeshire and Peterborough Foundation Trust (CPFT) First Response Service (FRS)	IMR / Chronology
Cambridgeshire County Council Social Services for Adults	IMR / Chronology
Re-think Carer Support - Provide peer support by carers for carers of adults with mental health conditions	Subject matter advice and guidance
Cambridgeshire, Peterborough, South Lincolnshire (CPSL) Mind - Mind offers information and advice to people with mental health problems and lobbies government and local authorities on their behalf.	Subject matter advice and guidance
Refuge - A domestic abuse organisation empowering women to live free from violence	Subject matter advice and guidance

2.3. Each IMR author had no previous knowledge of the subjects of the review nor any involvement in the provision of services to them. They were selected as people independent from any clinical or line management supervision for any of the practitioners who provided care for them and could provide an analysis of events that occurred; the decisions made; and the actions taken or not taken.

3. **The Review Panel Members.** The following individuals have also been nominated by their organisations to sit on the panel:

Steve Hassall	Independent Chair and Author
Vickie Crompton	Domestic Abuse & Sexual Violence Partnership Manager - **Cambridgeshire County Council**
Mandi George	Lead Officer for Safe Accommodation & Domestic Abuse – **Huntingdonshire District Council**
Jim Bambridge	Senior Reviewing Officer, Homicide and Major Crime – **Cambridgeshire Constabulary**
Rachel Robertson	Domestic Abuse Lead – Think Family Safeguarding – **CPFT**
Emma Foley	Adult Safeguarding Lead **NWAFT**
Linda Coultrop	Named Nurse Safeguarding Adults, **ICB**

Claire Saggiarato	Named Nurse Safeguarding Adults, **ICB**
Donna Glover	Assistant Director: Adult Safeguarding, **Cambridgeshire County Council**
Elaine Joyce	Safeguarding Practitioner – **EEAST**
Jonathan Wells	Chair of Sun Network, **Rethink Carer Support**, Director of Health Watch Cambridgeshire and Peterborough
Martina Palmer	Senior Operations Manager, **Refuge**
David Saville	Detective Inspector Domestic Abuse Tactical Lead – **Cambridgeshire Constabulary**
Hannah Turner	Head of Services, **CPSL Mind**
Mandy Geraghty	Senior Operations Manager, **Refuge**
Maxine Matthews	Supervisor **Cambridgeshire Constabulary** Major Crime Review Team
Sam Hunt	Associate Director of Safeguarding, **CPFT**
Mike Seaman	Deputy Chief Nurse - **CPFT**

4. Author and Chair of the Overview Report

4.1. Steve Hassall was selected as the Chair of the Review Panel and Author of the report, he has no prior connection to the CSP prior to undertaking this review. He retired from policing after 33 years' service. As a former Senior Investigating Officer (SIO), he worked across a range of policing disciplines, including Major, Serious and Organised Crime, Counter Terrorism and Safeguarding, in both overt and covert investigative and senior management positions. He gained experience of reviews working extensively in partnership with other agencies and diverse communities. He was a trained overt and covert SIO and a practitioner and advisor for achieving best evidence interviews.

4.2. Steve worked across a number of Public Protection and Safeguarding portfolios, managing and overseeing MAPPA[6] and MARAC[7] processes. Steve also had overall strategic and operational command of multiple incidents and investigations including those involving domestic abuse and homicide.

4.3. Steve has not worked for any agency in Cambridgeshire or Huntingdonshire and has no connection with any of the agencies involved in this review. He

[6] MAPPA - Multi-Agency Public Protection Arrangements, is the process through which various agencies such as the Police, the Prison Service and Probation work together to protect the public by managing the risks posed by violent and sexual offenders living in the community.
[7] MARAC - Multi-Agency Risk Assessment Conference is a meeting where information is shared on the highest risk domestic abuse cases. They are attended by representatives from police, health, child protection, housing, independent domestic violence advisors (IDVAs), probation and other specialists from the statutory or voluntary sectors

has completed the relevant Home Officer DHR Chair training. Steve has been the Chair and Author of 6 DHRs and is also a trainer for Sancus Solutions. He was responsible for design and delivery of training for Offensive Weapons Homicide Reviews (OWHR)[8] on behalf of the Home Office. This training has been provided to over 90 delegates, comprising of OWHR Chairs and Authors and key local authority, police and health personnel. There is an extensive input on safeguarding and equality and diversity included in these training inputs.

5. Terms of Reference (ToR) for the Review

5.1 At the first panel meeting, the panel considered the ToR referenced in the Multi-Agency Statutory guidance for the conduct of Domestic Homicide Reviews 2016 (section 2 paragraph 7) and adhered to the guidance with some case specific terms. The aim of the DHR is to identify lessons to be learned from homicides with a view to implementing improvements, to prevent future homicides and ensure that individuals and families are better supported and protected. In order for these lessons to be learned as widely and thoroughly as possible, professionals must be able to understand fully what happened in each homicide, and critically, what needs to change in order to reduce the potential for such tragedies to occur in the future.

Timeframe under Review.

5.2 The DHR considered the interventions and contacts between agencies and Maria and Christopher, the subjects of the review, in the period **01.02.15** to the date when Maria died in **February 2021** (this was based on the absence of any indication, or suspicion of, domestic abuse; however, there were concerns documented in GP records, with regards to Christophers mental wellbeing, as early as 2016. This indicated that his mental ill-health was primarily related to the breakdown of his marriage around 2015, associated difficulties in maintaining access to his son and leg pain.

