Domestic Violence Homicide Review
Oversight Report

Death of Maria
Aged 59

Died: February 2021

Independent Panel Chair and Author Steve Hassall

Date report completed 25th November 2024

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A tribute to Maria[1] 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.

1. INTRODUCTION

PREFACE:

1.1. Before formally introducing this Domestic Homicide Review (DHR), the Huntingdonshire Community Safety Partnership (CSP) and Domestic Homicide Review (DHR) Panel would like 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

[1] A pseudonym chosen by the victim's family to protect her identity

and friends and the exacerbated trauma they have suffered as a consequence of Christopher's[2] connection to her untimely passing.

1.2. No words can adequately describe their loss; however, we are motivated to undertake a review and compose a report that properly reflects the circumstances leading to the events of February 2021, and ensures that lessons are identified so that others can benefit from that learning in the future. The Panel would also like to express sincere thanks to Maria's family and friends for their contributions. This review could not have been completed without their challenge and support. Maria's death was an appalling and shocking tragedy for her family and friends, and through the Chair, the Panel offer heartfelt condolences for their loss.

1.3. The impact on professionals who were involved with Maria and Christopher in the days and weeks prior to the incident, and those attending the incident itself, is acknowledged by the Review Panel. The Independent Chair and author of this review would also like to thank all those staff from statutory and voluntary agencies and organisations who assisted in compiling and reviewing the information culminating in this report; all have been deeply touched by these tragic circumstances.

1.4. A central operating principle of this review has been to be guided by compassion, and empathy, with Maria's 'voice' at the heart of the process. This report examines agency responses and support given to Maria, a resident of Huntingdonshire, prior to the point of her homicide in February 2021.

1.5. In addition to agency involvement the review has also examined any relevant background or trail of abuse, whether support was accessed and whether there were any barriers to accessing support. By taking a holistic approach the review seeks to identify appropriate solutions to make the future safer.

1.6. Cambridgeshire Constabulary alerted Huntingdonshire Community Safety Partnership of the circumstances of Maria's death in February 2021. Her son, Christopher, was arrested at the scene of Maria's homicide and later charged with her murder. In November 2021, after a trial, he was found not guilty of murder by reason of insanity. He was subject of a Section 41 Hospital Order with restrictions. Huntingdonshire Community Safety Partnership commissioned a DHR on the 12th January 2022.

1.7. The review has considered agencies contact/involvement with Maria and Christopher from 1st February 2015, until the date of Maria's death in February 2021. This time period was agreed by the Panel due to the lack of any information indicating any evidence of domestic violence and abuse (DV&A); however, the commencement of the review period corresponds with the breakdown of Christopher's marriage, which the evidence indicates had a bearing on his mental wellbeing.

1.8. The key purpose for undertaking DHRs is to enable lessons to be learned from homicides where a person is killed as a result of domestic violence and abuse. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able

[2] A pseudonym chosen by the victim's family to protect his identity

to understand fully what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

2. TIMESCALES

2.1. The Independent Chair was appointed to conduct this DHR on the 12th January 2022. The DHR was completed 25th November 2024.

2.2. Delays were initially incurred due to staff sickness absence within the CSP and the Chair was unable to speak to anyone from the CSP until 31st March 2022. An explanation for the delay in commissioning and initial progression of this DHR was provided by the CSP: - *'Following notification of the death of Maria, the Chair of the Huntingdonshire Place Based Board acknowledged that the criteria for a DHR had been met. This resulted in an all agency and organisation scoping exercise to establish what information was known or held that related to the victim or her family. At the time, the team responsible for commissioning the DHR were experiencing high levels of staff absence due to prolonged periods of ill health. Alongside the fact that the CSP was operating as part of the Huntingdonshire Place Based Board which had not met for over 12 months following the pandemic. This therefore meant that the DHR was not commissioned as quickly as would have been appropriate and for this, we apologise to the family. To prevent delays being experienced again should a similar situation arise, a number of new measures have been put it place'.*

2.3. Further delays were incurred in receiving the Individual Management Reviews (IMR)s from Cambridgeshire and Peterborough Foundation Trust (CPFT) and Cambridgeshire County Council (CCC) Adult Services, due to ongoing internal investigations in response to the homicide. The CPFT IMR was received by the Chair in December 2022.

2.4. On 1st April 2023, whilst completing the first draft of the report, the Chair was unexpectedly provided 7 media files by Maria's daughter Grace. The media files are one-sided recordings of telephone calls Maria engaged in with professionals, services, Christopher's manager and a work colleague in the days and weeks immediately preceding the homicide. The content of these files required competent translation and transcription by a reputable provider. The Chair made several appointments with a provider commissioned by Cambridgeshire County Council, but the provider failed to keep those appointments. The Chair was advised the service required to be provided by Huntingdonshire CSP, who had no access to a competent, reputable translation service at that time. After an elongated process of negotiations, the Chair sourced a reputable service on behalf of the CSP. There was then a series of further negotiations to obtain and agree estimates, costs and secure a contract. Further delays were incurred by the misdirection of a purchase order by the CSP. The transcripts of the translated media files were finally provided to the Chair on 28th February 2024.

2.5. The initial draft report was disseminated to the Panel members on 1st April 2024 with a deadline for feedback of 30th April 2024. A request to extend the deadline was requested

on behalf of GP Practice 1 and 2, due to an administrative oversight caused by a change in staff. This was duly extended until the 10th May 2024.

2.6. A further Panel meeting was convened on 11th June 2024 to agree a further draft of the report, inclusive of the feedback received by collective agencies to the initial draft. The CPFT representative explained they had not had the capacity to review and respond to the initial draft due to work pressures and requested a further extension to enable them to provide feedback. This was reluctantly agreed when the CPFT representative explained that their organisation would not be able to sign off the final report without an extension being granted. Initial feedback was received from CPFT on 28th of June 2024. A third draft of the report was circulated on 17th July 2024 and further feedback was received from CPFT on 31st July 2024. The final draft was shared with the Panel on 16th August 2024. A further panel meeting took place on 18th September 2024, where some revisions to the recommendations were proposed and agencies committed to providing their amendments. There was a further delay in CPFT providing their amendments which were received by the Chair on 21st November 2024. A final draft of the report was completed on 25th November 2024.

3. CONFIDENTIALITY

3.1. The findings of each review are confidential. Information is available only to participating officers/professionals and their line managers. The pseudonyms for Maria and Christopher were agreed with the family to protect their identity. Maria was aged 59 years at the time of her death and Christopher was 40 years old. They were both Polish nationals.

3.2. It was specified that all information discussed at DHR Panels is strictly confidential and must not be disclosed to third parties without discussion and agreement with the CSP/DHR Chair. The disclosure of information outside these meetings (beyond that which is agreed) would be considered as a breach of the subject's confidentiality and a breach of the confidentiality of the agencies involved.

3.3. The chronologies and IMRs are confidential. All agencies were asked to adhere to their own Data Protection procedures which include security of electronic data. From the outset, all submitted documentation was password protected and categorised as 'Official Sensitive,' in accordance with the Government Protective Marking Scheme (GPMS). Passwords were only issued to those directly involved in the Panel process.

3.4. For ease of reference, all terms suitable for acronym will appear once in full, and also in a glossary at the end of the report. The findings of this review are confidential. Information is available only to participating officers/professionals, their line managers and the respective agencies commissioning professionals and the family and close friends of Maria.

PSEUDONYMS

3.5. The victim's family agreed to choose the pseudonyms for the victim and perpetrator. The Chair chose the names to be used for all other relevant parties, including friends and

associates. The following pseudonyms have been used to protect the identities of the deceased, other parties, those of their family members and the perpetrator:

Pseudonyms:	**Relationship to Maria**	Age at time of incident
Maria	N/A	59 yrs
Christopher	Son / perpetrator	40 yrs
Stephen	Son	N/A
Grace	Daughter	N/A
Rebecca	Maria's close friend	N/A
Susan	Daughter of Rebecca	N/A
Margaret	Christopher's landlady	N/A
David	Boyfriend of Maria	N/A
Jane	Ex-daughter-in-law	N/A
Sean	Grandson	
Peter	Christopher's housemate	N/A
Mark	Christopher's employer	N/A

3.6. The deceased will be referred to herein as Maria. The perpetrator, her son, will be referred to as Christopher throughout.

4. TERMS OF REFERENCE (ToR)

4.1. The purpose for this individual review was discussed with, and agreed by, Maria's daughter, Grace. It was documented in the ToR and shared with all contributing partners. In this particular case, the purpose was:

a) Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations communicate and work individually and together to safeguard victims;
b) 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;
c) apply lessons learned to service responses including any changes to inform national and local policies and procedures as appropriate;
d) prevent domestic violence and homicide and contribute to a better understanding of the nature of domestic violence and abuse;
e) highlight good practice.

4.2. It was also agreed that the review would be conducted in accordance with the following principles:

- To identify and learn lessons, as well as highlight good practice, so that future safeguarding services improve their systems and practice for increased safety of

potential and actual victims of domestic abuse, and identify and control any risks emanating from serious mental health deterioration.

- Not to apportion blame to individuals or organisations, rather, to use the study of this case to provide a window into the system.
- A forensic, non-judgmental appraisal of the system to inform understanding of what happened, the context and contributory factors and what lessons can be learned.
- The review findings will be independent, objective, insightful and based on evidence while avoiding 'hindsight bias' and 'outcome bias' as influences.
- The review will be guided by humanity, compassion and empathy with Maria's voice' at the heart of the process.
- It will take account of the protected characteristics listed in the Equality Act 2010.
- All material will be handled within Government Security Classifications at 'Official - Sensitive' level.

4.3. **Key Lines of Inquiry:** The Review Panel considered both the 'generic issues' as set out in statutory guidance and identified and considered the following case specific issues: -

- 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.
- To produce a comprehensive, honest and balanced analysis of circumstances to inform organisational / agency learning and influence change.

5. METHODOLOGY

5.1 Cambridgeshire Police notified Huntingdonshire CSP of the circumstances of Maria's death in February 2021. The Chair of the CSP instructed that a DHR be commissioned on 24th February 2021. The Home Office was notified of the decision of the CSP on 26th February 2021. Maria's family were informed of the decision to conduct a DHR in November 2021, at the conclusion of the criminal justice process. The Chair was commissioned to conduct a DHR on the 12th January 2022.

5.2 Close attention was paid to the cross-government definition of DV&A and is included in the ToR. The following websites, policies, initiatives and scholarly articles have also been used as reference documents;

- HM Government Strategy for Ending Violence Against Women and Girls 2016-2020
- Multi-agency Statutory Guidance for the Conduct of DHRs published by the Home Office December 2016
- DHRs: Key Findings from analysis of domestic homicide reviews published by Home Office December 2016
- DHR Document Checklist
- Huntingdonshire District Council (HDC) website
- Cambridgeshire County Council website
- Cambridgeshire and Peterborough National Health Service (NHS) Foundation Trust web site
- Cambridgeshire Constabulary website

Mental Health Crisis Care Concordat

Cambridgeshire and Peterborough joint declaration on improving outcomes for people in mental health crisis

Beyond intimate partner relationships: utilising domestic homicide reviews to prevent adult family domestic homicide

Domestic Homicides and Suspected Victim Suicides During the Covid Pandemic

London DHR Analysis and Review

College of Policing Approved Professional Practice

5.3 The police contributors provided some context for Cambridgeshire. In the year ending April 2022, the force attended 14,267 incidents recorded with a 'domestic' identifier (marker). Of those incidents, an average of 36% were classified as violent (threat of assault, assault, injury) and 45% as verbal incidents. National statistics show that DV&A crimes accounted for 18% of all offences recorded by the police in the year ending March 2021.

5.4 Cambridgeshire Constabulary attends, on average, approximately eight hundred incidents a month that have 'mental health markers.' This equates to approximately 7% of all incidents attended by the Constabulary. Statistics for the year ending December 2021 identified close to four hundred incidents, where s136 Mental Health Act (MHA) interventions were considered, or used and managed, by the Constabulary over a 12-

month period. Proportionately, this equates to just over 4% of the mental health incidents attended.

5.5 In addition to the analysis of agency records, the Chair interviewed Maria's daughter Grace, her closest friend Rebecca and Christopher's landlady, housemate and his employer. Their accounts were recorded and shared with the review Panel. The Panel were also provided with access to material contained within some witness statements recorded during the course of the homicide investigation. One sided recordings of telephone conversations Maria engaged in with professionals, a colleague and Christopher's employer were also made available by Maria's daughter and shared with the Panel.

6. INVOLVEMENT OF FAMILY, FRIENDS, COLLEAGUES, NEIGHBOURS AND WIDER COMMUNITY

6.1 From the outset of this review, great care was taken not to retraumatise the family. The Panel were informed that a police Family Liaison Officer (FLO) had engaged with the victim's son Stephen, who was the family spokesperson. In common with all Maria's family, he was resident in Poland. The family had informally appointed Maria's close friend Rebecca as the point of contact with the police homicide investigation.

6.2 The family were informed by the police FLO that a DHR would take place at the conclusion of the criminal justice proceedings in November 2021. At the first Panel meeting on 3rd May 2022, it was unclear as to who would be a single point of contact for the family. The necessary enquiries were made by the FLO and on 26th May 2022, the Chair was advised that Maria's daughter Grace, would be the single point of contact for the family. The Panel was advised that Grace spoke no English and would require any, and all, communication translated into Polish.

6.3 On the 26th May 2022, The Chair approved a letter to be sent to Grace on behalf of the Huntingdonshire CSP. This correspondence expressed condolences to the family for their loss, explained the purpose and process of the DHR and introduced the Chair of the DHR to Grace. Regrettably, there was then a delay incurred in translating this letter into Polish by the council. The translated letter was eventually sent by email to Grace on 16th June 2022.

6.4 As a consequence of there being no initial response to the letter, the Chair wrote a further email on 30th June 2022, requesting confirmation from Grace that she had received the letter sent on 16th June. There was a further delay in translating this message into Polish and the email was sent by the CSP on 4th July 2022. Grace responded directly to the Chair on the 5th July 2022 confirming that she had received the letter and requesting to be kept informed of developments. She stated that she had no questions at that time.

6.5 The Chair maintained email and telephone contact with Grace. During these early interactions supported by the CCC translation service, the Chair explained that some information that was necessary to conduct the review had been withheld due to agencies

conducting their own internal reviews. The Chair has maintained email and telephone contact with Grace, supported by a translator provided by CCC translation services. During those conversations, the Chair has continued to apologise for the delays due to withheld information from agencies, and more recently for the delay in Huntingdonshire CSP translating the media files she provided to the Chair in April 2023, and the extensions to deadlines provided to CPFT to provide feedback on the earlier drafts of the report and proposed recommendations. The Chair explained the ToR, the scope of the review and the rationale. Grace was reassured the family would receive a copy of the report for their consideration and be able to provide any feedback, before publication.

6.6 The Chair arranged for Grace to attend and address the third Panel meeting via Microsoft Teams (MS Teams). This meeting was held on 5th January 2023. Grace was supported by a translator commissioned by CCC translation services. Grace helpfully and eloquently provided the Panel with some deeply moving insights into the life and nature of Maria and her loving relationship with Christopher. Grace has continued to provide significant and valuable information and support to the review with regards to Maria and Christopher's background. She also provided the media files which audit recordings of some of Maria's conversations with professionals and others in the hours, days and weeks preceding her homicide. The Chair and Panel thank her and her family for their courage and contributions to helping protect future potential victims of DV&A and homicide.

6.7 A photograph of Maria was displayed at each Panel meeting, part of the agenda made specific reference to Maria and her family and updates on the family were provided by the police or the Chair.

6.8 Information provided to the review illustrates that Maria was involved in a long-term relationship with David from around 2010, although it is not believed they had been co-habiting together for several years prior to her death. The Chair made telephone contact with David in May 2022 and explained the process and purpose of the review. David expressed some frustration that he had not been kept informed about the circumstances of Maria's death and the subsequent investigation. David told the Chair that he wanted time to consider whether he was willing to engage with the review and agreed he would call the Chair back. David has not called the Chair or responded to several follow up calls and text messages requesting contact.

6.9 Christopher's former wife Jane was also approached by the police, on behalf of the Chair, at the outset of this review. Jane explained to the police that she continued to harbour concerns for her own and her child's safety. She declined to engage with the review on this basis.

6.10 The evidence indicates that the breakdown of Christopher and Jane's marriage resulted in significant dispute between them regarding child access. The evidence also indicates that Family Court proceedings took place with regard to this dispute. The details of these proceedings were requested from the Family Court by the Chair, but the request was refused.

6.11 In October 2022, the Chair made contact with Christopher's responsible clinician, to explore if Christopher would be able and willing to engage with the review. The clinician

explained that engaging with the review could be detrimental to Christopher's mental wellbeing, as he was responding well to psychiatric treatment, but was prone to relapses when discussing any events associated with Maria's homicide. The clinician advised that Christopher was therefore unfit to engage with the review. As a consequence, all background information learned by the review, is based on agency records and/or the accounts of people who knew Christopher, or otherwise came into contact with him.

7. CONTRIBUTORS TO THE REVIEW

7.1 The Review Panel was comprised of agencies from Cambridgeshire, Peterborough and Huntingdonshire where Maria and Christopher had been resident prior to, and at the time of, the homicide.

7.2 A range of local partners and agencies were contacted on the 26 February 2021, shortly after Maria's death to inform them of the potential for the matter to be subject of a DHR. This action was taken by the Huntingdonshire CSP. There were only six initial returns, as follows: -

- Independent Domestic Violence Advisor (IDVA) – No trace.
- Housing – Trace – Maria only.
- Refuge – No trace.
- Probation – No trace.
- Change, Grow, Live (CGL) (drugs and alcohol service) – No trace.
- NHS Primary Care – Trace – Maria and Christopher.

7.3 As a consequence of the limited information available from these returns, the Chair initiated a further scoping request on 30 March 2022 directed to the following organisations/agencies: -

- East of England Ambulance Service NHS Trust. (EEAST)
- Cambridgeshire Constabulary.
- Cambridgeshire and Peterborough Foundation Trust (CPFT) First Response Services (FRS).
- Cambridgeshire County Council Adult Social Care.
- Cambridgeshire County Council Housing Services.
- 111 Service.
- North West Anglia NHS Foundation Trust. (Hospital Services)
- Cambridgeshire and Peterborough Integrated Care Board (ICB). (Primary Care)
- Crown Prosecution Service. (CPS)
- Chorus Housing.
- East of England Immigration Compliance and Enforcement Team

7.4 From this exercise the Review Panel was selected, based on those agencies who held information, those agencies which did not hold information, but may be able to assist and, those needed for legitimacy of the process were also invited.

7.5 Positive scoping responses were received from the below listed agencies, most of whom were 'contributors' to this review: -

- Cambridgeshire Constabulary.
- CPFT FRS.
- Cambridgeshire County Council Adult Social Care.
- Cambridgeshire and Peterborough ICB. (Primary Care)
- Places for People Homes, also known previously as Chorus Homes and Luminous.
- CPS.
- East of England Immigration Compliance and Enforcement Team
- North West Anglia NHS Foundation Trust (NWAFT). (Hospital Services)

7.6 The independence of IMR authors was confirmed and IMRs were commissioned and received from the following agencies/organisations: -

- Cambridgeshire Constabulary.
- CPFT FRS
- Cambridgeshire County Council Adult Social Care.
- Cambridgeshire and Peterborough ICB - (Primary Care).
- Places for People Homes, also known previously as Chorus Homes and Luminous.
- North West Anglia NHS Foundation Trust - (Hospital Services).
- EEAST.

7.7 Expert advice was sought from the following organisations: -

Rethink Carer Support – Provide peer support by carers for carers of adults with mental health conditions. They focus on improving mental health and drug and alcohol support services through enhancing the status and engagement of carers.

Refuge – A domestic abuse organisation empowering women to live free from violence.

7.8 This overview report is an anthology of accounts provided by family and friends as well as information and facts from the agencies and organisations represented on the Panel; most of which were potential support agencies for Maria and Christopher.

8. THE REVIEW PANEL MEMBERS

8.1 The following representatives were agreed as members of the Review Panel. It is the responsibility of the Panel to provide rigorous oversight and challenge to the information presented and to make an honest, diligent, and thorough effort to learn from the past. The Panel members were of the appropriate level of expertise and were independent, having no direct line management of anyone involved in the case.

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 Coultrup	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, Cambridgeshire, Peterborough, South Lincolnshire (CPSL) Mind
Mandy Geraghty	Senior Operations Manager, Refuge
Maxine Matthews	Supervisor Cambridgeshire Constabulary Major Crime Review Team
Sam Hunt	Associate Director of Safeguarding, CPFT

8.2 The review Panel met on 7 occasions during the course of this review. Following discussion of a draft of the ToR at the first Panel meeting, these were issued with key lines of enquiry and chronology/IMR templates for completion. Partner agency IMR authors were briefed on the key lines of enquiry in advance of IMR completion and submission to aid relevant and consistent reporting.

8.3 At that first meeting, the Review Panel considered the brief information about agency contact with Maria and Christopher. The scoping returns demonstrated contact with Maria and Christopher was predominantly with health professionals. Contact between Maria, Christopher and agencies escalated considerably between late January and February 2021, in the period immediately preceding Maria's death.

8.4 It was noted from the scoping returns that there was an absence of any information illustrating 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, associated difficulties in maintaining access to his son and leg pain. As a result, the Review Panel agreed that an appropriate and proportionate time period to be reviewed would be from **1st February 2015 to** the date of Maria's death.

8.5 Where there was relevant agency involvement with Maria or Christopher prior to these dates, agencies were asked to summarise this and review any issues pertinent to the DHR. Significantly, it was established that there had been contact with Maria and

Christopher during the recognised COVID lockdown periods which will be examined during this report.

8.6 No immediate, urgent interventions or actions were identified by Panel members and timescales were set for submission of the Chronologies. Full minutes were recorded, and an action tacking system put in place to monitor actions to be completed. This process applied to all subsequent meetings.

8.7 It was agreed by the Panel that should any issues of concern be identified by any person involved in the DHR, which fell outside of the agreed timescales, then these could be brought to the Panel for discussion relating to relevance.

8.8 Once all chronologies were received, a further Panel was convened and used the opportunity to comprehensively discuss the information that had been identified. As a result of these discussions and analysis conducted, IMRs, from those agencies who had contact with either Maria or Christopher during the Review timeframe were commissioned.

8.9 A number of Agencies then compiled IMRs, and submitted these to the Chair and Panel for discussion at the subsequent Panel meetings. Each of these IMRs was compiled by an independent author. Comments were sought from all agencies, via a feedback loop to the Chair, to inform analysis and the writing of an initial draft of the overview report. There were delays in the submission of IMRs by CCC Emergency Duty Team (EDT) and CPFT. These IMRs were submitted on the 5th September 2022 and 6th December 2022 respectively.

8.10 A further Panel meeting took place in January 2023 to consider the information contained in the IMRs submitted by EDT and CPFT, as well as additional background information provided by the ambulance service, with regards to an event on 14th February 2021. The Panel directed that further background information required to be provided by Cambridgeshire Constabulary with regards to events reported to the police in January and February 2021. The Chair also committed to make further enquiries with the 101 service as a consequence of disparities between agency records and the accounts provided by Maria's friends and family.

8.11 As outlined, further information, in the form of media files, was provided to the Chair by Grace, the daughter of Maria on the 1st April 2023. The translated transcriptions were finally provided to the Chair on the 28th February 2024.

8.12 A further Panel meeting was convened 11th June 2024 to consider an initial draft report and agree recommendations, but this was subject to a request from CPFT to extend the deadline for feedback until 28th June 2024. A further draft was circulated on 17th July 2024 and further feedback was received from CPFT on 31st July 2024. A further draft of the report was considered at the Panel meeting on 18th September 2024 where amendments were proposed to recommendations which agencies committed to provide. Amendments proposed by CPFT were received by the Chair on 21st November 2024.

8.13 The finalised report was agreed on the 18th September 2024 by the DHR Panel and an Executive Summary Report produced. An appropriately redacted report had previously been presented to the CSP Standing Panel on 17th July 2024.

8.14 Due to the significance of information known to agencies from combined chronologies, the author has taken the decision to detail the merged timelines and information known to agencies in a comprehensive chronology in section 14. There is significant, relevant and cumulative information which clearly illustrates, and gives context to, a sudden, rapid and serious decline in Christopher's mental wellbeing towards the end of January 2021.

9. AUTHOR OF THE OVERVIEW REVIEW REPORT

9.1 Sections 36 to 39 of the Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews December 2016 sets out the requirements for review Chairs and Authors. In this case, the Chair and Author was the same person.

9.2 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 Crime, 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 has experience of working with diverse communities. He was a trained overt and covert SIO and a practitioner and advisor for achieving best evidence interviews.

9.3 SH worked across a number of Public Protection and Safeguarding portfolios in the north of England, managing and overseeing MAPPA[3] and MARAC[4] processes. SH also had overall strategic and operational command of multiple incidents and investigations including those involving domestic abuse and homicide.

9.4 SH has completed the Advocacy After Fatal Domestic Abuse (AAFDA) training and maintains continual professional development through the monthly AAFDA DHR network training events. He 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 (OWHRs)[5] on behalf of the Home Office. This training has been provided to over 90 delegates, comprising of OWHR Chairs and Authors and key

[3] 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.

[4] MARAC is a multi-agency meeting which facilitates the risk assessment process for individuals and their families who are at risk of domestic violence and abuse. Organisations are invited to share information with a view to identifying those at "very high" risk of domestic violence and abuse. Where high risk has been identified, a multi-agency action plan is developed to support those at risk.

5 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.

local authority, police and health personnel. There is an extensive input on safeguarding and equality and diversity included in these training inputs.

10. PARALLEL REVIEWS

10.1 A Serious Incident (SI) Review was carried out to examine the care and treatment provided to Christopher by CPFT from the point of the referral of Christopher to this service on 1st February 2021.

10.2 The Coronial Inquest into the death of Maria was suspended pending the outcome of the criminal justice process and this DHR.

10.3 At the first Panel meeting on the 3rd May 2022, a discussion was had to identify any prior DHR reports within the local area which may contain lessons learnt pertinent to this review. CSP records were examined and the DHR into the death of Sally, in August 2015,[6] was thought to be worthy of consideration given some similarities in regards to the mental illness suffered by, and the treatment provided to, the perpetrator in that case. This agenda item remained throughout the Panel meetings and was regularly reviewed.

11. EQUALITY AND DIVERSITY

11.1 The Chair and the Review Panel considered the nine Protected Characteristics under the Equality Act 2010 during the DHR process in evaluating the various services provided and these have been regularly revisited throughout the review. The below is a synopsis for each category:

<u>Age:</u>

11.2 Maria was a 59-year-old woman and her son Christopher was 40 years old at the time of her death. From the Home Office Analysis 2021, the proportion of victims and perpetrators was examined in different age ranges. Studying the age of victims showed that Maria was in the 3rd age range (50-59 yrs = 18%) with a likelihood of victimisation. An estimated 28.4% of women aged 16 to 59 years have experienced some form of DV&A since the age of 16 years (Office of National Statistics, 2019). The Protected Characteristic of age is not considered relevant to this review.

<u>Disability:</u>

11.3 The Equality Act 2010 defines disability as: "A physical or mental impairment' that has a 'substantial' and 'long-term. negative effect on a person's ability to do normal daily activities.' There is no information to suggest Maria fell into this definition relating to physical disability; however, records and accounts indicate that she suffered mental health problems including depression, stress and anxiety from as early as 2013.

11.4 There are accounts and records to show Maria was prescribed antidepressant medication from as early as 2014 and was first referred to mental health services in May 2016, after

[6] DHR Overview Report - Death of Sally

expressing thoughts of self-harm. She was further referred to mental health services on a number of occasions between September 2017 and April 2020, for anxiety and low mood. She was discharged by mental health services, due to the onset of the Covid 19 pandemic and staff re-deployments, in April 2020. CPFT reported that Maria was appropriately assessed as being safe to discharge in these circumstances.

11.5 The first concerns regarding Christopher's mental wellbeing were relayed during a GP consultation in July 2016, when he told the GP that he sometimes felt like ending his own life. He denied he would act on these thoughts, but was diagnosed with signs of depression in February 2017 and prescribed a single course of antidepressant medication. The Review Panel identified that the Protected Characteristic of disability required appropriate consideration.

Gender reassignment: Not Applicable to this Review.

Marriage and civil partnership:

11.6 Maria was a widow and unmarried at the time of her death. Christopher was married to Jane in 2010, but their marriage had broken down by 2016. Christopher and Jane had a son in 2011 and their marital breakdown caused disputes between them regarding child access. There is evidence this had a profound impact on his mood and overall mental wellbeing. This was cited by him when he initially expressed thoughts of self-harm to his GP in July 2016.

11.7 Christopher's marriage was relevant to this review. Information from relatives, friends and professionals indicate that his mood and depression was primarily connected to the breakdown of his marriage and access to his son. Maria was directly impacted by his marital breakdown as she sought to support him in establishing and maintaining access to his son, her grandchild, whom she loved dearly. The review panel determined that marriage was relevant to the review.

Pregnancy and maternity:

11.8 Maria had five adult children from two marriages. Both her husbands died prematurely from illnesses, prior to Maria migrating to the UK. At the time of her death, only Christopher remained in the UK, all of her other children were resident in Poland.

11.9 As outlined, Christopher had a son who was born in 2011 and resided locally with his mother. There is no suggestion that pregnancy or maternity has any bearing on this review.

Race:

11.10 Maria and Christopher were economic migrants of Polish origin. In accessing services this presented potential challenges with language, interpretation and understanding. The Panel noted that there were significant issues to consider as to how their Polish origin impacted on their ability to engage with, understand and access services and, as to how their heritage might have affected service perspectives of them and the corresponding quality of service they were provided. There is some evidence that Maria was discriminated against as a consequence of her non-English speaking ethnic background by one service, which is further described in the analysis sections of this review. The protected characteristic of Race was considered to have a bearing on this review.

Religion or belief:

11.11 Maria and Christopher are believed to have been Roman Catholic. In the weeks and days preceding the homicide, Christopher made a number of religion-based references, inferring he was speaking to God and accusing Maria of summoning the devil. He told police that God told him to ask for a cup of tea at a random house he knocked at the door to. Whilst he made several religious based statements in the weeks and days prior to the homicide, the Panel takes the view this was associated with his mental illness rather than any sinister religious fanatism on his part. Religion was not considered relevant to the review.

Sex:

11.12 Sex always requires special consideration. Maria was female and her son Christopher is male. Crime Survey of England and Wales (CSEW) data showed that 1.7 million women experienced DV&A during 2021, which equates to 7 in 100 women. Women are more likely to experience repeat victimisation, be physically injured or killed and experience sexual violence and abuse. Two in every three victims of DV&A are women. DV&A is a hidden crime and it is estimated that less than 24% of DV&A crime is reported to police. As a woman, Maria was statistically more likely to be a victim of DV&A.

11.13 There is no information that suggests Maria had ever been subject to physical, or any other form of, abuse by Christopher. In contrast, there is substantial evidence of them sharing a close, loving and mutually supportive relationship.

11.14 From an examination of DHRs, Home Office records show that the majority (80%) of victims of domestic homicide were female and for perpetrators 83% were male. Extensive analytical studies of domestic homicide in reviews reveal gendered victimisation across both intimate partner and familial homicides. Males represent the majority of perpetrators. Females represent the majority of victims.

11.15 The Panel agreed that the Protected Characteristic of sex be given appropriate consideration during this review.

Sexual orientation:

11.16 The sexual orientation for each is believed to have been heterosexual and has no bearing on this review.

Intersectionality:

11.17 Intersectionality was discussed at length during Panel meetings. In simple terms, intersectionality describes the ways in which systems of inequality, based on any of the protected characteristics, and/or class and other forms of discrimination, “intersect” to create unique dynamics and effects. In this case, Maria and Christopher’s Polish heritage and mental ill-health contributed a unique set of characteristics.

11.18 Records and accounts indicate that interpreters were not consistently used by professionals engaging with Maria and Christopher. There was a parallel disparity of professional opinion on the abilities of Maria to adequately express and understand the English language, which was not her first language. On occasions, there is evidence that this undermined professional's understanding and accurate recording of Maria's

communications and their assessments of her own and Christopher's situation. On these occasions, there was a corresponding absence of attention given to ensuring Maria understood, and was able to act on, the professional advice offered on what support was available to her. In parallel, Christopher's limited command of the English language was an impediment to him initiating and maintaining friendships and relationships. This contributed to him becoming more socially isolated after the breakdown of his marriage.

Other factors discussed of Note

Unconscious Bias:

11.19 The Panel have discussed whether there is evidence of differential service or 'conscious/unconscious bias' from any public body for anyone subject of this report. There is evidence illustrating one service discriminated against Maria by declining to offer a service, at least partially, on the basis of her non-English speaking background. There is no evidence that this extended to other practitioners responding to Maria and Christopher. There is evidence of inconsistent use of interpreter services which appears to have undermined professionals, and Maria's own, understanding of information relayed. Any intersectionality of the applicable protected characteristics will be explored in the context of the report.

Victim blaming:

11.20 This has been increasingly researched and is now understood in a much wider context within society and professional organisations. Victim blaming can be identified as the following: -

- Blaming the victim occurs when people hold the victim responsible for his or her suffering. When people blame the victim, they attribute the cause of the victim's suffering to the behaviours or characteristics of the victim, instead of attributing the cause to a perpetrator or other situational factors.
- Ironically, victim blame often stems from a desire to see the world as a just and fair place where people get what they deserve. This belief in a just world lets people confront the world as though it were stable and orderly.
- By derogating victims and blaming them for their negative outcomes, people can maintain the belief that the world is a fair place after all.

12. DISSEMINATION

Huntingdonshire CSP.
Cambridgeshire Police and Crime Commissioner.
Domestic Abuse Commissioner.
Maria's family (Polish translation).
All Agencies involved in the review.

13. BACKGROUND INFORMATION (THE FACTS)

13.1 This review relates to Maria's homicide that took place in her one-bedroom flat in a small town in Huntingdonshire in February 2021. Maria had lived in the flat since 2014 and, in the week prior to her death, she had periodically accommodated her son Christopher at her home, as a consequence of him being evicted from his previous residence the week beforehand. The police case summary represents the sequence of events as they occurred on the day/evening of the homicide.

13.2 On a day in February 2021, Christopher visited several shops in the local area claiming he had won the lottery. On one occasion the police were called to a local convenience store, where it was alleged, he had consumed a beer without paying for it. The police spoke to Christopher and his mother Maria, who had been called by the shopkeeper to assist in resolving the issue. The police were satisfied there were no criminal offences and Christopher left on the direction of the police. An adult at risk referral form[7] was submitted by the responding officers to the Multi Agency Safeguarding Hub (MASH) [8] due to concerns for Christopher's mental health and welfare.

13.3 Later the same evening, sometime between 20.30 and 21.00 hrs, Maria returned to the shop and purchased some cigarettes. This was captured on CCTV and was the last known sighting of her.

13.4 The next morning at 07:22 hrs, Christopher attended the convenience store again. The shop assistant noticed that his trousers and shoes were covered in blood and called the police to report the matter. They informed the police call handler that their call related to the same man who was taken away from the same shop by police officers the previous evening.

13.5 When the police arrived at the store, Christopher walked towards their vehicle. He began speaking to the officers in broken English saying he just wanted beer. Police noted blood staining on his clothing and footwear and initially thought he had self-harmed, but could see no obvious, visible injuries. He was also behaving in an odd manner, but was not threatening. One of the officer's described Christopher was, 'just staring through' him. The officers were concerned that he may have been suffering from a mental illness.

13.6 The officers attempted to speak to him to establish who he was and what had happened. Christopher appeared to believe this line of questioning referred to the blood on his clothing and footwear and he said to the officers, "*Come with me, I show you*." He then walked away and the officers followed him for a short distance until he entered a nearby block of four flats, via a communal entrance door. The officers asked him where the blood on his clothing had come from, whereupon he pointed to the communal stairway of the flats and said, "*He told me to do it*." The officers noted that there was no other person present in the vicinity of where Christopher was pointing.

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[7] The submission of this referral alerts community safety partnership agencies to safeguarding and welfare concerns through the MASH

[8] MASH is a team which brings together agencies (and their information) in order to identify risks to vulnerable people at the earliest possible point and respond with the most effective interventions

13.7 Christopher then entered the ground floor flat and beckoned the officers to follow him inside. They could see into the kitchen area and saw dismembered human body parts wrapped in polythene. Christopher told the officers words to the effect of "*It's the devil. Bad lady"* and '*It's my mum*." He was arrested on suspicion of murder and replied, "*Yesterday I killed my mum."*

13.8 He was taken to the police custody facility. As a consequence of his demeanour and behaviour and, in accordance with the Police and Criminal Evidence Act (PACE) Code of Practice, the police sought immediate support, advice and guidance form mental health professionals. This determined that Christopher was fit to be detained, but that he was unfit to be subject of a police interview. It was further determined that he should be transferred out of police custody as soon as practicable and detained in appropriate, secure accommodation. A murder investigation, managed by the Bedfordshire, Cambridgeshire and Hertfordshire Major Crime Unit was commenced.

13.9 In accordance with the direction given by the mental health professionals, Christopher was not interviewed by the police and was later charged with the murder of Maria.[9]

13.10 Forensic examination and pathology confirmed that the remains found in the flat were of Maria. The exact time and cause of death was not established, but it appeared likely this occurred sometime between the late the previous evening and the early morning prior to Christopher's arrest. During the post-mortem examination, Maria was noted to have suffered some defensive wounds indicating she was attacked with a bladed weapon. The pathologist observed that it was probable that the fatal wound was inflicted to her neck area, although the exact cause of death was unascertained.[10]

13.11 The police investigation established that Christopher had been residing at his mother's address for one week, due to his eviction from his previously rented accommodation for failing to pay the rent. He was signed off sick from work and was associated to two recent incidents of attempted residential burglaries and a shoplifting allegation, each of which was reported to the police. It was also established that between the 20th and 21st February 2021, Christopher made 7 emergency services 999 calls, 3 of which were to the police. He also made a further call to the police 101 non-emergency service.

13.12 Telephone analysis conducted by the investigation identified a text message from Christopher's to Maria's phone at 10.25 hrs on the morning prior to the homicide. The message was written in Polish and is translated as, '*It's coming*.'

13.13 There were no recorded domestic incidents on police systems between Maria and Christopher prior to this event.

13.14 In November 2021, Christopher was tried for Maria's murder at Cambridge Crown Court. He was found not guilty by the jury by reason of insanity. Christopher was made subject of an indefinite Hospital Order with a section 41 restriction. In summing up the evidence at the trial, the judge made the following observation to the jury in respect of Maria, *"You*

[9] Police Case Summary
[10] Post-Mortem report

know that she tried to get help from social services, from her GP, by dialling 111, and she tried to get help from the police. None of those agencies gave her the help that she sought."

14. CHRONOLOGY

Background Information on Victim and Perpetrator

14.1 The following part of the report combines elements of the background, overview and chronology sections of the Home Office DHR Guidance overview report template. The narrative is told chronologically to give background history of Maria and Christopher prior to and including the timescales under review stated in the ToR. It is built on the lives of Maria and Chritopher to give context to their story. It is punctuated by subheadings to aid understanding.

14.2 Evidence provided to the review demonstrates Maria and Christopher had a mutually loving and supportive relationship. 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 22nd January 2021.

14.3 Maria's strong and enduring love and support for Christopher, following the breakdown of his marriage and associated onset of his depression, is clear and obvious from the evidence provided to the review. Her growing concern for his abrupt, rapidly declining mental ill health and her tireless efforts to secure professional help for him, in the days and weeks prior to her untimely death, is similarly, clearly evident from the accounts and records provided to the review.

The Victim

14.4 Maria was born in Tyszowce, Poland in 1961 and spent her childhood growing up in an orphanage in a town called Cieszyn. Maria was the youngest of nine children and, as a consequence of 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.

14.5 In spite of these early challenges, Maria worked hard in school and qualified as a shoemaker. She left the orphanage when she was 18 years old and married her first husband. The marriage broke down when Maria was about 25 years old, leaving her with 3 young children to care for. She married her second husband, whom she had 2 further children to, but her second husband was reportedly abusive to her and she divorced him, leaving her with 5 young children to care and provide for.