Victim: Maria aged 59 Years. **Children:** 5 adult children. Maria's other children all reside in Poland. Her daughter Grace has been interviewed as part of this review and her evidence provides insights into Maria's life and experiences.

Specific Terms: Key Lines of Inquiry:

5.3 The Review Panel considered both the 'generic issues' as set out in statutory guidance and identified and considered the following case specific issues: -

[8] Offensive Weapons Homicide Review is a Home Office pilot aimed at dealing with the under researched and reviewed area of homicides involving offensive weapons in 4 pilot sites across the UK.

- *To better understand the life, relationships and context for the death of Maria.*
- *To identify and examine any evidence of abusive behaviour perpetrated by Christopher.*
- *To identify and understand the timeline and any events associated with the deterioration of Christopher's mental health.*
- *To identify whether the victim or perpetrator, or any other person sought out services in response to Christopher's deteriorating mental health.*
- *To identify and assess the response of services to any request for support or reported concern from the victim, perpetrator or any other person.*
- *To examine the actions/responses of relevant agencies, services and professionals having contact with Maria and Christopher during the agreed timeline.*
- *To examine the impact of Covid 19, in particular lockdowns, on both an individual's ability to access information and support and agency responses.*
- *To ensure that the family and friends of Maria are given the opportunity to make a meaningful and effective contribution to this review and are offered and provided with appropriate specialist support to enable them to be an integral part of the process.*
- *To produce a chronology and initial summary which will seek to identify any actions already taken or changes implemented.*
- *To consider relevant research and lessons learnt from previous DHRs where there are similar characteristics.*
- *To consider potential gaps in service provision, alongside potential barriers to accessing services.*

The Review Panel and Chair discussed and agreed additional enquiries that the Chair would pursue with friends and family members:

- *Whether family, friends or colleagues were aware of any abusive conduct by Christopher towards Maria, prior to her death and,*
- *To consider potential gaps in service provision, alongside potential barriers to accessing services.*

6. Summary Chronology

Maria

6.1 Maria was born in Poland and grew up in an orphanage after the premature death of her father. Her surviving mother was unable to afford to care for all of her children and was forced to give up her three youngest to be cared for by the local authorities. She left the orphanage at 18 years old and married her first husband. The marriage broke down leaving her

with 3 young children to care for. She married her second husband, whom she had 2 further children to, but he was abusive and she divorced him, leaving her with 5 young children to care and provide for.

6.2 Maria worked in a factory, but was forced to stay at home to look after her children as a consequence of her marital breakdown. She was described as a wonderful and loving mother who did everything for her children. She cleaned houses to provide for them and, as they grew older, she worked as a cleaner in a sports facility. Her former employer described her as diligent, punctual and truthful.

6.3 In 2009, Maria came to England for a vacation to visit her two eldest sons, Stephen and Christopher, who were economic migrants. She decided to stay and found employment where she met her close friend Rebecca, a fellow Polish national. Maria relied heavily on Rebecca to translate on her behalf due to her limitations in expressing and understanding English. There is substantial evidence to support an assessment that Maria did not speak English fluently and struggled to understand English, which was not her first language.

6.4 Maria initially resided with both her son's, before finding her own accommodation in the St Ives area. She worked in a number of roles including as a cook and at different factories in the Cambridgeshire area.

6.5 Throughout her time residing in the UK, Maria maintained daily contact with all of her children, but she had the majority of personal contact with Christopher, as he continued to live locally to her when Stephen returned to Poland in 2018. She also had frequent contact with her grandson, who is the son of Christopher and his estranged wife Jane.[9] Maria had never intended to stay in England as long as she did, but Christopher's marriage to Jane broke down around 2015 and he experienced child access challenges which prompted her to remain in support of him. Maria was planning to return to reside in Poland when she was prematurely killed.

6.6 Maria was physically healthy and was described as a happy and kind person, but her residence seemingly had a detrimental impact on her mood and she suffered enduring mental ill-health. As early as 2013 she reported low mood and stress to her GP. She was disturbed by the conduct of other residents in the communal block where her flat was located. She was also distressed that her home was surrounded by fences and large trees, which caused her to feel uneasy and she was later diagnosed with claustrophobia. Over the years, this was recurrent and, on occasions, escalated and she was referred to secondary mental health services in May 2016. Maria also made reference to childhood trauma when

[9] Account of Maria's daughter Grace

describing the impact of her residence on her mental wellbeing,[10] but there is no further information in relation to this.

6.7 In January 2021, Maria got a new job and was very happy with the appointment. Around about the same time as this however, she started to express significant concerns regarding Christopher's mental health.[11] She noted her observations in her daily diary entries and reported this to a number of professionals and services over the following weeks prior to her death. Maria also provided accommodation for Christopher at her residence, after he was evicted from his lodgings, the week before her death.[12]

Christopher (Perpetrator)

6.8 Christopher is the biological son and second eldest child of Maria. Christopher was born prematurely and Maria was only seven months pregnant at the point of his birth. Nonetheless, he had a normal childhood and he was well-behaved, clean and tidy. He loved Maria unreservedly and never caused her any problems. He was described as calm and well-mannered by those who knew him and there were no historic physical or mental health problems.