14.6 Maria worked in a shoe factory when her children were very young, but she was eventually forced to stay at home, in order to look after her children, as a consequence of her marital breakdown. She cleaned other people's houses to provide for her children. As the children grew older, she found work as a cleaner in a sports facility. She was described as diligent, punctual and truthful by her former employers in Poland.

14.7 Maria raised all of her children on her own, without any support from their fathers. She was described as a strong woman who looked after and protected all her children. She provided her children all the support they required and was described as a wonderful and loving mother who did everything she could for her children.

14.8 In 2009, Maria came to England for a vacation to visit her two eldest sons, Stephen and Christopher, who had both migrated to England for economic reasons. She decided to stay and initially resided with both Stephen and Christopher, before finding her own accommodation in the St Ives area of Cambridgeshire. According to her daughter, Maria was planning to return to reside in Poland permanently.

14.9 Both of her former spouses were deceased when Maria left Poland, but she was in good health and would regularly go running and boxing to maintain her fitness. She kept in close contact with all of her children on a daily basis, 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.[11]

14.10 Soon after arriving in England, Maria sought and found employment at a chocolatier outlet where she met her close friend Rebecca, a fellow Polish national, who lived in an adjoining county. Over the following years, they maintained a close friendship and Maria would speak to Rebecca on the telephone most days. Maria did not speak English well and Rebecca supported her translating English. Much of Rebecca's support in this regard involved Maria's interactions with housing services.

14.11 Whilst Maria was physically healthy and was described as a happy and kind person, her home had a significant and obvious, detrimental impact on her mood. She lived in a one-bedroom flat in a multi-occupancy block with other residents, one of whom continually prevented her from sleeping, due to noise they made throughout the night. With Rebecca's support this was reported to the council on multiple occasions over a substantial period of time.

14.12 Maria was similarly distressed that her home was surrounded by fences and large trees, which caused her to feel uneasy and she was later diagnosed with claustrophobia. She told Rebecca that she always felt there was something wrong with the house, as though there was a dark presence there.[12]

14.13 Maria worked in a number of roles including at a restaurant as a cook and at different factories in the Cambridgeshire area. Her most recent employment was working at a Huntingdon based factory.

14.14 According to her daughter, Maria never intended to stay in England as long as she did, but the breakdown of Christopher's marriage and the associated child access challenges caused her to remain to support him. Grace described that Jane prevented Maria from seeing her grandson after she and Christopher separated. This had a significant impact on Maria as she was used to seeing her grandson regularly and loved him dearly.[11]

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[11] Account of Maria's daughter Grace
[12] Account of Maria's close friend Rebecca

14.15 Around 2010, Maria formed a relationship with David, a Ugandan national, whom she met in the local area. Police records describe Maria and David set up home together around 2010. In May 2014, Maria moved into the flat where she lived until the date of the homicide.[13] David moved out in 2017, but reportedly retained a close relationship with Maria up until the time of her homicide.[14]

14.16 Maria suffered enduring mental ill-health. As early as 2013 she reported low mood and stress to her GP. Over the years, this was recurrent and, on occasions, escalated and appears to have been primarily associated to her anxieties regarding her housing. She was referred to secondary mental health services in May 2016, after disclosing thoughts of self-harm and taking her own life to her GP. Maria also made reference to childhood trauma when describing the impact of her accommodation on her mental wellbeing,[15] but there is no further information in relation to this.

14.17 Housing records describe that Maria indicated that the people she lived with before she was allocated her flat behaved negatively towards her, although there is nothing which illustrates the nature of this negativity or the identity of those concerned.

14.18 Maria's residence was a ground floor, one bedroom flat contained within a block of four flats. Medical records indicate that she had asked her son to move into her flat with her in May 2016. This would coincide with the period when Christopher's marriage to Jane broke down, although Maria told her housing provider that it was Stephen who had moved in with her.[13] The records indicate this remained the position until December 2016, when Maria told her GP that her son had moved out of her property.[16]

14.19 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.[17]

14.20 Christopher's landlady, Margaret described Maria as being blunt, but reflected that this could have been a misinterpretation on the basis of her not speaking English well. Margaret clashed with her and Christopher during COVID lockdowns due to their lack of compliance with lockdown rules. Maria provided accommodation for Christopher at her residence, after he was evicted from his lodgings, the week before her death.[18]

14.21 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. She relied heavily on her friend Rebecca to translate on her behalf when dealing with authorities.

14.22 Maria was a determined provider to all of her children. It is clear she endured a difficult childhood and adolescence, but she overcame the many, substantial challenges she faced throughout her life, to provide for, and take care of, her children. In spite of her

[13] Housing Records
[14] Cambridgeshire Constabulary IMR
[15] CPFT Records
[16] GP Records (GP Practice 2)
[17] Account of Maria's close friend Rebecca
[18] Account of Christopher's landlady Margaret

challenging upbringing, she was described as positive and gave unconditional support to those needing her help.[19]

14.23 Maria had no criminal convictions in the UK or Poland.

The Perpetrator

14.24 Christopher is the biological son and second eldest child of Maria. He came to England as an economic migrant in 2007. He has no criminal record in the UK, but reportedly has historic convictions for criminal damage and burglary in Poland.[20] No further information with regards to the nature or background of these convictions has been provided to the review.

14.25 His sister described him as a very quiet person who didn't really show any emotions. She recalled he was born prematurely and that Maria was only seven months pregnant at the point of his birth. Despite this, he had a healthy childhood and there were no health problems. Maria had divorced Christopher's father, who later died, when he was still quite young.

14.26 He never had any mental health illnesses and didn't have any problems with alcohol or drugs to Grace's knowledge. She recalled knowing that he was a good boy when he was at school, he was very clean and tidy and never caused Maria any problems. She described he was very calm and well-mannered in general and recalled that he never used profane language. Grace described that he loved Maria unreservedly and wasn't able to understand how or why this had happened.

14.27 Christopher finished college and qualified as a mechanic and did his national service in the Army when he was 19 years old. He moved to England around 2007, to join his older brother Stephen, who was then working in England.

14.28 On arriving in England, he met Jane through social media. Jane is also a Polish migrant who continues to live locally with her son. He married Jane in 2010 and they had a son together in 2011. Grace indicated his marriage broke down around 2015 or 2016.[21]

14.29 Police records describe his marriage to Jane had broken-down by the time their child was aged 4 years. After this, Christopher reportedly started drinking heavily and this behaviour appears to have distanced him further from his estranged wife, leading to significant disputes between them concerning access to their son.[20]

14.30 In July 2016, Christopher attended a GP consultation for leg pain, associated to him suffering from varicose veins. At the end of the consultation, he told the GP that he sometimes felt like killing himself. He explained that he wouldn't follow through with these thoughts and that his low mood was linked to his marital breakdown, lack of access to his son and the pain in his leg. There is no evidence to indicate that Christopher suffered any episode of mental illness prior to this consultation. Similarly, there is no known familial history of mental illness.[22]

[19] Account of Maria's close friend Rebecca
[20] Police IMR
[21] Account of Maria's daughter Grace
[22] Account of Maria's daughter Grace

14.31 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.

14.32 In February 2017, Christopher attended another GP consultation and reported low mood linked to his marital breakdown and challenges with child access. He was diagnosed with signs of depression and prescribed a single course of antidepressants. This diagnosis coincided with a short-term spike of further incidents, reported to the police by Jane, with regards to him attempting to gain access to their son without her consent. These incidents are discussed in more detail in the chronology and analysis sections of the review.

14.33 Medical records indicate Christopher remained on sick leave as a consequence of his varicose veins throughout the rest of 2016 and up until September 2017.

14.34 The evidence indicates that his initial symptoms and eventual diagnosis of depression, between July 2016 and February 2017, was an isolated event of mental ill-health. There is no evidence that he suffered any other, or further episodes of, mental ill health until January 2021.

14.35 Maria told Rebecca that the difficulties in maintaining access to his child had caused Christopher to become depressed. She also described that he and Jane smoked marijuana recreationally and that he'd inherited a debt to a local drug dealer when their marriage broke down. As a consequence of his efforts to repay this debt, he had little money left from his earnings, which undermined his capacity to sustain himself, and Maria often had to provide financial support to Christopher.[23]

14.36 The disputes with his estranged wife over child access continued for several years, during which time he was reportedly allowed only limited, supervised contact with his son, as directed by Family Court proceedings. There is evidence that his lack of contact with his child frequently brought him into conflict with Jane and was a contributing factor to his diagnosis of depression by his GP.

14.37 Maria told Rebecca that Christopher was a good man and a good husband and father and that he was very quiet and sensitive. She described that he worked hard for his family, but that when he suffered with varicose veins, he was unable to work for a period of time and money became scarce. Maria said that she thought his wife believed she could find someone better than him and left him during the period he was unable to work.

14.38 Christopher was employed consistently from when he arrived in England, but his long-term episode of ill-health associated with varicose veins, prevented him working and reportedly impacted on his financial viability between 2016 and 2017. He didn't have the resources to engage legal representation to challenge his wife regarding her denying him

[23] Account of Maria's close friend Rebecca

child access. Maria helped him financially to contest the matter in court. Maria said the situation added to Christopher's depression.[24]

14.39 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.[25]

14.40 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.[26]

14.41 His former landlady described that he lived with her for approximately 2 years, until the weekend prior to the homicide. She said he lived in the street adjacent to her home beforehand. She described him as an ideal tenant who was clean, tidy and hardworking. 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.

14.42 Margaret recalls that he loved Maria dearly and that he was a good cook and would prepare Sunday lunch for Maria every week. She described him being a quiet man, who kept himself to himself and didn't speak English well. He frequently listened, and danced, to music on his headphones and was flamboyant in his dress and eccentric in his nature. He spoke a lot about friends, but Margaret never really knew of any close friends. He didn't have a girlfriend, although he tried very hard to have a relationship, but struggled because of his English language deficiencies. Margaret described that he paid a lot of attention to his appearance and the style of clothes he wore.

14.43 Margaret recalled seeing him get angry, but described he was mostly meek and mild. During the COVID pandemic, he was verbally aggressive to Margaret because she objected to him bringing his son and Maria to the house in lockdown. She also heard him being verbally aggressive to his mother on the telephone, but reflected that he was never aggressive to her in person, when she was there.

14.44 Margaret met Christopher's wife Jane, when his son came to visit him. She recalled Jane once saying to her that Christopher was 'mad,' but she was never provided any rationale for this statement and Margaret didn't take it seriously.

14.45 Margaret described having a friend who had a close relative who was diagnosed with schizophrenia, she explained that her friend had experienced, at first hand, the symptoms of this mental illness over a long period of time. Margaret said her friend met Christopher early in his tenancy and then told her that something wasn't right with him. She advised Margaret to put a lock on her bedroom door. Margaret initially ignored her friend's advice as she had no reason to be concerned about Christopher.[27]

[24] Account of Maria's close friend Rebecca
[25] Account of Christopher's manager Mark
[26] Cambridgeshire Constabulary IMR
[27] Account of Christopher's landlady Margaret

14.46 Margaret's other tenant, Peter described him as the ideal housemate. He recalled he was very quiet, tidy and polite. He noted there was a language barrier, as he didn't speak good English, which prevented Peter getting to know him particularly well. He alluded to his love of music and described he would often have his headphones on and be singing along and dancing to music in the house. Peter noticed this mostly in the kitchen as Christopher liked to cook and would have his music playing at the same time.[28]

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

14.48 In late 2020 and into January 2021, Margaret noticed Christopher's behaviour started to grow increasingly strange. He suddenly stopped going to work and kept telling her that he was on holiday, she described this went on for several weeks. He also started drinking vodka, and would drink all weekend. She said he would drink vodka from early in the morning.

14.49 He started to continually wear a fleece with the hood up and would have his earphones in. He would be continually talking and laughing, as if he was having a telephone conversation with one of his friends, but Margaret suspected he was talking to himself. Other times, he would be completely and uncharacteristically silent. At times, he would be dancing without any music on and he stopped eating as he normally would. Margaret described finding it very strange being in the kitchen with him when he was talking away to no one.

14.50 He started to light candles all around his bedroom and would leave them burning when he went out, which Margaret told him was dangerous and asked him to stop. He would also get up for a cigarette in the night and leave a candle burning in the kitchen when he went back to his room. He later adorned his room with fairy lights which Margaret described as looking like a grotto. She subsequently evicted Christopher for non-payment of rent and growing concerns for her own safety.[27]

Combined narrative chronology

14.51 This overview comes from a collective of family, friends, work colleagues, agency records and other accounts and from statements given to police. Maria's diary entries and one-sided recordings she made of telephone conversations she had with individuals, professionals and services have also provided insights. Some of these recorded conversations are entirely in Polish and have been translated to English. Some recordings are partially in Polish and some recordings are in English, which have also had to be translated. The translation service preparing the transcripts of the recordings noted that Maria spoke, *'very poor English which was not grammatically correct and was difficult to understand.'* The time and date of each of the recordings of these telephone

[28] Account of Christopher's housemate Peter

conversations cannot be accurately established, but the content of the conversations provide clear indication as to the dates and the parties engaged on the calls.

14.52 This section of the report seeks to chronicle the evidence provided by the respective witnesses and takes account of the criminal investigation. The chronology is presented initially to assist with an understanding of what family, friends, colleagues and agencies knew at different times, before thematic analysis is considered.

14.53 This section also describes audited contacts that Maria and Christopher had with various agencies during the review period 01/02/2015 to 22/02/2021. There is also a brief summary of significant contacts with agencies for Maria prior to the commencement of the review period. Analysis of service engagement and responses is included in the Analysis at section 16 of this report.

2007: (Source - Grace) Christopher came to England as an economic migrant to join his brother Stepen who was working in England at that time.

2009: (Source - Grace) Maria travelled to England for a holiday, primarily to visit Christopher and his elder brother Stephen. Maria decided to remain and seek employment. She initially resided with both Stephen and Christopher for short periods, prior to finding employment and her own accommodation.

2010: (Source - Grace) Christopher married Jane, a fellow Polish national, whom he met on social media.

2011: (Source - Grace) Christopher and Jane had a child called Sean together.

2013 – 15: (Source - GP Practice 2) As early as 2013, Maria reported stress and low mood, primarily associated with her housing issues. She was prescribed antidepressants. There were noted difficulties in her understanding of English by the GP practice and appropriate measures were put in place to manage this.

May 2014: (Source – Housing Records) Maria moved into her home which was the scene of the homicide.

1st February 2015: Review Period Commences.

May – Nov 2015: (Source - GP Practice 1). Christopher was treated for leg pain. The record indicates he was supported by an interpreter during consultations.

2015 – 2016: (Source - Police IMR) Christopher's marriage to Jane broke down around this time period.

2015 – 2016: (Source – Rebecca) Christopher was unable to work due to his varicose veins for a period around this time. This contributed financial hardship to his family and Maria said that his wife had left him as a consequence.

Oct – Dec: (Source - GP Practice 2) Maria requested support from her GP to challenge the refusal by her housing providers to re-house her. She also reported bruised ribs from a fall at

work. There is no further information regarding this or evidence of routine enquiry. She said her son was living with her.[29]

2016

March – June: (Source - Housing Records) Maria's application to be re-housed on medical grounds was refused by her housing provider.

April: (Source - GP Practice 2) Maria requested a letter from the GP in support of her housing situation.

16th May: (Source - GP Practice 2) Maria expressed thoughts of self-harm and suicide and was referred to Mental Health Services. She said she'd asked her son to move in with her.[30]

May - June: (Source - GP Practice 2) Maria was seen at mental health clinic. She reported continuing concerns regarding her housing. She continued to be prescribed antidepressants.

15th July: (Source - GP Practice 1) At the end of the consultation for his leg pain, Christopher told the GP, "Sometimes I feel like killing myself." He expressed sadness from the pain he was suffering in his leg and his separation from his wife and child. The GP invited him to return for a further consultation to discuss his mood. Interpreter support was provided during this consultation and the record documented a requirement for him to be supported by an interpreter for all consultations from this date onward.

19th July: (Source - Police IMR) Jane contacted police and reported Maria, Christopher and Stephen went together to watch Sean's swimming lesson in breach of child access arrangements. After the lesson, Sean ran to Maria and hugged her and she passed him to Christopher. Jane objected to Christopher having physical contact with Sean and a scuffle ensued. Maria alleged Jane assaulted her by forcing her arms apart. The police assessed reasonable force was applied by Jane and no crime was recorded for this incident. Jane also retrospectively alleged Maria attended her son's swimming lesson 3 days previously. She also reported Maria and Christopher had been to her workplace the week beforehand, where they were verbally abusive to her regarding child access.

Police recorded a 'verbal domestic incident'. A Domestic Abuse Stalking Harassment (DASH) assessment[31] was completed in respect of the collective of incidents which indicated standard risk. Maria was advised to seek legal advice concerning access to her grandson. There was no indication of referrals to other agencies.

31st July: (Source – Police IMR) Jane reported Maria attended a swimming lesson insisting on seeing her grandson. Maria was joined by Christopher and they followed Jane and her son. Jane called police fearing they would abduct her son.

[29] The identity of the son living with her was not documented in the record
[30] She later told her housing provider that Stephen moved in with her because of her depression.
[31] DASH is a risk assessment tool that helps calculate the level of risk to a victim.

No police resources were immediately available to attend and Jane was visited at home that evening. Christopher was present when police attended and Jane explained she had agreed pre-arranged access to her son, but resented contact outside of that arrangement.

Police determined there were no offences. The incident was recorded as a ‘verbal domestic’ and a DASH assessment indicated standard risk. No referrals were made to other agencies.

11th Aug: (Source - GP Practice 1) Christopher reported ongoing leg pain and low mood. He spoke to the same GP as his previous consultation and was prescribed analgesic medication. The GP made several attempts to discuss his mood with him, but he refused to discuss this without providing any explanation.

26th Aug: (Source - GP Practice 1) Christopher presented with leg pain and requested more time off work. He was diagnosed as suffering from work-related stress. He asked for advice from the GP regarding a letter he’d received from his employer, terminating his employment due to prolonged absence from work. The GP signposted him to the Citizen Advice Bureau. There is no information related to his mood, which he reported as being low in a GP consultation 2 weeks previously. The nature of his work-related stress was not recorded.

12th Sept: (Source - GP Practice 1) Christopher wanted to discuss Employment Support Allowance and requested the GP provide a letter to the council. He explained he lived in a single room and was not permitted to see his son due to his living environment, which he described as unsafe. He said he was teetotal. A medical certificate was provided for stress from 22nd August, which was subsequently renewed in November until January 2017. A letter was also provided by the GP for the council regarding his work situation and accommodation.

19th Sept: (Source – Police IMR) Jane contacted police alleging Christopher was persistently following her and questioning her friends about his son. She also reported seeing him drunk in the street and him not turning up for visits with his son. No offences were recorded by police and there was no further police action taken or referrals to other agencies.

Oct: (Source – GP Practice 2) Maria told the GP she had bruised her right arm by walking into a lamppost five days previously. She showed the GP a picture she had taken of the lamppost. There is no further information indicating any routine enquiry or consideration of DV&A.

20th Oct: (Source – Police IMR) Christopher’s son’s school reported he tried to take his son off the premises, in breach of a Prohibited Steps Order.[32] Staff intervened and took the child back into school and it was alleged that he followed them inside. Police attended and escorted him away from the school. No offences were recorded. Information regarding this incident indicates that Maria was present and was passive.

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[32] A Prohibited Steps Order is an order which prohibits a party (usually a parent) from a certain activity relating to a child(ren), and which also prohibits a party from exercising their parental responsibility. The background to the Prohibited Steps Order have not been ascertained as Christopher’s wife declined to engage with the review and the Chair’s request for access to records was refused by the Family court.

A child protection referral [33] was shared with agencies via the MASH. There was no further police action.

28th Oct: (Source – Police IMR) School staff reported Christopher had returned to his son's school, in breach of the Prohibited Steps Order, and refused to leave. Police attended and advised him to seek legal advice. No offences were recorded. A child protection referral was shared with Education and Children's Services via the MASH. There was no further police action.

2017

13th Jan: (Source - GP Practice 1) Christophers medical certificate was extended until July 2017.

Jan: (Source - GP Practice 2) Maria presented with a new episode of low mood. She requested a CT head scan due to headaches and trembling which she suffered for many years. Her antidepressant prescription was increased. She said her son left one month previously[34] and raised concerns about her housing.

6th Feb: (Source - GP Practice 1) Christopher reported low mood. He described separating from his wife 6-months previously, not seeing his child for 2 months and referenced an ongoing custody dispute. He was diagnosed with signs of depression and prescribed a single course of antidepressant medication.

15th Feb: (Source – Housing IMR) Maria sent an email and a letter requesting to move address due to the property causing her severe anxiety. She referenced the property condition and alluded to some negative behaviour she was subjected to from people she used to live with.[35] Maria advised her son Stephen had moved in with her because of her depression. Her email was supported by a letter from her GP advising that her living conditions were causing her to suffer claustrophobia.

16th Feb: (Source – Police IMR) Christopher reported his rented property had been attacked with stones on 2 separate occasions. He indicated someone did not like him and was trying to scare him, but explained he had no enemies. This incident and the report made, concerning a similar incident, which occurred on the 30th January 2017, where Christopher described chasing a suspect away from the location, were investigated and finalised without a suspect being identified. Police established no evidence to indicate he was being targeted.

Rebecca said that Christopher was in debt to a local drugs dealer,[36] but there is no information to indicate these events were connected to this. There is no other information to indicate he was involved in any conflict, other than his ongoing dispute with his ex-wife regarding child access.

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[33] A referral happens when someone contacts children's services because they are concerned about a child's safety and well-being. A referral can be made by anyone

[34] There is no indication as to which son Maria was referring to in the record although she later told her housing provider that Stephen had moved in with her.

[35] There is no further information describing the nature of the negative behaviour or identify whom was responsible

[36] Account of Maria's close friend Rebecca

17th – 19th Feb: (Source – Police IMR) An unidentified friend of Jane reported on her behalf, that Christopher was harassing Jane by his continued efforts to get access to his son. The friend described he had commenced legal proceedings to secure child access, but then failed to attend court hearings and Jane had been awarded full custody, which he refused to acknowledge.

Police contacted Jane who said she'd been told he was posting malicious information about her on social media because she was preventing him seeing his son, but she hadn't personally seen the posts. A DASH risk assessment graded the risk as 'standard.' She was advised to tell Christopher to desist from this behaviour and inform him that any further reports would be reported to the police as harassment. No agency referrals were made, and the incident was closed.

21st Feb: (Source – Police IMR) Jane reported Christopher was continuing to contact their son against her wishes and in contravention of a Family Court Order. She described this was a regular pattern of behaviour and that he frequented his son's school at the end of the school day in order to see him. Jane was advised to seek legal advice and a child safeguarding referral was made to the MASH. There was no further police action.

5th March: (Source – Police IMR) Jane reported Christopher and Maria attended her son's school so they could speak to him. Jane referred to an order in place from the civil court, granting her sole custody of their son, and preventing his contact outside of permitted arrangements. Police viewed the court order, which did not specify sole custody, but stated he was only permitted supervised visits. Jane was advised to seek legal advice. This report was recorded as a standard risk domestic incident. No further action was taken by police and no referrals were made.

May: (Source – GP Practice 2) Maria was prescribed the maximum dose of citalopram[37] (40mg). There is no rationale recorded for the dosage increase.[38]

June: (Source – GP Practice 2) Maria presented with anxiety and was prescribed Propranolol,[39] subject to a review by the prescribing GP. There is no information as to the nature and causation of her anxiety.

July: (Source – GP Practice 2) Maria was reviewed by her GP. She described all her problems related to her housing and that she was trying to resolve this with the housing provider. She explained her father died when she was 5 years old, but didn't want to discuss her childhood.[40] She added that her son was living with her at this time.[41]

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[37] Citalopram is a type of antidepressant known as a selective serotonin reuptake inhibitor (SSRI). It is often used to treat low mood (depression) and also sometimes for panic attacks.

[38] NICE guidelines recommend in depressive illness commencing at 20mgs and increasing at intervals of 3-4 weeks, if required, to a maximum of 40mgs. Other literature states 10mgs increased in steps of 10mgs gradually to a maximum of 40mgs.

[39] Propranolol is a beta blocker prescribed to reduce anxiety although it is used for other medical purposes including migraine.

[40] There is no further information indicating any childhood trauma, which Maria later alluded to when she engaged in counselling with CPFT.

[41] The identity of the son residing with her is not recorded but she indicated Stephen was living with her in the letter she wrote to housing earlier in February.

Sept: (Source – GP Practice 2) Maria requested another letter from the GP to support her re-housing application. She reported mould in her flat and made reference to a cat being killed. She stated her son moved back in with her.[41] A printout of her medical summary was provided to assist her application.

11th Sept: (Source – GP Practice 2) Maria was referred to CPFT Mental Health Services due to anxiety, low mood and worries about her housing. The record notes she had been prescribed medication for this since July 2014. She indicated she was living with her 35-year-old son.[42]

Oct – (Source - CPFT IMR) Maria was assessed and triaged for counselling with the Integrated Psychological Therapy Service.

2018

12th Jan - 11th May: (Source - CPFT IMR) Maria attended 12 therapeutic sessions. She disclosed a history of abuse as a child and explained this contributed to her claustrophobia.[43] She identified her family as her safety net whom she telephones when feeling low. The sessions focused on her housing, which caused her flashbacks to her childhood. She described her neighbours added to her anxiety. She was recorded as being able to articulate her challenges clearly to professionals and was discharged on 11th May 2018.

There is no information to indicate whether interpreter support was engaged in these sessions.

April: (Source – GP Practice 2) Maria reported mild anxiety and requested further evidence to support her application to be rehoused. She mentioned her son had moved out of her address.

May: (Source – GP Practice 2) Over several consultations, Maria reported a flare up of a skin irritation which she described was caused by stress. The final consultation was an emergency appointment where she presented with a 'list of problems,' which are not further described. She requested her medical notes were updated to reflect the impact her housing was having on her wellbeing. She was certified sick with stress and provided a copy of the consultation for her housing provider.

June: (Source – GP Practice 2) Maria presented with continued skin irritation and anxiety. She explained the council wouldn't help her to be re-housed.

Aug: (Source – GP Practice 2) Maria informed the GP she intended to take the council to court.[44] She asked for a copy of her medical records and requested they reflect the new symptoms she had developed as a consequence of her housing situation, including reference to her claustrophobia. There is no description of the other new symptoms, but

[42] There is nothing to indicate which of Maria's sons were living with her at this time, but Christopher would have been 37 years old at this point and Stephen was older.
[43] There is no further information with regards to the nature of the abuse she reportedly suffered as a child.
[44] There is no evidence Maria subsequently took any legal action in respect of the council.

these possibly refer to the stress, anxiety and skin irritation she presented with over the previous weeks and months.

10th Aug: (Source - Police IMR) Maria reported Jane took her son to Poland without Christopher's permission. Police established Christopher was only permitted weekly, two-hour, supervised visits at a contact centre. There were no orders in place preventing the child's movement. Maria was advised that he should seek legal advice.

2019

2019: (Source – Margaret) Christopher took up tenancy at the home of his landlady, Margaret.

April / May: (Source – Housing IMR) Maria wrote to her housing provider expressing further concerns about her property and a lack of natural light due to the surrounding environment. She explained she was afraid of the dark, which is why Stephen had moved in with her. She also reported people waking her several times in the night. The housing provider encouraged her to report her concerns to the relevant authorities.

July: (Source - GP Practice 2) Maria reported increased anxiety as a result of her housing situation and requested further support to resolve this. The GP explained there was nothing further they could do in this regard. She was prescribed medication to reduce her anxiety and help her sleep. She was referred to mental health services.

Aug: (Source – CPFT IMR) Maria was referred to CPFT due to her increasing anxiety, including sleep problems and panic attacks, related to her current housing situation. The GP referral documented a history of anxiety and depression. She was triaged to the Psychological Wellbeing Service (PWS).

17th Oct: (Source - GP practice 1) Christopher reported he had been advised by a solicitor to request an independent mental health assessment and a letter for the court demonstrating he was mentally stable. A thorough assessment was undertaken by the GP in the belief they would be able to provide a letter as requested.

Christopher described he had been working and living with his landlord and two friends for the past 2 years. He explained he separated from his wife between 3 to 4 years previously and denied any aggression or violence towards her or his child. He admitted using marijuana historically, but denied he did this presently. He admitted moderate, excessive alcohol consumption, but didn't drink daily or in the morning.

He reported there was no familial history of psychiatric disorders. There was a discussion about him suffering from reactive depression, when prescribed sertraline[45] in February 2017. Christopher explained this was an isolated event caused by problems with his wife and with work at that time. He said he hadn't taken the antidepressants and felt much better. He reasoned this was why he hadn't felt it necessary to see the GP for the past 2 years. He denied any thoughts of self-harm or hearing voices.

[45] Sertraline is a type of antidepressant known as a selective serotonin reuptake inhibiter (SSRI). It's often used to treat depression, panic attacks, obsessive compulsive disorder (OCD) and post-traumatic stress disorder (PTSD).

The GP was ultimately unable to provide a letter for the court as Christopher hadn't been seen at the surgery for more than 2 years.[46]

21st Nov: (Source – GP Practice 1) Christopher made a further request for a letter to be provided to demonstrate he was mentally stable. He was advised the GP was unable to provide this due to the lack of GP consultations in the 2-year period beforehand.

Nov: (Source – CPFT IMR) Maria was assessed by PWS. It was noted she lived alone and identified her son as a safety factor.[47] She reported claustrophobia and post-traumatic stress disorder (PTSD) and was referred for integrative psychological therapy. A letter was sent from the PWS to her housing provider confirming she was suffering severe depression and anxiety. The letter confirmed she was on a treatment list for high intensity psychological therapy.

2020

2nd Jan: (Source – Housing IMR) The housing provider returned the letter from PWS to Maria and advised her to take the matter up with the local council.

Jan: (Source – GP Practice 2) Maria presented with increased anxiety, increased heart rate and sleeplessness. She associated her symptoms with her housing. She was subject to an electrocardiogram (ECG) and her medication was adjusted. The outcome of the ECG is not recorded.

March 2020 Global COVID 19 Pandemic Lockdown

Outcome - Significant impact on clinical services throughout the NHS, including restrictions on department attendances.

Jan – April: (Source – CPFT IMR) Maria engaged in a further 12 integrated psychological therapy sessions. She identified her children as protective factors and added she is able to contact her son if she needs support.[47] The record describes her issues were associated with her housing. This was exacerbated by the onset of the Covid 19 pandemic lockdown when she felt unwell, isolated and without support. The therapy ended prematurely due to the lockdown restrictions. CPFT have confirmed that her discharge was subject to appropriate assessment and safety considerations prior to discharge.

March – April: (Source – GP Practice 2) Maria reported sustained anxiety and requested another letter for the council regarding her housing situation. Her antidepressant medication was increased and she was provided with a further letter in support of her housing application.

March – April: (Source – GP Practice 1) The GP practice recorded a change to Christopher's address. The address is not specified, but the record indicates the address was still in Huntingdon, which is at odds with the account provided by his landlady who

[46] There is no information indicating any concerns were raised by anybody, regarding his mental health up to this point, which would cause him to request a mental health assessment.

[47] Stephen had returned to Poland in 2018 and therefore Maria may have been referring to Christopher although this cannot be confirmed

described he moved into her home in 2019 and had been living in the adjacent street for some considerable time beforehand.[48]

July: (Source – GP Practice 1) Christopher presented with ear, nose and throat (ENT) problems. He was referred to acute ENT services.[49]

Aug: (Source – GP Practice 2) Maria reported difficulties breathing when stressed and anxious. She asked for an inhaler and made additional requests for Ventolin.[50] There was a discussion about her psychological therapy and strategies for anxiety and panic.

The record notes Maria's poor English but clarifies that she was able to understand without the support of an interpreter.

Nov: (Source – GP Practice 2) Maria reported pain between her shoulder blades and explained she'd had an accident 4 years earlier. She showed the GP a picture of the bruising she'd taken at the time of the reported accident. She was offered a face-to-face appointment. No further outcome is documented.

2021

There is considerable evidence illustrating Maria's determined and enduring support to, and concern for, Christopher in maintaining access to his son over the previous years. Her determination and concern for, him was increasingly evident in the weeks and days immediately preceding her death. During this time, Maria sought support from a range of services and professionals to address his unpredictably rapid and seriously deteriorating mental health.

The evidence indicates an abrupt, rapid and serious decline in Christopher's mental health occurred in the latter part of January 2021. Whilst Margaret provides some evidence that his behaviour started to grow stranger as early as December 2020,[48] it is clear that it only became of concern to Maria on the 22nd January 2021, which she made reference to in her diary entry for that day.

Over the following days and weeks, Maria, her friend Rebecca and Rebecca's daughter Susan and Christopher's landlady Margaret, sought support to address Christopher's abrupt, rapid and serious decline in mental health from a range of services and professionals. Ultimately, they were unsuccessful in securing the necessary treatment and intervention that his illness warranted.

Grandmothers Day [51]

22nd Jan: (Source – Rebecca) This date was a Polish festival where grandparents are celebrated. On this day, it is traditional for grandchildren to present their grandparents with flowers. Christopher came to Maria's home with flowers and started dancing and talking to her as if he were a small child. Maria described his eyes were different and not how they would normally, or should, look. She was alarmed by his behaviour.

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[48] Account of Christopher's landlady Margaret
[49] There is no corresponding hospital record of this event
[50] Ventolin is a medication that opens up the medium and large airways in the lungs
[51] In Poland, "Grandma's Day" is celebrated on January 21. "Grandpa's Day" is celebrated a day later, on January 22

22nd Jan: (Source – Maria's translated diary entry) states, *Christopher came with flowers, very nice bouquet but stranger.*

22nd Jan: (Source – Mark) Christopher suddenly and uncharacteristically stopped attending work. His manager tried to contact him by telephone, text and email, but was unable to get any response from him.

Jan: (Source – Grace) Maria said Christopher brought flowers and told her, "Mum, I love you so much". Maria had asked him if the flowers were for her, but he told her they were for him. She noticed that his face had changed and looked strange. From that day on, she continually referred to his increasingly strange behaviours, her growing concerns for him and her attempts to summon medical help. Grace told Maria that he might be suffering from schizophrenia, based on Grace's own knowledge of someone who suffered with this condition. Grace reflected that Maria's description of his behaviours closely resembled those of the person she knew.

Jan: (Source – Margaret) Christopher repeatedly claimed he was on holiday. He increased his alcohol consumption and stopped eating. He continually wore a fleece with the hood up when he was in the house. He wore earphones and frequently talked and laughed, as if he was having a telephone conversation with one of his friends, but it appeared he was talking to himself. On other occasions, he danced without any music playing or remained completely and uncharacteristically silent.

23rd Jan: (Source - Maria's translated diary entry) states, '*Christopher came – I don't know what to think about his behaviour he either took something or someone has following him. He was talking such things that I would never thought of saying it. All the time was saying that he is talking to the devil and other time with God.'*

Jan: (Source – Rebecca) Christopher was hearing and responding to voices. He told Maria God was speaking to him. He stopped going to work, but remained convinced he was still attending work. He told Maria that she'd fallen out of a tree and God had given her invisible hearing aids. He said he'd started a new relationship with a woman who had a son. He told Maria the woman's and child's names were the same as those of his estranged wife and child.

Christopher went to Maria's home, looked out of the window and said to Maria, "Look outside the window, no-one is there, they're scared, why did you bring the devil?" Maria also reported he'd taken wide strides towards her and said, "Ring the police, quickly". He was continually seeing imaginary things and hearing and responding to imaginary voices.

Maria was extremely worried and told Rebecca that she knew Christopher was ill, as there was such a significant, disturbing change in his behaviour. She was so alarmed by his behaviour that she tried to call his ex-wife Jane, in order to stop Christopher from seeing his son, as she was concerned, he might cause their child harm.[52]

25th Jan: Source - Maria's translated diary entry) states, *'Christopher came as my phone got broken- I think its for the bin as its old. Today he was behaving the same. Grace says that this might be schizophrenia. I spoke to Stephen he is also worried about Christopher.'*

[52] There is no evidence this was brought to the attention of any professional or agency

27th Jan: (Source - Maria's translated diary entry) states, '*Today Christopher looked a bit better but there is still something not right with him. He went home. In an hour he came in shorts and long socks to his knees. Not sure what to think about it.'*

28th Jan: (Source – Mark) Christopher continued to be uncharacteristically absent from his workplace without explanation and was similarly uncontactable. Mark called Maria and she told him that Christopher was unwell and that she was very worried about him. She described that he refused to see the GP.

Contact 1 - GP Practice 1

28th Jan – (Source - GP Practice 1) Maria called Christopher's GP and reported his strange behaviours including talking to ghosts and hearing voices. She said that his manager had contacted her and told her he hadn't attended work for the past week. She expressed concerns that he had mental health issues and queried if it was possible he was suffering from schizophrenia.

The GP reported having a long discussion with her and noted difficulties due to her poor English. The record documents that both Maria and Christopher were residing outside the practice catchment area.

The record describes that a plan was discussed over the telephone, which was reportedly agreed to by Maria, that the situation made it impractical for them to come to GP Practice 1 in Huntingdon, as Christopher was residing in St Ives and may need acute mental health support. Maria was signposted to NHS 111 (Option 2).[53] The record documents the circumstances were subject of a, 'See on Symptoms' (SOS) review [54] and that safety netting took place.[55] There is no evidence the GP made any attempt to contact Christopher in response to Maria's concerns. In reference to this consultation, Maria's diary entry states, '*I called the doctor and I told them that there is something wrong with Christopher – that he has changed and that I am worried about him. Doctor told me to call psychologist.'*

28th Jan: (Source - Maria's translated diary entry) states, '*Christopher's manager called and wrote to me that Christopher has not been at work since Tuesday. I called the doctor and I told them that there is something wrong with Christopher – that he has changed and that I am worried about him. Doctor told me to call psychologist. I went to Christopher- he slept and didn't want to speak to me. Told me that he is tired physically and mentally. He told me that he loves me and that I should go. I spoke to Christopher's manager and he told me that he booked him AL.'*

Police incident -1

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[53] 111 option 2 is an urgent service offering assessment and signposting advice for anyone experiencing a mental health crisis, or requiring support to manage their symptoms. Signposting to 111 option 2 is the default method that Primary Care services refer to and advise patients and carers to do the same.

[54] A 'see on symptom' (SOS) approach results in patients being discharged to an SOS pathway as an outcome of their last review by a clinician when it is clinically safe to do so, and then relies on the patient to self-refer if there are any issues with their condition.

[55] Safety-netting advice is information shared with a patient or their carer designed to help them identify the need to seek further medical help if their condition fails to improve, changes, or if they have concerns about their health.

29th Jan: (Source – Police IMR) Approximately 22.00 hrs, the occupant of a private residence in St Ives was sitting inside their home when Christopher entered their lounge through the rear, unlocked patio door. The homeowner challenged him and he mumbled something incoherently before calmly and slowly walking out of the house. He loitered outside for several minutes and sat on a wall opposite the house before leaving. The police were alerted by the occupant. No property was stolen and police recovered CCTV of the suspect. A report of crime was recorded for attempted burglary in accordance with Home Office Crime Recording (HOCR) Rules.[56] The police were unable to identify Christopher as a suspect at that time.

29th Jan: (Source - Maria's translated diary entry) states, '*Christopher came for a while but he still behaving weird. He walked inside the house, walked out and stood on the edge of the door. He asked me if I would like to burn some oils- but not to burn any citrus once but only different one. I told him that I don't burn any oils for the night. He told me that he loves me and he went.'*

<u>Police incident - 2</u>

30th Jan: (Source – Police IMR) Just before 17.00 hrs, Christopher entered another private residence in St Ives, this time via the insecure front door. He walked into the house holding a mobile phone to his ear. He was challenged by the occupant, but didn't respond and calmly walked out of the house. The occupant recorded an image of him on their mobile phone and a clear CCTV image was obtained from the front doorbell device. Christopher loitered outside for a short time before walking away. The police were alerted by the occupant and they recorded a crime report for attempted burglary. Due to the geographic, temporal, modus operandi and suspect description similarities, the attempted burglaries on the 29th and 30th January, (Police incidents - 1 and 2) were connected and investigated together. The police were unable to identify Christopher as a suspect at that time.

<u>Ambulance call - 1</u>

30th Jan: (Source – Margaret and Peter) Sometime just before 22.00 hrs, Margaret was watching TV when water started to leak through her ceiling. She went upstairs and into the bathroom with her other tenant Peter. They found Christopher in the shower looking totally bemused. He was fully clothed, including his shoes and socks. Margaret asked him what he was doing, but he seemed, 'totally vacant.' His housemate Peter described that he looked 'dazed and vacant.' They managed to get him out of the shower and his sodden clothing. Peter took his clothing away to clean and dry for him, whilst Margaret called an ambulance.

Margaret told the operator Christopher was, "totally out of it." Approximately 30 minutes later, a Polish speaking operator called back and asked to speak to Christopher. He told the operator he hadn't felt well earlier, but was now just feeling tired. He then wandered off and Peter cleared up the bathroom.

30th Jan: (Source – EEAST IMR) The record describes the ambulance service received a call from Margaret via the 999 service at 22.23 hours. She reported Christopher was fully

[56] HOCR are aimed at ensuring that crimes are recorded consistently and accurately

clothed in the shower and he only spoke Polish. The call was appropriately coded as, 'Mental Health Concerns' and was assigned Category 3 status.[57]

The incident was transferred for further triage with a clinician. The paramedic clinician telephoned Margaret, then spoke with Christopher through an interpreter. An assessment documented he was not alone and was with the home owner. He was noted to be fully alert, orientated, and talking in full sentences. He stated that he was okay and thought that his mum had called 999. He denied any mental health problems and said he wanted to go back to bed. He said he'd felt unwell with his mental health earlier, but since going to bed he felt better. He declined further triage and was given, 'worsening advice'.[58]

30th Jan: (Source – Margaret) No ambulance was dispatched to the incident and there was no further follow up enquiry made with Christopher or Margaret.

30th Jan: (Source - Maria's translated diary entry) states, '*I called Christopher but he did not answer. Lady asked for Christopher's shoes. Tomorrow someone should come to see [translation unsure of the wording]. I prayed to God for Christopher- I known that this is as a result of lack of contact with Sean.'* [59]

31st Jan: (Source - Peter) Peter went to Christopher's room with his clothes, which he'd washed and dried after the shower incident the previous evening. Christopher denied he'd been in the shower in his clothes and denied the clothes were his. He told Peter to throw them away. Peter described he was quite aggressive when he said this, which was out of character, as he'd never shown any signs of aggression towards Margaret or Peter.

31st Jan: (Source - Maria's translated diary entry) states, '*Rebecca called and said that it might be schizophrenia. I went to Waitrose then to Christopher. Today he feels a bit better and said that he is going to work tomorrow. I gave my number to Christopher's neighbour in case there was a need. At 20:35 Christopher came. He wanted to borrow £20. He was saying look how dark is outside – everyone is hiding as they are scared - what have you done - gave me the devil - and then he left.'*

Contact - FRS - 1

31st Jan: (Source - Maria's translated diary entry of the 1st February) states, '*I called 111 (-2) last night and they wanted to speak to him. I told them that he is not able to speak as he doesn't realise that he is unwell. He told me to call the doctor.'* [60]

1st Feb: (Source – Mark) Maria called Christopher's manager and repeated her concerns regarding his mental health. She said he'd been talking to an imaginary person and was rude to her for interrupting him.

Contact 2 - GP Practice 1

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[57] This relates to patients who have potentially urgent conditions that are not life threatening, but do require treatment or transport.

[58] 'worsening" advice -. to get in touch with a service after a few days if symptoms have not improved, or a recommendation to self-care.

[59] 'Sean' is the pseudonym for Christopher's son

[60] There is no corresponding FRS record of the contact Maria alludes to in her translated diary entry.

1st Feb: (Source - GP Practice 1) Maria was supported by an interpreter in a consultation with Christopher's GP. She reported he was in, 'a very bad state' and was not going to work. She explained he lived in St Ives, but she'd been unable to register him with a local surgery.[61] Maria was told he needed to register with a new practice by the GP. She was again signposted to NHS 111 (Option 2). The GP documented they would review the case if he returned to their catchment area.

Contact - FRS - 2

1st Feb: (Source – CPFT IMR) Maria telephoned the FRS just before 19.00 hrs reporting her concerns regarding Christopher's mental health. She described she'd called FRS the previous evening,[62] and his GP earlier that day, but that no one had helped her.

She explained he had a history of depression linked to his divorce 4 years previously. She described he experienced thoughts of taking his own life during that period.

She said he was seeing and responding to ghosts and was not communicating normally with her, nor speaking to other people. She explained he had questioned who she was at one point. She described him visiting her home the previous evening and telling her that people were hiding before he left.

She said he was becoming angry and making references to God. She said she was unsure if he was eating, but explained he looked as though he'd lost weight. The record describes she reported he had stopped going to work the previous Thursday and that his difficulties appeared to have started late the previous week.

Maria said she thought he needed to be admitted to hospital for observation, but the practitioner explained that he would require an assessment to enable the FRS to identify the support he required. She expressed concern that he wouldn't engage with practitioners, but agreed to helping them try to engage him the following day. A plan was agreed for FRS to call her after 15.30 hrs the following day to make arrangements to try and engage him.

Maria expressed additional concerns regarding Christopher's job, access to sick pay and his lack of access to GP care, due to him residing outside the catchment area. The record describes that advice was provided in respect of these concerns.

The record acknowledges there may have been some difficulty with gathering some information over the telephone, including Maria's own assessment of any risk to Christopher himself. The practitioner documented that Maria did speak good English overall. There was no recorded enquiry or outcome into any risk Christopher might pose to Maria or others during this interaction.

The FRS plan to try and engage Christopher was agreed by the FRS clinical lead and reviewed by the senior clinician, who noted Maria's doubts that he would engage with practitioners, but recognised her descriptions of his behaviours may indicate he was suffering with a mental illness. Whilst he was not known to mental health services, it was considered prudent to try and engage him though a 'cold call', as the FRS were best placed to make an assessment if he was willing to engage with them. The senior clinician also

[61] There is no record of any enquiry made by Maria to register Christopher at GP Practice 2 up to this point in time.
[62] There is no corresponding FRS record of the call Maria told the practitioner she had made to FRS the previous evening.

acknowledged a requirement to establish important, additional background information from Maria including, recent stressors, illnesses, drug and alcohol use, familial history of mental illness and any history of risk towards Christopher or others.

1st Feb: (Source – Transcript of recording of outgoing call made from Maria's phone) The time and date of the call cannot be established, but the content of the discussion makes clear that the recording pertains to the call Maria made to CPFT FRS on the 1st February. (Contact – FRS – 2) Only Maria's side of the conversation is captured on the recording. Of note, there are several instances during this call where Maria indicated she was unable to understand what was being said to her. At one point she asked for a translator, but this was not provided.

Maria described she was calling about her son Christopher and explained that she had called the previous evening around 21.00 hrs, on the advice of his GP, whom she'd spoken to the previous week.[63] She relayed that during her call to 111 the previous evening, a male operative had advised her to re-contact his GP. She explained she followed this advice and re-contacted Christopher's GP who told her that they couldn't help her as he was residing outside their registration area.[64]

She reported Christopher had a mental problem and was speaking to imaginary people. She said that she'd been trying to get him help for over a week, but that no-one would help. She explained he'd stopped going to work, but that he didn't realise that he wasn't going to work. She described that he was showing signs of schizophrenia and he refused to answer his phone or speak to anybody.

She reiterated she'd spoken to his GP the previous Thursday,[63] who had advised her to call 111 if anything bad happened. She explained that she'd called 111 the previous evening, because Christopher came to her home and told her, "You is in window, look, is very dark, everybody, people hiding because scared. Look, come to window, is very dark, what you doing? You bring me devil."

Presumably in response to questions posed, she again reiterated she'd spoken to a 111 practitioner the previous evening, whom she'd explained everything to. She repeated that she had called Christopher's GP earlier that day,[64] as she was advised by the 111 practitioner the previous evening. Further responses by Maria reiterated the GP's refusal to help him because he lived outside their registration area.

She explained that she'd told his GP everything during calls she'd had the previous Thursday and again earlier that day. She described that she'd been supported by a translator in this regard, but that still, no-one had helped her. She explained that Christopher wasn't going to work and she suspected he wasn't eating as he was "very skinny" and was different in every way.

Maria said she had visited Christopher earlier that evening whilst speaking to his GP. She explained that he refused to speak to the GP and asked her to go home. She described he was suffering with depression and starting to show signs of schizophrenia. She said that he refused to speak to anybody and that when she visited him earlier that evening, he had questioned who she was and why she was there.

[63] Contact 1 – GP Practice 1
[64] Contact 2 - GP Practice 1

She went on to describe the initial incident which led to her concerns, when he brought her flowers.[65] She said that he was just smiling and not speaking and that his eyes and face were different. She said that the following day, he claimed he was talking to God all of the time. She explained he claimed to be having conversations with imaginary entities and when she challenged him about his claims, he called her a liar. He told her that these entities and "ghosts" were speaking to him and that he would tell her what they told him to say. She explained that the previous Saturday he was speaking to a lot of imaginary entities and was telling her to be quiet whilst he was speaking to them.

Maria said she had started to become scared by his behaviour, which was why she'd called his GP the previous week, the 111 service the previous evening and his GP again earlier that day. She reiterated that she called 111 the night beforehand, because he came to her home just before 21.00 hrs. He then told her to come to the window and said to her, "Look is dark, very dark, people hiding, nobody in street. Come here. What, you scared? What you doing? You bring devil for me." She described he then left abruptly. She explained that she'd tried to reassure him that it was dark and nobody was in the street because it was night time, but that he told her, "No, you liar, you bring me devil." He then left abruptly. She explained that he had never behaved in this way before and described he had become someone who didn't appear to know or understand anything.

She related that he suffered depression for a long time after his marriage broke down when he was experiencing problems maintaining access to his son. She explained that he wanted to kill himself during this time. She queried that now he was talking to himself, as to whether his depression could have developed into schizophrenia. Presumably in response to a question posed, she confirmed that he suffered with depression 4 years earlier, she added that his condition had changed, because he was now speaking to himself and with other imaginary entities. She described that his mental illness, "now is schizophrenia."

Maria responded to questions regarding Christopher's GP and explained that she'd told the GP that he needed to be taken to hospital for observation or provided with medication to help him. She reiterated that he wasn't going to work and didn't know that he needed to go to work. She explained that she couldn't accommodate Christopher as she had a new job that she couldn't afford to lose. She appealed for help for him and repeated that no-one wanted to help her.

Maria described the conversations she had with Christopher's manager. She explained she'd told him that she didn't know what was wrong with him, but that he was unwell. She said that almost every day of the previous week, he'd insisted he would go to work the following day, but hadn't gone to work. She said she'd appealed to his manager not to terminate his employment because his depression had worsened and he didn't realise he needed to go to work. She explained that she'd asked his manager to call emergency services, because he spoke English fluently and she reasoned that he might get the treatment he needed if his manager were to call emergency services.

She again appealed for help and asked, "Who help me?" She alluded to a further week going by without him receiving any help whilst his illness was worsening. She made reference to him smiling at her and telling her he loved her prior to him becoming ill and

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[65] See Maria's translated diary entry for 22nd January

compared this with him now not wanting to speak to her. She described, “Him don’t speak normal any more, not any more, from this time, don’t speak normal, nothing.”

She went on to describe a further event which occurred at her home over the previous weekend. She explained he came and asked her if she wanted to burn aromatherapy oil. She said that she told him that she didn’t want to burn oil but he was convinced that she did, because something inside his head was telling him this. She explained this conversation went back and forth and finally he left via her front door. Later, she found him standing outside her front door, with his back to the door, stood silently. When she opened the door, she explained that he berated her for opening the door and told her not to. She described his behaviour was, “like stupid, but him don’t know, is like different Christopher, is not him and angry, start angry more, more angry start. “

She described that when she spoke to him, he told her not to say anything because God was telling him that she, “don’t make me stop.” She explained that he believed God was telling him what to say to her and when she challenged him, he insisted that God was telling him what to say to her and she should sit quietly and not try to make him stop.

She described visiting him earlier that evening, when his GP had called her.[66] Christopher told her that he didn’t want to speak with anybody and didn’t need a doctor. He accused her of calling the GP for herself and told her she should leave. She explained that he refused to speak to the doctor because he didn’t realise he was ill. She described that he had also informed her that he didn’t need a sick note because he was still going to work every day, but she explained that he hadn’t attended work for more than a week.

Maria was seemingly questioned about his history of depression and she repeated that he’d experienced thoughts of taking his own life after his divorce and the associated difficulties he faced maintaining access to his son.

She reiterated that he refused to speak to her or anyone else and wouldn’t answer his phone. At this point the conversation appeared to be focused on making arrangements for FRS practitioners to visit Christopher at his home the following day. Maria expressed reservations that if she were to go to his home, and Christopher saw her, that he would leave. She said that she would wait outside his address for the practitioners to arrive. She described it was a 7-minute walk from her home to his address and appealed for help because he wouldn’t speak to anyone on the phone, he had no medication, nobody had examined him and nobody would help.

She queried what would happen if he refused to speak to the practitioners. She explained that he was sick and didn’t want to speak to anyone because he believed he was well. She again referred to him becoming, “more angry.” She expressed her wish that he should be taken to hospital for observation.

She went on to describe the challenges she had experienced, and she requested advice about obtaining a sick note for Christopher. She explained she had been speaking to his manager and reasoned that he needed a sick note to explain his absence from work, so that he didn’t lose his job. She repeated that the GP wouldn’t help Christopher as he was living

[66] Contact 2 – GP Practice 1

outside their registration area. She made further repeated references to the GP refusing to help him because of this.

She asked the practitioner if they would call Christopher's manager to explain his situation. She reasoned that she didn't know what to say to his manager, as he didn't have a sick note from the GP. Presumably in response to what she was told in this regard, Maria said, "So, I need to go to GP? God, I don't know, I just don't know." She expressed further concerns that he would lose his job without a sick note and struggle to find alternative employment in the future. She added, "Christopher don't go nowhere, because him is different, like no person so, how I doing?"

Shortly after this, the call was concluded.

1st Feb: (Source - Maria's translated diary entry) states, '*I called the doctor. I spoke to someone in relation to Christopher. I told her that he needs help as he is not conscious of anything. I told her that I called 111 (-2) last night and they wanted to speak to him. I told them that he is not able to speak as he doesn't realise that he is unwell. He told me to call the doctor. Doctor called- told me that he can't help me as Christopher is not resisted [registered] in his surgery and that I need to re-register him. I called 111(2) and I spoke over an hour and they are going to call me tomorrow after 15:30.*'

<u>Contact - FRS - 3</u>

2nd Feb: (Source - CPFT IMR) Just after 16.00 hrs, a practitioner from FRS called Maria. She reiterated that Christopher needed help. She described he had, "bad depression" and "was in another world" and wouldn't accept that he needed help. She said he refused to talk on the phone and she'd tried everything to get him help. Maria added that she'd contacted his GP who wouldn't help and that she'd called an ambulance, but when the ambulance came, they left him because Christopher changed his mind.[67]

Maria said she was unsure if he was currently taking drugs. She acknowledged he had used drugs in the past, but dismissed this was the case at that time. She explained he had not been to work since Thursday 21st January, but that he claimed he was still going to work and that his manager had called her to ask what was going on with him. She explained there was no history of mental illness in her family and agreed he would benefit from someone trying to engage and assess him. Arrangements were made for FRS to visit Christopher that evening, with Maria's support.

The record describes Maria's conversational English was 'good' and documents that she stated that Christopher's English was the same and he wouldn't require an interpreter.

2nd Feb: (Source – Margaret) Maria arrived at Margaret's home that evening and told her she'd called some medical professionals who were coming to see Christopher at 20.00 hrs, but she didn't want him to know. She described he had been talking to imaginary children in her kitchen and that she was very worried about him. She said the medical people were coming to see him as he needed help. Maria then hid in Margaret's house, so that he remained unaware of her presence whilst she awaited the FRS practitioners.

<u>Contact - FRS - 4</u>

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[67] There is no corresponding ambulance record to confirm that Maria ever called an ambulance regarding Christopher.

2nd Feb: (Source – CPFT IMR) Just before 20.30 hrs, Maria telephoned FRS and reported she was waiting for someone to visit. She was informed the FRS practitioners were enroute to Christopher's address. She said she would await their arrival.

Contact - FRS - 5

2nd Feb: (Source – CPFT IMR) The record describes that just after 20.30 hrs, 2 practitioners from the FRS met with Maria at Margaret's address. Christopher was upstairs in his bedroom when they arrived. Margaret told the practitioners about him showering fully clothed, including his jacket and shoes, on the previous Saturday evening. Margaret added he was sleeping a lot, eating less, was not going to work, stating that he was on holiday; and he had not paid his rent. Margaret described that she suspected he may be using drugs, but was unsure.

Maria described he had visited her and told her there were people hiding, but she had been unable to see anybody hiding. She expressed concerns that he was saying he was on holiday when this was untrue. She explained she had seen a change in his behaviour and believed he should be taken to hospital.

Whist the practitioners were talking to Maria and Margaret, Christopher came downstairs. The practitioners greeted him and introduced themselves to him, but he didn't acknowledge them. He went into the kitchen, put some food on a plate and returned to his bedroom.

The practitioners went to his room, supported by a telephone interpreter, as Margaret informed them his English was poor. They found him sat in the dark and tried to speak to him, but he refused to engage and became agitated. He then raised his voice telling the practitioners to, 'Get out' and to leave him alone.

The FRS practitioners concluded they were unable to ascertain his capacity or assess his mental health state and, as there had been no less restrictive actions tried, they did not feel there were sufficient grounds to request an assessment under the Mental Health Act (MHA) that evening.[68]

The FRS practitioners noted that he was reasonably kempt and there were no signs of neglect. He didn't display any odd behaviour, or appear to be responding to unseen stimuli. There were no signs of behavioural disturbances and there were no reports of risk to him or any concerns regarding his immediate safety.

The FRS practitioners advised Maria and Margaret they could contact emergency services, if he became a danger to himself or others and, that Maria could re-contact FRS for further support if required. She was directed to encourage Christopher to engage with his GP. She was also advised that she could contact the Adult Services Emergency Duty Team (EDT) to request consideration for a MHA assessment.

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[68] Under the Mental Capacity Act (MCA) 2005, Capacity should be assumed unless there are indications that it is not present. The MCA code of practice says that people should not assume you lack capacity because of:

- Your age
- Your appearance
- Any mental health diagnosis or any other disability or medical condition you may have

2nd Feb: (Source – Margaret) Margaret recalls she and Maria spent some time with the FRS practitioner's downstairs telling them that Christopher was acting very strangely. They described his sudden, uncharacteristic and continuing failure to attend work, him showering fully clothed, talking to himself and lighting candles in his room. Maria told them he was seeing and talking to children in her kitchen, she also explained that he was her son and that she knew he wasn't well and needed help. Maria described him bringing flowers to her the week beforehand and speaking to her like he was a small child. The practitioners asked Maria if he had been ill before and she told them that he suffered from depression due to his separation from his wife.

Whilst Margaret and Maria were talking to the practitioners, Christopher came downstairs and went into the kitchen without acknowledging anybody. Margaret told him that some people wanted to speak to him and he said something similar to, "I won't be a minute." He then withdrew back to his room, but didn't return downstairs.

When the practitioners went to his bedroom, he was sat in the dark. He refused to engage with them and became agitated telling them to, "get out"' and "leave me alone." He continued shouting aggressively for about five minutes.

A short time later, the practitioners came downstairs and told Maria there was nothing they could do. Margaret described being shocked and said something to the effect of, "You can do nothing?" The practitioners said they would need to get a doctor to make an assessment, as he wouldn't talk to them, so there was nothing further they could do. Margaret said she felt like Maria's and her own concerns about him were dismissed.

The practitioners told Maria that if she wanted help, she needed to call a Peterborough telephone number. Maria continued to tell them that he was ill, but they re-iterated there was nothing they could do and advised her to call the Peterborough number they had provided.

For the first time that night, Margaret wedged a chair against the inside handle of her bedroom door, due to her increasing concerns for her own safety. The following day, she had a lock fitted to her bedroom door.

2nd Feb: (Source- Maria's translated diary entry) states, *'I called the doctors again and asked (Redacted) for the doctor to give a sick note to Christopher for a month. Doctor didn't call. I had a call from 111. I told he about what is going on and he said that ambulance will come today around 20:00. They arrived at 20:40, they wanted to speak to him but he told them to go away from his house as he is watching a video.'*

2nd Feb: (Source- Rebecca) Maria said that when the 111 practitioners came to see Christopher, he became uncharacteristically loud and angry and shouted at them to get out of his house. She was upset they didn't do anything in response to the strange behaviours she reported, either in terms of giving him any medication or referring him to a doctor.

Contact 3 - GP Practice 1

3rd Feb: (Source - GP Practice 1) An 'AskMYGP' [69] task was submitted whereby Maria requested a sick note on behalf of Christopher. The GP attempted to contact Christopher by

[69] AskMyGP is an online general practitioner consultation platform which aims to improve patient access to healthcare and cut down on unnecessary appointments

telephone, but his phone was switched off. Maria was informed and was again advised he needed to re-register with a new GP in the locality where he resided.

3rd Feb: (Source – GP Practice 2) This record documents a new patient registration form was completed by Christopher on 3rd February 2021.[70]

FRS and GP Practice 1 – FRS Plan

3rd Feb: (Source – CPFT IMR) Following the attempted FRS face-to-face assessment the previous evening, the FRS senior clinician called GP practice 1 to establish if they had any recent contact or concerns regarding Christopher. The practice reported he had a consultation with a GP on the 1st January 2021.[71] A message was left for the GP to re-contact the senior clinician the following day when they were back in the surgery.

4th Feb: (Source – GP Practice 1) The GP record of this event describes the GP returned the call made by the FRS senior clinician the previous day, where FRS were enquiring about Christopher's medical history. The GP advised the FRS senior clinician there were no mental health issues previously documented in his medical record.[72]

The record documents the FRS senior clinician informed the GP that FRS would, 'observe and review as required,' as Christopher refused to engage until he was advised that mental health was recorded in his medical history.[73]

It was noted that Christopher was still living outside the surgery catchment area. The GP reiterated their advice to the FRS senior clinician that he should re-register at a new practice local to his home address.

4th Feb: (Source – CPFT IMR) The CPFT record of this same event describes the GP advised they had not seen Christopher since December 2019, when presenting with ENT problems, and there had been no mental health concerns during that presentation. The GP was unaware of any previous mental health concerns, although they acknowledged Maria had contacted them to raise the same concerns as she had with FRS.

The GP explained he was now living outside their catchment area and advised he should register at a local practice. The FRS senior clinician enquired into the possibility of the GP engaging Christopher regarding generalised health queries as a way of initiating a discussion about his mental health. The record describes the GP told FRS they would try to offer him an appointment.[74]

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[70] This is in direct contrast with Maria's translated diary entry of the 4th February, but possibly alludes to Maria attempting to sign the registration form on Christopher's behalf, Maria's diary entry states, '*I went to apply to change the doctor's surgery but I couldn't as they said that he needs to sign it or speak to them on the phone. I went to Christopher so he could sign it but didn't want to and was angry.'*

[71] There is no corresponding record of a GP consultation with Christopher on the 1st January

[72] There was no reference made to Christopher expressing thoughts of ending his own life to his GP in July 2016, or his diagnosis with signs of depression in February 2017, which is documented in his GP record.

[73] This record is the only indication that Christopher ever expressed that his engagement with FRS was conditional on mental health being recorded in his medical history. There is no other information to indicate this was the case.

[74] There is no evidence the GP made any subsequent attempt to offer Christopher an appointment

Prior to this conversation between the senior clinician and Christopher's GP, there was a discussion between the senior clinician with the clinical lead FRS practitioner. They noted Christopher's refusal to engage with practitioners and him raising his voice and telling them to leave. They acknowledged FRS had been unable to assess his mental health or make a judgement on his capacity to make decisions about his care and treatment. They concluded they had no power to remain at his address in light of his demands they leave.

The senior clinician documented a plan which recognised that health professionals were required to attempt to further engage Christopher, in order that his mental health could be assessed. They considered whether a MHA assessment was appropriate on the evidence available, given that Christopher would not engage voluntarily.[75] They assessed and documented the following risks: -

Risk to health – He was reported to be eating less but was observed to prepare food for himself and didn't appear malnourished. His personal care appeared adequate, albeit the odd behaviour of showering with his clothes on.[76] His medical history did not show any previous mental illness, as far as could be ascertained,[77] although Maria reported he suffered a depressive episode when his relationship broke down 4 years previously, this appeared to have resolved itself spontaneously. Therefore, there was no argument he had an established diagnosis that had responded to inpatient treatment. It was acknowledged there was potential that his mental health might deteriorate further if it was not treated, but as it was not clear what the problem was, in terms of mental illness or drug misuse, the senior clinician assessed there were insufficient grounds to pursue a referral in relation to risk to his health, based on the evidence available.

Risk to self – There was no previously known risk of harm to himself and no reported existing risk of harm to him from others, as far as could be ascertained. It was noted this was difficult to assess as he refused to engage.

In considering the reported recent behaviour of him seeing and talking to ghosts and feeling people were hiding, whilst this was considered unusual and out of keeping with his usual presentation, it was not felt this represented an immediate risk necessitating an immediate referral for a MHA assessment. They felt it was a reasonable, and less restrictive, course of action to ask his GP to try and engage with him to facilitate a further assessment. In arriving at this conclusion, they were reassured that Maria was in regular contact with him and she had been told how to seek further help.

Risk to others – As far as could be ascertained from Maria, there was no history of violence towards others. Maria did not state that she felt threatened by him, more that she was concerned for his mental wellbeing.

The FRS senior clinician concluded the key risk was a further deterioration in his mental state, if he was developing a psychotic illness. They reasoned if this was linked to illicit drug use, it may resolve spontaneously and, if not, he would likely need treatment whereby, he voluntarily engaged with this, or met the threshold for detention under the MHA.

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[75] In considering this they sought to evaluate if Christopher was suffering from a mental health disorder of a nature and degree to warrant detention in hospital

[76] On face value this statement is contradictory, but is not expanded on in the FRS record

[77] Christopher expressed thought of taking his own life in July 2016 and was diagnosed with signs of depression in Feb 2017

The FRS did not consider any further attempts to engage him would likely be successful. They concluded his care should be handed back to his GP in an attempt to persuade him to engage in a discussion about his mental health.

The FRS closed Christopher's case and documented that his care was handed over to his GP. The basis for this decision was that FRS had attempted a face-to-face assessment by cold calling and he had been clear he did not wish to engage with mental health services. In parallel, the GP was requested and, reportedly agreed, to take steps to contact Christopher and support him in accessing services.[78] FRS were similarly satisfied Maria was provided with the necessary information to seek further help if his mental health deteriorated. The FRS senior clinician added a caveat to the record directing that Christopher's case should be placed on the consultant list, if he or Maria contacted FRS again in the future.[79]

Contact 1 – GP Practice 2 - 1st application to transfer GP surgeries

4th Feb: (Source – Maria's translated diary entry) states, '*I went to apply to change the doctor's surgery but I couldn't as they said that he needs to sign it or speak to them on the phone. I went to Christopher so he could sign it but didn't want to and was angry*.'

Feb: (Source – Rebecca) Maria tried to persuade Christopher to transfer GP surgeries, but he continued to refuse to sign the registration form. This was because there was a Polish doctor at his existing surgery, who he had seemingly bonded with. Simultaneously, he refused to acknowledge there was anything wrong with him or that he needed any medical support. In desperation, Maria signed the transfer form in Christopher's name and took it to her own GP' surgery (GP Practice 2). She was questioned regarding the signature and she admitted having signed the form because she was unable to get him to sign it. The transfer application was refused by GP Practice 2 at that time.

Maria was working and going to Christopher's GP almost daily, trying to get help for him. She had told his GP he was sick and needed medication and a sick note, as he wasn't going to work. Christopher's GP wouldn't help her and told her he would have to come into the surgery himself if he needed medication. She told the GP he refused to come to the surgery or accept that anything was wrong with him, but that she knew he was unwell as he was her son and that he needed medication. The GP repeated their direction that he would have to come to the surgery before he could be given any medication.

Feb: (Source – Margaret) A day or two after the visit by the FRS, Margaret called Christopher's manager; to verify he was on holiday. She was told he wasn't on holiday, but had abruptly stopped attending work without explanation. His manager told her he had been trying to make contact with him, to check on his welfare, but he'd had no response to emails, phone calls and voicemail messages.

Feb: (Source – Mark) Mark recalled this conversation with Margaret and added that she also expressed her concerns to him regarding Christopher's mental health. She told him she had

[78] There is no acknowledgement of this in the GP record and no record of GP Practice 1 making any subsequent attempt to engage Christopher on this basis

[79] There are key discrepancies in the records of this same event documented by GP Practice 1 and FRS. The GP record documents a reiteration that Christopher needs to register with another GP practice and makes no reference to agreeing to offer Christopher an appointment, which would be inconsistent with the stance the GP practice continually maintained throughout their engagements with Maria.

contacted the ambulance service on two occasions, to try and get him some help, but that they wouldn't do anything to help him.[80]

Mark recontacted Maria who said she was very worried about Christopher and had called mental health services to try and get him sectioned, but that they wouldn't help her. She explained that throughout the time he wasn't working he had a vacant look in his eyes and his mind was anywhere except where it should be. She described him as being, 'spaced out.' She said he kept telling her he was going back to work, but then he didn't go to work.

4th Feb: (Source – Mark) Mark made an unannounced visit to Margaret's home, where Christopher was living. He described that Christopher was in his bedroom sat on his bed. Mark asked him to return to work, as he didn't want him to lose his job, but explained he couldn't afford to keep him as an employee if he wasn't coming to work. It seemed as if what Mark was saying wasn't registering with him, but he kept repeating that he was going to return to work.

Mark told him he'd been trying to make contact to check on his welfare and asked why he hadn't responded to any calls; or called him to explain why he was absent from work. Christopher said he'd lost his phone, but Mark noticed his phone next to him on his bed. Mark asked him what it was and he responded uncharacteristically abruptly by saying, "It's a phone."

5th Feb: (Source – Maria's translated diary entry) states, '*Rebecca called. She is looking a help for me and what should I do when none one is able to provide medical help.'*

Notice of eviction

Feb: (Source – Margaret) Around this time, Christopher's landlady decided to serve notice of eviction on him. She explained he had abruptly and uncharacteristically stopped paying his rent the week before the shower incident on 30th January. Margaret made this decision primarily because of her increasing concerns regarding his strange behaviours and her growing fears for her own welfare and safety. He was provided at least one-weeks' notice informing him that he had to leave her home by the 14th February.

8th Feb: (Source – Maria's translated diary entry) states, '*Christopher did not turned up to work.'*

Contact 2 - GP Practice 2 - Registration

9th Feb: (Source - GP Practice 2) A new registration was received for Christopher by Maria's GP practice (GP Practice 2).

9th Feb: (Source – Rebecca) Maria managed to obtain another GP registration form and eventually persuaded Christopher to sign this. She reasoned with him that he needed to have a GP to go to if anything happened, or he became sick.

9th Feb: (Source – Maria's translated diary entry) states, '*I went to Christopher's after work and spoke to him about signing the papers to register with the doctor.'*

EDT Contact - 1

[80] There are no records held by EEAST to indicate any other calls to their service beyond those made by Margaret on 30th Jan and later on the 14th Feb

9th Feb: (Source – Rebecca) Sometime between 18.00 and 19.00 hrs, Rebecca's daughter Susan rang Cambridgeshire County Council out of hours Social Services for Adults EDT. Susan reported their concerns to the operator about Christopher's mental health; Susan was told that someone would call her back.

Later that evening, Susan was called by the EDT. She repeated their concerns regarding Christopher's behaviour over the previous 2 to 3 weeks. The practitioner explained that depression affected people differently. Susan was told that his behaviour could be a one-off event and was advised that if his disturbing behaviour were to continue, she should call back and EDT would come and take him for an assessment. The operator explained they were not able to do anything the first time these types of concerns were raised with them, as they might be a one-off. Susan explained to the operator that 111 practitioners had been to see him, but that he had refused to talk to them. The EDT practitioner told Susan they were unable to see any record of the 111 visits on their system. The practitioner again reassured her that if the strange behaviours continued and she had concerns, or Maria felt unsafe, she should call them and they would have the power to take him away to conduct a mental health assessment.

9th Feb (Source – Rebecca) At just before 21.30 hrs, Susan texted Maria the following message, which has been translated from its original Polish, *Hi Maria, it's Susan. I phoned the number (Redacted).[81] This is nr Cambridgeshire County Council Out of hours Social Services for Adults. They should have now Christopher's personal details and run down of his situation. They told me themselves that I can call them back if anything happens.[82]*

Contact 3 - GP Practice 2

10th Feb: (Source – Rebecca) Maria tried to get an appointment for Christopher with her own surgery (GP Practice 2), but the surgery would not see him, because he was still registered at GP Practice 1.

10th Feb: (Source – Maria's translated diary entry) states, '*I went to the doctors but they have told me that he is still belonging to the other one. Christopher dint come and did not answered his phone until after 7.'*

11th Feb: (Source – Rebecca) Maria was still working and going to Christopher's GP almost daily, trying to get him some help. Eventually, she managed to obtain a sick note from his GP after explaining that he was liable to lose his job and be destitute as a consequence of his unexplained absence from work.

Contact 4 - GP Practice 1

11th Feb: (Source – GP Practice 1) Just before 16.00 hrs an AskMYGP task was sent to Christopher's GP, on behalf of Maria, requesting a sick note for Christopher. The record documents her continuing concerns for his mental health and her fears that he may be suicidal, she added she had contacted FRS in the past regarding this.

She described she was still awaiting his registration with the new surgery. The record describes that unsuccessful attempts were made to contact her on the number provided, to

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[81] This is confirmed as the telephone number for Cambridgeshire County Council Out of Hours Social Services for Adults

[82] Copy of text message from Susan to Maria on 9th February 2021

advise her to contact NHS 111 (Option 2) if he was suffering a mental health crisis, and that the GP was happy to discuss this if she called back. A message was sent to the reception staff to continue attempts to contact her. The record documents a backdated sick note was issued for Christopher for the period 25th January to 24th February 2021.

11th Feb: (Source – Transcript of recording of outgoing call made from Maria's phone) The time and date of this call cannot be established; however, the content of the discussion indicates this was a call to GP Practice 1 and occurred around the 11th February. The recording audits only Maria in the conversation which has been translated from its original Polish.

Maria described the problems she had experienced in registering Christopher with an alternative GP and stated that she had been to the surgery the day beforehand. She appealed for help in completing the registration form, which she described she had finally managed to get him to sign on the 9th February, but she explained that he was still registered at GP Practice 1. She described he was depressed and said that he would lose his job if he wasn't provided with a sick note by the GP. She expressed her concern that he would hang himself because he was so ill.

She then described the conversation that Rebecca's daughter Susan had with the EDT. She said that she'd given the number for the EDT to someone at GP Practice 1 reception, so they could call EDT and ask about Christopher. She explained that she had called the 111 service on 3 occasions and they had come to see her once and that the 111 practitioners had done nothing and that, "no-one made any notes." Maria then seemingly described that when Susan telephoned the EDT, they had no record of Christopher because the FRS practitioners hadn't recorded anything. She explained she'd asked the 111 practitioners to take him to the, "ER."

She said that she knew Christopher was, "planning something" and explained that she had finally managed to talk him into signing the form 2 days previously, so that he could obtain a sick note because he hadn't been to work. She reiterated that he hadn't wanted to sign the form.

She appeared to explain he was being evicted from his accommodation the following weekend. With regards to this she said, "I won't take a sick person in because I don't know what's wrong with him." She explained the EDT told Susan that his illness could be something that happened once in a lifetime, where he simply did not remember what he was doing, or what he had done, for a period of time. Maria was seemingly explaining that he didn't remember he wasn't going to work, but hadn't been to work for a considerable period of time and that she knew this to be true from his manager.

She said that she didn't know what to do anymore and explained she was suffering with her own health. She expressed her concern that if he did something to harm himself, she would blame herself and queried why no one would help her as, "the contributions were paid." She asked what she should do in light of the fact that no GP would treat him. She explained that Christopher told her he didn't need a sick note because he was convinced, he was going to work every day, which was untrue.

The next part of the discussion appears to be centred on Maria trying to arrange a sick note for Christopher. She explained that he refused to talk on the phone. She described she'd tried to get him to come to her home to speak to the doctor, but that he'd refused to answer

his phone until after 19.00 hrs. She made reference to his limited English language capability, which she described as worse than her own. She expressed a preference that any contact from the GP should be at her home, or through her, because he wouldn't answer his phone or wouldn't understand because of his limited English. She said, "So I know he won't answer, and what will I do?" She then appeared to have made an arrangement for a call to her own number and remarked, "But what can I do if they don't give me the sick note, then what?"

Maria then invited the person she was talking with to, "Say that I said that his life is in danger, I know it one hundred percent, just write it down and I will just hold someone responsible because it can't be like that." She also described, "For three weeks all I've been doing is running around."

She then reiterated the conversation Susan had with EDT who appeared to have informed her that his illness might be temporary and resolve itself. Maria explained that his illness was not resolving itself and that one of her friends had queried if he might be possessed. Maria said she'd considered this, but wasn't able to say because no-body would examine him. She again appealed for the GP to issue a sick note to protect his employment status so that she could then try and engage with, and appeal to, other services to try and get them to examine him.

Maria invited the person with whom she was speaking to record the fact that she was requesting a sick note and requested, "Please write it down, I want it written down."

She explained he hadn't been to work for 3 weeks and that when he came to her home his hands were sweaty. She described asking him if he'd been drinking and him responding that he had been to work, and questioning her as to why she would think he had been drinking when he had been working. She expressed her concern that his thoughts were, "tumbled with all this and he went crazy, he just doesn't want to live anymore." She explained this was why she believed he was depressed and said she knew he wouldn't attend the surgery, or talk to the GP and queried why doctors didn't understand this.

She asked what she was supposed to do and whether it was expected that she, "Leave him like this?" She explained that she had been to GP Practice 2 previously with his registration application, on the same day that she had obtained the form. She said she'd been asked who had signed the form and she'd admitted signing the form because Cristopher refused to sign anything. She explained her predicament that because he refused to sign the form, he was unable to access care, or a sick note. She asked what she should do in these circumstances.

She repeated her appeal for help in completing the form which he'd now signed as she was unaware of much of the detail that needed to be included on the form. She explained that she would similarly struggle translating Polish to English on Google translate.

Maria repeated her appeal for help and again referred to her own health struggles. She explained, "I don't know, I'm doing everything I can, but I won't leave him, I will feel guilty all my life that I saw what was happening to my child and I couldn't help."

Maria then appeared to express frustration that she hadn't been able to get an appointment for Christopher at GP Practice 2 because of him still being registered at GP Practice 1. She

explained how careful she'd had to be when persuading him to sign the form and described her fears that he might stop at any point and refuse to sign it.

She explained that Christopher's landlady had also called 111, but that later others came to the address. It is possible that Maria was expressing the fears conveyed to her by his landlady in this part of the conversation. She referenced concerns that he would get up in the night and start cooking and fall asleep. She described him bathing with his clothes and shoes on. She also mentioned him talking to himself for 4 hours, but questioned whom he was talking to.

Maria said she didn't know what was in his head and whether he would ever get back to how he was previously. She said that he had asked her for sleeping tablets approximately 6 weeks earlier, as he wasn't able to sleep. She said that she refused to give him anything hoping that he would go to the GP. She explained that she'd initially thought he may have been on drugs, but had dismissed this as it wouldn't have lasted for so long and he would have returned to work by now. She said something had happened to him and queried if this might be connected to the length of time he was depressed as a result of not being able to see his son.