6.9 Christopher qualified as a mechanic in Poland and did his national service in the Army when he was 19 years old. He came to England as an economic migrant in 2007, to join his older brother Stephen. and met Jane who is also a Polish migrant. He married Jane in 2010 and they had a son together in 2011. Christopher's marriage broke down around 2015.[13] After this, he reportedly started drinking heavily and this behaviour appears to have led to significant disputes with his ex-wife concerning access to their son.**Error! Bookmark not defined.**

6.10 In July 2016, Christopher attended a GP consultation suffering from varicose veins. He told the GP that he sometimes felt like killing himself. He explained that his low mood was linked to his marital breakdown, lack of access to his son and leg pain. There is no evidence to indicate that Christopher suffered any episode of mental illness prior to this consultation[14] and there is no known familial history of mental illness.[13] In February 2017, he again reported low mood to his GP, linked to his marital breakdown and challenges with child access. He was diagnosed with signs of depression and prescribed a single course of antidepressants. There is

[10] CPFT Records
[11] Account of Maria's close friend Rebecca
[12] Account of Christopher's landlady Margaret
[13] Account of Maria's daughter Grace
[14] GP records

no evidence that he suffered any further episodes of mental ill health until January 2021.

6.11 This disclosure to the GP coincided with a series of incidents which were reported to the police, primarily by Christopher's estranged wife Jane, concerning Christopher's attempts to maintain access to his son against her wishes. In total there were 10 incidents reported to the police between July 2016 and August 2018. There was no report of any abusive or threatening conduct by Christopher at any incident.

6.12 Christopher also inherited a debt to a local drug dealer, when his marriage broke down, as a consequence of his own and his wife's recreational use of marijuana. This undermined his capacity to sustain himself, and he relied on Maria for financial support.

6.13 The disputes with his estranged wife over child access continued for several years, during which time he was allowed only limited, supervised contact with his son, as directed by Family Court proceedings. Maria told friends that Christopher was a good man, a good husband and father who was quiet and sensitive. She described him working hard for his family, but experiencing financial difficulties when he became unfit to work for a period of time due to his varicose veins. Maria opined that his wife believed she could find someone better than him and left him during the period he was unable to work.

6.14 Whilst he was employed consistently from when he arrived in the UK, his long-term episode of ill-health associated with varicose veins, prevented him working and impacted on his financial viability between 2016 and 2017. He didn't have the financial resources to engage legal representation to challenge his wife regarding her denying him child access.[Error! Bookmark not defined.]

6.15 Christopher worked for Mark for approximately 3.5 years. Mark described him as a good employee who was hard-working, trustworthy and well-liked by his fellow workers. Mark was aware that he liked a drink and, as a consequence of this, he occasionally didn't turn up for work on some Fridays, but his application and commitment meant that Mark largely overlooked these infrequent transgressions.[15]

6.16 He reportedly had a number of acquaintances, but no close friends were identified and, following his marriage break-up, he seemingly lived an isolated existence, preferring to work long hours.[16]

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[15] Account of Christopher's manager Mark
[16] Cambridgeshire Constabulary IMR

6.17 His lived with his former landlady for approximately 2 years, until the weekend prior to the homicide. She described him as an ideal tenant who was clean, tidy, polite and hardworking. He loved to cook and prepared Sunday lunch for Maria every weekend. He was a quiet man who kept himself to himself and didn't speak English well, which impacted on his ability to establish and maintain relationships. He worked all through the Covid pandemic and walked to and from work every day at 07.30 hrs, returning home at about 18.30 hrs.

6.18 There is evidence that Christopher was a frequent user of marijuana in the past and his landlady suspected on occasions, that he continued to, when he lived with her. She reflected that he would occasionally be, 'spaced out' and sometimes hyperactive.

6.19 In late 2020 and into January 202**1**, his landlady noticed Christopher's behaviour becoming increasingly odd. He suddenly stopped attending work telling her that he was on holiday, he started drinking vodka excessively and continually wore a fleece with the hood up and his earphones in. He persistently talked and laughed, as if he was having a telephone conversation with one of his friends, but his landlady suspected he was talking to himself. Other times, he was completely and uncharacteristically silent. At times, he would dance without any music on and stopped eating as he normally would. He uncharacteristically stopped paying his rent and his landlady evicted him for this due to growing concerns for her own safety.[17]

Relevant information during the review

6.20 There is clear evidence that neither Maria or Christopher spoke or understood English proficiently, which was not their first language. The translation service who interpreted recordings of calls made by Maria to various professionals noted that Maria spoke, *'very poor English which was not grammatically correct and was difficult to understand.'*

6.21 From analysing the information provided by agencies concerned in this review and from family, friends and others associated with Maria and Christopher, it can be established that they maintained a mutually loving and supportive relationship. There is no evidence of any tension or animosity between them prior to Maria's first recorded concern about his mental illness in her diary entry of 22.01.21, which stated, *'Christopher came with flowers, very nice bouquet but stranger.'*

[17] Account of Christopher's landlady Margaret

6.22 From that point on, it appears to have been clear and obvious to lay people who provided evidence to the review, that there was something tangibly wrong with Christopher's mental health. They each recount instances and incidents of uncharacteristically odd or unusual behaviour by him, which caused them concern. In parallel, his landlady feared for her own safety as a consequence of his disturbing behaviours.[17] Maria's diary entries describe her worries about his illness and the telephone recordings she made illustrate that she also became scared by his conduct, although her friend Rebecca reported that Maria harboured no concerns that he would ever physically harm her, but feared he may inadvertently set fire to, or flood, her home.[18]

6.23 Maria first reported her concerns to Christopher's GP (GP Practice 1) on 28.01.21. Repeated concerns about his mental health were subject of separate reports to a range of professionals and services by Maria, Christopher's landlady and Maria's friend Rebecca and her daughter Susan.

6.24 The evidence illustrates it was similarly apparent to professionals who had direct or indirect contact with him, on or after the 28.01.21, that he was suffering with a mental illness. This was either on the basis of their own observations, or through the growing concerns reported to them by Maria, Margaret, Rebecca and Susan. The combined risks that existed, and persisted, in this case were documented by an FRS senior clinician on 04.02.21, after an attempted face-to-face engagement by FRS practitioners on 02.02.21. They acknowledged the risk his mental health might deteriorate further if he was developing a psychotic illness. Separately, they recognised the risk his mental health might deteriorate further if it was not treated. The FRS do not maintain a caseload, which diminished any opportunity for FRS to monitor and control the risks they documented in their record. This accurate assessment of active risks was never documented or managed by any other agency or professional outside the FRS, who closed Christopher's case to their service on 04.02.21.

6.25 GP Practice 1 received substantial information from Maria in her appeals to access help and support for Christopher between 28.01.21 and 11.02.21. She was appropriately signposted to the FRS by Christopher's GP (GP Practice 1). The FRS, in turn, encouraged her to try and get Christopher to engage with his GP after their unsuccessful attempt to engage him, however; the GP's priority, when she contacted them on the 1st, 3rd and 4th February 2021, was to transfer his care to an alternative GP practice. GP Practice 1 was acutely aware he was suffering a sustained mental illness on the basis of substantial information provided to them by Maria.

[18] Account of Maria's close friend Rebecca

6.26 The FRS were similarly presented with substantial information from Maria indicating he was suffering a mental illness, which prompted them to attempt a 'cold call,' face-to-face engagement on 02.02.21, but there were important omissions in the information they recorded from Maria, and his co-resident and landlady, in relation to their individual fears for their own safety. The FRS did not consider new information reported to them by GP Practice 1 on 11.02.21, that concerns about Christopher's mental illness were escalating, as a new referral and they did not re-open or review Christopher's case.

6.27 The Cambridgeshire County Council Adult Social Services Emergency Duty Team (EDT) were initially alerted to mental health concerns by Maria's friends daughter Susan on 09.02.21, The EDT practitioner explained they had no record of any FRS engagement with Christopher on 02.02.21, but reassured Susan she could call back and they would take him for a Mental Health Act (MHA) assessment if her concerns about Christopher's behaviour continued.[19]

6.28 On 11.02.21, the EDT were contacted by GP Practice 1. The GP left a message describing Maria's maintained concerns about his mental health and requested the EDT contact Maria to consider the necessity to conduct a MHA assessment. The EDT tried to call the GP back, but the surgery was closed. They noted from records that there was a previous attempt by the FRS to engage Christopher, but he had refused. They concluded there was no indication of any urgency and that Maria required the services of an interpreter and so did not pursue the matter further.

6.29 On 21.02.21, the EDT were alerted to mental health concerns, on behalf of Maria, by her friend Rebecca. She explained he was experiencing a mental health crisis and had previously refused to speak to the FRS, she requested the EDT undertake a MHA assessment due to his worsening mental illness. The EDT noted previous contact with both the FRS and the EDT, but directed that Rebecca should re-contact the FRS as a least restrictive option.

6.30 On 30.01.21, the ambulance service was alerted to mental health concerns by Christopher's landlady who had discovered him fully clothed in the shower after water came through her ceiling. He was spoken to over the phone by a paramedic who described him as alert and oriented. He told the paramedic he thought his mother had called the ambulance. He said that he'd felt unwell with his mental health earlier, but wanted to go back to bed. He was given worsening advice. There was no advice sought, or referral made, to mental health services.

[19] There is no corresponding EDT record of this call

6.31 On 14.11.21, Christopher was evicted from his landlady's home due to non-payment of rent and fears she maintained for her own safety from his increasingly strange behaviours. His landlady called an ambulance at this time reporting that he might be suicidal and was experiencing a mental health crisis. The paramedics recorded he appeared 'very distant, fidgety and staring at a single spot whilst talking.' He was conveyed by ambulance to Hinchingbrooke hospital in response to their concerns about his mental health. There was no advice sought, or referral made, to mental health services.

6.32 That same evening, Christopher was examined at Hinchingbrooke hospital in response to a mental health complaint, having been conveyed by ambulance due to his unusual behaviour, suicidal thoughts and acute confusion. The hospital ruled out any physical illness and discharged him 'home' after he had been evicted from his residence because of his landlady's fears for her own safety. There was no advice sought, or referral made, to mental health services.