She described that 2 days previously, he had spoken to her normally, but had then refused to answer his phone until after 19.00 hrs. She recalled berating him because he was aware the GP might call, but described he didn't want help. She explained he had, "Closed in on himself, like a wall."

She requested the person she was speaking with to, "talk to the doctor," because she had been asking for help for so long. She explained she had been to her own GP the day previously and they refused to treat him because he was still registered at GP Practice 1. She said she couldn't stand it any longer and expressed her fear that he would, "do something to himself." She reiterated that he was still registered with GP Practice 1 and that no-one would help her. Maria queried as to whom would be responsible if something were to happen.

There was then an apparent agreement by the person she was speaking with to help Maria with the registration form. Maria then appeared to make reference to an arrangement for further discourse with the GP later that day, which most likely alludes to the conversation between Maria and the GP at GP Practice 1 later that afternoon. (Contact – 6 - GP Practice 1)

<u>Police incident – 3</u>

11th Feb: (Source - Police IMR) The record describes Christopher's landlady contacted police and spoke to a call handler in the control room.[83] She described his concerning behaviours and explained he was saying he was on holiday and not going to work, in spite of his manager's assertions to the contrary.

Margaret described she had called the NHS 111 service on 30th January, because he'd taken a shower fully clothed and flooded the house. She explained he'd refused any help

[83] Margaret said she did not speak to anyone from Cambridgeshire Constabulary at the time of making the report or subsequently. She recalls all interaction with the police with regards to this event occurred online.

from practitioners over the telephone. She related the visit by 111 practitioners to her home address trying to engage him and his refusal to speak to them.

She told the call handler she was getting more concerned about his mental health and indicated his behaviour was beginning to frighten her. She said he had seen his GP and was signed off sick from work.[84] She explained he was being evicted in the following days and wanted her call to be logged in the event he refused to leave or if there were problems. The record describes that she did not request an officer to attend her address.

The incident was recorded and a flag was placed on Margaret's address in the event of any future problems. An email response was sent to Margaret by the police acknowledging her report. No resource was despatched and the incident log was closed with no further police action being taken. No referral was made to the Integrated Mental Health Team (IMHT), who were on duty in the Force Control Room (FCR) at the time of this report, or subsequent to the incident being closed.

11th Feb: (Source – Margaret) Christopher's landlady was growing increasingly concerned about his mental health and more worried about her own personal safety and welfare. She called the police non-emergency number at approximately 16.00 hrs. She was placed on hold and decided to end the call and report her concerns via the Cambridgeshire Constabulary online service.[85]

At 16.17 hrs, Margaret made the following online report to Cambridgeshire Constabulary: - *Mid-January my lodger, Christopher (who is Polish and speaks very little English) was at home and he told me he was on holiday. He has not been to work since and his work (Redacted) were very concerned for his welfare as they hadn't heard from him. On 30 January I rang 111 as Christopher went it the shower with all his clothes on, and was flooding the lounge below, when I knocked on the door he just into his bedroom and ignored my friend Peter and myself. (The next day Peter when to give him his dried clothes and he said they were not his). 111 said I was to ring for an ambulance. The ambulance person had a Polish interpreter speak to him. He told them he was ok, so that was all they could do. He had worried his mother so much that she arranged for 111 operators to attend the house to speak to him. He walked off, went upstairs and watched a film. He ignored their interpreter and told them to get out of his bedroom when they went to speak to him. I am getting more and more concerned as to his mental health. He and his mother hold the view that covid doesn't exist and he frequently invites people to his bedroom. I happened to notice that he was burning candles all around his bedroom as well, not realising it was dangerous. I now have a lock on my lounge door (I sleep in the back part of the house) and, when Peter (other housemate) is here I feel ok. Unfortunately, Peter works shifts and at night I am very, very worried for my own welfare now. He is meant to be moving out of Sunday, but seems to have forgotten that also. I do want him to leave on that day for my own sanity. I would appreciate it if the above could be noted in case of problems. Thank you.*[86]

Contact 5 – GP Practice 1

[84] Maria managed to get a sick not for Christopher on that day 11th Feb but Christopher had not seen a GP and Margaret's email makes no reference to him seeing a GP

[85] The police recognise that people might not always want or need to call them on the phone, so they offer other options including; online reporting forms, Twitter (X) and live chat

[86] Email from Christopher's landlady Margaret to Cambridgeshire Constabulary dated 11 Feb 2021

11th Feb: (Source – Transcript of recording of incoming call made to Maria's phone) Maria made a recording of a telephone call she received around this time. The time and date of the recording cannot be accurately established; however, the content of the discussion indicates this was a conversation initiated by GP Practice 1, to make arrangements for Maria to collect the sick note she refers to in her diary entry of the 11th February.

Maria agreed to collect the sick note from the surgery when she finished work that afternoon. She made reference to Christopher's serial failure to answer his phone and refusal to speak to anyone. She reiterated he had not attended work for 3 weeks and was only sleeping. She referenced people not helping him and said, "I need some help for my son because he going to kill self."

Contact 6 – GP Practice 1

11th Feb: (Source – GP Practice 1) At 16.45 hrs, Christopher's GP telephoned Maria, supported by an interpreter. She told the GP there was something different about Christopher and that he'd told her all his past medical history was hers and that he forgave her. She described he also told her about a new relationship he was having with a woman who had a child, with the same names as his ex-wife and child. She also described he was mentioning souls and said that God was telling him to do things.

Maria discussed his previous history of depression, linked to his divorce and child access issues. She explained he now saw his son every few weeks.

The record documents Christopher expressed no wishes to harm himself or others,[87] but had told Maria he felt very low and introverted, and was acting on voices. She described he lived with his landlady and was currently in bed pretending to go to work and doing other odd things, including telling her, 'She had brought the devil with him.'

The record describes Christopher was seen sitting in a car watching other children.[88] A safeguarding referral was considered unnecessary, as the GP concluded any safeguarding concerns would have been identified, assessed and managed by the FRS.

Maria was advised about NHS 111 (Option 2) and was reportedly informed the GP would contact FRS directly.[89] The record documents she required a Polish interpreter to support her.

GP Practice 1, FRS and EDT engagement (EDT Contact - 2)

11th Feb: (Source GP - Practice 1) The record describes that as a consequence of their earlier conversation with Maria, the GP contacted FRS who advised the GP to contact the EDT, as FRS were unable to force entry to make a MHA assessment and Christopher had refused to engage with them previously.

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[87] Maria made several references to GP Practice 1 staff that day, in 2 separates phone calls, where she expressed fears that Christopher would hang himself, that his life was in danger and that he didn't want to live anymore. In a separate call to GP Practice 1 that day she described she needed help because Christopher was going to kill himself. There is no recording of Contact 6 with GP Practice 1 and so no evidence to contradict the GP record that Maria reported Christopher "has not expressed any wishes to harm himself or others".

[88] There is no other information to provide any further explanation of this in the record. There is no information in any other account or agency record with regards to Christopher being seen watching children

[89] There is no evidence to indicate that Maria was aware of the GP's contact with FRS, and subsequently, with EDT

The record documents the GP then made contact with EDT who agreed to make direct contact with Maria to discuss the need for a MHA assessment.

11th Feb: (Source - CPFT IMR) The FRS record of the same event describes the GP from GP Practice 1 telephoned FRS and informed the FRS practitioner about the telephone conversation they had engaged in with Maria that day.

The FRS practitioner explained to the GP that FRS colleagues had spoken to Maria previously and made all reasonable attempts to engage with Christopher on, 'previous occasions.'[90] They advised the GP they'd provided Maria with details of how to get in touch with the EDT if required. The FRS practitioner provided the GP with the telephone number for the EDT and, the record describes the GP was updated on the previous plan which had been documented in FRS records.[91]

The record documents the GP did not indicate that Maria was in fear for her safety and the practitioner concluded, there was no change to the presenting situation from when FRS had unsuccessfully attempted to assess Christopher.[92]

The call was documented by the FRS practitioner as a handover from FRS to the GP[93] and the practitioner concluded there was nothing to warrant FRS re-opening the case. The record documents there was no further role for FRS at that stage.[94] There is no evidence the case was placed on the consultant list, in response to this call, as was directed in the record made by the FRS senior clinician on 4th February.

11th Feb: (Source – EDT IMR) The EDT record of this event describes the GP (GP Practice 1) contacted the EDT, but was reportedly unable to get any response from a practitioner and left a message with the call centre leaving their contact details. The record describes the GP explained that over the last number of weeks, Maria had been reporting Christopher's unusual behaviours. The GP conveyed that Christopher had no history of mental ill-health [95] and that they had never personally met him. The GP stated all the information was provided third hand by Maria. The GP also reported Maria did not speak good English and would need interpreter support.

In response to the message left by the GP, an EDT social worker attempted to call the GP Practice 1 surgery, but it was closed and no other contact number had been left by the GP. The social worker undertook a system check and noted that Christopher was not known to Adult Social Care, but that he was recorded as having contact with FRS, including the fact

[90] FRS only attempted to engage Christopher on 1 occasion

[91] The FRS plan was based on the GP from GP Practice 1 engaging Christopher to discuss his general health, as a means to assessing his mental health. It also documented that Christopher's care was handed back to his GP by FRS on this basis

[92] The FRS plan for the GP to engage Christopher to discuss his general health, as a means of assessing his mental health, had not been implemented by the GP who had made no attempt to engage Christopher on this basis at any point. The FRS plan had not been recorded in the GP record (see footnote 79)

[93] The FRS recorded in their plan of the 4th Feb, that the handover to GP Practice 1 took place on that date. FRS previously documented they had closed Christopher's case on this basis on the 4th Feb

[94] The GP's call was not treated as a referral to FRS and the case was not placed on the consultant list for review as directed by the FRS senior clinician on 4th Feb in the event of any further contact with FRS by Maria or Christopher, which this indirectly was

[95] Christopher expressed thoughts of taking his own life to the GP in Jul 2016 and was diagnosed with signs of depression in Feb 2017. See paragraph 16.29 for the GP Practice's explanation of how past medical history is recorded.

that he had refused to engage with FRS practitioners.[96] The social worker recorded there were no social care concerns.

The social worker decided not to call Maria, as the GP had advised she did not speak English. In parallel, the social worker concluded there was no information to indicate any urgency or emergency and concluded there was no necessity to pursue the matter further. A note was placed on the system by the EDT social worker for the information of FRS.[97]

11th Feb: (Source – Maria's translated diary entry) With regards to this event she wrote, '*After work I went to Christopher's doctor surgery and I told him that he still doesn't attend work and I told him that he has worrying thoughts. I asked for sick note again for him.'*

Later in the same entry for the same day, she noted, '*The lady from reception call in relation to a sick note.'* The diary entry for the following day, 12th February, merely records that Maria went to GP Practice 1 to collect his sick note.[98]

11th Feb: (Source – Transcript of recording of outgoing call from Maria's phone) Maria recorded a telephone call she made around this time. The time and date cannot be accurately established, but the content of the conversation indicates this was a call to Christopher's manager on the 11th February. The relevant extracts are summarised in the following paragraphs.

Maria confirmed she was speaking to Mark and described she had been trying to get a sick note for Christopher for 2 weeks. She explained he had a mental problem and that she'd been to the GP earlier that day and told them she was concerned he may kill himself. She explained he was seriously depressed and that the GP had agreed to provide a sicknote, which she'd arranged to pick up from the surgery the following day.

She made arrangements to deliver the sick note to Christopher's workplace the following afternoon and explained the GP had retrospectively signed him off work from the 25th January until the 24th February.

She went on to describe the impact of Christopher's depression on his persona and thanked Mark for his patience. She explained she had been continually asking for help for him, but that nobody wanted to help, including those who had been to see him.

11th Feb: (Source – Maria's translated diary entry) The unedited entry for this date states, '*After work I went to Christopher's doctor surgery and I told him that he still doesn't attend work and I told him that he has worrying thoughts. I asked for sick note again for him. The lady from reception call in relation to a sick note. After work I went to Christopher as he wasn't answering his phone. The landlady told me to get out and she was physically touching me kind of shaking. I told her that Christopher is unwell and I have the right as a mother to come and see if he is ok and weather he has eaten anything. Christopher told me not to visit him at his address and that he will come to me.'*

[96] There was no reference in the record to the 2 calls which Rebecca's daughter Susan reportedly had with EDT on the evening of the 9th Feb as recalled in the account of Maria's close friend Rebecca and referred to in a text to Maria's phone from Susan

[97] This would not have alerted FRS of the contact with EDT as there was no open referral to FRS as they had closed the case on 4th Feb and did not treat the GP's call as a new referral

[98] Maria's translated diary entry for 11th and 12th Feb make no reference to her being made aware of the GP contacting FRS, EDT or the outcome of these interactions.

11th Feb: (Source – Transcript of recording of outbound call made from Maria's phone) Maria recorded a telephone call she made to an unidentified work colleague around this time. The date and time of the recording cannot be established, but the content of the discussion indicates the call was made on the 11th February. Much of the content of the conversation is irrelevant to this review, but the relevant extracts are summarised in the following paragraphs.

Maria described she had been to the doctors after work that day and told them that she thought her son wanted to kill himself. She explained she needed help and had been asking for help for 3 weeks. She said that no-body wanted to help and that she'd been provided with a sick note for Christopher until the 24th of February.

She explained her son was suffering with serious depression and wasn't attending work. She reasoned that, as a mother, she knew her child better than anyone. She described that her heart was heavy and she was unable to sleep because of her concerns for him. She added that he refused to go to the doctors and wouldn't speak with anybody. She appeared to reason that the only way he would get help was if he was taken to hospital against his will, because of his refusal to engage with medical professionals.

12th Feb: (Source – Maria's translated diary entry) states, '*After work I picked up Christopher's sick note. Ladies asked me to say hello to him. Christopher wasn't answering his phone all day. I don't know what to do. I pray to God to help him to come back to be himself.'*

13th Feb: (Source – Maria's translated diary entry) states, '*Christopher wasn't answering his phone.'*

<u>Ambulance call – 2 and Eviction</u>

14th Feb: (Source – EEAST IMR) The records describe that at 18.13 hours, Christopher's landlady called 999 requesting an ambulance. She reported he was having suicidal thoughts, struggling with his mental health and exhibiting strange behaviours. She also said he'd been told to leave her property as she didn't feel safe. The record makes reference to the earlier incident, where Christopher was spoken to by the ambulance service on 30th January. (Ambulance call – 1)

Margaret reported Christopher was Polish and appeared to be, 'going downhill.' She explained this was his last day at her property and said he was crying and didn't know where he was going to go. She expressed concerns he was going to harm himself. The ambulance crew arrived at the address just over 30 minutes later.

Margaret informed the paramedics he had been exhibiting odd behaviour's including him showering fully dressed, bringing strangers into the house and not going to work. She mentioned he'd spoken about suicide and self-harm. She described he'd stopped paying his rent without explanation, but believed he was still paying rent. Others, who were present, but not identified in the record, advised the paramedics that he had been wearing the same clothes for weeks at a time.[99]

Margaret told the paramedics that he had to leave her home as she no longer felt safe, but that he couldn't remember their conversation about this. The paramedic's noted Margaret was

[99] The unidentified person was likely to be Peter, Christopher's housemate

visibly upset and that Christopher would be homeless that night. He denied taking drugs, but admitted consuming alcohol. He agreed to be conveyed to hospital, but the paramedic's remarked he appeared fidgety and wouldn't make eye contact. They noted he kept staring at the same spot whilst talking. They documented that he could be verbally aggressive.[100]

The ambulance left with Christopher at 19.46 hrs and handed his care over to staff at Hinchingbrooke Hospital at 20.30 hours.

14th Feb: (Source – Margaret) With regards to the same event, Margaret recalls that Christopher was due to be evicted that day. She described he went to Maria's for lunch and returned about 18.00 hrs. She reminded him he had to leave that day and he became visibly upset and asked if he could stay if he provided her some money. Margaret felt that she had to decline his request, but was concerned about his welfare and his mental health, as it seemed clear to her that he needed professional help. She asked him if he would speak to paramedics if she called him an ambulance, to which he agreed.

One of the paramedics spoke Polish and they were at her home for a considerable time, physically examining and talking to Christopher. She told the paramedics about the strange behaviours she'd witnessed and related what Maria had told her and the FRS. She asked the paramedic if he might be bi-polar or have schizophrenia, as he appeared to be responding to different people. The paramedic said they thought it might be more serious than that.

The paramedics checked his vital signs and tried to engage him in conversation, but he was mostly vacant. Margaret told them he was being evicted that day and couldn't come back to her address.

The paramedics told Christopher they were taking him to be assessed by a doctor. They repeatedly asked him where he was going to go when he was released from hospital, as he couldn't go back to Margaret's home. This topic didn't appear to register with him and he continued to stare vacantly. The paramedic asked him if he'd taken drugs or drank alcohol and he said he'd had a, "little bit."

As the paramedics were conveying him to the ambulance, Margaret told them that she needed his key, as he was being evicted. The paramedic again made it clear to him that he couldn't return to Margaret's home and he then handed over his key. He was then placed into the ambulance.

Hospital admission and discharge

14th Feb: (Source - North West Anglia Foundation Trust (NWAFT) record and discharge note) The record describes Christopher was admitted to Hinchingbrooke Hospital due to a mental health complaint. There is reference to a note from the ambulance personnel indicating he was conveyed to hospital due to unusual behaviour and suicidal thoughts. Christopher explained the ambulance was called by his landlady and that he didn't know why he'd been taken to hospital. He denied feeling suicidal or having consumed alcohol.

[100] There was no further information in the record to expand on Christopher's verbal aggression

He was subject to a CT scan of his head, a chest X-ray and blood tests. He was discharged with no follow up treatment at 23.07 hrs the same evening. The hospital record describes he was, 'discharged home.'

The address where he was evicted from that day was recorded in the hospital record as his home address. There were no referrals to mental health services and the record stipulated there were no safeguarding concerns. There is no evidence the services of an interpreter were accessed during this event.

14th Feb: (Source – Maria's translated diary entry) states, '*Christopher came and eat dinner. He spoke to Stephen and Grace. I went to bed at 10hrs. At 10 to 2 am Christopher came and said that he was in hospital and asked if he could sleep here as he forgot his keys.'*

15th Feb: (Source – Rebecca) Christopher arrived at Maria's home in the early hours of the morning. Maria said that he was discharged from hospital after his landlady called an ambulance, due to concerns for his mental health. She didn't know why he was discharged from the hospital. He had walked to her home from the hospital and had nowhere to go, as he had been evicted. Maria said she couldn't let him sleep outside.

Contact 4 - GP Practice 2

15th Feb: (Source - GP Practice 2) Christopher's registration application was accepted by GP Practice 2. He was recorded as living in St Ives[101] and his mobile telephone number was documented on the record.

15th Feb: (Source – Margaret) In the early evening, Christopher arrived at Margaret's house to collect some of his belongings. She was shocked to see him as she expected him to still be in hospital. He told her the hospital discharged him in the early hours of the morning and he had walked back to his mum's home. She was concerned about this due to the considerable distance involved and the fact he was clearly mentally unwell.[102]

Contact 5 – GP Practice 2

16th Feb: (Source - GP Practice 2) Maria attended GP Practice 2 reporting she was very concerned about Christopher. Maria and Christopher were given a telephone appointment with the GP for later that day.

Contact 6 - GP Practice 2

16th Feb: (Source – GP Practice 2) During a telephone consultation with the GP, Maria explained Christopher seemed, 'lost' and had not been himself for 4 weeks. She remarked that he was angry and not going to work. The GP spoke with Christopher who said his mood was okay now and couldn't remember how he had been feeling. He denied experiencing low mood or feeling depressed and didn't feel he needed help from a doctor.

The record describes Maria agreed he was better than he had been 2 to 3 weeks previously, but she reflected he was not his normal self. The GP directed they would call Maria and Christopher back in 3 days, but offered the option for them to call back sooner if they

[101] Christopher's address was not documented in the record.
[102] RAC Route Planner indicates the distance between Hinchingbrooke Hospital and Maria's home is 6.53 miles and estimates it would take 2 hours 22 minutes to walk the most direct route

required. They were advised they could contact NHS 111 (Option 2). The record describes Maria saying she had telephoned NHS 111 (Option 2) previously, but hadn't found this helpful.

There is no evidence the services of an interpreter were accessed in this consultation. The record reflects that Maria didn't speak good English and noted a degree of uncertainty about how much Christopher understood what was being said.

16th Feb: (Source – Rebecca) Maria tried to make an appointment for Christopher to see the GP at her own surgery after his registration was accepted. She managed to get a telephone appointment. She told the GP he was very ill and needed medication. She said that he believed he was still going to work, but he hadn't been to work for 3 weeks. She described the GP asked him how he was and he said he was ok. Maria told the GP that he was not ok and that he was ill. She said that she reminded the GP that she was his mother and therefore knew he was sick and needed medical help.

Maria told the GP she needed help, as she had to work and he was acting so strangely and was coming and going randomly, which she was struggling to cope with. She said the GP was unable to prescribe any medication over the phone and she would need to make an appointment for him to see the GP in person.

16th Feb: (Source - Maria's translated diary entry) states, '*After work to the doctor's surgery. Doctor (Redacted) called- he spoked to Christopher and with me. Christopher told him that he feels ok but he is still not like he was before. Doctor is going to ring on Friday at 15:20.'*

Transfer - from GP Practice 1

17th Feb: (Source - GP Practice 1) A record was made by GP practice 1 indicating Christopher was being transferred and that his medical notes were waiting to be sent to GP practice 2.

17th Feb: (Source - Maria's translated diary entry) states, '*Christopher was pilling (?) and I am always giving him activity to do so he doesn't think about strange things.'*

18th Feb: (Source - Maria's translated diary entry) states, '*Christopher got £200 for 3 weeks. He took out £50 and gave me £20. I took his card and told him that if he needs the money, we will go together to cash point.'*

19th Feb: (Source – Margaret) Christopher went to Margaret's home. A number of boxes containing his belongings were stored in the back bedroom and he was searching through them for his passport. Margaret believed he needed his passport to register at the GP's surgery.

Contact 7 – GP Practice 2

19th Feb: (Source - GP Practice 2) The GP attempted to contact Christopher by telephone, which was pre-arranged during the previous telephone consultation on 16th February, but he didn't answer. The GP then spoke to Maria on the telephone. An appointment was made for Maria to attend the surgery with Christopher the following Tuesday 23rd February at 17.00 hrs.

19th Feb: (Source – Transcript of recorded incoming call made to Maria's phone) Maria made a recording of a telephone call she received. The time and date of the call cannot be

accurately established. The topic of the discussion indicates the recording relates to the conversation with the GP, as described in the GP record for the 19th February. (Contact 7 – GP Practice 2). As with all the call recordings, only Maria's side of the conversation is captured.

Maria said she'd just returned home from work and queried if the GP had spoken to Christopher. The conversation indicated the GP then offered an appointment for Monday 22nd February, but Maria explained she was working all day that day.

Maria said that Christopher looked normal, but that he was not back to himself and was lost and not normal like he had been previously. She explained she wanted someone to check his brain to see if there was any abnormality and indicated she had requested this of his previous GP (GP Practice 1). She expressed concern he had no medication which she thought he needed to help with his condition.

She told the GP she would need to attend any appointment with Christopher as she was concerned the GP didn't know him. She described that he didn't remember he was sick and couldn't remember anything. She expressed concern he would say that he was well and didn't need any help.

There was some dialogue about the timing of an appointment and Maria explained that she'd had to stay at work late that day because someone hadn't turned up for work.

The recording appears to indicate a face-to-face appointment was made for Tuesday 23rd February at 17.00 hrs.

19th Feb: (Source – Rebecca) Maria managed to make a further telephone appointment with the GP for Christopher on the 19th February, but on the day of this appointment, she was required to stay at work. Maria said the GP tried to call him, but he hadn't picked up. She later spoke with the surgery and tried to arrange a face-to-face appointment, so the GP could observe him. The appointment was arranged for the following Tuesday the 23rd February.

19th Feb: (Source – Maria's translated diary entry) states, '*Doctor (Redacted) called – Christopher didn't spoke to him as he said that he forgot and that his phone was dead. I have made arrangements for Tuesday at 5 to come with Christopher. Christopher send me pictures today but when I asked him about it he said that he doesn't remember that he has send it to me. In the evening he had another weird behaviour episode. He stood and was thinking, finally he approached me and whispered to my ear- mum call the police. Now call the Police! Only don't say it to anyone – call the Police. He behaved very weird. He was dancing as if he was 10 years of age and he was making strange moves. In the evening he wanted to go out for the cigarette with his pans and jumper.*'

<u>Police incident - 4</u>

20th Feb: (Source – Police IMR) Between 18.50 and 20.21 hrs, a series of seven calls were made to the police from Christopher's mobile phone. The majority of calls were abandoned without the police operator engaging in any dialogue with the caller. Two of the calls received in the FCR were from members of the public reporting they were calling on behalf of a foreign male who claimed to have won the lottery. The first of these calls, at 19.47 hrs, was terminated by the caller and no other details were recorded and no resources were despatched. Christopher's phone was not recognised on the police system as a previous

caller. At 20.21 hrs, another member of the public called the police having been asked to speak to them by an unidentified male regarding his lottery ticket. No details were recorded, or resources despatched. This call was not linked to the earlier call at 19.47 hrs by the police.

During this period, Christopher's handset also made 3 calls to the 999 service and 1 call to the police 101 service. None of these calls were received by the FCR, due to the caller discontinuing the call before any connection was established.

Police incident - 5

20th Feb: (Source – Police IMR) At 23.25 hrs police received a 999 call from the complainant for one of the attempted residential burglaries, which were reported to police on 30th January (Police incident – 2). The complainant reported the intruder who gained access to their home on 30th January, had returned and was knocking at their front door. The caller reported they had recorded an image of the intruder on 30th January and believed the male at their front door was the same person as in the image recorded on their phone.

Police arrived at the scene at 23.37 hrs and found Christopher sat on the porch outside the address. They asked him why he was at the address, but noted that he wasn't engaging. He told the police he spoke little English, but made reference to having a winning lottery ticket. Police noted he was not answering their questions and was acting strangely. He denied consuming alcohol, or being under the influence of drugs. He told the police that he'd had his head checked by ambulance staff a few weeks earlier and that he was, 'not mental.'

Police arranged for a telephone interpreter. Christopher then explained that God had sent him to the address to drink tea. The police viewed the image of the intruder recorded on the complainant's phone and concluded that the image was not that of Christopher.[103]

The police advised him not to return to the address, or to attend any other addresses asking for tea. They warned him he would be liable to be arrested if he did not heed this advice. He reportedly confirmed he understood this instruction. The police then followed him to Maria's address where they left him outside.

The record documents the officer's consideration that no offences had been committed. The police submitted an adult at risk concern for welfare referral due to Christopher's strange behaviour.[104] The investigating officer for the attempted burglary offences was also notified of Christopher's details for any necessary further enquiry.

The police closing code for the incident was not tagged with a mental health code and was not referred to the IMHT for review when they were next on duty in the FCR.

The police did not link this incident to the email that his landlady, Margaret sent to police on 11th February. (Police incident – 3)

20th Feb: (Source – Maria's translated diary entry) states, '*Christopher wanted his bank card. He told me that he managed to get himself a sick note and that Margaret was going to give him back £180. He went to look for a place to live and that in two weeks he will be going back to work and that he spoke to Mark. He wanted his card but I didn't give it to him. He*

[103] The image was confirmed to be that of Christopher by the homicide investigation
[104] The submission of this referral alerts community safety partnership agencies to safeguarding and welfare concerns through the MASH

wanted £10 so I gave it to him and he went off. He came back at 3am- he was walking around the house at all time and was going outside for the cigarette. I woke up at 10 am – Christopher wasn't there.'

21st Feb: (Source - Police IMR) at 10.25 hrs Christopher sent Maria a text. The text was in Polish and is translated as, *it's coming*.[105]

21st Feb: (Source – Margaret and Peter) Christopher went to Margaret's house to collect the boxes of his belongings and was ringing the doorbell constantly. She recalled he came and went about a dozen times. Peter described he picked up a number of boxes and placed them on the driveway and kept standing outside having a cigarette. Peter also saw him knocking at the doors of a number of houses nearby. He asked Peter for a lift, but he wasn't able to oblige him because he had other plans. Peter saw him ride off on a pedal cycle carrying a plastic bag with some of his belongings. He left the rest of the boxes on the driveway which remained there until the following morning.

<u>EDT Contact - 3</u>

21st Feb: (Source - EDT IMR) The record describes Rebecca telephoned the EDT and said she was calling on behalf of Christopher's mother Maria, due to her limited English fluency. She reported Christopher was evicted from his flat due to rent arrears, was now living with Maria and was having a mental health crisis. She expressed concerns about his mental health and said Maria was struggling to cope with him.

She described he was acting oddly, he was whispering, talking about the devil, speaking like a child at times and believed that God was speaking to him. She reported he hadn't slept well the previous night so his mother felt that she needed to be awake as well. The record describes there didn't appear to be any concerns regards his appetite or any aggression towards Maria; he was just acting bizarrely. There was also reference to an occasion when he went out of the flat in his underpants.

The record reflects Rebecca felt he needed to be assessed again and said that she had spoken to someone previously about this, but was not sure if Christopher was known to services.[106]

The EDT social worker advised her they were unable disclose details due to confidentiality but was aware of previous contact with the FRS and EDT. There is nothing in the record to indicate what these previous contacts referred to, and there is no evidence that Rebecca's reference to speaking to someone previously about this was explored by the social worker.

The EDT social worker discussed safeguarding issues and was reportedly informed that he wasn't showing any aggression. There was some mention of potential drug use, but this was unclear.

The EDT social worker explained to Rebecca that prior to a MHA assessment the FRS would need to assess him again, as a least restrictive option to an assessment under the MHA.[107]

21st Feb: (Source – Rebecca) With regards to this same event, Rebecca said she called the same number as dialled by her daughter Susan on the 9th February. She requested to speak

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[105] There is no evidence this was reported to any agency or professional prior to Maria's homicide

[106] There is no corresponding EDT record of Rebecca's daughter Susan's 2 calls with EDT on 9th February.

[107] Christopher's mental health was never assessed by any professional prior to his arrest for Maria's homicide

with the operator Susan spoke to, but she was told this wasn't possible. She told the operator the background with regards to Christopher and asked them to send someone to take him for an assessment. She argued the behaviours they had earlier reported to the previous EDT operator were continuing and worsening. The operator told her, "It doesn't work like that," and advised her that she would have to ring NHS 111 (Option 2). She told the operator that he refused to talk to the 111 service previously and argued that the previous operator told Susan, that if his strange behaviours continued, they should call this number and someone would take him for an assessment. The operator told her they had a record of Christopher, but that she would need to re-contact NHS 111 (Option 2) in any event. She repeated that he refused to speak with the 111 operators, but the EDT operator continued to insist she contact NHS 111 (Option 2) again.

In response to the outcome of her call to the EDT, Rebecca called Maria and told her she would have to call 111 (Option 2) again. Maria said she would do this the following day, as Christopher had found a property to rent and had asked her for money to pay the initial rent. Maria explained she was getting ready to accompany him to speak with the property owner to ensure they were aware of his circumstances and wouldn't evict him.

Maria said Christopher arrived home in the early hours of the morning and kept her awake playing loud music. She said she saw him sneaking out of the house early that morning, but didn't know where he had been.

Police incident - 6

21st Feb: (Source – Police IMR) Just after 18.00 hrs, police responded to a report of robbery and shoplifting at a local convenience store. On arrival they spoke to Christopher and it was established he had taken and consumed a beer at the shop, believing he had been extended credit as a result of him winning the lottery. It became apparent that he had misinterpreted an advertising email he received from the Euromillions lottery. The responding officers described he appeared 'vacant' and, at times, 'confused.' They were initially unsure if this was a consequence of his obvious English language limitations, but came to the conclusion he had, 'mental health issues.'

Christopher said he was of no fixed abode, but had been periodically staying at his mother's home, but that he no longer wanted to stay there.

Whilst the police were dealing with him, Maria arrived and spoke to the officers. She explained he was experiencing 'significant stress' due to separating from his wife and was unable to see his child. She explained he'd been evicted by his landlady for failing to pay his rent. She added that he had a mental health crisis whilst living at his landlady's home, which resulted in an ambulance attendance and an assessment by mental health services. She described him showering whilst fully clothed and flooding his landlady's house. She also described he had said to her, "Look, it's dark outside, there is no one here, why did you summons the devil." Maria reportedly described he made this comment to her during daylight hours. The officer's asked Christopher if he was stressed and he replied, "Of course I'm stressed, I have a 9-year-old child I cannot see."

Maria told the officer's she'd taken his bank card to control his spending, as he had spent 4 weeks of his benefit money on purchasing lottery tickets. She explained he had been staying at her home, but she didn't want him living with her, as his behaviour was causing her anxiety.

She felt unable to deal with this as she worked full-time. The record reflects Christopher was effectively homeless and that Maria confirmed he was sleeping rough.

Maria paid the shop owner for the beer he'd consumed using his bank card. The report describes the officer's observed there was minimal communication between Maria and Christopher at the scene, but noted there was no obvious animosity between them. The record reflects Maria, 'made no disclosures of abuse or violence' towards her.

The record describes Christopher refused to return to his mother's home and the officer's assessed his capacity, in view of their concerns regarding his mental health. In making this assessment, they observed he was able to make his own decisions and assess risk. The basis for this was that he acknowledged that not having somewhere to sleep was not ideal and that he may get cold, but that he still wanted to walk around for the night.

He was asked if he had any mental health issues and he responded that he felt great, had never wanted to harm himself and didn't feel he needed any help. The police concluded he was suffering an episode of mental ill-health. He was advised he was not being detained, but must not return to the shop. The police reportedly observed Maria leave the location on foot, but they did not observe where Christopher went.

The police completed and submitted an adult at risk referral form, as a means of alerting the MASH to their concerns regarding Christopher. These were documented as him being of no fixed abode, with minimal access to services; and being financially unstable as a consequence of being unemployed.[108]

The record notes that he didn't believe he had mental health issues, did not wish to engage with services and was not previously known to the police.[109] The record describes that, 'whilst engaging with Christopher he appeared vacant and, at times, confused.' Initially it was unclear to the police if this was due to his broken English or because of another reason. The record then goes on to illustrate that the primary contributing factor to the welfare concerns was that he was suffering from, 'significant stress' caused by his lack of access to his child.

No interpreter services were utilised in the interaction between police, Christopher and Maria.

There is no reference in the records to the conversation the police had on the telephone with Maria's close friend Rebecca, whist dealing with this incident.

The IMHT mental health professional, who was on duty in the FCR at this time, was not consulted by the responding officer's and the incident log was not coded for their attention.

21st Feb: (Source – Rebecca) With regards to Police incident - 6, Rebecca described she called Maria after missing a call from her at about 18.20 hrs, Maria said Christopher had left her home whilst she was getting ready to accompany him to see the property he was supposed to be renting. Maria said she was now at a local shop because he believed he'd won the lottery and had stolen a can of beer. Maria said the police were at the shop and that he went to the shop earlier that morning and took a can of beer, which he hadn't paid for.

Maria asked Rebecca to speak to the police on her behalf. Rebecca told the police that he was not himself, that he was always really quiet and would never take beer or property, or

[108] Christopher was employed. His failure to attend his workplace, whilst being convinced he was working, or on holiday, was continually cited by Maria and his landlady as being a symptom of his mental illness

[109] Christopher was known to Cambridgeshire Constabulary as he was involved in multiple incidents during 2016 / 17 regarding his child access disputes with his ex-wife. He was also subject of police contact at Police incident – 3 and Police incident - 5 between 11th and 20th Feb

claim to have won the lottery, or be pretending to go to work, if he was well. She told them that no one knew him better than his mother and that it was clear he needed help. She asked the police to take him away. She explained that Maria was scared he might leave the gas on and burn the house down, or flood the house, as he had previously showered with all his clothing on at his previous residence.

She told the police that he was very sick and was hearing and responding to voices. She said he claimed he was talking to God and accused Maria of bringing the devil. She said that he had twice stolen beer, which was completely out of character and indicative of how sick he was.

Whilst on the phone to the police, Rebecca overheard Christopher state that, *they are not real police," and that he would call the real police. She also overheard him claiming that he'd won the lottery, but insisting Maria had changed his ticket. She told the police Maria was scared, and she had to go to work and wasn't able to sleep because she was so worried about him. Rebecca said the police told her there was nothing they could do.

Feb 21st: (Source – Transcript of recording of incoming call made to Maria's phone) Maria recorded the telephone interaction with Rebecca whilst the police were dealing with this incident. The time and date of the call cannot be accurately established, but the content of the discussion makes clear this was the call referred to by Rebecca, whilst the police were dealing with Police incident - 6. Maria's dialogue with Rebecca has been translated from its original Polish.

In common with all the recordings, only one side of the conversation has been recorded from Maria's phone.

Maria told Rebecca the police were present because Christopher went to the store and opened a beer. She said she was glad the police were there and appeared to tell the responding officer that she was speaking to a colleague. She asked Rebecca to tell the police whom she had called regarding Christopher. Maria explained to the police that she had called 111, but that Rebecca had called another number to try and get help for him. Maria then handed the phone to the responding police officer.

The police officer established that Rebecca called Adult Social Services. The officer learned that he had been showing signs of mental illness for about 4 weeks, but that he hadn't been diagnosed with anything and wasn't taking any medication. The officer queried if it was the relationship with his child that was causing him to be stressed and in response to something said by Rebecca the officer reflected that he, "Just gets annoyed."

The officer confirmed that NHS 111 (Option 2) practitioners had previous contact with him and that Rebecca separately contacted Adult Social Services. The officer queried if he was going to go to Maria's address and was seemingly told that he had gone to Maria's home at 03.00 hrs.

The officer explained they intended to make a referral to the services, Rebecca had alluded to, with details of what had occurred at the shop. The officer then asked Rebecca to explain this to Maria and requested she ask her if she was planning to take him home with her. Presumably in response to a further question posed by Rebecca, the officer provided a short list of services who would receive the police referral.

Maria then spoke to Rebecca and appeared to explain that he'd visited the shop in the morning and again in the evening and opened cans of beer on each occasion. She described he came to her home at 03.00 hrs and had gone out every hour since. She explained that when she got up at 10.00 hrs, he was gone.

Maria said she didn't want to take him home with her. She requested Rebecca to ask the police to take him away for observation and do something to help him. She expressed concern she would be unable to sleep because of his disturbing behaviours during the night. She told Rebecca, "I'm afraid that he will do something." She then repeated her request for Rebecca to ask the police to take him away. She expressed concerns that he remained unaware that he was ill.

Maria asked Rebecca to tell the police that his face was markedly different and was an obvious sign he was sick. She said it was clear he was very confused. There was some conversation that likely refers to Maria's planned visit to see the property he claimed he'd found to rent, but this hadn't materialised as he'd left her home whilst she was getting ready to go with him to see the property earlier.

Maria repeated she wanted Rebecca to tell the police that she didn't want him to return to her home, as she would be unable to sleep. She explained he would continually go out and wasn't aware of what he was doing. She said he had episodes which happened suddenly and that when she talked to him, he was not conscious of what she was saying and that he talked to himself. Maria concluded this part of the conversation by expressing it would be better if the police took him to hospital for observation, "because I'm afraid."

The recording indicates Maria handed her phone back to the police officer who spoke with Rebecca. The police were presumably informed that Maria did not want him to return to her home as they queried if there was anywhere else, he could go and then reiterated, "Where else is he meant to go?"

Presumably in response to Rebecca requesting that he be taken to hospital, the officer responded that he was, "Not displaying anything that makes him an immediate risk. An ambulance is not going to come and pick him up." The officer then agreed to ask him if he felt like he needed to go to hospital and handed the phone back to Maria.

Maria then told Rebecca that Christopher had just accused her of changing his lottery ticket. She described he'd told her that he knew that she never went to work and that she observed things through a camera. He said that instead of going to work she walked around town and pretended to be tired. Maria reiterated that he had just told her this and asked Rebecca to relay this information to the police.

The police officer then spoke to Rebecca again. The officer queried if he had any friends or family other than Maria. The officer then asked Rebecca, "Has he done that before? Or is it just the worry that he may?" The officer described that he was being spoken to by another officer and expressed their concern that they weren't sure what to do with him as he didn't feel like he needed to go to hospital.