6.33 The police were first alerted to concerns about Christopher's mental health by his landlady on 11.02.21. In her email to the police, she informed them that she had grown very concerned for her own welfare due to his increasingly odd behaviours. The police chose to respond with an email acknowledgement advising her on what to do in an emergency. There was no advice sought, or referral made, to mental health services.

6.34 Late in the evening of 20.02.21, police responded to an emergency 999 call from a householder who had previously reported an attempted burglary at their home on 30.01.21. The householder reported the intruder had returned to their house. Police attended and found Chritopher outside, he claimed he had won the lottery and that God had sent him to the address to ask for a cup of tea. In spite of the assurances given by the householder and their showing officers the image they had taken of the intruder on their mobile phone at the time of the attempted burglary, the police erroneously concluded that Christopher was not the intruder and did not see fit to exercise their legitimate grounds to arrest him. Despite their documented concerns for his mental health, which caused them to submit an adult at risk referral for the attention of the MASH, the police did not appear to consider their powers under the MHA. The police did not link this event to the email they received from his landlady 9 days previously and there was no advice sought, or referral made, to mental health services.

6.35 On 21.02.21 police attended a further incident involving Christopher at a local convenience store, where Maria was in attendance. He seemingly believed he could take what he wanted from the shop as a consequence of

winning the lottery. At the same incident, he made reference to the responding officer's and declared that they were not real police. He accused Maria of changing his lottery ticket and believed she was stalking him through a camera. It is clear the police were concerned for his mental health, but did not appear to have fully considered their powers under the MHA, or conclude that he met the criteria to be detained under the MHA. Similar to the previous police incident, Christopher remained convinced he had won the lottery despite being shown evidence to the contrary, the officers concerns for his mental health again prompted them to make an adult at risk referral. They did not link this event to the incident the previous evening or the email they received from his landlady 10 days previously. There was no engagement with, or referral to, mental health services.

6.36 GP Practice 2 were first recorded as being alerted to concerns about Christopher's mental health by Maria on 16.02.21, but they had no access to his medical records at this time as he was in the process of being transferred from GP Practice 1. The GP spoke with Maria and Christopher during a telephone consultation that day. Maria reported he was 'lost', 'not himself for 4 weeks', 'angry' and, 'not going to work'. Christopher told the GP he felt ok and a further telephone consultation was arranged for the 19th February, but Christopher did not answer the GPs call on that day.

6.37 Only GP Practice 1 held any historical record of Christopher suffering from any episode of mental ill health, prior to January 2021. The records indicate that this materialised during a GP consultation in July 2016, when he expressed thoughts of taking his own life to the GP. In a subsequent GP consultation, in February 2017, he reported having, 'low mood' and was diagnosed with signs of depression.

6.38 Whilst there is some evidence to indicate his behaviour started to become more concerning as early as late 2020, it is clear from Maria's diary entries, that she only became acutely concerned about his mental health on 22.01.21, which was just 4 weeks prior to the homicide. As outlined, she first raised her concerns regarding his deteriorating mental health with his GP (GP Practice 1) on 28.01.21, just over 3 weeks before her homicide.

6.39 In the following days and weeks prior to Maria's homicide, access to insightful information and opportunities to monitor, assess and mitigate the combined, active risks identified by the FRS senior clinician were presented to a number of professionals and agencies. Neither risk was seemingly recognised and the necessary situational awareness required to assess and control the combination of active risks was undermined by vulnerabilities in information gathering, recording, collation, analysis and interpretation and sharing. Any plan to control the combined active risks was further

undermined by vulnerabilities in service collaboration, cooperation and professional assessments.

6.40 From the outset, Maria continually struggled to engage appropriate treatment and support for his mental illness. The evidence indicates there was a parallel absence of professional support to Maria, which her situation warranted, as a close and concerned relative of someone who was seriously mentally unwell and who was not consenting to be treated. She was effectively left isolated to try and understand and navigate the complexities of agencies and services available to advise and support her whilst dealing with the impact of Christopher's illness. In parallel, the existing system and individual and collective agencies demonstrated a range of vulnerabilities in assessing, managing and responding to the risks posed by his rapid mental health deterioration.

6.41 In the 25 days preceding her untimely death, Maria engaged directly, and on several occasions, with Christopher's GP (GP Practice 1), her own GP (GP Practice 2), the FRS and the police. Indirectly, there was further engagement with the EDT through Maria's close friend Rebecca, her daughter Susan and the GP from GP Practice 1. In parallel, the ambulance service, the FRS, Hinchingbrooke hospital Emergency Department (ED), the GP at GP Practice 2 and the police all had separate, direct contact with Christopher. The GP at GP Practice 1, FRS, EDT and the police also had indirect contact with Christopher during this 25-day period. As alluded to, each of these agencies were either alerted to, or came to the conclusion, that there were mental health concerns.

6.42 In addition to the direct and indirect engagements, there were a series of discussions between the FRS, GP Practice 1 and the EDT. A reported outcome of the earliest discussion between the FRS and GP Practice 1 on 04.02.21, was an agreed plan aimed at having Christopher's mental health assessed by the GP. This plan was never implemented, nor effectively re-visited. On 11.02.21, there were further discussions about Maria's continuing concerns for his mental health between GP Practice 1 and the FRS, and separately, between GP Practice 1 and the EDT, but no referrals were recorded or responded to by the FRS or EDT and there was no useful outcome from either of these discussions. This was a unique opportunity to consider alternative responses in light of the fact that the FRS plan had not been implemented and Christopher had not been assessed by a health professional. The evidence indicates Maria remained unaware of, and oblivious to, these discussions.

6.43 Maria's efforts to access the treatment and support that Christopher's illness warranted were initially undermined by the repeated direction from GP Practice 1 for him to re-register at an alternative GP Practice as he was

residing outside their catchment area. The GP did appropriately signpost her to the NHS 111 (Option 2) service. On contacting the FRS, she expressed her concerns that GP Practice 1 refused to treat Christopher, but was advised by the FRS to encourage him to see his GP, whom she had reported was refusing to treat him. She similarly advised GP Practice 1 of the difficulties she experienced registering Christopher with an alternative practice, whilst informing them that his condition was worsening. She explained to GP Practice 1 that he refused to acknowledge he was ill or needed medical help, and therefore, continued to refuse to sign the registration form that was necessary to facilitate his transfer to an alternative GP practice.

6.44 After their attempted face-to-face engagement with Christopher on 02.02.21, the FRS noted that there was a risk his mental illness might deteriorate if he wasn't assessed by a health professional. Their plan to mitigate this wholly relied on his GP offering him an appointment to discuss his general health as a means to assessing his mental health. The FRS contacted GP Practice 1 on 04.02.21 to enquire into Christopher's past medical history. They were inaccurately advised by the GP that there was no record of mental illness in his medical records and told that he needed to register at an alternative surgery. According to the FRS record, the GP (GP Practice 1) agreed to implement the FRS plan by offering Christopher an appointment with a view to assessing his mental health. There is no corresponding acknowledgement of the FRS plan in the GP record. This plan was never implemented, due to Christopher's status as requiring to be registered at an alternative GP practice. The plan was not effectively revisited and the risk that his mental illness would deteriorate without treatment was not mitigated, despite opportunities which presented themselves during subsequent discussions involving GP Practice 1 and the FRS and GP Practice 1 and the EDT. In parallel, opportunities to mitigate this risk were missed during interactions and engagements with the police, the EDT, the ambulance service and Hinchingbrooke hospital.

7. Conclusion

7.1 The root cause to these tragic events was that Christopher was suffering with a psychotic illness, which resulted in him taking Maria's life due to the delusional beliefs he held at the time. This was compounded by the absence of a clear pathway for individuals who require informal mental health support, at least for a brief period, but are not consenting to a referral.

7.2 This root cause summary clearly reflects that the combined, active risks, identified by the FRS senior clinician, as being his mental health deteriorating if he was developing a psychotic illness, and/or his mental

health deteriorating if it was not treated, were not effectively monitored and controlled. A clear pathway was undermined by the lack of coordinated, collaborative and cooperative working practices between the GP service, the FRS and the EDT. In parallel, collective agency situational awareness of the evolving, active risks was undermined by an absence of appropriate collaboration and information sharing by the ambulance service, the police and Hinchingbrooke hospital when responding to mental health concerns reported to them.

7.3 The position adopted by GP Practice 1 to repeatedly direct Christopher's re -register at an alternative GP practice, whilst he was suffering a mental health crisis, was a significant, undermining factor to the outcome of events. This not only destabilised his continuity of care, it also contributed insurmountable challenges for coordinated agency collaboration and cooperation to conduct a health assessment of his illness and manage the combined, active and continually evolving risks. In parallel, this deprived Maria of a competent, professional source of support when it was needed most, to help her navigate the complexities of services available to assess and respond to his deteriorating mental health.

7.4 The evidence indicates that a combination of siloed ways of working by the GP service, the FRS and EDT, the police, the ambulance service and Hinchingbrooke hospital, coupled with inadequate clinical handovers of information and care plans stifled opportunities to access and triangulate information that was readily available to individual agencies, but was not shared and / or subject to an informed, collaborative assessment and evaluation to consider effective responses to the evolving and escalating risks. The ambulance service, the police and Hinchingbrooke hospital did not seek to appropriately engage, or share information with, the FRS and/or other crisis mental health services to inform their responses to events reported to them, or to alert these services to the evolving and escalating risks that were brought to their attention. In tandem, the considerations made to the 'least restrictive option' was used to justify services declining to assess Christopher's illness, except as a last resort.

7.5 There were several opportunities offered to other professionals and agencies to assess and control the combined risks outlined by the FRS senior clinician, but shortfalls in agency collaboration, information gathering and analysis, allied to vulnerabilities in information management and sharing, and the absence of adequately resolute risk identification, assessment and management application, combined to undermine these opportunities.

7.6 Inconsistent utilisation of interpreter services during key transactions contributed to a flawed understanding of the highest risks as expressed by Maria. In turn, this shortfall discriminated against her on the grounds of

her non-English-speaking ethnic background. Interpreter services were vital to inform and maintain an accurate assessment of the active and evolving risks. The service was equally critical to ensuring that Maria had a clear understanding of decisions and actions and was able to raise, discuss and resolve her concerns. The lack of consistent and appropriate interpreter support maintained inadequate identification, assessment and management of the highest risks and seriously undermined Maria's ability to access the system of support available to her.