The phone was handed back to Maria who told Rebecca that he had just spoken to her in Polish. She said he'd told her that when he lived at another address, she had called an ambulance so that he would be taken away. Maria reiterated that he was accusing her of changing his lottery numbers and that he knew through a camera that she went into the city

instead of going to work. She told Rebecca he refused to go back with her and insisted he would, “Walk all night.” She said she hoped the police would do something with him because she was, “shaking all over” and felt, “weak.”

Maria reiterated the things he’d said to her about his lottery numbers, her not going to work and expressed, “God, I don't know. I just don't know, and do you know what kind of things he might be thinking?”

Maria concluded this conversation with Rebecca by saying, “I don't know, don’t know what to do. I'll say I don't know, because I want to sleep. I asked for help.”

21st Feb: (Source – Rebecca) Later that evening, Maria called Rebecca again. Maria was on her way home from the shop, having returned there to buy cigarettes for Christopher, who accompanied Maria home from the shop after the incident earlier with the police. Maria said she went to buy him cigarettes as she didn’t want him to go out because she was so worried about him. Whilst talking on the phone, Maria arrived back home and told Rebecca Christopher had left.

Whilst they continued their conversation, Rebecca overheard him return to Maria’s home and ask her if she’d purchased his cigarettes. He then went into the garden to smoke. Maria went to check that he was still in the garden and confirmed this to be the case. She then said he’d told her that he was going somewhere, but that he had a key, so she intended to try and sleep because she had to work early the following morning. At the end of the call, Maria said that she was going to go outside and check that he had a key and was then going to go to bed.

15. OVERVIEW

15.1 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 in the weeks and days prior to Maria’s homicide. They each recount instances and incidents of uncharacteristically odd or unusual behaviour by him, which caused them to be concerned about his mental health. In parallel, his landlady grew increasingly concerned for her own personal safety as a consequence of his disturbing behaviour.[110] Maria’s diary entries describe her concerns about his odd behaviours 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 accidentally set fire to, or flood, her home.[111]

15.2 The evidence illustrates that it only became clear to Maria that he was suffering with a mental illness from the 22nd January 2021, which she documented in her diary entry for that day. Maria first reported her concerns to Christopher’s GP (GP Practice 1) on 28th January. Repeated concerns about his mental health were subject of separate reports to a range of professionals and services by Maria, Christopher’s landlady Margaret, Maria’s friend Rebecca and her daughter Susan.

[110] Account of Christopher’s landlady Margaret
[111] Account of Maria’s close friend Rebecca

15.3 The evidence illustrates it was similarly apparent to professionals who had direct or indirect contact with him, on or after the 28th January, that he was suffering with a mental illness. This was either on the basis of their own observations, or through the maintained concerns reported to them by Maria, Margaret, Rebecca and Susan. The combined risks that existed and persisted in this case were insightfully documented by the FRS senior clinician in the FRS record of the 4th February, after an attempted face-to-face engagement by FRS practitioners. 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 review has learned that the FRS do not maintain a caseload, which minimised any opportunity for them to monitor and control the risks which they documented in their record. This insightful 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 4th February.

15.4 GP Practice 1 received substantial information from Maria in her appeals to access help and support for Christopher between 28th January and 11th February. She was appropriately signposted to the FRS by the GP. 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 of February, appears to have been to transfer his care to an alternative GP practice. The evidence illustrates GP Practice 1 was acutely aware he was suffering a deterioration in his mental health on the basis of substantial information provided to them by Maria.

15.5 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, but there were important omissions in the information they recorded from Maria and his co-resident and landlady. The FRS did not consider new information reported to them by GP Practice 1 on 11th February, that concerns about Christopher's mental health were continuing, as a new referral and they did not re-open, or review, Christopher's case.

15.6 The EDT were initially alerted to mental health concerns by Maria's friends daughter, Susan, on 9th February, The EDT practitioner explained they had no record of any FRS engagement with Christopher but reassured Susan she could call back and they would take him for an assessment if her concerns about Christopher's behaviour continued.[112]

15.7 On 11th February, the EDT were contacted by a GP from GP Practice 1. The GP requested the EDT contact Maria to consider the necessity to conduct a MHA assessment. The EDT noted there was a previous attempt by the FRS to engage Christopher, but he had refused. They concluded there was no information to indicate any urgency and that Maria required the services of an interpreter and so did not pursue the matter further.

15.8 On 21st February, the EDT were alerted to mental health concerns by Maria's friend, Rebecca. She reported 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

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

to his worsening mental illness. The EDT noted previous contact with both the FRS and the EDT, but directed Rebecca to re-contact the FRS as a least restrictive option.

15.9 On 30th January, the ambulance service were alerted to mental health concerns by Christopher's landlady. In a later phone call with a paramedic he said that he'd felt unwell with his mental health earlier, but wanted to go back to bed.

15.10 On 14th February, his landlady called an ambulance reporting he might be suicidal and was experiencing a mental health crisis. He was conveyed to Hinchingbrooke Hospital in response to concerns about his mental health.

15.11 That same evening, Christopher was examined at Hinchingbrooke Hospital ED in response to a mental health complaint. 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.

15.12 The police were first alerted to concerns about Christopher's mental health by his landlady on 11th February. In her email to the police, she also informed them that she was concerned for her own safety, but the police chose to respond with an email acknowledgement advising her on what to do in an emergency.

15.13 Late in the evening of 20th February, police responded to an emergency 999 call from a householder who had previously reported an attempted burglary at their home. The householder reported the intruder had returned to their house. Police 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 Christopher on their mobile phone at the time of the attempted burglary, the police concluded that he 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, the police did not consider their powers under the MHA, or discuss their concerns with a mental health professional, or refer the incident to the IMHT. The police did not link this event to the email they received from his landlady 9 days previously.

15.14 On 21st February police attended a further incident involving Christopher at a local convenience store. He seemingly believed he could take what he wanted from the shop as a consequence of winning the lottery. 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. The police did not discuss the matter with a mental health professional, who was on duty in the FCR, at the time of this incident. Similar to the previous police incident, the police did not link this event to the incident the previous evening or the email they received from his landlady 10 days previously.

15.15 GP Practice 2 were first recorded as being alerted to concerns about Christopher's mental health by Maria on 16th February, 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'. A further telephone

consultation was arranged for the 19th February, but Christopher did not answer the GPs call on that day.

15.16 Only GP Practice 1 held any historical record of Christopher suffering from any episode of mental ill health, prior to January 2021. This materialised during a GP consultation in July 2016, when he expressed thoughts of taking his own life. In a subsequent GP consultation, in February 2017, he was diagnosed with signs of depression.

15.17 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 22nd January 2021, which was just 4 weeks prior to the homicide. She first raised her concerns regarding his deteriorating mental health with his GP (GP Practice 1) on 28th January 2021, just over 3 weeks before her homicide.

15.18 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.

15.19 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.

15.20 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. Each of these agencies were either alerted to, or came to the conclusion, that there were mental health concerns.

15.21 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 4th February, was an agreed plan aimed at having Christopher's mental health assessed by a health professional. This plan was

never implemented, nor re-visited. On 11th February, 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 fruitful outcome from either discussion. 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.

15.22 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. 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 later 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 primary care provider.

15.23 After their attempted face-to-face engagement with Christopher on 2nd February, 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 4th February 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 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 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.

Psychiatric reports

15.24 Shortly after his arrest, Christopher was assessed by a mental health nurse. He appeared to be suffering from an acute mental disorder and appeared to be responding to unseen stimuli.

15.25 An Approved Mental Health Professional (AMHP) examined him later on the day of his arrest. Christopher explained that he was Jesus. He said the cat had told him that Maria was an evil person and her efforts to defend herself was proof that she was the devil. He

said that it was his mother he had killed, but she was the devil and he had killed her because God had told him to.

15.26 A further mental health assessment was carried out, either on the afternoon of his arrest or the following morning, by the criminal justice liaison and diversion service. Christopher said that he had known since the 23rd of January that he was Jesus and that God had been telling him so regularly. He said that Maria had mental health problems, had bad things in her and she was the devil. He said that God instructed him to kill her. He referred to Margaret calling for an ambulance two weeks previously; he said that he couldn't understand this as he was fine and did not require hospital admission. He said that he did not want to harm himself as he was Jesus.

15.27 Christopher was examined by another consultant psychiatrist a few days later. He told the consultant, in a matter-of-fact way, that he was Jesus and that he had come to realise this on precisely 23rd January.

15.28 Another consultant psychiatrist later described he was responding to voices. He said that he believed he had been Jesus Christ since childhood. Over the last month he had heard God's voice telling him that he was Jesus. He referred to how he was wandering for 3 days without sleep from the 23rd to the 26th January and then slept for 3 days. During this period, he said that he ate only half a slice of bread each day like Jesus. He said, "'Believe me, my mum was devil, and the devil was moving inside her." He said that he heard God's voice commanding him to go to his mother's house and kill her. It was thought that the likely diagnosis was, 'bipolar affective disorder, current episode mania with psychosis.'

15.29 He was later examined by a specialist forensic consultant psychiatrist to assess his fitness to enter a plea and stand trial for the murder of Maria.

15.30 The report made reference to the isolated episodes of mental ill health in 2016 and 2017. It describes that his mental health deteriorated and he began to have auditory hallucinations whereby he heard God talking to him and telling him that he was himself a god. He said that initially he disagreed with what he heard and said that he was not a god. He was told not only that he was a god, but also that he was the Holy Spirit and Jesus and that he was the chosen one. He referred more than once to his special or chosen status. He said that God had been talking to everyone, but he was the only one who answered. It also appeared that he had visual illusions or hallucinations, tactile hallucinations and a feeling of being controlled (passivity).[113]

15.31 Christopher developed the delusion that Maria had the devil inside her. He appeared to have come to this conclusion because of what he believed was a change in her appearance, but he also said that God told him so. Specifically, he thought that her eyes had become very dark. She was not like his mother. At this time, the outside world had what can be called, an apocalyptic feel to it, in that it appeared to him that there was no one on the streets.

[113] Passivity experiences are hallmark symptoms of schizophrenia. They are characterized by the belief that one's thoughts or actions are influenced or controlled by an external agent

15.32 The report describes that he was completely sure about what he was doing, and he was not worried in any way. He described how he had to inflict the injuries he caused to Maria, but at the same time he did not believe that he was killing her. He knew that killing his mother was murder, but that was not what he believed he was doing. He believed that he was doing it for the good of the world. He did not believe that he did anything wrong or bad. He said that God would not let him kill his mother. At the end of the consultation, Christopher said, “I had to do it. It was the right thing to do.”

15.33 The specialist consultant psychiatrist came to the view that Christopher was suffering either from a bipolar affective disorder or manic-depressive illness presenting as mania, or he had been suffering from a schizo-affective illness, specifically schizo-mania. They concluded that he was fit to enter a plea and stand trial for the murder of Maria.

16. ANALYSIS

Agency Contact

16.1 The analysis is based on agency records provided to the review. The accounts of friends, relatives and other identified parties, Maria’s diary entries and the recordings of her telephone conversations were also included in this analysis. **Note: -** After the initial draft report was submitted for review by the DHR Panel, new information was submitted by both GP Practice 1 and GP Practice 2, which had not previously been made available to the review.

16.2 The unpredictable and rapid decline in Christopher’s mental health serves to amplify the impact of service responses, decisions and actions in this case. It is important to note that his serious decline in mental health only became apparent to Maria on the 22nd January, less than 4 weeks before her homicide, and she first reported her concerns to GP Practice 1 on the 28th January.

16.3 It is important for all agencies to have the tools and confidence required to identify potential risk, intervene at an early stage, where and if possible, and refer on as appropriate for comprehensive risk assessment, management and control. An examination of what was known at key times by professionals and agencies, demonstrates there were a number of tipping points whereby improved information gathering, recording, collation, interpretation and collaboration could have enhanced collective situational awareness, professional assessments and informed interventions.

16.4 It is impossible to assess risk effectively without comprehensive, insightful data and information. It is equally problematic to control any combination of developing risks without maintaining an enlightened assessment of the evolving risk picture through sustained information gathering and the sharing of insights. Agency collaboration and coordinated, cooperative, responsive interventions are similarly key to effective risk control.

16.5 This case highlights there are lessons to be learned with regards to information gathering, recording, evaluation and dissemination, professional assessments, intervention

management, service collaboration, cooperation and coordinated responses and customer services. This meant that critical information around a combination of active and evolving risks, which was readily available and recognisable, was not effectively accessed, interpreted, triangulated and evaluated to maintain dynamic insight to the developing combination of active risks; and to inform the necessary, responsive and collaborative agency interventions.

GP Practice 1

Note: - The analysis is based on records provided to the review by GP Practice 1 and the FRS, EDT and GP Practice 2 records. The accounts of friends, relatives and other identified parties, Maria's diary entries and recordings of calls she made to professionals, also formed part of this analysis. After a review of the initial draft report, a representative of GP Practice 1 provided additional information on 10th May 2024,[114] which had not previously been provided to the review. This additional information is clearly referenced in the following paragraphs.

16.6 GP Practice 1 were Christopher's long term primary care provider. In July 2016, Christopher disclosed to the GP that he sometimes felt like ending his own life. In February 2017, he was diagnosed with signs of depression. He was prescribed a single course of antidepressants. These were the only episodes of mental ill-health noted in his GP records during the review period, prior to the 28th January 2021.

Contact 1 - GP Practice 1

16.7 On 28th January, Maria contacted Christopher's GP to raise concerns about his mental health. The GP recorded engaging in a, 'long chat' with her and noted the conversation was difficult due to the, 'language barrier.' In her diary entries prior to this consultation, she recorded Christopher telling her he, *'is talking to the devil and other time with God.'* She queried in her diary entry of 25th January, as to whether he might be suffering from schizophrenia.

16.8 The GP record describes she reported he was, 'talking to ghosts' and 'hearing voices.' She queried if he might be suffering from schizophrenia and referenced his non-attendance at work. The record reflects she was, 'very worried' and that both Maria and Christopher were living in St Ives. The first outcome of this consultation was an accurate assessment by the GP that he may require acute mental health support and Maria was appropriately signposted to the NHS 111 (Option 2) service.

16.9 The more consequential outcome of the discussion was a reported agreement by Maria that it was, 'impractical' for him to be treated by his long-term primary care provider; notwithstanding he had engaged the services of this GP practice, after moving out of the local area, and was living approximately 5 miles away from the surgery. The cited impracticality was not further described in the original record, or any rationale for Maria agreeing to it being, 'impractical.'

[114] Letter from Medical Defence Union (MDU) to review Author dated 10th May 2024

16.10 The GP noted the language difficulties, but the record does not indicate whether this had any bearing on Maria's understanding of the cited, impracticality, or her reported agreement to, and responsibilities for, implementing any plan to register Christopher with another GP practice at this time.

16.11 It quickly became clear that she struggled to register him elsewhere, primarily as a consequence of his refusal to sign the registration form. It is feasible that his refusal to sign the form could have been an aspect of his mental health presentation. This inadvertently escalated the combined risks to her and Christopher considerably, whereby, his condition might deteriorate if he was developing a psychotic illness and his mental health would deteriorate without treatment. The decision to direct that he re-register with another GP practice, whilst experiencing a significant decline in his mental health had inadvertent, but far-reaching consequences. It effectively denied him continuity of care, and Maria access to appropriately sustained, professional medical support and advice in response to the circumstances she experienced at this time. In parallel, it seriously undermined the outcome of any collaborative plan for a health professional to assess his mental health and respond to his developing psychosis, as later became apparent in the interactions the GP had with the FRS and EDT.

16.12 Maria's diary entry in relation to this consultation offers some insight to her understanding of the impracticality she reportedly agreed existed to him being treated by GP Practice 1 and her associated responsibilities to register him elsewhere. It states, '*Doctor told me to call psychologist.'* She made no acknowledgement to her understanding of any requirement to register him at another GP practice, until after a further consultation with GP Practice 1 on 1st February.[115] To reinforce this, there is no evidence of her undertaking any steps to try and facilitate his registration with an alternative GP practice until after the 1st February.

16.13 There is no evidence the GP sought to engage interpreter support to overcome the documented language challenges. The services of an interpreter would have informed a more comprehensive understanding of Christopher's illness, which could have more helpfully informed the GP's assessment, plan and the outcome of this consultation. Critically, it would have enabled Maria to clearly understand, and potentially challenge, any impracticalities, she reportedly agreed existed. Her reported agreement stands in stark contrast to her subsequent inaction in this regard and her repeated announcements that the GP refused to help her when speaking to FRS, in follow up contacts with GP Practice 1 and in her corresponding diary entries. Finally, she would have been able to discuss the plan for her to re-register him; including any foreseeable challenges and requisite deviations caused by, for example, him refusing to sign the registration form; which effectively served to deny him continuity of care in the short, but critical, term. Similarly, it exposed Maria and Christopher to escalated risk and without the necessary access to an appropriately sustained, capable source of professional medical support when it was most needed.

16.14 Additional information was provided to the review on 10th May 2024, on behalf of GP Practice 1, with regards to this consultation. The, previously undisclosed, medical record

[115] Contact 2 – GP Practice 1

this information emanates from confirms that this telephone consultation with Maria took place at around 15.49 hrs on 28th January. The record documents that Maria was, '*going back home now'* and the GP recalled that Maria was on a bus on her way back to St Ives when they spoke. The relevant part of the undisclosed GP record states: *'? schizophrenia is going back home now – both live in St Ives is going to go see him. Plan: discussed situation agreed impractical to come back here, and in any case may need acute MH support.'* [116] The additional information provider refutes the reviews suggestion there was any discussion about a requirement for Christopher to re-register with an alternative GP during this consultation and suggests this is an unfounded assumption by the review.[117]

16.15 The original summary of the GP record which was provided to the review in the IMR documents, '*Spoke to patient's mum, long chat, difficult due to language barrier, concerned not been at work all week, may have MH issues she asked about schizophrenia, "both living in St Ives." Plan discussed during a telephone consultation the situation was agreed as impractical to come back here, (Huntingdon) may need acute MH support. Signposted to 111 option two.'*

16.16 The review acknowledges there is no written reference to any requirement being made for Christopher to re-register with an alternative GP Practice in the record of this consultation. However, given the GP record of this event makes specific reference to Maria and Christopher both residing in St Ives, coupled with the record of the following consultation, just 4 days later, on the 1st February, where the GP records*, 'patient in very bad state, and unable to register in new surgery. Plan: needs to register with practice in St Ives as outside practice area, advised to call 111 option two.'* On the basis of the reference to Maria's reported challenges registering Christopher at a new surgery in this consultation, the review considers that, on the balance of probabilities, the evidence indicates that it is more likely than not that the requirement for Christopher to register at an alternative GP practice was an early consideration by the GP which was conveyed to, but not clearly understood by, Maria.

Contact 2 – GP Practice 1

16.17 Maria's diary entry for the 31st January 2021 records that Christopher came to her home the previous evening and said to her, '*Look how dark is outside - everyone is hiding as they are scared - what have you done, gave me the devil.'*

16.18 Her diary entry for the 1st February indicates she followed the GP's advice of 28th January[118] and records, '*I called 111 (-2) last night and they wanted to speak to him. I told them that he is not able to speak as he doesn't realise that he is unwell. He told me to call the doctor.'* It is logical to assume that her diary entry is referring to a conversation she had with an FRS practitioner the previous evening of 31st January 2021.[119]

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[116] This record has not been provided to the Review
[117] Letter from Medical Defence Union (MDU) to review Author dated 10th May 2024
[118] Contact 1 – GP Practice 1
[119] There is no corresponding FRS record of the contact Maria refers to in her diary and during subsequent conversations with GP practice 1 and the FRS on 1st Feb.

16.19 Presumably, as a consequence of the advice provided by the FRS practitioner, alluded to in her diary entry, Maria re-contacted GP Practice 1 on 1st February. The record describes the GP called her back and was appropriately supported by an interpreter, which was good practice. She reported Christopher was in a, 'very bad state.' The record makes reference to her being unable to register him with another GP practice, although it doesn't describe any reason for her difficulties or indicate any rationale as to why she was attempting to re-register him at this time.[120] The GP record documents, '*Plan: needs to register with practice in St Ives as outside practice area, advised to call 111 option two to access help and support. Review if back in practice area.'*

16.20 Maria's diary entry makes reference to this consultation as follows, *'I called the doctor, I spoke to (Redacted) in relation to Christopher, I told her that he needs help as he is not conscious of anything. I told her that I called 111 (2) last night and they wanted to speak to him. I told them that he is not able to speak as he doesn't realise he is unwell. He told me to call the doctor. Doctor called told me that he can't help me as Christopher is not registered in his surgery and that I need to re-register him.'* This was the first acknowledgement of any requirement for Christopher to register with another GP practice, which is clearly indicative that she had not understood the impracticalities to treatment by GP Practice 1, and/or the GP's outlined plan, to which she reportedly agreed to, on 28th January.[121]

16.21 The consequences of this situated her in a veritable loop whereby; FRS had, and continued to advise her to contact Christopher's GP. Almost simultaneously, the GP advised her to contact FRS. When she contacted the GP, as she was directed to by FRS, she was unable to access any treatment or support, because the GP considered that his address precluded him being treated by the practice.

16.22 At this point, it is logical to assume the GP was made aware of her unsuccessful attempt to engage the FRS and they documented she'd had difficulties re-registering Christopher.120 It is similarly logical to assume that Maria informed the GP that the FRS had directed her to re-contact the GP, as was described in her diary entry. The GP didn't appear to consider the combined, active risks which were escalating on this basis. The GP repeated their advice for her to contact the FRS, but in light of the circumstances which had unfolded, and she had conveyed to the GP, there was a likelihood that the FRS would repeat their previous advice for her to contact the GP. A professional assessment of the active, evolving and escalating risks posed by his reported deteriorating mental health, allied to Maria's reported challenges in accessing appropriate professional medical treatment and support, would have been helpful. This could have caused more practical support to be offered to her in navigating and overcoming the challenges she faced at this point. This could have enabled Christopher to be assessed by professionals and treated earlier.

16.23 Additional information was provided to the review on behalf of GP Practice 1 on 10th May 2024. In respect of this event the new information argues that Maria was appropriately encouraged by the GP to arrange for Christopher to re-register with a local GP. The

[120] There is no evidence to indicate Maria had taken any steps or made any attempt to re-register Christopher at GP Practice 2 up to this point in time
[121] Contact 1 – GP Practice 1

information describes that the GP's continued to assist Maria while she was in the process of arranging for Christopher to re-register. The additional information argues that it is wrong for the review to suggest that the GP's prioritised re-registration and that Maria was denied support and advice.[122]

16.24 In contrast to the additional information provided on behalf of GP Practice 1, Maria's diary entry describing this event notes, '*Doctor called- told me that he can't help me as Christopher is not resisted [registered] in his surgery and that I need to re-register him.'* Furthermore, in the recording of her telephone conversation with FRS that same day she stated, "30 minutes ago doctor speak with me and tell not help him because is in Huntingdon registration, my son, but lives now in St Ives." Maria also told FRS during that conversation, "Doctor tell me, today, him, I don't help you, because him live in St Ives." In reference to the GP consultations on 28th January and 1st February, she stated, "I say everything, in Thursday, today. Nobody help me." In further reference to the 2 previous GP consultations she described, "Nobody want help me." She goes on to explain, "Nobody give me tablet, nobody give help, nobody observation him, nothing." Maria also stated, "So, now, when him don't have GP, because is in Huntingdon. Doctor say don't help him, because him live in St Ives." She also told FRS, "Doctor say don't help nothing to Christopher because him is in Huntingdon doctor and Christopher lives in St Ives." During this conversation, Maria also appealed to the FRS practitioner for help in obtaining a sick note for Christopher due to his GP's refusal to help him.

<u>Contact 3 – GP Practice 1</u>

16.25 On 2nd February 2021, Maria recorded in her diary, *'I called the doctors again and asked (Redacted) for the doctor to give sick note to Christopher for a month. Doctor didn't call.'* It seems logical to consider she made the request for a sick note on the basis of what she had been advised by the FRS in her call to them the previous evening.[123] The corresponding GP record is dated 3rd February and describes an unsuccessful attempt to make telephone contact with Christopher. The record documents the GP's response as follows, '*Patient needs to register in St Ives where he is living. Phone switched off; Mother informed.'* The record goes on to describe a new patient registration form was completed by Christopher on 3rd February.[124] Maria's diary entry for the following day, the 4th February, states – '*I went to apply to change the doctor's surgery but I couldn't as they said that he needs to sign it or speak to them on the phone. I went to Christopher so he could sign it but didn't want to and was angry*.'

16.26 There is no acknowledgement of the GP making contact with Maria in her diary entry for that day. The subsequent consultation with the GP on 11th February makes clear that no medical certificate was issued by GP Practice 1 in response to the request she made on the 2nd February.

16.27 There is no evidence of any professional assessment of the active, evolving and escalating risk factors at this point. These included his declining mental health and the

[122] Letter from Medical Defence Union (MDU) to review Author dated 10th May 2024
[123] Contact – FRS - 2
[124] This likely refers to Maria's failed attempt to register him at GP Practice 2 by signing the registration form on behalf of Christopher

interrupted continuity of his care. These should have been subject to ongoing consideration, as Christopher was still a patient at the practice and the GP had previously recognised, he may have a mental illness.[125] A concerted, professionally curious conversation with Maria at this point could have informed an assessment and evaluation of the most basic risks, such as the potential for him to lose his job due to the absence of a sick note. It would also have added insights to his declining mental health and refusal to acknowledge his illness, sign the registration form or agree to engage with medical professionals more generally. This could have provided early insights to the challenges Maria faced maintaining his continuity of care. This could have led to more informed, practical support for her in navigating and overcoming the challenges she faced, and could have enabled an earlier assessment of Christopher's mental illness.

FRS and GP Practice 1 plan

16.28 On 3rd February, GP Practice 1 was contacted by the FRS enquiring as to whether Christopher had ever suffered with mental ill-health. This was a direct consequence of the FRS attempt to engage him the previous evening.[126] The GP returned the FRS senior clinician's call the following day and confirmed there were, 'No MH issues previously documented in notes.' This was inaccurate, as he disclosed thoughts of taking his own life in July 2016 and was diagnosed with signs of depression in February 2017. This was also alluded to by Maria in her conversations with the FRS and the GP record describes that Christopher's cooperation with FRS was conditional on mental health being recorded in his notes.[127]

16.29 On 10th May 2024, the review was provided with additional explanatory information on behalf of GP Practice 1. This describes that GP records contain a 'Problem' section, divided into 'Active', 'Significant Past' and 'Minor Past'. The "Problem" section provides a summary of a patient's past medical history. It is automatically generated by computer software when a diagnosis is entered in the patient's records. This section of the records is reportedly, routinely relied on by GP's and other doctors as a record of a patient's past medical history. The new information argues that it was unreasonable to expect the GP to look beyond the 'Problem' section when providing details of Christopher's past medical history.[128] The additional information described that Christopher's 'Problem' section contained no reference to past mental health problems.[129]

16.30 Regardless of the arguments made by the additional information, it is clear that Christopher's GP records contain clear evidence of a history of mental illness and the information passed to FRS by the GP was inaccurate in this regard. The review takes the view that in all the circumstances, when considering the concerns raised by Maria, the acknowledgement by GP Practice 1 that Christopher might require acute mental health support; that it was both reasonable, and appropriate, to respond to a direct enquiry from a crisis mental health service provider with accurate information to inform an insightful assessment of risk.

[125] Contact 1 – GP Practice 1
[126] FRS – Contact - 2
[127] This is not documented in any FRS record provided to the review or referred to in the CPFT SI Review
[128] Letter from Medical Defence Union (MDU) to review Author dated 10th May 2024
[129] This record has not been provided to the review

16.31 During this interaction, the GP was made aware of the outcome of the FRS's attempt to engage Christopher. The GP record reiterates their advice to the FRS for him to register at another GP practice. Prior to this event, the GP assessed he may require acute mental health support [130] and was now made aware of his refusal to engage with the FRS, who are the crisis mental health team. The GP was similarly aware that his continuity of care was interrupted, because Maria reported her difficulties registering him with another GP.[131] A professional assessment of these combined risk factors could have helpfully informed and prompted more practical support to Maria and Christopher in overcoming the cumulative denial of access to support and treatment they were respectively subject to at this time.

16.32 FRS records, dated 4th February, describe the GP agreed to a plan to try and engage Christopher in a discussion about his general health, in order to generate an opportunity to assess his mental health. There is no acknowledgement of the FRS plan, or the active risks identified by the FRS senior clinician, in the GP record. The GP record describes the FRS were similarly advised that he needed to register at another surgery and that FRS would, 'observe and review as required.' This statement illustrates the likelihood the GP did not fully understand the role of the FRS, who work with consenting patients only. Christopher's lack of consent to engage with FRS effectively necessitated their withdrawal and required them to transfer responsibility for his care back to the GP. Any further attempts by the FRS to engage him would rely on a new referral to FRS. It seems clear to the review that the FRS do not maintain an, 'observe and review' functionality and therefore they discharged Christopher's care to the GP. The disparities recorded in the GP and FRS records, allied to the GP's position on registration, undermined the potential for Christopher to be assessed by a health professional and any concept of responsibility and accountability for risk and treatment planning, which was wholly conditional on the GP maintaining continuity of care at this point.

16.33 The plan outlined by the FRS was reasonable and appropriate in the circumstances. The implementation of the FRS plan by the GP could have led to his mental health being assessed earlier. Maria's situation at this point was summarised in her diary entry for 5th February, which records, '*Rebecca called. She is looking a help for me and what should I do when none one is able to provide medical help.'*

<u>Contact 2 - GP Practice 2 - Registration</u>

16.34 On the 9th February, Maria successfully persuaded Christopher to sign the registration form. The following day, she went to her own GP to try and get an appointment for Christopher, but was told he was still registered with GP Practice 1. In light of the unfolding circumstances, it would have been helpful if more urgency had been applied to maintaining continuity of care and any responsibility and accountability for his care and treatment planning by GP Practice 1. GP Practice 1 were aware of the disclosures made by Maria and accurately assessed that he may need acute mental health support on that

[130] Contact 1 - GP Practice 1
[131] Contact 2 - GP Practice 1

basis.[132] The GP was similarly aware of Christopher's refusal to engage with the FRS.[133] They were also alert to the interruption in continuity of care presented by Maria's stated challenges in re-registering him,[134] which increased the risk of his illness deteriorating without treatment.

16.35 In all these circumstances, it was appropriate and necessary to ensure his transfer was appropriately prioritised and supported by a comprehensive briefing to his new care provider with an urgent transfer of his medical records, which were still awaiting to be sent to GP Practice 2 on the 17th February. This undoubtedly served to undermine and delay any professional assessments applied by GP Practice 2 on the 10th and, separately on 15th February,[135] when his registration was eventually accepted, as they had no access to his records and remained unaware of the active and escalating risks and the absence of any assessment of his illness and aligned treatment and care plan. This would have appropriately, and more urgently, informed the situational awareness of GP Practice 2 and arguably provided Maria the opportunity to make an earlier appointment. This could have led to an earlier assessment of his illness.

16.36 On 10th May 2024, additional information was provided to the review on behalf of GP Practice 1. This describes that Christopher's records were transferred to GP Practice 2 on 17th February. The information argues that this was within 2 days of Christopher registering with GP Practice 2.[136] The information points to this being reasonably prompt given the 28-day guideline provided by NHS England.[137]

16.37 In contrast, the GP records provided to the review describe that Christopher's medical records were, '*waiting to be sent'* on 17th February. The records also indicate that Christopher's registration was received by GP Practice 2 on 9th February and that when Maria tried to make an appointment for him at GP Practice 2 the following day, this was refused on the basis that Christopher was still registered at GP Practice 1. The review acknowledges that his registration was not accepted by GP Practice 2 until 15th February, because his re-registration was delayed on the basis of him remaining registered at GP Practice 1.

16.38 The additional information concludes that GP practices do not, as a general rule, handover patients to each other. It stipulates that there are no protocols for this and no expectation from NHS England that handovers should take place. The view of GP Practice 1 and their representative is that the reviews position that a 'briefing or handover' should have taken place misunderstands the nature of GP services.[136] The review maintains the position that a briefing/handover would have been good practice and was appropriate and necessary in these circumstances. This could have caused Christopher to be assessed and treated earlier.

<u>Contact 4 - GP Practice 1</u>

[132] Contact 1 – GP Practice 1
[133] FRS and GP Practice 1 plan of 4th February
[134] Contact 2 – GP Practice 1
[135] Contacts 3 and 5 – GP Practice 2
[136] Letter from Medical Defence Union (MDU) to review Author dated 10th May 2024
[137] How to Register with a GP Surgery

16.39 On 11th February, Maria notes in her diary, '*After work I went to Christopher's doctor surgery and I told him that he still doesn't attend work and I told him that he has worrying thoughts. I asked for sick note again for him.'* This diary entry illustrates that Maria had been unsuccessful in her previous request for a sick note on behalf of Christopher from GP Practice 1 on 2nd February.[138]

16.40 The GP record for this event describes she contacted the surgery reception repeating her concerns about Christopher's mental health and expressed fears that he may be suicidal. She also made reference to contacting the FRS previously. The GP noted their advice would be for her to re-contact NHS 111 (Option 2) if he was experiencing a mental health crisis, although the GP documented they would be happy to discuss the matter with her in a telephone call, which is acknowledged as good practice.

16.41 The transcribed recording of her call to GP Practice 1 that day audits her reporting concerns that Christopher would hang himself. She also said that if he did something to himself, she would blame herself. She described knowing he was planning something and declared, "His life is in danger, I know it one hundred percent, write it down and I will just hold someone responsible because it can't be like that." She described, "He went crazy, he just doesn't want to live anymore," Of particular note, towards the end of the call she reflected, "I'm afraid that he will do something to himself, and because of some silly sick note." The person whom Maria was speaking to during this call has not been established, but if this was a member of the administration staff, this information should have been immediately communicated to a registered professional.

16.42 Maria's diary entry and her recorded telephone calls with GP Practice 1 that day indicate an absence of any prioritisation of support to Maria since she first raised her concerns about Christopher on 28th January. She had made a previous request to obtain a sick note for Christopher on 2nd February, but it took until the 11th February for the GP to retrospectively provide this.

Contact 5 – GP Practice 1

16.43 On 11th February, Maria received a telephone call from GP Practice 1 which she recorded. The purpose of this call was to make arrangements to collect the sick note she refers to in her diary entry of this date. In that call she reiterated Christopher hadn't been to work for 3 weeks. She made reference to people not helping him and said, "I need some help for my son because he going to kill self." The person whom Maria was speaking to during this call has not been established, but if this was a member of the administration staff, this information should have been immediately communicated to a registered professional.

Contact 6 – GP Practice 1

16.44 The GP called Maria back the same day, supported by an interpreter, which was good practice. She related Christopher told her all his personal and past medical history was hers and that he had a new partner with a child with the same names as his ex-wife and

[138] Contact 3 – GP Practice 1

son. She reported him referencing 'souls' and expressing God was telling him to do things and accusing her of bringing the devil. The record makes reference to him suffering an episode of depression following the separation from his wife 5 years earlier.

16.45 In a direct contradiction of what she reported to GP Practice 1 staff, in 2 separate calls that afternoon,[139] the GP recorded that Christopher expressed no wishes to harm himself or others. There is no corresponding explanation as to why Maria would repetitively express her fears to GP Practice 1 staff, in 2 separate telephone calls that day, that he would take his own life and, a short time later, inform the GP that he expressed no wishes to harm himself. Furthermore, this emphasises the necessity to ensure that the concerns she clearly expressed to GP Practice 1 staff that day were appropriately brought to the attention of a registered professional.

16.46 Maria was a rich source of insight into the combined risks identified by the FRS senior clinician, and the GP had interpreter support to explore this with her. A more professionally curious, enquiring conversation was necessary and appropriate to establish the rationale for the fears she expressed to GP Practice 1 staff that day. Similarly, this could have informed a professional assessment of the active and escalating risks posed by his deteriorating mental ill-health, the interruption to his continuity of care and the aligned absence of any professional assessment of, and treatment for, his illness.

16.47 During this telephone conversation, the GP recorded Christopher was seen sitting in a car watching children. It is logical to assume the GP recorded this information on the basis of their conversation with Maria. The record describes that the GP decided not to refer this as a safeguarding concern, on the assumption the matter would have been identified and assessed by the FRS when he refused to engage with their practitioners. The GP noted that his mental health was the priority in providing added rationale for this decision.

16.48 More professional curiosity could have established a more comprehensive perspective of any safeguarding concern, including the unlikelihood of FRS identifying and assessing any risks associated with this concern when he refused to engage with them. This conclusion drawn by the GP is again indicative of a misunderstanding of the role of the FRS. The subsequent conversation the GP went on to have with the FRS that evening, offered an opportunity to clarify if the safeguarding concern had been identified and resolved by FRS, but there is no evidence this was discussed in either the GP or FRS record of that event. A safeguarding referral would have alerted other professionals to assess and control any perceived threat posed. This could have caused his mental health to be assessed and treated sooner.

16.49 On 10th May 2024, additional information was provided to the review on behalf of GP Practice 1 with regards to this safeguarding concern. The new information explains that the Author's interpretation was taken from the IMR where it was stated, '*a safeguarding referral was not considered as it was felt his MH was the priority and if there was any threat FRS would have picked any safeguarding concerns up.'* The additional information

[139] Contacts 4 & 5 - GP Practice 1

clarified that the GP was not involved in the IMR and does not agree with this statement. The GP described that had they identified a safeguarding concern they would not have left it to FRS to deal with it. The GP stated that it was their clinical judgment that the report by Maria of Christopher 'sitting in a car watching other children' was not a safeguarding concern. The GP reported they did not understand Maria to be reporting that Christopher was a risk to children. They explained that had they had any concerns that he was a potential risk to children the GP would not have hesitated to make a safeguarding referral.[140]

16.50 The review acknowledges the additional perspective offered by the GP however, this poses a question as to why Maria's description of Christopher sitting in a car watching children was documented in the record on this basis. There is no evidence this was explored with Maria to any degree, to make an informed assessment and come to considered conclusion with regards to any safeguarding concern. The account of Maria's close friend Rebecca is arguably noteworthy in this regard; she made reference to Maria attempting to make contact with his ex-wife to prevent Christopher from seeing his own child, because she feared he might be at risk of harm from Christopher, although the review acknowledges there is no evidence this information was disclosed to any professional.

16.51 Maria was again appropriately signposted to NHS 111 (Option 2) and the GP documented they informed her they would make contact with the FRS separately, although Maria made no reference to having any knowledge of this arrangement in her diary entry which reflects, '*I went to Christopher's surgery and told him that he still does not attend work and I told him that he has worrying thoughts. I asked for sick note again for him. The lady from reception call in relation to sick note.'*

16.52 A professionally curious assessment would have acknowledged Maria's previous engagements with FRS resulted in them advising her to encourage Christopher to make contact with his GP. This should have prompted the GP to consider the impact of the interruption to his continuity of care, as should have been clear from Maria's unsuccessful attempt to secure an appointment with GP Practice 2 for Christopher the previous day.[141] More practical support would have been helpful at this point, including consideration by the GP to offer him an appointment to enquire into his general health, as a means of assessing his mental health; which was the plan reportedly agreed with the FRS senior clinician. This approach could have assisted Maria to overcome the challenges she was experiencing in securing an assessment of, and treatment for, his mental ill-health.

GP Practice 1, FRS and EDT engagement (EDT contact - 2)

16.53 The GP called the FRS to discuss Maria's repeated concerns about Christopher, which was good practice. The GP record describes they were advised by FRS to contact the EDT, as FRS had previously, and unsuccessfully, attempted to engage and assess him. The GP documented contact with the EDT and recorded an outcome indicating an

[140] Letter from Medical Defence Union (MDU) to review Author dated 10th May 2024
[141] Contact 2 – GP Practice 2 - Registration

agreement by the EDT to contact Maria directly, to discuss the requirement to undertake an emergency assessment under the MHA.