8. Learning

8.1 This case demonstrates the importance of maintaining continuity of primary care services, in order to maintain ownership and accountability for risk and treatment plans in cases of patients suffering episodes of mental illness. In parallel, primary care services have a pivotal role to play in supporting carers of patients with professional advice, guidance and practical assistance to overcome service access challenges or shortfalls.

8.2 The FRS service is not designed to hold a caseload. This means that on occasions they may see people who are unwell and do not consent to an assessment due to the presenting symptoms of their mental illness. This can result in potential risks not being fully explored and managed, as FRS are unable to continue trying to work with that person unless a further referral is received.

8.3 The absence of any process for FRS to refer internally to other CPFT services in circumstances such as unfolded here, maintains a high risk those patients remain unassessed, undiagnosed and untreated, as proved to be the case here. There is currently no provision for the FRS to make a referral where a person could be ill, but does not pose an imminent risk and all least restrictive options have not been exhausted. In this case, the absence of any internal CPFT referral options, required the FRS to rely on Maria and, separately the GP, to seek a MHA assessment from the EDT; however, the EDT did not accept these referrals when they were made. The only other opportunity for FRS to re-engage a non-consenting patient is in response to a new referral. New referrals were either not recognised as referrals, as in the case of the call to FRS from the GP on 11.02.21, or not conveyed as referrals, as in the case of the EDT response to GP Practice 1 on 11.02.21 or to Rebecca's call on 21.02.21. This illustrates a requirement to revise internal CPFT referral processes and improve liaison, information sharing and joint working between the FRS and EDT services.

8.4 The shortfalls in coordination, collaboration and cooperation between the FRS and EDT sustains an unreasonable degree of responsibility on carers to navigate a complex service delivery system. There services should work more cohesively to respond to concerns for mental health and resolve

simultaneous challenges accessing appropriate support and treatment, which were reported in this case. There is no existing coordinated, joint working arrangement, between the FRS and EDT, where potential referrals for MHA assessments can be discussed, assessed and collaborative plans and responses agreed, so that the primary responsibility for this is taken by clinicians rather than by carers. There is an aligned lack of easily available and clearly understandable advice and guidance on the Cambridgeshire County Council website in this regard. This also illustrates a requirement to improve liaison, information sharing and joint working between the FRS and EDT services. This requires to be aimed at increasing the provision of support to nearest relatives of mentally ill patients and improving service user satisfaction and outcomes. Both services and Cambridgeshire County Council should also ensure that service users and carers are provided accessible, easily understandable, advice and guidance in accordance with their needs and circumstances.

8.5 There were shortfalls in the responses from the EDT practitioners to the referrals made to this service by GP Practice 1 and, separately, by Maria's close friend Rebecca, on behalf of Maria, when they each requested the EDT to consider the requirement to conduct an emergency MHA assessment. There is an expectation that all EDT practitioner responses to requests, by, or on behalf of, a nearest relative are conducted in compliance with legislation.

8.6 The evidence indicates a lack of understanding by GPs on the role and responsibilities of mental health services. There is a requirement to revisit the recommendation made in a previous Huntingdonshire DHR for CPFT and the ICB to work together to ensure that all GP surgeries have absolute clarity over referral routes and the terminology to be used when prioritising cases.[20] This recommendation was founded on the basis of providing more clarity to the working relationship between mental health services and GP practices, which is relevant to this review and critical to maintaining ownership and accountability for risk and treatment planning and management.

8.7 Coordination, collaboration and cooperation shortfalls in clinical handovers undermined service risk assessments, management and responses. Whilst the combined, active risks were identified, the documented risks and treatment plan were not shared appropriately though robust and documented clinical handovers. Similarly, professional assessment and response opportunities were repetitively missed. Separate referrals, to the FRS and EDT by GP Practice 1 on 11.02.21, where the GP reported continuing and escalating mental health concerns to both the FRS and EDT, did not result in any constructive response to the concerns raised or

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any tangible outcome. The additional referral to the EDT by a family representative on 21.02.21 merely diverted the family representative back to FRS without any collaborative engagement or outcome. GP Practice 1 did not see fit to provide a clinical handover to Christopher's new primary care provider to update them on the active risks and the sustained absence of any health assessment of his deteriorating illness. These opportunities were missed because of siloed working practices and an absence of agency coordination, collaboration and documented clinical handovers of risk and treatment plans. This case illustrates a requirement to conduct and document appropriate clinical handovers between services, in circumstances such as these, to maintain collective situational awareness of evolving and active risks and agree responsibility and accountability for managing risks and treatment plans.

8.8 The inconsistent utilisation of interpreter support undermined the accuracy of information recorded by professionals and the authenticity of risk assessments and treatment plans. This similarly maintained barriers to, and discriminated against, non-English speaking service users on the grounds of their ethnicity. There was a parallel absence of any written advice and guidance made available in the native language of Maria. This illustrates the requirement for consistent use of interpreter services where there is any difficulty encountered by a professional, in understanding the service user, or where there is a requirement to provide complex or complicated information to a service user who experiences any difficulty in expressing or understanding English.