16.54 On 10th May 2024, additional information was provided to the review on behalf of GP Practice 1. This references a, contemporaneous record which was made by the GP which was not previously provided to the review as follows, 'C*ontacted FRS - they advised contacting EDT (telephone number redacted) as they are unable to force entry to make mental health assessment and previously, he has not engaged. Have contacted them (social care). they will make direct contact with mum to discuss need for emergency mental health assessment.'* The GPs representative argues that this demonstrates the GP clearly communicated the need for an 'emergency mental health assessment' to EDT and that it was reasonable for them to assume that EDT would act on this request.[142]

16.55 The review has considered the view of the GP in this regard and notes there is nothing in the additional information that indicates, 'that they clearly communicated the need for an emergency mental health assessment to EDT.' Rather, the GP record and the additional information reflects they asked the EDT to contact Maria to consider whether there was a need to conduct an emergency MHA assessment. The review acknowledges that it was reasonable for the GP to expect that the EDT would make direct contact with Maria on this basis.

16.56 The EDT record describes the GP made contact with the EDT contact centre and left a message, along with the GP's and Maria's contact details. Whilst the GP record is sparse on the detail of what was conveyed to the EDT, the EDT record illustrates the GP described Maria's concerns about Christopher over a number of weeks. The GP also described they had never met him and inaccurately conveyed that he had no history of mental ill-health.[143] This inaccuracy was conveyed notwithstanding the GP had discussed his previous episode of depression in the earlier consultation with Maria. The record documents the GP also indicated she required a Polish interpreter.

16.57 On 10th May 2024, additional information was provided to the review on behalf of GP Practice 1. This argued that, 'it is highly likely' that the GP 'would have provided this information' relating to Maria's reference to Christopher's history of depression to FRS during their telephone call. The GP Practice is unable to explain why the FRS and/or EDT recorded that Christopher had no history of mental health problems. The information suggests that it may be relevant that Christopher had not been formally diagnosed with depression and/or that Christopher had no prior history of delusion or schizophrenia, which was the presenting concern.[142]

16.58 It is true to say that Christopher was never formally diagnosed with depression, he was diagnosed with signs of depression in February 2017. This was after he initially disclosed thoughts of taking his own life to the GP in July 2016. In contrast to the additional information presented to the review, the FRS makes no reference to any discussion with the GP about Christopher's history of mental illness in the call on 11th February, the FRS

[142] Letter from Medical Defence Union (MDU) to review Author dated 10th May 2024
[143] Christopher disclosed thoughts of taking his own life to his GP in July 2016 and was diagnosed with signs of depression in Feb 2017

record merely documents that there was, '*No change to the presenting situation from when FRS attempted to assess patient.'* This indicates there was no new information with regards to this provided to the FRS by the GP in this call. The EDT record specifies that the message left by the GP described that, '*Over last number of weeks she (Maria) has called in re his unusual behaviour and there is no history re mental health. (The GP redacted) has never met Christopher and that the information has been provided third hand.'* The FRS and EDT records tend to support the conclusion that the GP continued to convey that Christopher had no history of mental illness.

16.59 The EDT record noted an absence of any urgency or emergency conveyed by the GP. The EDT social worker attempted to call the GP back to discuss the case, but the surgery was closed and the GP didn't leave any alternative means of contact. There is no evidence this was followed up by the GP, or that the GP informed Maria of this discussion, or the reportedly agreed outcome for the EDT to make direct contact with her. Her diary entries for the 11th and 12th February make no reference to her having any knowledge of the GP contacting FRS and/or the EDT, or the outcome of these interactions. Her diary entries indicate she remained unaware of the GP's discussions with the FRS and EDT. This position is reinforced by the absence of any subsequent, independent representation by, or on behalf of, Maria as the closest relative of a mentally-ill patient, to request an emergency MHA assessment by the EDT until the 21st February, when her close friend Rebecaa called the EDT on Maria's behalf. Rebecca remained similarly unaware of any previous engagement between GP Practice 1 and the EDT.

16.60 On 10th May 2024, additional information was provided on behalf of GP Practice 1. This information describes that once the GP had made the referral to the EDT, and that EDT had accepted that referral, it is not expected that the GP will monitor and follow up the referral. The position of GP Practice 1 is that the onus was on the EDT to contact the GP if further input from the GP was required.[144] The review notes that the EDT attempted to contact the GP, but the surgery was closed and no alternative means of contact were provided by the GP to discuss the necessity for an emergency mental health assessment. The review acknowledges that the EDT would have been cognisant of the unavailability of the GP, due to them returning the call out of hours, and there was no reasonable expectation that the GP should remain in the surgery awaiting contact from the EDT. Nonetheless, it would have been good practice to inform Maria of the outcome of this interaction so that she could have considered the options available to her as a consequence of the absence of any outcome from this event.

16.61 The review also notes that the position proposed by the additional information provided on behalf of GP Practice 1 illustrates a misunderstanding by GP Practice 1 of the referral process to the EDT. The EDT IMR and SI review describe that calls to the EDT are taken by non-clinical call handlers and are passed to clinicians for triage and assessment of information, taking into account presenting factors, history and assessment of risk. Based on this, the senior social worker/AMHP will make a decision as to whether a person meets the threshold for a MHA assessment. This process describes that the message left by the GP with the EDT contact centre would not be treated, or accepted,

[144] Letter from Medical Defence Union (MDU) to review Author dated 10th May 2024

as a formal referral by the EDT. However, as discussed at paragraph 16.157, it seems logical to conclude that the purpose of the GP's call was to request the EDT to consider the necessity to conduct an MHA assessment of Christopher by contacting Maria.

16.62 Whist the GP's decision to contact the FRS, and subsequently the EDT, was good practice. The absence of any active monitoring or follow up by the GP and/or the EDT undermined this unique, collaborative opportunity for professionals to discuss, assess and respond to Christopher's deteriorating mental health and the separate, but tangible, risks that he had not been assessed by a health professional and had no reliable access to professional medical support. Similarly, had the GP informed Maria of the outcome of their discussions with FRS and EDT, she would have been provided an opportunity to make an earlier independent representation to the EDT, as a nearest relative, to request consideration of a MHA assessment. This could have led to him being assessed, diagnosed and treated earlier.

16.63 The actions undertaken by the GP fell short of being acknowledged as a referral to the EDT and the inaccurate mental health history, conveyed by the GP, undermined a professional assessment of any consideration to undertake an emergency MHA assessment. It is acknowledged that the EDT should have followed this up with Maria, as was specifically requested by the GP.

16.64 The timing of the position adopted by GP practice 1, in requiring Christopher to register with a new GP practice, had a significant impact on the outcome of this case. This interrupted the continuity of care for a patient, who the GP accurately assessed may need acute mental health support.[145] It similarly undermined any concept of responsibility and accountability, to establish and maintain professional assessment of the active and evolving risk picture, and mitigate the active risks posed by his deteriorating mental health and the aligned absence of any assessment of his illness and access to treatment and support. The interruption to his continuity of care inadvertently escalated those combined, active risks that were accurately identified by the FRS senior clinician and similarly delayed the requirement for him to be assessed by a health professional.

16.65 In light of all the information known to GP Practice 1, with regards to his illness, and Maria's simultaneous, and repeatedly reported challenges accessing services, treatment and care; it appears to have been appropriate for GP Practice 1 to prioritise continuity of care, until such time as he had reliable access to an alternative GP practice. It was then appropriate to ensure an effective, and appropriately prioritised, handover took place with GP Practice 2. This could have served to brief GP Practice 2 on the presenting complaint, significant history and treatment and care plan, to enable uninterrupted and informed continuity of care. An agreement to offer him professional medical support and treatment in advance of this, and as repeatedly requested by Maria, and reportedly agreed to with the FRS on 4th February, could have led to an earlier assessment, diagnosis and treatment for his illness.

16.66 On 10th May 2024, additional information was provided to the review on behalf of GP Practice 1. The information argues that the GP's at GP Practice 1 continued to assist

[145] Contact 1 – GP Practice 1

Maria while she was in the process of arranging for Christopher to re-register. The information maintains that it is wrong to suggest that the GP's prioritised re-registration and that Maria was denied support and advice. The information indicates that this should be clear from the interactions on the 11th February when advice about re-registration was not documented by the GP. Instead, the GP's focus (and indeed the focus of all the GPs at GP Practice 1) was on assisting Maria to access acute mental health services for Christopher.[146]

16.67 In contrast to the position proposed by GP Practice 1 in this regard, the evidence is clear that there was no attempt to assess his mental illness by a health professional, prior to Maria's homicide, after the FRS attempted to engage him, which GP Practice 1 was uniquely positioned to resolve. The perspective of Maria in this regard, was repetitively referenced in her phone call to the FRS on 1st February,[147] where she made repeated statements describing that the GP refused to help her or to treat Christopher because he was living in St Ives. During that call, she also queried how she could obtain a sick note for Christopher as his GP was refusing to help him. Her diary entry of 2nd February reflects, '*I called the doctors again and asked (Redacted) for the doctor to give a sick note to Christopher for a month. Doctor didn't call.'* On 5th February, she wrote in her diary, '*Rebecca called. She is looking a help for me and what should I do when none one is able to provide medical help.'*

16.68 To reinforce Maria's perspective around the support she received during this time, her diary entry of 11th February states, '*After work I went to Christopher's doctor surgery and I told him that he still doesn't attend work and I told him that he has worrying thoughts. I asked for sick note again for him.'* In a call with GP Practice 1 on 11th February she stated, "I just don't know what to do anymore in general. I already have enough I'm undergoing treatment, I also have an anxiety neurosis, I can't sleep anymore because of all this. I keep thinking, if no one helps me, I just don't know anymore, if he does something to himself, I'll blame myself. Everyone tells me, but the contributions were paid, why doesn't anyone want to help me? And for three weeks all I've been doing is running around, do you believe me? But I would like you to help me with this, to talk to the doctor, because I have been asking for help for so long, I think to myself, I can't stand it, it would always be some kind of support, he hasn't been going for so long and I'm afraid that he will do something to himself and because of some silly sick note. And yet he is registered here, do you understand? Say that I have spent so much time, no one wants to help, but who will be responsible for this if something happens?"

16.69 In a separate call with GP Practice 1 on 11th February, Maria reflected her perspective by stating, "People don't help. Him, 3 weeks don't coming to work. I need this leave sick but I need some help for my son because he going to kill self."

16.70 In a call to Christopher's manager on 11th February, Maria reflected her perspective as follows, "I call to you because 2 weeks I ask about sick leave, because Christopher is mental problem and today, I asking again because I say I worry for him life and I worry about him, he may kill himself because is very depression and I speaking, speaking, and

[146] Letter from Medical Defence Union (MDU) to review Author dated 10th May 2024
[147] FRS – Contact - 2

doctor give me, tomorrow." During the same conversation. Maria described, "All the time I ask about help for him, nobody wants to help."

16.71 Maria's perspective is reflected in a further call she made to a work colleague on 11th February where she stated, "I go today after job to doctor and I say I think my son want to kill self, I need help. I, three weeks asking about help, nobody want help and (GP) give me sick day for 24th February."

16.72 Maria's close friend Rebecca recalled that during this period, Maria was working and going to Christopher's GP in Huntingdon almost daily, trying to get some help for him. She related that Maria told his GP that Christopher was sick and needed medication and a sick note, as he wasn't going to work. Maria told her the GP wouldn't help her and said that Christopher would have to come to the surgery. Rebecca said that Maria told the GP that he wouldn't come to the surgery as he refused to believe that anything was wrong with him, but that she knew he was very unwell, as he was her son, and he needed medication. Maria was told that Christopher would have to come to the surgery before he could be given any medication. Eventually, Maria did manage to obtain a sick note from Christopher's GP as she explained that he was very unwell, wasn't attending work, and would lose his job and be destitute.[148]

GP Practice 2

Contact 1 – GP Practice 2 - 1st application to transfer GP surgeries

16.73 Around 3rd February, Maria attempted to register Christopher at GP Practice 2. The evidence suggests she signed the registration form as a consequence of his refusal to sign it. The application for registration at GP Practice 2 was appropriately denied in these circumstances.

16.74 There is minimal information in relation to this transaction, but it seems logical to consider that it offered an isolated opportunity to enquire into the cause of Maria's actions, and thereby, inform an early assessment of the combined risks associated with Christopher's deteriorating mental health, the absence of any professional assessment of his illness and his aligned lack of treatment and refusal to engage with medical practitioners. This could have been overcome by an appropriately prioritised briefing from his previous care provider which regrettably did not take place.

16.75 There is insufficient information available to understand what was conveyed to GP Practice 2 during this transaction to assess the potential for conducting a professional assessment at that time. The circumstances of this case indicate that it would be good practice for GP surgeries to make relevant, diligent enquiries into events such as these to identify, assess and control any active risks.

Contact 3 - GP Practice 2

[148] Account of Maria's close friend Rebecca

16.76 On the 10th February, Maria tried to make an appointment at GP Practice 2, as she had persuaded Christopher to sign the registration form the previous day. She was told this could not be facilitated as he was still registered at GP Practice 1. Similar to Contact 1 – GP Practice 2, it seems logical to consider this offered a further opportunity to enquire into Maria's concerns and circumstances. As with the previous transaction, this could have been overcome by an appropriately prioritised briefing from his previous primary care provider. This could have exposed the combined, active risks posed by his deteriorating mental health, the absence of any professional assessment of his illness and the lack of access to professional treatment and support. The circumstances of this case indicate that it would be good practice for GP surgeries to make relevant, diligent enquiries when encountering events such as these to identify, assess and control any active risks.

Contact 5 – GP Practice 2

16.77 Maria went to the surgery on 16th February, after Christopher's registration application was accepted the previous day.[149] The record describes this was, 'due to her concerns.' The concerns she raised at the surgery are not described in the record. It seems logical to assume, in light of her frequently expressed objective to have Christopher examined, in previous and subsequent encounters with professionals, that the objective of her visit was to make a face-to-face appointment with the GP; so that Christopher could be examined, his illness assessed and he would receive any medication and treatment his illness warranted. Regrettably, she was only offered a telephone consultation later that day. There is no information to illustrate what Maria disclosed when she attended the surgery, but based on all the information, a face-to-face appointment should have been prioritised, and likely would have been, if GP Practice 2 had been made aware of the previous history, as reported by Maria to his previous care provider. This could have led to an earlier assessment, diagnosis of, and treatment for, his mental ill-health. The review acknowledges that the Covid lockdown in place at this time meant that initial telephone consultations were offered in preference to face-to-face consultations to prevent spread of the virus.

16.78 On 10th May 2024, additional information was provided to the review by the GP at GP Practice 2. The information describes the GP was the afternoon duty doctor and was working from home on 16th February, as they were self-isolating following a Covid contact. The GP was sent a message requesting advice about Maria's concerns by one of the reception team.[150] In response to the message, the GP asked the reception team member to add Christopher to the daily triage list so that the GP could speak to Maria and Christopher about her concerns. The GP described that this consultation was carried out during the Covid pandemic, when it was usual for all clinical assessments in general practice to be carried out in the first instance by telephone. The GP could not recall if they had access to Christopher's medical records.

16.79 The evidence provided to the review indicates the GP did not have access to Christopher's medical history at this time as his medical records were still waiting to be sent to GP Practice 2 on the 17th February. In these circumstances, the review

[149] Contact 4 – GP Practice 2
[150] Contact 5 – GP Practice 2

acknowledges that it was logical and appropriate for the GP to offer and conduct an initial telephone consultation.

Contact 6 – GP Practice 2

16.80 A telephone consultation took place that same evening of 16th February, between the GP, Maria and Christopher. Interpreter services were not utilised in supporting this consultation, which is at odds with the GP's previous, documented concerns and practices around Maria's English language fluency.[151] The record described she was 'very concerned' and acknowledged that, neither she nor Christopher spoke good English. The record posed the question as to how much Christopher understood what was discussed. Maria reportedly explained that he had not been himself for the past 4 weeks and seemed lost. She described he was angry and not attending work. She explained she had contacted NHS 111 (Option 2) in the past, but had not found this helpful. The GP spoke to Christopher who explained that he couldn't recall how he had been feeling, but now felt well and didn't believe he needed help from a doctor. Maria reportedly agreed that he seemed better than he had 2 to 3 weeks earlier. The GP arranged for a further telephone consultation on the afternoon of 19th February, but told Maria and Christopher they could call back earlier if required, or contact NHS 111 (Option 2). The options offered to Maria to call the GP back in advance of the next appointment or contact NHS 111 (Option 2) is acknowledged as good practice.

16.81 There is no recorded rationale for Maria's assessment that he was better than he had been 2 to 3 weeks previously. This assessment is at odds with her increasingly desperate efforts to get professional medical help for him and other events she experienced at that time. These include his continued absence from work whilst remaining convinced he was attending work, his eviction on the 14th February and unexpected arrival at her home in the early hours of the 15th February. He was discharged from hospital less than 48 hours previously, having been conveyed there in response to concerns about his mental health. Of note, 2 days before this consultation, Maria remarked in her diary entry – '*Christopher wasn't answering his phone all day. I don't know what to do. I pray to God to help him to come back to be himself.'*

16.82 The services of an interpreter would have informed a more insightful professional assessment of the combined and active risks posed by his mental health, the absence of any assessment of his illness by a health professional and his lack of access to, and reluctance to engage with, treatment and support for his illness. It would have provided more insight to the nature and history of his mental health deterioration and, Maria's simultaneous, unsuccessful efforts to access professional assessment of, and treatment for, his illness. This would have provided added insight to the risk picture and enabled an informed plan to be adopted that was appropriate to control the risks posed by the collective, attendant circumstances.

16.83 The services of an interpreter would have similarly exposed Christopher's reluctance to register with this GP practice, his serial failures to answer telephone calls and, Maria's

[151] Prior to 2015, the GP Practice 2 records documented that Maria required double appointments which is often put in place when there are communication difficulties

previous reflections to professionals, that he refused to acknowledge he was sick or required any professional help. In turn, this could have demonstrated the necessity for an earlier, face-to-face appointment, in preference to a further telephone consultation, which was vulnerable to the attendant risks and, as a minimum, would delay an assessment of his illness and access to any medication he might require to treat him. The services of an interpreter were critical to enabling the GP to identify and control these active risks. It could have proved pivotal if a face-to-face appointment had been prioritised on this basis as it could have led to an earlier assessment of, and treatment for, his illness.

16.84 There is nothing in the record to indicate the GP was aware of the previous conversations Maria had with GP Practice 1 and / or the FRS, other than Maria's reference to finding FRS unhelpful in the past. There is no evidence the GP sought to investigate the context to this remark, which could have illustrated a more detailed perspective of the nature and history of his mental illness and the aligned and sustained absence of, and his resistance to, any professional assessment of, or medical support and treatment for, his illness. Similarly, there is no indication the GP was made aware of the conversations between GP Practice 1, the FRS and EDT on 11th February. Access to this cumulative information would have informed a more enlightened and potentially more urgent response to the combined and escalating risks posed by the collective circumstances. Regrettably, the GP had not been briefed by his previous care provider and insufficient information was gathered during this consultation to assess and respond to the active combination of risks. The services of an interpreter were essential to achieving the necessary insights and outcomes from this telephone consultation.

16.85 On 10th May 2024, additional information was provided by the GP at GP Practice 2. The information describes that the judgement of the GP on the afternoon of 16th February, was that communication was satisfactory for the purposes of an urgent telephone triage consultation, but in retrospect, the GP acknowledged that the use of a translator would have allowed more information to be gathered which may have led to a different response.

Contact 7 – GP Practice 2

16.86 During the telephone consultation with Maria and Christopher on 16th February, the GP arranged a further telephone consultation with Christopher on the 19th February, but predictably, he failed to answer the call from the GP. There is no explanation as to the rationale for offering a further telephone consultation, in preference to a face-to-face appointment, which would have provided the opportunity for Christophers mental health to be assessed by a health professional by examination and observation. Maria made 4 separate references in her diary, on consecutive days between 10th and 14th of February, documenting Christopher's refusal to answer his phone. Similarly, she told the FRS on 1st February, and separately, GP Practice 1 repetitively, that he refused to talk on the phone. Regardless, a face-to-face appointment was not arranged until after he failed to answer the GP's attempted telephone follow-up.

16.87 As previously outlined, the services of an interpreter on 16th February were critical to identifying the combined active risks and to inform a plan to counter those risks, which

included the high probability that Christopher would not answer the GP's call. This could have led to an earlier assessment, diagnosis and treatment for his illness.

16.88 After the unsuccessful attempt to speak to Christopher on the telephone, the GP telephoned Maria on the afternoon of 19th February. This was good practice in light of the evolving circumstances. During this call, Maria continued to express concerns about Christopher's mental health and suggested he had a problem with his brain. The GP made appropriate arrangements for a face-to-face appointment with Christopher and Maria, to conduct a clinical assessment, on the 23rd February.

CPFT FRS

16.89 The FRS supports people experiencing a mental health crisis. They provide 24-hour access, seven days a week to mental health care, advice, support and treatment to anyone who feels they need urgent mental health care. People can self-refer to the service or be referred through their family / carer, GP, social care professional or other voluntary organisations. FRS staff triage phone calls and make a clinical decision as to whether further action is required. FRS liaise with CPFT Crisis Resolution and Home Treatment Team (CRHTT) to request admissions to this service, although the review has been informed that this is for consenting service users only.

16.90 The aims of the FRS are to:

- improve access to mental health services
- improve patient care, and
- reduce the number of people going to the police or emergency departments in a mental health crisis

16.91 Referral routes are:

- Patient self-referral via NHS 111 (Option 2).
- Carer referral of patient via NHS 111 (Option 2)
- Professionals telephone line for GP's, social care professionals, emergency services, voluntary organisations.

16.92 FRS response may involve telephone support or a face-to-face assessment and, if appropriate, referrals onto other CPFT services, e.g., CRHTTs.[152] The FRS do not hold a caseload or offer medication reviews, any requirement for either of these would therefore determine onward referral to an appropriate CPFT service.

Contact - FRS - 1

16.93 Maria's diary entry of 1st February references a call she made to the FRS the previous evening of 31st January. Her diary entry states, '*I called 111(-2) last night and they wanted to speak to him. I told them that he is not able to speak as he doesn't realise that he is unwell. He told me to call the doctor*.'.[153]

[152] This is for consenting patients only

[153] There is no corresponding FRS record of this call. It was suggested by the CPFT IMR author that Maria may have called 111 without selecting option 2, but her diary specifies she called 111(-2).

Contact - FRS - 2

16.94 Around 19.00 hrs on 1st February, Maria called the FRS and reiterated that she spoke with FRS the previous day and followed their advice to contact Christpher's doctor, but that nobody had helped her.[154] There is no corresponding FRS record of her call to FRS on 31st January, which she referred to in her diary entry and reiterated to the FRS practitioner on 1st February. It is clear from her diary entry, that she specifically refers to calling *'111 (-2).'* In parallel, her subsequent actions, in re-contacting his GP on the 1st February, corresponds with advice she reported she was given by the FRS practitioner the previous evening. There is no evidence the FRS explored this anomaly with her on this call or in subsequent engagements with her. The review can offer no explanation for this anomaly.

16.95 FRS records describe Maria first alerted them to her concerns about Chritopher's mental health on Monday 1st February. An interpreter service was not engaged in support of this interaction. Maria made reference to this call to FRS in the same diary entry of the 1st February and noted, '*I called 111 (2) and I spoke over an hour and they are going to call me tomorrow after 15:30.*'

16.96 The record describes she reported that he had a history of depression, which began 4 years previously. She explained he experienced thoughts of ending his own life at that time. She described he was becoming angry, seeing and responding to ghosts and referencing God. She explained he'd stopped going to work and wasn't talking to anyone and had questioned who she was at one point. She described his visit to her the previous evening, when he told her that people were hiding. The record describes he stopped going to work the previous Thursday, which was the 28th January, and that his difficulties appeared to have materialised late the previous week. She expressed her view that he needed to be admitted to hospital for observation. The FRS practitioner explained to her that he would need to be assessed to identify the support he required. She expressed doubts he would willingly engage with FRS practitioners, but agreed to support them in trying to engage him the following day.

16.97 The FRS practitioner noted difficulties with gathering some information, due to her understanding of English. This included, 'risk to self', although the FRS practitioner noted that Maria, 'does speak good English overall.'

16.98 The FRS triage assessment concluded that the concerns raised by Maria necessitated FRS to attempt a cold call visit to his home to try and engage him to assess his mental health. This indicates the situation, as reported by Maria, was considered to be one of high priority. An appropriate plan was agreed with her for the FRS to visit him at his home address the following day to see if he would engage with them. This is acknowledged as good practice.

16.99 In their review of the proposed plan, the FRS senior clinician directed that important, additional background information required to be collected from Maria including, recent

[154] FRS record

stressors, illnesses, drug and alcohol use, familial history of mental illness and history of risk towards Christopher himself, or others.

16.100 The commitment of the FRS in attempting to proactively engage Christopher to assess his mental health is acknowledged as good practice. The omissions in the information recorded in the FRS record of Maria's call on 1st February, which initiated the plan to attempt to conduct a 'cold call' engagement, however; provides compelling evidence of the added value interpreter support would have brought to the accuracy of information recorded from this interaction and the any subsequent professional assessment of risk that was based on this record. Whilst the practitioner notes Maria's conversational English was good, the record is inaccurate, in terms of identifying when Christopher stopped working and the point at which his problematic behaviour became apparent to Maria. In parallel, important information in respect of risk, alcohol and substance misuse and familial history of mental illness was not gathered, as noted by the FRS senior clinician.

16.101 In the recording of this call that Maria made, she made a number of references to not understanding what was being said to her and at one point asked for an interpreter. In parallel, much of the information she conveyed in her recording of this transaction was not documented in the FRS record, which served as one of the primary sources of information to inform the outcome of subsequent risk assessments. The challenges in understanding Maria's spoken English, as alluded to by other professionals and the translation service who prepared the transcriptions of Maria's recorded calls, may offer some explanation for this.

16.102 In addition to the information recorded in the FRS record, Maria outlined that when he came to her home and told her that people were hiding, he also accused her of bringing the devil. She described that when she sought to reassure him that it was dark outside and there was no-one in the street because it was night time, he called her a liar and again accused her of bringing the devil. She explained that he arrived at her home just before 21.00 hrs the previous evening, immediately engaged in this conduct and then abruptly left. She described that she was becoming scared by his behaviours. She also explained that he had never behaved in the manner he was now exhibiting, beforehand.

16.103 She described he had not been attending work for more than a week, but that he was convinced he was going to work every day and didn't acknowledge he needed a sick note to explain any absence. Whist describing that he previously suffered with depression, she made several references to his condition developing into schizophrenia, on the basis that he was consistently talking to imaginary entities.

16.104 She described other events that had concerned her, when he brought her flowers on Grandmother's Day, when he had asked her if she wanted to burn oils over the previous weekend and him speaking to and responding to numerous imaginary entities who were telling him what to say to her. She described his claims to be speaking to God and ghosts and that he called her a liar when she challenged him about this. She also described that when she had tried to interrupt him, he told her that God would tell him what to say to her and that she should sit quietly.

16.105 She also made repeated references to his GP refusing to help him because he resided outside the practice registration area. Her pleas for advice from the FRS, as to how she could source a sick note for him, provided telling insight into the difficulties she was experiencing in navigating the interruption in continuity of primary care to him at this time.[155]

16.106 The review recognises that no practitioner notes offer a full transcription of what was said, but the disparities reflected in the FRS record and the transcript of the recorded telephone call Maria made to the FRS provides compelling evidence of the added value interpreter support would have brought to this transaction and any subsequent assessment of risk. In parallel, Maria was clearly unfamiliar with, and evidently struggled to comprehend and navigate, the system to access appropriate professional, medical support for Christopher. An added and important benefit of utilising interpreter services could have been realised by providing her more clarity around the system of access and support to and from services. This was particularly relevant at the conclusion of the attempted engagement the following day.

<u>Contact - FRS – 3</u>

16.107 On 2nd February, FRS telephoned Maria to follow up on her referral of the previous day. The primary purpose of this call was to finalise the arrangements to attempt a 'cold call'. face-to-face assessment of Christopher later that day. The record reflects that she reported Christopher had depression and needed help. She explained he was in another world, refused to accept he needed help and refused to talk on the telephone. She again described her difficulties with his GP declining to help him. The information requirements, as directed by the FRS senior clinician after the previous day's call, were only partially met. Information was recorded in respect of familial history of mental illness, substance misuse and stressors, but there was no information recorded in respect of risk to him and / or others.

16.108 Arrangements were made to conduct a 'cold call' in an attempt to engage him at his home that evening, with Maria's support. The practitioner again noted her conversational English was good and that Christopher's was the same and they didn't require an interpreter. This statement is at odds with the assessment of other professionals who came into contact with Maria and Christopher, the accounts of others who knew them and the translation service who provided transcripts of Maria's recorded calls.

<u>Contact - FRS - 5</u>

16.109 The record describes that just after 20.30 hrs that evening, 2 FRS practitioners attended at Christopher's home. They initially spoke to Maria and his landlady who reported him showering fully clothed the previous weekend and explained he was sleeping a lot, eating less, no longer going to work and hadn't paid his rent. She thought he might be using drugs, but wasn't certain.

[155] Transcript of recording of telephone call made from Maria's phone

16.110 Maria reported he'd visited her and told her that people were hiding, but that she had been unable to see anyone hiding. She expressed concerns about his claims to be on holiday from work, which his employer had confirmed to be untrue. She explained that she'd seen a change in his behaviour and believed he needed to be hospitalised. No further information was documented by the FRS practitioners in respect of any concerns raised by Maria and Margaret, which could have provided a more comprehensive and accurate insight to a professional assessment of risk.

16.111 In addition to the information recorded by the FRS practitioners, Margaret recalls Maria informed them that he brought her flowers the week beforehand and was talking like a small child. She said Maria told them that he was talking to imaginary children in her kitchen.[156]

16.112 Maria's diary entries between 22nd January and 2nd February make reference to him talking to God and the devil, concerns he is suffering from schizophrenia and, her diary entry of 31st January, makes reference to him stating '*What have you done, gave me the devil*' when he described to her that people were hiding, which she had duly reported in her call to FRS on the 1st February,[157] but was not documented in the record. She also reported to Christopher's GP and the FRS practitioner the previous day, that he was, 'responding to ghosts and hearing voices.' In common with the additional information outlined in the previous paragraphs from the recording of Maria's phone call to FRS on the 1st February, none of these concerns are documented in the FRS record of this event, which appears to have served as the basis for a subsequent risk assessment by the FRS senior clinician.

16.113 It seems logical to conclude that Maria would share some, if not all, these concerns with the practitioners. This information would have added insight to any professional assessment of risk posed by the combination of his deteriorating illness and the simultaneous interruption in continuity of his primary care by his existing GP practice. This could have caused a more informed assessment and urgent intervention.

16.114 The practitioners sensibly utilised the services of a telephone interpreter in their attempt to engage Christopher. Regrettably, this was to no avail as they found him sat in the dark and he became agitated and raised his voice telling the practitioners to, 'get out' and, 'leave him alone.' They concluded they were unable to ascertain capacity or assess his mental health. They didn't feel they had the grounds to request an assessment under the MHA that evening.

16.115 The record documents the initial FRS plan as advising Maria to encourage him to see his GP and to contact emergency services if he became aggressive or a danger to himself or others. Aspects of this plan were immediately vulnerable, due to Maria's repeated references to the FRS regarding his GP refusing him treatment. She also repeatedly informed FRS that he refused to accept he was sick and similarly, refused to acknowledge he needed professional help. Maria was also advised that she could re-contact FRS for further support if required and request an emergency MHA assessment by the EDT.

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[156] Account of Margaret
[157] Transcript of recording of telephone call made from Maria's phone

16.116 MIND guidance on sectioning[158] describes that patients may be sectioned if their nearest relative or someone acting on their behalf has raised concerns about their mental health, which Maria and Margaret clearly did. The guidance explains that patients should only be sectioned under the MHA if: -

- They need to be assessed or treated for a mental disorder -

  The FRS acknowledged that he might be suffering from a mental illness. In parallel, the FRS senior clinician recognised that his mental health needed to be assessed by a health professional. Their documented plan relied on his GP engaging him in a discussion about his general health, in order to assess his mental health.

- Their health would be at risk of getting worse if they did not get treatment -

  The FRS senior clinician documented a risk that his mental illness would deteriorate without treatment. Similarly, the FRS were alerted to his GPs refusal to treat him and his refusal to acknowledge he was ill, or needed professional help.

- Their safety or someone else's safety would be at risk if they did not get treatment -

  Maria expressed that she was becoming scared by his behaviours and that he was expressing anger in her call to FRS on 1st February. She described a number of disturbing events whereby he claimed to be talking to God, accused her of summoning the devil and called her a liar when she challenged or tried to reassure him. Separately, his co-resident and landlady harboured her own fears for her safety from Christopher. She described taking physical precautions to secure her bedroom door after the FRS practitioners left her home. She had a lock fitted to her door the following day and later reported her fears to the police.[159]

- Their doctor thinks they need to be assessed or treated in hospital.

16.117 The FRS considered that Christopher did not meet the threshold for a MHA assessment based on the information they had available to them at that time. They did not pursue this as an outcome and existing practices prevented them from engaging directly with the EDT, therefore, responsibility for this consideration was effectively left with Maria at that time.

16.118 There is a notable absence of any documented assessment of risk posed by Christopher to others in the record. For the first time that evening, his landlady, and co-resident, took conscious, physical steps to secure her bedroom door, because of her fears.[160] Margaret was seemingly not invited to discuss any safety concerns she had as his co-resident, which her subsequent actions clearly indicate she maintained. A more professionally curious and assertive line of questioning and enquiry could have led to a more accurate assessment of the risks posed to, or feared by, others.

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[158] MIND information about Sectioning
[159] Account of Christopher's landlady Margaret and Police IMR
[160] Account of Christopher's landlady Margaret

16.119 A more accurate and comprehensive assessment could have been informed through more detailed exploration and documentation of the behaviours known to, and experienced by, Maria and Margaret. Regrettably, the practitioners concluded they had no option but to leave Christopher's address prematurely, in light of his demands they leave, as they had no powers to remain.[161] This was an erroneous conclusion, as the owner of the residence was Margaret and her consent to their presence was never withdrawn. They were at liberty to remain in the household to gather and document additional information from Maria and Margaret and exploit any further opportunities to observe and assess his behaviour, as might have materialised, but these were not pursued. Given that Maria and Margaret were present and FRS staff were not obliged to leave when Christopher refused to be interviewed, it would have been good practice for the FRS practitioners to make use of the opportunity to gather detailed information about his recent beliefs and behaviours. Family and friends are often key partners in assessing the risks presented by their loved ones. In this case it appears Maria and Margaret did not have a full opportunity to share their knowledge and the FRS risk assessment was therefore not fully reflective of their concerns.

16.120 In her account, Margaret concurs the practitioners provided Maria with a Peterborough telephone number,[162] but it is unclear if Maria understood her rights as a nearest relative and the options available to her. There is no evidence she subsequently pursued any course of action beyond attempting to access support for Christopher though his, and her own, GP. There is no record of her making any further calls to the FRS, EDT or emergency services. Her diary reference to this event merely states, '*They arrived at 20:40, they wanted to speak to him but he told them to go away from his house as he is watching a video.'*

16.121 Whilst the practitioners engaged the services of an interpreter in their attempt to engage Christopher, there is no evidence this extended to them outlining their initial plan to Maria. This would have enabled her to clearly understand the plan and explore any reservations or required deviations and contingencies her recorded calls indicate she was in the habit of doing. The evidence of her inaction in response to the FRS plan is indicative of her not understanding the plan as was relayed to her. This is most suitably summarised in her diary entry of 5th February 2021 which states - *Rebecca called. She is looking a help for me and what should I do when none one is able to provide medical help.*

16.122 The CPFT SI Review described that any decision to make a referral for MHA assessment by the FRS is a clinical one based on risk. There is no existing provision for referral where a person could be ill, but does not pose an imminent risk and all least restrictive options have not been exhausted.

16.123 In this case, the FRS tried to use other means to cause the consideration for a MHA assessment, in the form of Maria, and separately, the GP, by advising each of them to request a MHA assessment from the EDT; however, the EDT did not accept the referrals

[161] CPFT FRS IMR
[162] This is likely to be the Cambridgeshire County Council out of hours Social Services for Adults telephone number

from the GP, or Maria's friend Rebecca, when they were made. This highlights a gap in understanding of thresholds between services and the corresponding lack of systems to enable joint working and decision making. The complexities that are embedded within the Mental Health Service and the complexity of the MHA are also considered to be contributory factors to this.

16.124 When a face-to-face assessment has been undertaken by FRS, where there is a requirement to advise a nearest relative of their rights to call EDT to request consideration for an emergency MHA assessment, there is no handover process in place between the FRS and EDT Service. The two services must consider a joint pathway to improve communication, assessment and resolution of higher risk / complicated / complex cases and enhance service user outcomes and satisfaction with services. This requires to extend to all AMHP services in the region. Had such a pathway been in place at the time of this attempted engagement, the FRS could have alerted the EDT that they had advised a Maria of her rights as a nearest relative to apply for consideration of a MHA assessment. This would have been good practice and would have led to an appropriate, professional discussion between these services, an informed consideration of responsive interventions and enhanced both user service and satisfaction.

FRS and GP Practice 1 – FRS Plan

16.125 The FRS were aware of the challenges Maria experienced accessing primary care support from Christopher's GP. The FRS senior clinician attempted to overcome this, when contacting his GP over the following 2 days, which was good practice. Regrettably, nothing of value materialised from these discussions.

16.126 Regardless of the observation that the FRS do not carry a caseload, the day after their attempted face-to-face assessment, the FRS senior clinician telephoned Christopher's GP (GP Practice 1) querying if the GP had any recent contact with, or concerns about him. This was an appropriate enquiry, which could have enhanced an assessment of the combined risk posed by his illness deteriorating and the parallel absence of any health assessment of his illness to inform the necessary treatment and response plan. The FRS senior clinician noted that it had not been possible to form a complete impression of his mental state as he would not engage. Their documented aim was to try and develop a plan for further engagement with him, through health professionals, to assess him more fully. They felt it was the most reasonable and least restrictive course of action to ask his GP to try and engage him to enable an assessment of his illness. This is recognised as good practice.

16.127 The FRS senior clinician was informed by the GP that Maria had contacted them expressing the same concerns she raised with FRS, but that the GP was unaware of any previous episodes of mental ill health. The GP reiterated that he needed to register with a new GP.

16.128 According to the FRS record, the GP agreed to try and offer him an appointment to discuss his general health, as a means of assessing his mental health. At this point the FRS closed Christopher's case to FRS and rationalised this decision on the basis that

his care was handed back to his GP. Of note, the GP record makes no reference to such an agreement being made.

16.129 The FRS senior clinician demonstrated good practice in making proactive contact with the GP to add any pertinent information to inform any professional assessment and / or treatment plan. The only pertinent information recorded from this transaction related to the GP reporting that Christopher had no history of mental illness. This information, in isolation, did not mitigate the potential risks which underpinned the initial FRS decision to attempt a face-to-face assessment; which was predicated on the behaviours described by Maria, indicating that he may be suffering from a mental health illness, even though he was unknown to mental health services. The FRS senior clinician accurately summarised that the risks were that of a further deterioration in his mental state if he was developing a psychotic illness and a deterioration in his mental health if he was not treated.

16.130 The CPFT SI Review noted that at the time of the incident CPFT were not using the same Electronic Patient Record (EPR) as the GP practice and that risk assessment, formulation, decision making and other important clinical information was not fully documented in the EPR. This resulted in valuable information being lost in communication and the joint working arrangements failing to ensure all risks were known by all parties. The CPFT SI Review highlighted a requirement for ensuring clear, documented communication with GP practices which details the shared management plan and the named individuals involved.

16.131 Both the FRS and GP records demonstrate the FRS senior clinician was advised that Christopher needed to register with a new GP practice. The FRS were aware of the challenges experienced by Maria in trying to access support from his GP and his reluctance to engage with professionals, as Maria told them he refused to accept there was anything wrong with him and he made it clear to FRS that he did not wish to engage with them.

16.132 The vulnerabilities associated with transferring responsibility for his care to the GP, who continually maintained that he was required to register with a new practice, simultaneous to closing Christopher's case to crisis mental health services by the means outlined, were tangible at this point, but as has been alluded to, the FRS do not maintain a caseload, therefore this decision was not subjected to further consideration, assessment and contingency planning. The FRS senior clinician documented the potential risk that his mental health might deteriorate further if it was not treated. Follow-up enquiries with the GP, who reportedly agreed to implement the FRS plan, were both necessary and appropriate to monitor and control the combined risks documented in the FRS plan. In parallel, it would have been good practice to follow up with Maria, to consider any further information she could provide concerning his developing psychosis and continuing lack of access to professional assessment of, and treatment for, his illness, which were the significant risk factors recorded by the FRS senior clinician, but the existing ways of working prevented FRS pursuing either of these options. This would have provided insight to a maintained assessment of the risks and supported Maria with access to necessary and appropriate services. Either one of these pursuits could have led to an

enhanced professional assessment of the evolving circumstances and consideration of alternative interventions to mitigate the active and evolving risks.

16.133 It is clear the FRS recognised there was a considerable degree of risk posed from the information disclosed by Maria, which underpinned their consideration to attempt this assessment and was subsequently documented by the FRS senior clinician.[163] Regrettably, those risks were never subject to effective monitoring, dynamic and collaborative assessment and control by any agency or professional.

16.134 The CPFT SI Review noted that the FRS service was not designed to hold a caseload, which may result in potential risks being unable to be fully explored. It has been difficult to establish whether or not CPFT accepts referrals involving a non-consenting patient. There is an existing FRS protocol for, 'referrals for patients who are not consenting;' however, this protocol is for referrals into FRS and not for FRS to refer internally, when assessing the risks of non-consenting patients. CPFT staff have indicated that even FRS are not able to accept internal referrals of patients who are not clearly agreeing to be seen. It is challenging to see how a crisis mental health service can operate on this basis. The FRS triage system allows for a proportion of its referrals to be dealt with through an urgent home visit, whether there is patient consent or not. The main aim of such visits is to assess the situation as thoroughly as possible and ensure patient safety. This is good practice and it is what was attempted in this case. As previously alluded to, there are lessons to be learned around information gathering and recording, risk identification, evaluation and monitoring.

16.135 There are currently no services in CPFT that will accept an internal referral involving a non-consenting patient who does not meet the threshold for an emergency MHA assessment. As Christopher was not consenting to engagement with mental health services, the existing protocol curtailed any options for him to be referred internally onto other CPFT services such as CRHTT. The CPFT SI Review noted a requirement to ensure clear, documented communication between FRS and the EDT when non-consenting patients are presenting to either service, and being redirected to the alternative service. Both services need to review and extend protocols to manage the risks and challenges that exist in circumstances such as these.

16.136 The FRS senior clinician added a note to the record directing that Christopher's case should be placed on the consultant list, in the event that he or Maria were to contact FRS again.[164] The rationale for this is not documented, but logically, this process was sensibly aimed at generating a review of the case, in the event of new information emanating from further contact with Christopher or Maria.

GP Practice 1, FRS and EDT engagement

16.137 On the evening of 11th February 2021, FRS were contacted by Christopher's GP reporting continued concerns regarding his mental health, as disclosed by Maria. This was not acknowledged as a referral by the GP to FRS, which could have caused his

[163] FRS record 4th Feb
[164] FRS Record dated 4th February

case to be reviewed and re-assessed and necessitated consideration as to a further attempt to engage Christopher; or cause a discussion between FRS and EDT, given that all least restrictive options were seemingly now exhausted. In parallel, no action was undertaken to cause his case to be placed on the consultant list, as was directed by the FRS senior clinician on the 4th February, in response to any further contact by Maria or Christopher, which this indirectly was.

16.138 The record describes the FRS practitioner updated the GP with the plan, as was documented in the FRS record whereby the GP had agreed to offer Christopher an appointment as a means to assessing his illness and Maria had been informed of her right to request a MHA assessment from the EDT. Logically, this update would have focused on a central FRS planning expectation that the GP had agreed to try and assess his illness by offering him an appointment to discuss his general health, as a means to assessing his mental health. Any discussion around this should have alerted FRS to the fact that the GP had made no attempt to offer him an appointment, thereby escalating the risk of his mental health deteriorating without treatment and undermining a key aspect of the documented FRS plan. Logically, this should have led to more concerted contingency consideration and planning. The FRS practitioner concluded there was, 'no change to the presenting situation from when FRS attempted to assess' him. The FRS practitioner noted that the GP hadn't given any indication that Maria was in fear of her safety and advised the GP to call the EDT.

16.139 Aside from the fact that this could have been acknowledged as a referral, the ensuing discussion should have led to a more informed assessment, based on new information from Maria and the GP, that was previously unknown to the FRS, and a recognition that a key risk, which was the potential for his mental health deteriorating without treatment, was not being controlled, because the FRS control measure relied on the GP engaging directly with him, which had not materialised. This should have resulted in a re-assessment of the evolving risks and dynamic consideration of a revised approach to enable an alternative intervention.

16.140 This call was again documented as a handover from FRS to the GP. Similar to the position on 4th February, when the FRS senior clinician documented that FRS were closing the case as Christopher's care had been handed back to the GP, this is not acknowledged in the GP record. This presents a lack of clarity around responsibility and accountability for his ongoing care and, by default, escalated the challenges faced by Maria who was effectively passed around the system without any meaningful intervention taking place.

16.141 In conclusion, the FRS IMR analysis notes that the, detailed history recorded by the practitioner at the outset of Maria's interactions with FRS demonstrates they clearly considered the level of understanding of Maria, (Contact – FRS – 2)[165] but it doesn't indicate whether the practitioner was able to clearly understand what Maria told them. As alluded to, several professionals pointed to the challenges in understanding Maria because of the limitations in her English fluency. The translation service who produced the transcripts of Maria's recorded calls described Maria as follows, 'This person speaks

[165] CPFT FRS IMR

using very poor English. The speech is not grammatically correct and at times difficult to understand.' This may offer some explanation as to why much of the description she provided of Christopher's recent behaviours and Maria's own fears as a consequence of his conduct were not recorded. The FRS senior clinician also identified additional, background information as an outstanding requirement from this call.

16.142 The sentiment outlined in the IMR also appears to be at odds with Maria indicating that she did not understand what was being said to her on 5 separate occasions during the recording of this conversation. At one point she asked for an interpreter. This was particularly relevant as Maria was asking for advice and support in light of Christopher's GPs reluctance to treat him. She also appealed for help and guidance in anticipation that Christopher would refuse to engage with the FRS practitioners or acknowledge he needed medical support or intervention.

16.143 With regards to the risk Christopher may have posed to others, the FRS practitioner's assessment in regards to the attempted face-to-face engagement on 2nd February, noted there were, 'no reports of risk to self or concerns regarding immediate safety.' Post the attempted face-to-face engagement, under the heading, 'Risk to Others,' the FRS senior clinician documented that Maria, 'did not voice that she felt threatened.' Of note, there was an absence of any reference to his co-resident and landlady in either of these assessments. In the record of the telephone conversation with the GP on 11th February, the practitioner documented that the GP, 'did not give any indications that Maria was in fear for her safety.' Either in isolation, or collectively, none of these statements inspire confidence that the risk to Maria and / or others was purposefully explored to any significant degree, either during the attempted face-to-face engagement, or subsequently in the post event assessment, or in the conversation with his GP on 11th February.

16.144 The FRS assessed the risks posed by Christopher's mental illness, as described by Maria, to be substantial enough to warrant an attempted 'cold call', face-to-face assessment. Having come to this conclusion, the risks identified, and documented as being liable to worsening without intervention, required active and reliable oversight and management. The subsequent planning, collaborative decision making and actions undertaken by FRS and GP Practice 1 were insufficient to establish responsibility and accountability for assessing his illness, maintaining his healthcare, or achieving and maintaining any reliable oversight, management and control of the active and escalating risks.

Cambridgeshire County Council Adult Social Care EDT

16.145 EDT is a social care service that responds to emergencies in children and adults. In addition, EDT social workers, who are also trained AMHPs can conduct emergency assessment under the MHA that cannot wait until the next working day. AMHPs are mental health professionals who have been approved by a local social services authority to carry out duties under the MHA. They are responsible for coordinating assessments and admissions to hospital in circumstances where patients meet the threshold to be sectioned under the MHA.

16.146 Patients may be sectioned if they or someone has raised concerns about their mental health. Patients should only be sectioned under the MHA if: -

- They need to be assessed or treated for a mental disorder;
- Their health would be at risk of getting worse if they did not get treatment and/or;
- Their safety or someone else's safety would be at risk if they did not get treatment;
- Their doctor thinks they need to be assessed or treated in hospital.[166]

16.147 It is a common misconception that EDT is an extension of the daytime Mental Health or AMHP services, but this is not the case. The EDT service is run by Cambridgeshire County Council. Referrals are accepted from carers, relatives and professionals referring patients out of hours. Calls are taken by non-clinical call handlers and are passed to clinicians for triage and assessment of information, taking into account presenting factors, history and assessment of risk. Based on this, the senior social worker/AMHP will make a decision as to whether a person meets the threshold for MHA assessment. Any referral would be discussed with an EDT social worker, and information relayed to the call handler is not treated as a formal referral.[167]

<u>EDT Contact – 1</u>

16.148 In her account, Maria's close friend Rebecca describes that sometime between 18.00 and 19.00 hrs on 9th February 2021, her daughter Sandra called the EDT in relation to their shared concerns regarding Christopher's mental ill-health and Maria's ongoing challenges to access medical support for him.[168] Maria's diary entry of 5th February made reference to, '*Rebecca called. She is looking a help for me and what should I do when none one is able to provide medical help.'* The number called from Susan's phone has been confirmed as that of Cambridgeshire County Council Out of Hours Social Services for Adults.

16.149 Rebecca recalls that Susan was called back by an EDT practitioner later the same evening. She relayed their concerns regarding Christopher's behaviours and explained that FRS practitioners had previously attempted to engage him unsuccessfully. The EDT practitioner advised that they could not see any record of any FRS interaction with him. The practitioner explained that his behaviours might be associated to an isolated depressive event. Susan was advised that she should call back on the same telephone number if his strange behaviours continued, or Maria felt unsafe. Susan was reassured the EDT would undertake an emergency MHA assessment if either of these circumstances prevailed. Susan confirmed she had contacted the EDT on the telephone number of Cambridgeshire County Council Out of Hours Social Services for Adults in a text message to Maria at 21.27 hrs that same evening.[169]

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[166] MIND information about Sectioning
[167] CPFT SI Review
[168] Account of Maria's close friend Rebecca
[169] Text message from Sandra to Maria states *Hi Maria, it's Susan. I phoned the number (Redacted). This is nr Cambridgeshire County Council Out of hours Social Services for Adults. They should have now Christopher's personal details and run down of his situation. They told me themselves that I can call them back if anything happens*

16.150 There is no corresponding EDT record of this reported interaction. EDT have made repeated searches of their records, interviewed staff who were on duty on that evening and undertaken staff log book and system reviews, but no record of this interaction has been traced. The review is therefore unable to explain this anomaly.

EDT Contact – 2

16.151 The first recorded interaction by the EDT occurred on the evening of 11th February. The record describes Christopher's GP called and left a message with the EDT call centre. The GP reported concerns regarding Christopher's unusual behaviour, as recounted to the GP by Maria. The GP confirmed they had never met him and that all the information was third hand from Maria. The GP added that there was no history of mental health in his records and that Maria would require interpreter support.

16.152 An EDT AMHP made checks on their system and noted that Christopher was not known to Adult Social Care, but had previous contact with FRS, through their attempted engagement with him.

16.153 On face value, the EDT record lacks any clarity on the AMHP's understanding of what the underlying purpose of the call to the EDT by the GP was. Similarly, the lack of any substantive subsequent action by the EDT AMHP calls into question their understanding of what the purpose of the GP's call was. The corresponding GP record stands in stark contrast to the EDT contact centre record and documents the GP's purpose in calling EDT as follows, 'Have contacted them (social care) they will make direct contact with mum to discuss need for emergency MH assessment.'[170] The same GP record includes reference to the GP being advised to contact the EDT by the FRS, as FRS didn't have the power to force entry to conduct a mental health assessment.

16.154 The EDT AMHP made attempts to contact the GP on the phone number provided, but the GP surgery was closed and there was no alternative number provided. The AMHP concluded there was no indication the referral was urgent. They decided not to make contact with Maria, on the basis that she required an interpreter, and did not pursue the matter further. They updated the system with details of the interaction so that the information would be available to the FRS. There was no simultaneous or subsequent contact made with the FRS, or with the GP, by the EDT.

16.155 During this transaction, the AMHP noted they were aware of FRS's previous contact with Christopher, through their attempted face-to-face engagement. They similarly noted the record reflected that FRS had advised Maria to call the EDT, after their attempted face-to-face assessment on 2nd February, but concluded that it was unclear what the rationale for the FRS advising her of this was.

16.156 Collectively, this should have informed some logical consideration that concerns about Christopher's mental ill-health were continuing and potentially escalating and that Maria had been advised to contact the EDT to exercise her nearest relative right to request consideration of a MHA assessment. In parallel, included in the FRS records was an

[170] GP Practice 1 records

assessment by 2 separate FRS practitioners, that Maria's conversational English was good and referencing her not requiring the services of an interpreter. It therefore seems illogical as to why the AMHP took the decision not to contact Maria, on the basis of her requiring interpreter support, which would have been available to them in any event. This decision discriminated against Maria on the basis of her non-English-speaking background.

16.157 On the basis of the GP's call to EDT, whose role is to respond to emergency situations outside of normal hours that cannot wait until the next working day,[171] the documented FRS advice, to both Maria and the GP, to make contact with the EDT and the collective content of the records available to the EDT AMHP; it seems logical to conclude that the purpose of the GP's call was to request the EDT to consider the necessity to conduct an MHA assessment of Christopher. The GP's call also indicated that this consideration required to be informed by EDT gathering information known to his nearest relative who was his mother.

16.158 The GP record illustrates a belief that this purpose was achieved in their call to the EDT, but the EDT record is inexplicably vague as to the purpose of the GP's call, or the interpretation of any analysis of records undertaken by the AMHP. It seems clear there were shortfalls in respect of the recording of requirements by the EDT, which could have more clearly defined the purpose of the GP's contact and supported the AMHP in progressing this matter with the urgency it was seemingly conveyed and certainly warranted. Similarly, the assessment of any risk considerations, emanating from the analysis of the FRS records referred to, is not documented in the record. This event was a unique, but regrettably missed, opportunity that could have led to an earlier assessment of, and treatment for, his illness.

16.159 A call should have been made to Maria by the EDT AMHP, preferably supported by an interpreter, to gather the necessary information to assess the requirement for an emergency MHA assessment. Regardless as to whether Christopher would have met the threshold for a MHA assessment, based on Maria's information, she would have been able to seek appropriate advice and support in accessing services and making contingencies. Similarly, she could have been signposted back to the FRS and this, in and of itself, could have generated a productive discussion between the FRS and EDT, which could have redefined the now redundant aspect of the FRS plan, centred on the GP undertaking an assessment of his illness, and led to a new referral, earlier assessment of, and treatment for, his illness.

16.160 Within the IMR analysis of the EDT record and AMHP response, there is a statement which documents, 'Even if an interpreter had been used and the EDT worker had spoken to mother, based on the information available, his mother would have been advised to contact NHS 111(Option 2).' [172] From a legal perspective a nearest relative has the right to request an assessment under s13(4) of the MHA and this request then needs to be

[171] Cambridgeshire County Council Website
[172] EDT IMR

considered by an AMHP.[173] The IMR analysis appears to undermine the nearest relatives legal right to request an emergency MHA assessment from the EDT and the aligned requirement for the EDT to consider this, as it is suggestive that Maria would have been automatically referred to NHS 111 (Option 2) by default. Similarly, this position reinforces an unintended and unproductive cycle of cross referrals between services, whereby patients are denied legitimate access to services and users are passed around the system without any meaningful intervention taking place. To exacerbate this concern, clear and easily understandable information regarding the nearest relative rights under the MHA, on the Cambridgeshire County Council website, was found to be challenging to access by the review Author.

<u>EDT Contact – 3</u>

16.161 On 21st February, the EDT were telephoned by Maria's close friend Rebecca. In her account, Rebecca describes that she called the same telephone number as that previously called by her daughter on the 9th February. She requested to speak to the same person whom her daughter had spoken to, but was told this wasn't possible. She told the operator about the background to their previous call with the EDT and explained that Christopher's strange behaviours were continuing and worsening. She requested the operator to send someone to, 'come and get him' in response.

16.162 She was told by the operator that, "it doesn't work like that" and advised to call NHS 111 (Option 2). She argued that he refused to speak to the 111 practitioners and that the previous operator told her daughter that if his strange behaviours continued, they should call this number back and that someone would come and take him to conduct an assessment. The operator told her they had a record of Christopher, but insisted that she was required to contact NHS 111 (Option 2) in any event.[174] Under Section 13 (4) of the Mental Health Act, it is the duty of a local social services authority, if so required by the nearest relative of a patient residing in their area, to make arrangements under subsection (1) for an AMHP to consider the patient's case with a view to making an application for his admission to hospital; and if in any such case that professional decides not to make an application they should inform the nearest relative of their reasons in writing. There is no evidence of any consideration being given to this requirement in the EDT record.

16.163 The EDT record of this event makes reference to Rebecca mentioning she had spoken to someone about this matter previously, but does not expand on this beyond her expressing uncertainty as to whether Christopher was known to services. The record reflects she was calling on behalf of Maria, as Maria did not speak good English. She described that he was evicted from his residence due to rent arrears, was now living with Maria and suffering a mental health crisis which she was struggling to cope with. She explained he was acting oddly, whispering and talking about the devil. She described

[173] **Section 13 MHA** – 'It shall be the duty of a local social services authority, if so, required by the nearest relative of a patient residing in their area, to make arrangements for an approved mental health professional to consider the patient's case with a view to making an application for his admission to hospital; and if in any such case that professional decides not to make an application he shall inform the nearest relative of his reasons in writing.'

[174] Account of Maria's close friend Rebecca

that he was speaking like a child at times and claiming that God was speaking to him. She reported he went out of the flat in his underpants recently. The record reflects there didn't appear to be any concerns about his appetite or any aggression directed towards Maria. Rebecca reportedly reflected that he is just acting bizarrely and thought he needed to be assessed again.

16.164 The EDT social worker advised they were unable to disclose details due to confidentiality, but confirmed they were aware of a previous contact with the FRS and with the EDT. The social worker explained that prior to a MHA assessment, the FRS, 'would need to assess again, as a less restrictive option to an assessment under the MHA.'

16.165 There are several references made to the 'least restrictive option' in EDT and FRS records. This is indeed a principle in the MHA, but It can be argued that the "least restrictive" principle has little relevance on decisions as to whether to undertake a MHA assessment or not, as a decision to undertake a MHA assessment, in and of itself, is not at risk of being restrictive. In this case the option of undertaking a MHA assessment appears to have been seen as a last resort, but this did not have to be the case. The review does not believe this is, or should be, the intention of the least restrictive option principle.

16.166 The EDT record makes several references that create an illusion that Christopher had been previously assessed by mental health services. It notes that Rebecca described that he needed to be, 'assessed again' and the EDT social worker advising her that the FRS would need to 'assess him again,' as a least restrictive option. As has been documented, Christopher was not subject to any mental health assessment prior to his arrest for Maria's homicide. The commentary in the record suggests he had been subject to a previous mental health assessment, and thereby by default, without any previous assessment necessitating any requirement for emergency intervention.

16.167 Whilst AMHPs in the EDT deal with MHA assessments that cannot wait until the next working day, the threshold for accepting referrals is higher than that for daytime services. It is the AHMP's duty to scrutinise referrals and follow the Mental Health Code of Practice principle of applying the least restrictive measure. Therefore, a MHA assessment should only be considered, where all other options have been exhausted, and the risks are high enough to warrant detaining someone in hospital and treating them against their will.[175]

16.168 Rebecca made her call on behalf of Maria, as the nearest relative of Christopher, which was acknowledged in the record. A nearest relative has a legal right to request a MHA assessment. Social Services have a duty to consider the mental health of the patient if their nearest relative asks them to, which indirectly was the case here. The record provides minimal evidence demonstrating the AMHP undertook the necessary scrutiny to inform an insightful and comprehensive consideration of his mental health, based on all the information that would have been available to them, had they taken steps to gather it from Maria. Similarly, there is no documented consideration or rationale as to why he did

[175] EDT IMR

not meet the threshold for an emergency MHA assessment. Rather, the record is indicative of being process rather than risk driven. This transaction provides reinforcement of the unintended, but unproductive cycle of cross referrals between services, whereby patients are denied legitimate access to services and users are passed around the system without any meaningful intervention taking place.

16.169 There is no reference in the EDT record of Rebecca informing the EDT AMHP of Christopher refusing to engage with FRS previously, as outlined in her account. Regardless, the record acknowledges the EDT AMHP was aware of previous contact with FRS and the EDT. These contacts likely relate to the attempted face-to-face assessment by FRS and the call to EDT by the GP requesting EDT consider a MHA assessment for Christopher. Given that a MHA assessment should only be considered where all other options have been exhausted, this poses an obvious question as to what options were left available, that served to undermine justification for the requirement to undertake a MHA assessment. FRS had attempted to assess him without success and closed the case on the basis that any further attempts would likely be unsuccessful. In parallel, the GP subsequently made contact with EDT to request consideration of a MHA assessment, but the EDT AMHP concluded that it was appropriate to signpost back to FRS. This again reinforces an unintended, but unproductive cycle of cross referrals between services, whereby patients are denied legitimate access to services and users are passed around the system without any meaningful intervention taking place.

16.170 The EDT AMHP documented that they referred the matter back to FRS by placing a note on the system. This action would not serve to alert FRS that the matter required renewed attention, or follow up action, as there was no open referral to FRS and they would not be checking clinical records unless a new referral prompted them to do so. Similar to the event on 11th February, there was no follow up conversation between the EDT and FRS regarding this event. This highlights a gap in the system requiring a formal framework such as a protocol or a prescribed, documented handover process between the FRS and EDT. This protocol requires to be in alignment with a mandatory obligation to maintain documented contact, on case progression, key decisions and developments with nearest relatives and / or their representatives. The rights of service users, such as Maria, need to be clearly defined, easily understandable and readily accessible to ensure they are able to access legitimate and necessary support.

16.171 There is currently no mechanism to coordinate, manage and review cases requiring collaboration between the FRS and EDT, which these circumstances clearly dictate require a resolution. As a consequence of this process anomaly, there was no productive discussion or collaborative assessment that took place between the FRS and EDT at any point. The CPFT SI Review noted a requirement for clear, documented communication between the FRS and EDT, when non-consenting patients are presenting to either service, and being redirected to the alternative service. The absence of this exposed Maria, as a service user, to the denial of appropriate and necessary service and support. Both services need to review and extend protocols to manage the risks and challenges that exist in circumstances such as these. This could have led to an earlier assessment of Christopher's illness and caused him to be treated earlier.

East of England Ambulance Service NHS Trust (EEAST)

16.172 EEAST have policies and procedures in place for safeguarding. The creation and maintenance of these policies is informed by national and regional guidance. Policies are reviewed annually to reflect the dynamic changes within the safeguarding arena. The safeguarding team maintains a strategic overview on all safeguarding partnerships across the Eastern region and, where necessary and appropriate, Trust policy & procedures are changed where a need is identified.

Ambulance call – 1

16.173 The first recorded contact with the ambulance service occurred via a 999 call shortly before 22.30 hrs on Saturday 30th January 2021. The record describes Christopher's landlady called the service and reported he had showered fully clothed and only spoke Polish. No further information was recorded in respect of her concerns.

16.174 In her account, Margaret recalls she told the operator about other strange behaviours he was exhibiting and that he was acting as though he was, 'totally out of it.'[176]

16.175 The call was appropriately coded as a mental health event and the record indicates that an ambulance was initially dispatched to the address. A decision was made in the ambulance control room to further triage the incident and a paramedic telephoned Christopher and spoke to him. The record documents this was supported by a Polish interpreter and that he was, 'alert, orientated and talking whole sentences well.' He reportedly said that he thought his mother had called for an ambulance. He denied having any mental illness and said he wanted to go back to bed. He was asked if he felt unwell with his mental health and he indicated that he had earlier, but felt better since going to bed. There is a reference to him being, 'given worsening advice since a triage was declined.' An ambulance was not dispatched.

16.176 Margaret's account describes she was telephoned by an operator who asked to speak to Christopher. She overheard him tell the operator that, 'he was alright now, although he hadn't felt well earlier, but was now just tired.' She estimated the operator spent about 5 minutes on the phone with him. She added that nobody spoke to her or called her back to enquire as to whether he had recovered.[176]

16.177 There is no indication in the record to document the professional mental health background of the paramedic making the call to Christopher. The record makes clear that no triage took place as he declined this. In such circumstances, it would be good practice to ensure as much background information as possible is collected and documented regarding the reported mental illness to inform a professional assessment. It seems clear that Christopher's maintained denial of his illness was one of the presenting factors of his mental health deterioration, but there was minimal independent information collected from Margaret in the record, who was the primary source of concern about his mental ill-health, which would have provided more insight to a professional assessment.

[176] Account of Christopher's landlady Margaret

16.178 The record describes Christopher expressed the view that his mother had called the ambulance, which was without any foundation, and which the paramedic would likely have been aware of from the record. This should have prompted a professionally curious, follow-up conversation with Margaret, who was present whilst the paramedic was speaking to him. This could have provided more accurate insights to their professional assessment of his mental illness and led to a more informed and urgent intervention. Similarly, it would have been good practice if the paramedic had sought advice and guidance from a registered mental health professional; as a minimum, this would have provided added insights about his mental illness to mental health services.

Ambulance call - 2 and Eviction

16.179 The record describes that just before 18.15 hrs on 14th February 2021, Christopher's landlady rang 999 to request an ambulance. She reported that her Polish lodger was going through a terrible phase and appeared to be going downhill. She indicated that he might be bipolar and said that this was his last day at her property as a lodger. She explained he had been crying and didn't know where he was going to go. She reported concerns he was going to harm himself.

16.180 The call was appropriately coded as a mental health event. An ambulance was dispatched and arrived on scene shortly before 19.00 hrs. Margaret advised the crew that he had been exhibiting odd behaviours, including showering fully dressed, bringing strangers into the house and not going to work. She also reportedly said that he'd spoken about suicide and self-harm. The crew were advised he had stopped paying his rent without explanation, but that he believed he had been paying rent. A bystander advised the crew that he had been wearing the same clothes for weeks at a time.

16.181 The ambulance log documents that Margaret told the paramedics that he had been asked to leave her home as she no longer felt safe, but that he didn't remember this conversation. The crew noted she was visibly upset and that he would be homeless that night. It was documented that he agreed to be conveyed to hospital and the crew noted he was 'distant, very fidgety and will not make eye contact.' They also documented that he, 'stares at a single spot while talking' and that he could be, 'verbally aggressive.' The log also includes descriptives of him appearing, 'very confused' and 'unable to answer simple questions.' He denied taking drugs, but admitted to consuming alcohol. There is a reference to him having spoken about self-harm and suicide, but denying having those thoughts that day. He was noted to be alert and orientated by the crew.[177]

16.182 The detail documented in the ambulance log is thorough, concise and an excellent example of professionally curious information gathering, informed professional assessment and decision making. The paramedics could have provided more insight into the reference to his verbal aggression, which may have provided added value to any assessment of risk to others he posed. Similarly, it was appropriate for the crew to complete and submit an adult at risk referral form, given the circumstances as documented in the record. This would have alerted other services to this event, which could have led to a more collaborative assessment and informed response.

[177] Ambulance log

North West Anglia Foundation Trust (NWAFT) Hinchingbrooke hospital

Hospital admission and discharge

16.183 The only relevant contact occurred on the evening of 14th February 2021, when Christopher was conveyed to the Emergency Department (ED) from his landlady's home by the EEAST crew.

16.184 The hospital record makes reference to the ambulance log and describes he was brought to the ED due to unusual behaviour and suicidal thoughts. Christopher said his landlady called the ambulance and that he didn't know why he'd been brought to the ED. He denied feeling suicidal, taking drugs or consuming alcohol.

16.185 He was treated by way of a CT scan of his head, a chest x-ray and blood analysis. Nothing of note was observed and his case was discussed with, and reviewed by, the ED consultant before he was, 'discharged home' at 23.07 hrs that evening. In a discharge note, addressed to his GP (GP practice 1), it was documented that there was no follow up treatment required and that no safeguarding issues were identified.

16.186 There is no evidence to indicate the services of an interpreter were utilised during this transaction, which would have enabled a more informed assessment. This was a unique opportunity to engage him regarding his deteriorating mental health, given it was the only occasion, in the days and weeks preceding Maria's homicide, that he independently consented to engaging with medical professionals. Regrettably, the opportunity was missed.

16.187 There was no physical illness, either reported to, or detected by the ambulance crew from their observations. The call to the ambulance service was based solely on mental health concerns, and the ambulance response was coded as a mental health event. Margaret's account, and the detail recorded in the ambulance log, demonstrate that he wasn't suffering from any obvious physical illness. It is logical to conclude that he was conveyed to the hospital because the ambulance crew were sufficiently concerned about his mental health to warrant this action. It is acknowledged that there are a number of physical conditions that can cause, or contribute to, the odd behaviours reported to, and documented by, the ambulance crew, which required to be investigated. Given there was no physical illness reported, or subsequently detected, it is also entirely possible that, at this single point in time, Christopher himself recognised he needed professional help to tackle his mental illness. Regrettably, the treatment plan adopted at the hospital did not adequately reflect either, the concerns initially reported by Margaret, or those documented in the ambulance log.

16.188 The hospital record provides clear indication that the ambulance log was not given suitable and appropriate consideration in informing his treatment plan. This is most aptly demonstrated from the record illustrating that he was, 'discharged home'. It was clearly documented in the ambulance log that he would be homeless that night because of him being evicted, due to concerns for his landlady's safety. Similarly, the hospital record indicated that he was brought to the ED for confused behaviour and suicidal thoughts.

This is in contrast to the ambulance log which documented that Christopher denied feeling suicidal. In parallel, the hospital record documents his denial to consuming alcohol which was at odds with the information in the ambulance log recording his admission in this regard.

16.189 Appropriate medical tests were undertaken that ruled out any physical cause for the odd behaviours reported. There is no evidence in the hospital documentation to indicate that any consideration was given to referring him to the on-call psychiatric team, which appears to have been appropriate in these circumstances. Given that he had consented to attend hospital, this offered a unique opportunity. A referral to the on-call psychiatric liaison service could have led to an earlier assessment of, and treatment for, his illness. The review understands that 24/7 liaison mental health services are commissioned by the ICB and provided by CPFT at other Acute Hospitals in the area, but not Hinchingbrooke. If such a service had been available, it is likely that Christopher would have been assessed by a mental health professional whilst at hospital, which might have led to his mental illness being assessed and treated earlier. In the absence of a referral to the on call psychiatric liaison service, options should have been explored for him to remain at the hospital until the psychiatric liaison team came on duty at 08.00 hrs the following morning.

16.190 The discharge letter to the GP noted that no safeguarding issues were identified. This was at odds with the reality of the situation. Had the practitioner given due regard to the information recorded in the ambulance log, they would have noted that he was homeless at that point in time. Similarly, when discharging him, 'home,' they should have considered that Margaret's safety might be at risk, as his eviction that day was based on concerns for her safety, which was documented in the ambulance log. Finally, Christopher's own welfare should have raised some concern due to his homeless status and his reported 'acute confusion,' which was documented in the hospital record.

16.191 The safeguarding concerns were readily identifiable and should have been documented and referred to appropriate agencies. This would have enhanced the situational awareness of all agencies, including mental health services, and could have caused a more informed and collaborative assessment and earlier intervention.

Cambridgeshire Constabulary

16.192 The review recognises that police officers and staff are not mental health professionals, but the police service frequently encounters people suffering with mental illness. The evidence provided to this review illustrates there are a number of lessons to be learned from the responses provided by police officers and staff to the mental health concerns documented in the police records of events prior to Maria's homicide.

16.193 Between July 2016 and August 2018, there were several incidents reported to the police. Primarily these illustrate a sustained dispute between Christopher and his ex-wife regarding child access. Of note, there was never any suggestion of violent or threatening conduct on his part, in any of the matters reported to police. These incidents provide useful context into events in his life which may have had a detrimental impact on his mental wellbeing. They are not deemed otherwise relevant to the findings of this review.

IMHT

16.194 The IMHT is staffed by full-time mental health nurses and a team manager and is based at Cambridgeshire Constabulary headquarters (HQ) in the FCR. The core duty of the IMHT is to provide professional mental health telephone triage and assessment by phone and provide general and incident specific advice to officers. The IMHT works closely with the FRS who are the mental health trusts emergency response service for mental health crisis. The role of the IMHT relevant to this review is outlined as, but not limited to: -

- Trawling police incidents for mental health elements.
- Contact by phone with queries on specific individuals with mental health issues.
- Providing general advice on how to deal with mental health disorders.
- Enabling referrals and communication into healthcare.
- Speaking to members of the public directly on the telephone.
- Assisting with compiling multi agency management plans for those with complex needs including mental ill-health.[178]

Police incident -1 & 2

16.195 On 30th January 2021, the police recorded two crimes of attempted residential burglary. These occurred at approximately 22.00 hrs on Friday 29th January (Event 1) and around 17.00 hrs on Saturday 30th January (Event 2). The police recovered mobile telephone and doorbell CCTV images of the suspect at Event 2. After an initial investigative assessment, these crime events were linked as likely to have been committed by the same suspect.

Police incident – 3

16.196 Just after 16.00 hrs on 11th February, police were contacted by Christopher's landlady, who submitted an online report. In her report she described her knowledge and experience of his odd behaviours and the unsuccessful attempts to have him assessed by 111 operatives. She described her growing concerns for his deteriorating mental health. She made reference to behaviours she deemed to be dangerous and described the physical measures she had taken to secure her living environment in response to her being, 'very, very worried' for her own welfare. She added he was due to move out of her home the following Sunday and asked for her report to be logged, in the event that any problems arose.[179]

16.197 Just before 19.00 hrs that evening, the police replied to her by way of email. In their reply the police noted that (NHS) 111 were aware of his mental well-being and advised her to take herself to safety and call 999 if she felt to be in immediate danger. They also advised her to call an ambulance if he experienced a mental health crisis and was in immediate danger.

[178] Cambridgeshire Constabulary extracts of IMHT procedural guidance
[179] Email from Margaret to Cambridgeshire Constabulary dated 11th February 2021

16.198 The police incident log associated with this event documents a number of erroneous conclusions. The log recorded that Christopher's mother was living with him, which was inaccurate. Furthermore, the log states that 111 operatives had triaged him, which was similarly inaccurate. Finally, the log depicted that Margaret's email referred to a single event which occurred in January, whereas her email described a continuum of mental health concerns, of which the January incident was but one. There was no reference to the concerns she clearly expressed for her personal safety and welfare. There was no follow-up contact with Margaret or any resource dispatched in response. The incident was not flagged for the attention of the IMHT who were on duty in the FCR at the time.

16.199 The police reasoned that because Margaret didn't express any expectation that a resource would be dispatched in response to her email, that the matter was appropriate to be dealt with by an email response.[180] On face value, her email describes she was a, frequently lone, female residing with a mentally unstable male, whose illness was worsening and whom she described was causing her to be, 'very, very worried' for her own welfare. As such she was vulnerable. In reality, Margaret was also 65 years-old, which could have escalated an assessment of her vulnerability, but the police made no enquiries to conduct any risk or safeguarding assessment in response.

16.200 As a minimum, the police should have contacted Margaret to gather further information as to why she maintained such serious concerns for her own safety from Christopher. This would have provided more accurate insight and assessment and could have caused a re-consideration and re-prioritisation of the police response to this event. According to the police IMR, the matter was not flagged for the attention of the IMHT because Margaret was not a health professional. It is clear that this event should have been brought to the attention of the IMHT, as it was pivotal to acknowledging a potential risk that Christopher posed to others. As a minimum, this would have enhanced the situational awareness of agencies, including mental health services, and could have led to an earlier assessment of, and treatment for, his illness. More concerted information gathering and information sharing was necessary and appropriate by the police in responding to this event.

<u>Police Incident 5</u>

16.201 Just before 23.30 hrs on 20th February, police received a 999 call from the householder for the attempted burglary (Police incident - 2). They reported the intruder at their home on 30th January had returned to their address. In the incident log, the call was cross referenced to the previous report of attempted burglary. The log references the caller stating their belief that the male outside their address was the intruder from the attempted burglary. The householder described they had a mobile phone image of the intruder, recorded at the time of the attempted burglary, which they believed was of the same male who was now outside their home.

16.202 The police response was appropriately prioritised and they found Christopher sat outside the householder's address. They sensibly engaged the services of a telephone

[180] Police IMR

interpreter. During their conversation with him, they learned that he believed he'd won the lottery and had been sent to the address by God to ask for a cup of tea. The responding officers concluded that he was not the intruder reported by the householder on 30th January. There is no rationale recorded on the incident log for the officers coming to this conclusion, which was erroneous in any event.

16.203 The evidence demonstrates the householder rang 999 on the basis of their belief that Christopher was the intruder at their home on 30th January. In response to that event, the police recorded a crime of attempted burglary, which invokes a power of arrest. The crime report included reference to mobile phone and doorbell CCTV images of the suspect. The occupant had the image available to the responding officers. In parallel, the dispatch of the officers was urgently prioritised on this basis. There is no corresponding, rational explanation on the incident log as to why the responding officers did not exercise their legitimate grounds to arrest him for attempted burglary on this basis. Had they exercised their grounds to arrest him, he would have most likely been subject to a mental health assessment that could have led to earlier treatment of his illness.

16.204 In contrast, the responding officers chose to disregard the sustained, and accurate, belief held by the occupant and issue, 'strong words of advice' to Christopher. They concluded there were, 'no offences' and warned him not to attend any other addresses asking for tea, or else he would be liable to arrest. No rationale is documented on the log to explain the basis for the officer's reluctance to trust in the belief of the occupant, nor is there any evidence on the incident log of the officers undertaking any assessment of the mobile phone or CCTV images of him. The log does include reference to the officer's examining the CCTV footage from the doorbell device for this incident, so it seems plausible they were also able to view the footage of the intruder on 30th January, both of which were confirmed images of Christopher. In parallel, the occupant clearly held steadfast in their belief that he was the intruder on the 30th January, as they requested the responding officer to update the investigating officer for the attempted burglaries, about this event. The responding officer later included this update, at the request of the occupant, on the associated crime investigation log for the attempted burglary.

16.205 Having chosen not to exercise their power to arrest him for attempted burglary, there is no evidence the officers undertook any consideration to exercising their powers under s136 of the MHA. In exercising this power, the officers would need to be satisfied that he was suffering from a mental disorder, was in a public place and posed a risk to himself or others.

16.206 Christopher's conviction he had won the Euromillions lottery and was sent to a random address by God, at 23.30 hrs, to ask for tea, was clearly indicative of him suffering a mental disorder, given the police ruled out alcohol and / or drugs. He was in a public place and exhibiting strange behaviour, as noted by the responding officers. The evidence illustrates that he was attempting to gain access to a domestic residence, where he had no legitimate right of access. This behaviour, in isolation, was concerning enough for the occupier to call 999 and summon police assistance, presumably in response to some concern for their own safety. In parallel, his conduct, in attempting to gain access to a random domestic residence late at night, where he had no legitimate right of access, arguably posed a risk to himself from any householder who might

understandably perceive him to be a threat. There is no evidence the officers undertook any form of risk assessment on this basis. Had they exercised their legitimate powers under the MHA, this could have led to an earlier assessment of, and treatment for, his illness.