8.9 There was a concerning absence of documented risk assessments in agency records to provide reassurance that risks were appropriately identified, assessed, reflected in decision making and prioritised for responsive action. In parallel, there was evidence of excessive passivity by professionals responsible for identifying, assessing and controlling risks. This undermined decision making, agency responses and the accuracy and reliability of referrals that were made and / or overlooked clear and obvious safeguarding concerns which were apparent to the police on 11.02.21 and the ambulance service and Hinchingbrooke hospital on 14.02.21. This illustrates a requirement for improvements in documented enquiry and outcomes in identifying, assessing and managing the potential risks posed by mental illness and any associated safeguarding concerns. Appropriate enquiries and information collection should be prioritised on relatives and other close associates of potentially mentally ill patients as they are a rich source of insight to assessing risks to self or others.

8.10 Vulnerabilities in effective records management undermined informed consideration of decision making, assessments and actions. This was

reflected in the inability of the GP to accurately inform crisis mental health teams in respect of Christopher's history of mental ill-health. Similarly, the police were unable to link 3 separate reports made to them regarding concerns for Christopher's mental health which illustrates a requirement to maintain compliance with National Incident Recording Standards. Collectively, there is an expectation that all agencies document and maintain records in an appropriately accessible format, to enable triangulation of information and enable accurate risk assessment to inform decision making.

8.11 When responding to separate episodes of concerns about his mental health, the police did not engage, or share information with mental health services to inform either, their own dynamic decision making in response to each event, or the collective situational awareness necessary for services to assess and respond to the active, evolving risks which included his landlady's fears for her own safety and welfare as a consequence of Christopher's increasingly concerning behaviour and the risks posed to Christopher and/or others offered by his attempts to enter residential properties where he had no legitimate right of access late at night.

8.12 The ambulance service were alerted to mental health concerns on 2 separate occasions. Whilst they were able to link these records internally, there is no evidence they engaged with, or shared this information with mental health professionals to inform their own dynamic assessments and decision making, or to enhance collective situational awareness of the evolving, active risks that were brought to their attention, which included him being evicted from his home due to his landlady's fears for her own safety as a consequence of his increasingly disturbing behaviours.

8.13 Hinchingbrooke hospital were similarly alerted to mental health concerns and were informed that Christopher was effectively homeless as a consequence of his landlady's fears for her own safety. They did not engage, or share any information with, mental health professionals to inform their assessments and decision making or to enhance collective situational awareness of the evolving, active risks that were brought to their attention.

8.14 These events collectively illustrate the requirement for all agencies to improve collaborative working and information sharing to enhance and maintain cross agency situational awareness and inform responses to dynamically evolving and active risks. This can be achieved by engaging professional mental health advice and sharing relevant and accurate information regarding mental health concerns that come to their attention.

9. Recommendations

1. It is recommended NHS England review Primary Care contracts and Primary Care Patient Transfer policy to ensure that registration to a different GP Practice is completed within 2 working days to ensure that information sharing, and continuous care is provided to patients at risk of acute episodes of mental ill health.

2. It is recommended that NHS England, supported by the ICB, review Primary Care staff training on IT systems to ensure that all Primary Care staff are competent in the use of search buttons for obtaining relevant medical history to share information with other health professionals when required.

3. It is recommended that CPFT and the ICB work together to ensure that all GP surgeries have absolute clarity over referral routes and the terminology to be used when prioritising cases.

4. It is recommended that CPFT review existing processes for non-consenting adults with regards to their Crisis Services to ensure they are fit for purpose and support the service user and their families/carers.

5. It is recommended that CPFT undertake an audit of the existing process in place for non-consenting adults. This should be focussed on improving communication and collaboration across Crisis Mental Health Services (CPFT and Local Authority) to ensure it is fit for purpose and supports the service user and their families/carers.

6. It is recommended that CPFT and the ICB negotiate and agree the provision of 24-hour mental-health liaison services at Hinchingbrooke hospital.

7. It is recommended that Cambridgeshire County Council ensure that accessible, easily understandable information regarding a nearest relative right to request an emergency MHA assessment, under S13 of the MHA, is made available to service users on their website and in hard copy. This should be in a format and language appropriate to their needs and circumstances. This information should be accessible to all services who are likely to advise a nearest relative of their right to request a MHA assessment.

8. It is recommended that EEAST, Cambridgeshire Constabulary and NWAFT ensure policies are introduced to ensure that interactions with persons who are suspected to be suffering with a mental health disorder are discussed dynamically with a registered mental health professional to inform dynamic decision making, risk assessment and management. This recommendation should extend to a requirement to share the outcome of risk assessments, involving persons who are suspected to be suffering

with a mental health disorder, with mental health services to maintain situational awareness to evolving, active risks.

9. It is recommended that all services apply consistent use of interpreter services where there is any evidence of a communication difficulty encountered by a professional, in understanding the service user, or where there is a requirement to provide complex or complicated information to a service user who expresses any difficulties in expressing or understanding English. Advice and guidance in relation to services and support should also be made available in written form in the first language of the service user.

10. It is recommended that all services develop and maintain frontline practitioner awareness and capabilities with regards to the assessment of risk posed by a mentally unwell patient to themselves or others. This should include a requirement to document risks and outcomes of assessments to inform decision making and collaborative situational awareness through appropriate sharing of the outcomes of risk assessments with mental health professionals.

11. It is recommended that all services take steps to ensure all frontline practitioners are subject to appropriate safeguarding training to establish and maintain reliable identification of safeguarding concerns and cross agency referrals regarding concerns.