16.207 The police submitted an adult at risk referral, in light of his, 'strange behaviour,' In describing the incident, the reporting officer documented in the referral, 'Officers were able to confirm by a picture provided by an occupant at the address that the male who entered the property two weeks ago and the male involved in today's incident are not the same male.'[181] This statement is wholly inaccurate and, in isolation, it undermines the insight to any subsequent risk assessment undertaken by agencies required to respond to any safeguarding concerns in respect of Christopher. The subsequent homicide investigation confirmed the images recorded on the 30th January, by the occupant, were of Christopher. It is therefore inexplicable as to why the responding officers came to this errant conclusion.

16.208 The IMHT were not on duty in the FCR at the time of this incident, but the officers could have called the FRS Professional line for professional mental health support and guidance, which would have alerted them to previous contacts with the FRS and enhanced the situational awareness of mental health services with regards to the evolving risks posed by Christopher's conduct. The log was subsequently closed using the code, 'Safety / Security Concern.' Similar to the report made by Christopher's landlady, the matter was not appropriately tagged to cause a review by the IMHT, when they were next on duty in the FCR, as it was not coded to reflect any concern for Christopher's mental health. As neither event was appropriately tagged, no link between Margaret's report on 11th February and this incident was made, and the FRS and other mental health services were not dynamically alerted to these events. Given the circumstances described by the responding officers, this log should have been appropriately coded to alert the IMHT to the concerns about Christopher's mental health.

16.209 With regards to the police incident log, National Standards for Incident Recording (NSIR) [182] defines an incident as: 'A single distinct event or occurrence which disturbs an individual's, groups or community's quality of life or causes them concern.' This was clearly the case here, and caused the occupant to report their concern to the police via a 999 call. NSIR dictates that incident management is part of the process of restoring situations to normality and involves: -

- Initial support followed by investigation:
  This was partially achieved by the call handler creating the log, collecting, assessing and documenting information from the occupant and dispatching a priority response. There is minimal evidence of any appropriate responsive investigation by the responding officers to the circumstances that were outlined in the initial report by the complainant.

- Analysis and diagnosis:

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[181] Adult at Risk referral submission
[182] The main aim of the national standard for incident recording counting rules is to ensure that all incidents, whether crime or non-crime, are recorded by police in a consistent and accurate manner.

The log contains no information illustrating any analysis and diagnosis of the circumstances that were initially reported by the complainant.

- Resolution and recovery with, ultimately, incident log closure:
  This was only partially achieved. The documented resolution does not correspond with the complaint that was conveyed by the occupant when they called the police to report this incident. In parallel, the disposal code, allocated in closing the incident, did not reflect the mental health concerns as were documented by the responding officers.

16.210 In simple terms, the incident log should reflect the management and resolution of the incident as reported, or provide a clear, documented rationale for any diversion to the management and resolution of the incident as it was initially reported. The incident log for this event neither demonstrated management and resolution of the incident as was reported or recorded any rationale for diverting from this requirement.

<u>Police incident – 6</u>

16.211 The record describes that just after 18.00 hours on 21st February, police responded to a report of robbery and shoplifting at a convenience store. There were two separate calls to the police regards this incident from the shopkeeper and from Christopher. The initial report was an allegation that a male suspect had taken beers, was refusing to leave the store and arguing with the shopkeeper. There was an indication that the suspect was, ‘possibly intoxicated.’

16.212 A response was appropriately prioritised on the basis that the suspect was being verbally abusive and refusing to leave the shop following shoplifting of beer, which he had already consumed. Prior to police arriving at the scene, Christopher also called the police. He was recorded as being initially reluctant to engage with the call handler. A subsequent entry on the log, presumably informed by his call, indicates the incident was caused by the shop refusing to check his lottery ticket. He was described as being, ‘evasive’ when asked questions and he was instructed to wait outside the shop for responding officers.

16.213 Police arrived a short time later and found Christopher at the shop. Officers spoke separately with him, the shopkeeper and Maria, who arrived at the shop shortly after the police. The responding officers believed that he was experiencing, ‘mental health issues.’ There is reference to him speaking broken English and mistakenly believing the store was extending him credit as a result of him winning the lottery. The police ruled out any crime and noted that he had reimbursed the shopkeeper for the beer he’d consumed. The responding officers declared an intention to submit an adult at risk referral for his mental health and housing issues.

16.214 The incident was not brought to the attention of the IMHT mental health professional, who was on duty in the FCR at that time. Similarly, the police log was not flagged for the subsequent attention of the IMHT. The disposal code utilised in closing the log was, ‘Theft / Shoplifting,’ which was at odds with the assessment made, that no crime had occurred, and the corresponding focus on Christopher’s, ‘mental health issues.’ The recurrent lack of engagement with, or referrals to, the IMHT or other mental health

professionals maintained an inability to readily link repeated mental health concerns reported to the police about Christopher between 11th and 21st of February, which would have enhanced agency situational awareness and enabled a more comprehensive, professional assessment of the evolving risk picture, as was reported to the police, and could have caused his illness to be assessed and treated earlier.

16.215 No discussion was sought by the responding officers with the on duty IMHT mental health professional, who was available to support frontline officers with professional mental health advice. It was necessary and appropriate for the responding officers to contact the IMHT, given the concerns alluded to in the adult at risk referral, which documents that Christopher appeared, 'vacant' and 'sometimes confused.' Similarly, the officers documented they were aware that he was known to mental health services, who they described had responded on at least two occasions, to recent mental health crisis. In parallel, the officers noted they were informed by Maria, that he had accused her of summoning the devil. The officers also recorded that he was effectively homeless, as Maria was reluctant for him to reside with her and that he refused to return to her address. A comprehensive discussion with the IMHT could have led to an earlier assessment of, and treatment for, his illness.

16.216 The adult at risk referral was undermined by a series of inaccuracies and omissions. The referral indicated that he was unemployed, which was inaccurate. In fact, his wholly uncharacteristic, cessation in attending his place of employment, whilst insisting that he was still attending work, or pretending to be on holiday, was repeatedly pointed to by Maria and his former landlady, as being a presenting feature of his deteriorating mental health. The responding officer later submitted a witness statement to the homicide investigation describing that Maria informed them that he was, 'suffering from stress, had a sick note from his GP and was not currently working.[183] This retrospective statement is at odds with the commentary in the adult at risk referral describing he was unemployed.

16.217 In the adult at risk referral, the police document that he was not previously known to police. This was similarly inaccurate; there were a series of previously described interactions between Christopher and the police involving disputes with his estranged wife regarding access to their child between 2016 and 2018. This was relevant on the basis the police recorded that he was stressed due to the separation from his wife and child, which they portrayed as the primary contributing factor for his mental health issues at this time. He was separately the subject of mental health concerns brought to the attention of the police by his landlady on the 11th February. Additionally, on the previous evening of 20th February, he was subject of police contact as a consequence of him being identified as a suspect for attempted burglary, which was dealt with by the police as a mental health concern, but not coded appropriately.

16.218 The responding officer recorded asking Christopher on a number of occasions, if he felt that he had any mental health issues, or felt like harming himself. His documented responses indicate he didn't believe he had any mental health issues and had never wanted to harm himself. The reality of the circumstances which unfolded at this incident, as documented by the responding officers, stands in stark contrast to his reassurances

[183] Police IMR

that he didn't have any mental health issues. This is not reflected in any meaningful assessment by the reporting officer; either as to the reliability of his assurances, given the circumstances that had unfolded, or considered as a justification to seek advice from the on duty IMHT mental health professional.

16.219 Having undertaken documented enquiries into the potential for Christopher harming himself and accepting his personal assurances as mitigating this, it was appropriate, and necessary, for the officers to undertake parallel, documented enquiries to assess any risk he posed to others. No such enquiries or assessments were documented in the police log or adult at risk referral. Similarly, there is no evidence the officers appropriately considered their powers more widely under s136 of the MHA. This would require the officers to be satisfied: -

- That Christopher had a mental health disorder:
  The circumstances clearly indicate he was suffering with his mental health and the police recorded their view that he had 'mental health issues' on the log.

- That Christopher was in a public place:
  Which he clearly was.

- That he presented a threat to himself or others:
  The officers were aware he had been verbally abusive to the shopkeeper and had flooded his previous residence. Rebecca reported she advised the police that Maria was scared that he might flood or set fire to her home.[184] In the recorded telephone conversation, which took place during this incident, Maria told Rebecca that she was happy the police were there and requested she ask the police to take him away because she was afraid. She also described that she was, "shaking all over" as a consequence of his behaviours.[185]

16.220 There is no reference in the police log or adult at risk referral to the telephone conversation the police engaged in with Rebecca, although they do later reference this in their retrospective witness statement to the homicide investigation.[186] This was particularly relevant, given what she recalls she told the officers in her account. Rebecca described telling the police that Maria was scared he might flood or burn her house down. She reported he was hearing and responding to voices; claiming that he was talking to God and accusing Maria of bringing the devil. She also told them that he was accusing Maria of changing his winning lottery ticket.[184]

16.221 There is no evidence in the police log or the adult at risk referral that any of the information provided by Rebecca, or the concerns raised by Maria, were considered by the officers in any assessment of the potential for Christopher to cause harm to others. Despite the information from Rebecca and Maria being made available to them, the police did not see fit to either engage with the on duty IMHT mental health professional for advice, or refer to this information in considering any form of risk assessment. Rather, they recorded that Maria told them that his primary mental health issue was the stress he

[184] Account of Rebecca
[185] Transcript of recording of telephone call to Maria's phone
[186] Police IMR

was suffering as a consequence of his separation from his wife and child. The omission in the referral, of what Rebecca recalls she told the police and what was disclosed to them during the recorded telephone conversation between Maria, Rebecca and the police that evening, further served to undermine the accuracy and authenticity of this referral.

16.222 In a retrospective witness statement, provided to the homicide investigation, the responding officer made reference to, 'there was no inference of violence or the threat of violence from Christopher towards Maria.' This statement reflects an inappropriate degree of impassivity to any assessment made of the threat Christopher posed to others and does not inspire confidence this was explicitly and appropriately explored by the responding officers.

16.223 The responding officers did not elicit the support of translation services whilst dealing with this incident. This was appropriate given their initial queries as to whether Christopher's confusion was a consequence of his English language challenges. Furthermore, they relied on Maria to interpret on behalf of Christopher. As has been widely reported, Maria's own English language fluency was imperfect. In parallel, using a family member to translate maintains the potential for undermining any independent viewpoint. Rebecca acted as a competent translator; at least during aspects of this incident, but, as previously outlined, the officers made no reference to their telephone conversation with Rebecca in the log or adult at risk referral.

16.224 The vulnerabilities already alluded to in the police linking, and appropriately sharing information about, previous mental health concerns which were brought to their attention, ensured the responding officers remained unaware of the concerns that were reported to, and recorded by, the police in the days and weeks preceding this incident. Similarly, this undermined the situational awareness of agencies, including mental health services, to the dynamically evolving risks posed by Christopher's increasingly concerning conduct. This aspect further undermined informed assessment and decision making by responding officers. In parallel, the inability to readily link this information undermined the accuracy and reliability of the adult at risk referral submission and any corresponding risk assessment made by collaborating agencies, considering the appropriate response to safeguard Christopher and / or others.

17. ANALYSIS OF THEMES

GP Registration – Ownership and Accountability

17.1 Christopher's interrupted continuity of care had a defining and detrimental impact on the tragic events that unfolded. This deficiency escalated the combined risks, accurately summarised by the FRS senior clinician, that his mental health might deteriorate if either, he was developing a psychotic illness and / or if his mental ill-health wasn't treated. Similarly, it destabilised the FRS plan to have Christopher's illness assessed by a health professional in accordance with least restrictive practice.

17.2 When concerns were first raised with GP Practice 1 on 28th January, it was recognised and documented that he might need acute mental health support. At the direction of the GP, Maria sought and accessed acute mental health support from the FRS, who tried unsuccessfully to engage him. The plan pursued by the FRS to facilitate his mental health assessment by a health professional, in an attempt to curtail the active risks, relied on him having maintained access to GP care. This was a critical component to assessing his mental health and formulating a treatment and safety plan. Whilst the vulnerabilities to this aspect of the FRS plan should have been clear and obvious to the FRS, in light of the circumstances reported to them by Maria, it was reasonable for them to try and elicit the support of the GP to exercise ownership of, and accountability for, risk and treatment planning by trying to assess his mental health. Regrettably, the plan was immediately undermined by his interrupted continuity of care. This similarly undermined any ownership and accountability for the active risks and treatment plan.

17.3 The lack of clarity around ownership and accountability for ongoing care and treatment planning between GP Practice 1 and the FRS, prompts a requirement to revisit a previous Huntingdonshire DHR which made a recommendation for CPFT and the Clinical Commissioning Group (CCG) (now 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.[187] Whilst the situation here is not entirely congruous with the background to that recommendation, it was founded on the basis of providing more clarity to the working relationship of mental health services and GP practices, which is relevant to this review. The observation in the GP record of 4th February that the FRS would, ‘observe and review’ is noteworthy in this regard and illustrates a misunderstanding of the role of the FRS by the GP. Similarly, the additional information provided on 10th May 2024 on behalf of GP Practice 1 with regards to their call to the EDT on 11th February describes, ‘Once a GP has made a referral to another provider, and the provider has accepted that referral, it is not expected that the GP will monitor and follow up the referral.’[188] This likewise demonstrates a shortfall in the knowledge of the GP about the role of the EDT whereby, information provided to an EDT call handler is not treated as a formal referral.[189]

17.4 This case demonstrates the importance of maintaining continuity of primary care, in order to maintain ownership and accountability for risk and treatment planning. Maria was the primary source of information to inform the evolving risk picture, but the information she provided was either not sourced effectively, or not subject to appropriate evaluation and assessment. Notwithstanding, that it may have been administratively appropriate for Christopher to register with another GP practice, it was within the gift of GP Practice 1 to maintain their services to him until he was registered at an alternative practice, where ownership and accountability for his care could be suitably transferred. This was all the more important and appropriate given the GP’s early recognition that he may require acute mental health support, which was effectively withdrawn as a consequence of his lack of consent, which resulted in an outstanding requirement to

[187] DHR Overview Report - Death of Sally
[188] Letter from Medical Defence Union (MDU) to review Author dated 10th May 2024
[189] CPFT SI Review

have his illness assessed by a health professional; and the repeated and escalating concerns reported to the GP by Maria.

17.5 The role of the GP is critical in cases of mental ill-health. This is arguably more especially so with non-consenting patients. It is not uncommon for mentally unwell patients to present by denying or underestimating their illness, as was the case here, and resist any approach from, and engagement with, mental health services on this basis, which was similarly the case here. Without sustained, reliable access to primary care services, ownership and accountability becomes less clear and this sustains the risk that seriously mentally ill patients remain unassessed and untreated, as was the case here. The maintenance of ownership and accountability through reliable, accessible GP services is critical to the effective management of risks and treatment planning. In parallel, GP services have a pivotal role to play in supporting carers of mentally ill patients with advice, guidance and practical assistance to overcome any service access challenges or shortfalls.

17.6 In common with the previous Huntingdonshire CSP DHR,[190] the transfer of Christopher's care to an alternative GP practice had the capacity to destabilise his illness and continuity of care, albeit he hadn't been treated for any signs of mental illness since 2017. There is no evidence this was given appropriate consideration by GP Practice 1 at any point after Maria first raised her concerns on the 28th January. Reviews such as this should remind services to remain alert to the increased risk when circumstances change from what individuals had come to consider as the norm. As alluded to by Maria's close friend Rebecca, Christopher had reportedly bonded with a Polish speaking GP at GP Practice 1, this relationship could have enabled the GP to assess his illness earlier and overcome the likely challenges that would have been experienced by an alternative primary care provider with whom he was reluctant to engage.

17.7 The circumstances as were known to GP Practice 1 required a formal briefing and handover of Christopher's care to GP Practice 2. A handover was necessary to effectively transfer the responsibility for immediate and ongoing care between the healthcare professionals responsible for Christopher. There is no evidence any such briefing or handover took place, and the evidence indicates that his medical records were still awaiting transfer some 8 days after his registration was initially received by GP Practice 2 on 9th February. This meant that GP Practice 2 had incomplete and/or delayed information which compromised safety, quality and Christopher's and Maria's experience of health care. Had such a handover occurred, this could have alerted GP Practice 2 to the fact that his illness had not been assessed by any health professional and caused a more urgent response. More especially so, in light of Maria's attempts to secure face-to-face appointments for Christopher with GP Practice 2 on 10th and 16th February.

17.8 This tragic case serves to emphasise the critical necessity for all GP practices to provide continuity of access to reliable primary care services whenever there is a concern of serious mental ill-health.

Translation Services

[190] DHR Overview Report - Death of Sally

17.9 Regardless of the commentary in some agency records describing that Maria and/or Christopher spoke and understood English well enough to dispense with interpreter support, the evidence makes clear that neither Maria or Christopher spoke or understood the English language proficiently. The evidence suggests this maintained a barrier to them accessing and engaging some services because of their difficulties in expressing and understanding English.

17.10 It is fair to say that language barriers were recognised in interactions with Maria and/or Christopher, and translation services were appropriately utilised by agencies on a number of occasions. This was certainly the case in regard to the historical practices of both GP surgeries, who put in place appropriate measures to provide their primary care in the years preceding Maria's homicide. Similarly, the ambulance service made use of competent translation services in each of their interactions with Christopher. The FRS had a telephone translator available during their attempt to engage him and the police accessed telephone translation services in their interaction with him on 20th February.

17.11 The evidence indicates that translation services were not reliably provided during a number of key transactions, which had a detrimental impact on professional assessments, responses and user service. The consequence of this oversight undermined professional recognition and assessment of risk, as the information about Christopher's deteriorating mental health and his non-engagement with treatment was not reliably recorded and assessed. The recordings of telephone calls Maria made with services make clear that some of his high-risk behaviours and her personal fears for her own safety were nor accurately documented in agency records.

17.12 During her call to the FRS on 1st February, she made several references to not understanding what was being said to her. At one point she asked for translator support. The evidence indicates that in two key transactions, she wasn't able to clearly understand what she was advised. The first took place when she reportedly agreed it was impractical for Christopher's long-term GP to treat him at a time when his deteriorating mental health indicated that he might need acute mental health support. She took no immediate action to try and register him elsewhere in response to this advice, which was at odds with her subsequent, sustained efforts to re-register him after the 1st February. In parallel, she was deprived of the opportunity to challenge the reported impracticality of him being treated by his long-term GP, and discuss contingencies to any foreseeable challenges she might experience in registering him elsewhere. The recordings of calls she made make clear that she was in the habit of foreseeing and raising potential challenges to accessing support and questioning what she should do in response to any of these challenges materialising. She made repetitive references to both GP practices and FRS about Christopher's refusal to accept he needed help and/or sign the registration form.

17.13 A second key event occurred at the conclusion of the FRS attempt to engage Christopher. Maria was reportedly advised of her right as a nearest relative to request a MHA assessment from the EDT. Her subsequent inaction in response to this, over the following 3 weeks, stands in stark contrast to her sustained efforts to get treatment for his illness. This suggests that she likely remained unaware of her nearest relative right. It

was critical that she understood her rights in this regard. As a minimum, she should have been provided with a written document, in her own language, explaining her rights and the services and support available to her more widely.

17.14 On the 11th February, the GP contacted the EDT and requested they contact Maria to inform consideration of a requirement to conduct a MHA assessment. The GP advised that Maria would require the support of a Polish translator. The EDT did not contact her and documented that a consideration for this decision was on the basis that she did not speak English. This resulted in a consideration to undertake a MHA assessment not being explored by the EDT. Translation services were available and should have been utilised to explore the circumstances at that time, rather than closing the event with no action. This decision discriminated against Maria on the grounds of her non-English speaking, ethnic background.

17.15 The admission and discharge event at Hinchingbrooke hospital on the night of the 14th February, offered a unique opportunity to engage Christopher regarding his mental health, given it was the only occasion in the weeks and days preceding Maria's homicide, that he independently consented to engage with health professionals. There is no evidence the services of an interpreter were utilised during this consultation, which could have informed a more accurate assessment of his illness and caused a referral to the on call psychiatric team.

17.16 On 21st February, the police did not engage translation services when they attended the incident at the convenience store and spoke to Christopher and Maria; rather they relied on Maria to translate, which was not only inappropriate, but in light of her limited English proficiency, it was unproductive in terms of making any informed professional assessments and decisions.

17.17 It is obvious that language barriers can result in misinformation and misunderstanding, whether it involves physical or mental health. For this reason, the role of translation is vitally important to ensuring non-English speaking patients and users understand the information presented to them. By removing the language barrier, patients and users will receive a better healthcare service and crucially, a quicker diagnosis and treatment plan.

17.18 The reliable use of translation reduces the risk of a patient and/or user misunderstanding what has been presented to them. Translation reduces the risk of experiencing communication errors. This helps patients and users take greater control by accessing the right help at the right time. With clear communication from healthcare professionals, patients and users can better self-manage their situations and understand what treatment is required and what to expect.

17.19 Existing systems of mental health care and support are complicated and remain unclear to many who work within the system, regardless of any language barriers. Using translation services that specialise in the mental health space would provide added benefits by ensuring that communications are both culturally authentic, medically accurate and provide clarity around services. This would build improved patient and service user trust and confidence, earlier diagnosis of risks and illnesses and better outcomes.

Partnership Working

17.20 A root cause of these tragic events documented by the CPFT SI Review was that Christopher was suffering with a psychotic episode, which resulted in him taking his mother's life due to the delusional beliefs he held at the time. This was potentially 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.

17.21 The CPFT SI Review also observed there were missed opportunities for services to work together collectively to support Maria in response to her concerns. This resulted in her being left to navigate the complexities of different services to seek support for her concerns, rather than there being an identified single point of contact. The evidence provided to this review demonstrates there were a number of opportunities for agencies to collaborate, co-operate and record and share information and coordinate responses more effectively, to overcome the risks posed by a patient suffering a serious mental illness who was not consenting to a referral.

17.22 After the FRS attempted to engage Christopher, there was a requirement to inform Maria of her right to request a MHA assessment from the EDT. Whilst this was appropriate, the circumstances offered an opportunity for the FRS to discuss the case directly with the EDT and share the information about his illness and his behaviours, as provided to them by Maria, but there was no existing agreement in place between the FRS and the EDT to facilitate this. This could have proved to be beneficial, given the recognition by the FRS senior clinician that Christopher needed to be assessed by a health professional whilst he was subject to a simultaneous interruption in the continuity of his primary care. In isolation, this would have alerted the EDT to the risks, as outlined by the FRS senior clinician, which would provide important insight to any subsequent consideration to conduct a MHA assessment when they were subsequently contacted by the GP and, separately by, Rebecca. It is acknowledged that the FRS practitioners did not consider that Christopher met the threshold for an MHA assessment at the time they attempted their face-to face engagement, but the FRS senior clinician recognised the tangible risk that his illness would deteriorate without treatment. Had an early discussion taken place between the FRS and EDT, this would have enabled clinicians to consider the next steps to be taken in having his mental health assessed, rather than this being the sole responsibility of Maria. The requirement to resolve this gap in service provision is all the more important given that the FRS is not designed to carry a caseload, which sustains the potential that risks associated with mental ill-health are not appropriately assessed, evaluated and controlled; more especially in regard to non-consenting patients.

17.23 With regards to the first handover of Christopher's mental health care back to his GP on 4th February, the combined risks that were active were accurately identified by the FRS senior clinician as being the potential for his mental health to deteriorate if he was suffering a psychotic illness and/or if he didn't receive treatment. The CPFT SI Review observed that CPFT were not using the same EPR as GP Practice 1. This would have resulted in the GP not having documented access to the risks identified by the FRS senior clinician and the FRS plan to mitigate those risks, in which the GP's role was pivotal. This undermined informed collaboration and clear ownership and accountability

for the risk and treatment plan. The evidence provided to the review indicates the GP remained unaware of the risks as documented by the FRS senior clinician.

17.24 The CPFT SI Review noted that whilst in subsequent coroner statements and during interviews, FRS staff were able to articulate and share their risk assessment, risk formulation and clinical decision making, this was not clearly documented within the EPR. Similarly, clinicians shared in interview and in their coroner statements about Multi-Disciplinary Team (MDT) discussions which they undertook to make decisions around the input and care offered by FRS, along with their options for next steps. This clinical discussion was not documented within the EPR either.

17.25 During this review, it became evident that there was substantial information about Christopher's deteriorating mental illness and the parallel absence of any responsive health assessment, which became known by, or was reported to the GP (GP Practice 1), the ambulance service, the police, Hinchingbrooke hospital and the EDT. Much of this information was not known to, or shared with, FRS and/or other crisis mental health services, which served to undermine the collective situational awareness of the developing risks associated with the rapid decline in his mental health.

17.26 On 11th February, GP Practice 1 phoned the FRS regarding Maria's continuing concerns. This event offered the FRS an opportunity to assess and evaluate new information that they were previously unaware of. This included the fact that his illness was continuing and had not resolved spontaneously, which the FRS senior clinician had noted might transpire, if his illness was as a consequence of drug misuse. In parallel, the FRS were alerted to the absence of any assessment or treatment of Christopher's illness by a health professional, which the FRS senior clinician had similarly documented contributed the risk that his illness would deteriorate without treatment. This should have been treated as a new referral and prompted a re-assessment of the case and caused a clinical discussion to consider the necessity to attempt a further face-to-face engagement or initiate alternative responses to enable his illness to be assessed. Notwithstanding that, the advice provided to the GP to make contact with the EDT was appropriate in the circumstances.

17.27 The CPFT SI Review noted that it was also clear that on the two occasions the EDT were contacted, by the GP, and later by Rebecca, there was no clear evidence that the EDT acted upon the information reported to them, in terms of contacting the FRS or redirecting this information to the FRS; which would have allowed for a clinical discussion between professionals from both services regarding the active risks and a collaboratively planned response. The referral from the GP remained unactioned by both the FRS and the EDT, as neither service acknowledged the GP's contact as a formal referral, whereas the GP recorded their expectation that the EDT would contact Maria directly to consider the necessity for a MHA assessment. The second recorded contact with the EDT, by Rebecca, resulted in her being advised to re-contact the FRS, as the least restrictive option. This was again a missed opportunity for the EDT to contact the FRS to handover the referral directly and engage in a professional discussion to explore the active risks and collaborate on a response. The absence of communication by the EDT to the FRS regarding the GPs and Rebecca's concerns deprived FRS the opportunity to assess new information and act on the redundant plan that was specified

by the FRS senior clinician, as they remained unaware of aspects of the additional concerns and contacts which had materialised.

17.28 According to the CPFT SI Review, during the EDT discussion with Rebecca on 21st February, the social worker noted there was no evidence that Christopher had come to the attention of emergency services. There is no information to explain how the social worker came to this conclusion, but the evidence is clear that he was subject to 2 separate emergency calls to the ambulance service on 30th January and 14th February, regarding concerns for his mental health and was admitted to Hinchingbrooke hospital on 14th February, in response to mental health concerns. Similarly, he had been subject of 2 separate reports to the police on 11th and 20th February, where concerns for his mental health were identified, but which had not been notified to the IMHT. The evidence illustrates that information in relation to these events was not dynamically shared with crisis mental health services to inform collective situational awareness, collaborative assessments and decision making.

17.29 A key requirement to maintaining situational awareness and coordinating responses is effective handover. Clinical handover should ensure that lapses in continuity of patient care, errors and harm are reduced in either the hospital or community setting.[191] The evidence provided to this review indicates that handovers between the FRS and GP Practice 1 and separately between GP Practice 1 and GP Practice 2 and finally, between the EDT and FRS either did not take place, or were not optimised, whereby critical detail was either omitted or not clearly and appropriately conveyed and/or recorded. The absence of effective handovers undermined responsibility and accountability for Christopher's continuity of care and maintained an illusion that he had no history of mental illness and/or that his mental illness had been assessed by health professionals. This stifled collaborative and coordinated assessments and informed responses to the active and evolving risks.

17.30 This case demonstrates the necessity for agencies to collaborate and coordinate responses by maintaining collective situational awareness through access to shared information and clearly documented records, to establish and maintain accountability and responsibility for actions and inform maintained risk assessment, evaluation, decision making and coordinated responses.

Risk Assessment and Management

17.31 Risk cannot be eliminated, but it can be rigorously assessed and managed or mitigated. A risk assessment should identify key factors that indicate a pattern or that risk is increasing. Risk is dynamic and can be affected by circumstances that can change over the briefest of time-frames. Therefore, risk assessment needs to include a short-term perspective and frequent review. Clear communication of the outcome of a risk assessment and the management plan is essential. A formulation and plan should specifically describe the current situation and say what needs to be done to mitigate the risk in future.

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[191] BMC Medical Education - Teaching Clinical Handover

17.32 As previously outlined, and as evidenced by the recording of calls made to services by Maria, there were vulnerabilities exposed in information gathering to identify, document, assess and evaluate the highest risks. There was a parallel absence of evidence of any concerted determination to explore and scrutinise the risks posed to self or others by professionals. In addition to the omissions of key risks Maria referenced in her calls to services, there was additional information available, had professionals applied the necessary resolve to collect it. This included the risk posed to his co-resident and landlady Margaret. Similarly, Maria's fears that he might harm his own child, as she relayed to Rebecca,[192] were not exposed by professionals. In parallel, the risk posed to Christopher himself by attempting to gain access to random, private residences late at night and Maria's repeated reports that he would take his own life were not resolutely explored and considered. His questionable reassurances that he was not suffering from any mental illness, whilst being convinced he'd won the lottery and was being extended credit as a consequence, was not subject to appropriate scrutiny.

17.33 From all the agency records provided to the review, it is noteworthy that only the FRS senior clinician documented any risk evaluation, assessment and management planning considerations. Regrettably, there is no evidence the FRS plan, which was sensibly aimed at having Christopher's illness assessed by a health professional, was acknowledged by, or acted upon, by any other agency or professional outside the FRS. This meant that when the FRS closed Christopher's case, there was no-one with responsibility for his care who had any knowledge of, or took ownership of, and accountability for, implementing the plan to assess his mental health.

17.34 There was a notable absence of any documented risk assessments, evaluation and control planning in any record made by either GP, the police, the EDT, the ambulance service or Hinchingbrooke hospital, when responding to events as reported by Maria and / or others. The purpose of risk evaluation is to make decisions based on the outcome of the risk analysis regarding which risks require treatment and the priorities of that treatment. Thus, the risk assessment process is an aid to decision making regarding the prioritisation of the management of risks.

17.35 The assessment and management of the risk of a person with a mental illness causing harm to themselves or another is a fundamental component in responding to mental health concerns. As outlined, the evidence from the recordings Maria made of calls she engaged in with various services illustrate that many of her fears were not accurately recorded. In parallel, it is clear that any threat Christopher might pose to his co-resident and landlady was not documented as being considered, assessed and evaluated by the FRS, the police, the ambulance service or Hinchingbrooke Hospital when they stipulated there were no safeguarding concerns at the point of his discharge.

17.36 There is also evidence of an incompatible degree of passivity on the part of the FRS, EDT and the police when they each reference that Maria did not directly indicate that Christopher posed a threat to her. Each instance where this is passively described in a record illustrates the likelihood that the threats posed to her, or others, were never

[192] Account of Maria's close friend Rebecca

subject to appropriately rigorous and intrusive enquiry and evaluation.[193] None of the agency records document any resolute enquiries, with either Maria or Margaret, with regards to any threats Christopher may pose to them, himself or others.

17.37 The vulnerabilities outlined in the police linking information reflecting the repetitive mental health concerns that were either reported to, or observed by them, were similarly detrimental to informed risk assessment and evaluation by responding officers. There was an aligned absence of appropriate engagement with IMHT mental health professionals by police officers responding to mental health concerns which undermined collective situational awareness of, and response to, the evolving, active risks.

17.38 The ambulance service were made aware of mental health concerns on 2 separate occasions, there is no evidence these events were referred to mental health professionals to inform collaborative situational awareness. On 14th February, whilst responding to concerns for his mental health, the ambulance crew was informed that he was effectively homeless as a consequence of being evicted from his address, due to his landlady's concerns for her own safety. No referrals were made in response to this situation to alert collective agencies to the evolving, active risks.

17.39 Hinchingbrooke hospital were similarly alerted to concerns for his mental health on the 14th February. Their discharge note illustrating that he was discharged, 'home' after being evicted from his address, due to his landlady's concerns for her own safety, is similarly indicative of an absence of any concerted risk consideration, assessment and evaluation. The hospital documented there were no safeguarding concerns and no referrals were made by the hospital to alert collective agencies to the evolving, active risks.

17.40 Risk assessment and evaluation is fundamental to informed decision making. The evidence illustrates a sustained absence of risk assessment and evaluation by agencies and professionals, which served to undermine the quality of decisions that were made in response to the attendant circumstances.

Least Restrictive Practice

17.41 As previously outlined, there are several references made to the 'least restrictive option' in the EDT and FRS records when each service considered the necessity to undertake an assessment of Christopher's mental health. This is indeed a principle in the MHA, but It can be argued that the "least restrictive" principle has little relevance in decisions as to whether to undertake a MHA assessment or not, as a decision to conduct a MHA assessment is not at risk of being restrictive. In this case the necessary option of undertaking a MHA assessment appears to have been seen as a last resort, but this did not have to be the case.

Customer / User service

[193] FRS records of 4th and 11th Feb, EDT Contact – 2, Police incidents – 3, 5 and 6

17.42 A number of studies have highlighted the benefits of user involvement in mental health services. In contrast, research has shown that service users have found it difficult to influence service providers and have any real impact on decision-making across all levels of mental health service delivery. Studies have demonstrated that user participation in decision making is an important outcome to service user involvement and enables them to exercise some control and choice about treatment, and make services more responsive to their needs. Service users are also a valuable source of knowledge and information to inform risk and treatment planning in cases of mental illness.

17.43 As has been outlined, the absence of any clear ownership and accountability for Christopher's continuity of care was seriously detrimental to the ongoing assessment and evaluation of risk and treatment planning. Similarly, Maria was denied competent and appropriate standards of service from a collective of care providers. Every contact Maria had with any care provider was wholly reactive to concerns she raised dynamically. No agency or professional took responsibility for maintaining case appropriate, proactive engagement with her to gather added insights to the evolving risk picture, or to provide her updates on any agency considerations, decisions, plans and responses, and/or, to identify, consider and overcome her service access concerns and challenges.

17.44 The evidence provided to the review illustrates that an absence of appropriately reliable, empathetic and responsive service user engagement undermined Maria's experience of services. The lack of any noticeable focus on user engagement and response, maintained and escalated the active risks that should have been clear and obvious. The circumstances of this case underline the importance of achieving documented user involvement by maintaining resolute engagement with carers and/or patients, as this is critical to sustaining necessary, dynamic insights to evolving risks and informing treatment plans. It is similarly crucial to identify and overcome any inappropriate denial to appropriate treatment, care and support to control those risks.

COVID

17.45 On 4th January 2021, the Prime Minister announced the third national lockdown commencing on 6th January 2021. People were told to stay at home; however, people could still form support bubbles (if eligible) and some gatherings were exempted from the gatherings ban (for example, religious services and some small weddings were permitted). The lockdown rules had significant impacts on clinical services throughout the NHS, including restrictions on department attendances and face-to-face GP appointments.

17.46 There is some evidence that the lockdown restrictions had a bearing on the considerations of GP Practice 2 to offer an initial telephone consultation on 16th February. As has been previously described, the duty GP was self-isolating and working from home on that afternoon. The GP explained the offer of a telephone consultation, as an initial response to Maria's concerns about Christopher, was in accordance with the surgery Covid policy. The review acknowledges that this was the policy of most, if not all, GP surgeries nationally during Covid lockdowns, which was sensibly aimed at minimising transmission of the virus. There is no evidence in the records of GP Practice 1 that Covid lockdown restrictions had

any bearing on the decision making of the GPs from GP Practice 1, although the review notes that Maria did not engage in any face-to-face consultations with either GP practice.

17.47 The telephone consultations Maria engaged in with GP Practice 1 were appropriate to the circumstances, as the primary objective of these were aimed at securing an opportunity for Chritopher to be examined, which did not materialise because of the reasons previously discussed. On that basis, the initial telephone consultation with GP Practice 2 offered Maria the only opportunity to arrange a face-to-face assessment with a GP, but a follow up telephone consultation was arranged by the GP. It remains unclear as to whether Christopher would have consented to attend a face-to-face appointment, but there is no evidence that the telephone consultation was offered in preference to a face-to-face appointment as a consequence of the lockdown rules.

17.48 There is no evidence that any GP considered it appropriate or necessary to conduct a home visit, to examine and/or observe Christopher, in response to Maria's concerns. In parallel, there is no evidence this was influenced by Covid lockdown restrictions. Similarly, there is no evidence this influenced the ambulance service decision not to deploy an ambulance to the incident reported on 30th January. The possibility that Covid lockdown restrictions had a bearing on these decisions cannot be discounted, but there is no evidence to indicate they did.

17.49 There is no evidence in any other record to indicate that the lockdown restrictions had any bearing on Maria's interactions with services after she first reported her concerns on 28th January. The FRS attempted to conduct a face-to-face engagement by visiting Christopher at home on 2nd February, the ambulance service responded to his landlady's emergency call on 14th February and Christopher was admitted to the Hinchingbrooke hospital ED on the same evening; similarly, the police responded to incidents of concern on the 20th and 21st February.

18. CONCLUSION

18.1 As outlined by the CPFT SI Review, 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.

18.2 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. The clear pathway referred to in the SI Review 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.

18.3 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.

18.4 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 risk picture. 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 illness, except as a last resort.

18.5 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.

18.6 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.

18.7 Key information was frequently not reliably recorded in service records and 2 key interactions were not recorded by the FRS and EDT respectively. Whilst there is no conclusive evidence that the reported interactions between Maria and the FRS on 31st January (Contact – FRS – 1), and between Rebecca's daughter Susan and the EDT on 9th February (EDT Contact – 1), took place; it is the judgement of the review that on the balance of probabilities, given the substantial circumstantial and other supporting evidence provided to the review, that it is more likely than not that these transactions did

occur and were either not recorded, or recorded in a manner that rendered the record to be irretrievable.

19. LESSONS TO BE LEARNT

19.1 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.

19.2 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.

19.3 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 EDT; however, 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 11th February, or not conveyed as referrals, as in the case of the EDT response to GP Practice 1 on 11th February or to Rebecca's call on 21st February. This illustrates a requirement to revise internal CPFT referral processes and improve liaison, information sharing and joint working between the FRS and EDT services.

19.4 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.

19.5 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.

19.6 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.[194] Whilst the situation here is not entirely congruous with the background to that recommendation, the 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.

19.7 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 11th February, 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 any tangible outcome. The additional referral to the EDT by a family representative on 21st February 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.

19.8 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

[194] DHR Overview Report - Death of Sally

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.

19.9 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 11th February and the ambulance service and Hinchingbrooke hospital on 14th February. 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.

19.10 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.

19.11 When responding to separate episodes of concerns about his mental health, the police did not engage, or share information with the IMHT or FRS 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.

19.12 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.

19.13 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.

19.14 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.

20. 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.

APPENDICES

APPENDIX 1 – Glossary

AAFDA - Advocacy After Fatal Domestic Abuse

AMHP - Approved Mental Health Professional

CCC - Cambridgeshire County Council

CCG - Clinical Commissioning Group (Now the ICB)

CCTV – Closed - Circuit Television

CGL - Change, Grow, Live (drugs and alcohol service)

CPFT - Cambridgeshire and Peterborough Foundation Trust

CPSL - Cambridgeshire, Peterborough, South Lincolnshire (MIND)

CRHTT - Crisis Resolution and Home Treatment Team

CSEW - Crime Survey of England and Wales

CSP - Community Safety Partnership

DASH - Domestic Abuse Stalking Harassment Assessment

DHR - Domestic Homicide Review

DV&A – Domestic Violence and Abuse

ECG – Electrocardiogram

EEAST - East of England Ambulance Service NHS Trust

ED - Emergency Department

EDT - Emergency Duty Team (part of Cambridgeshire County Council Social Services for Adults)

ENT - Ear, Nose and Throat

EPR – Electronic Patient Record

FCR - Force Control Room

FLO - Family Liaison Officer

FRS - First Response Services (part of CPFT)

GP – General Practitioner

GPMS - Government Protective Marking Scheme

HOCR - Home Office Crime Recording Rules

HQ – Headquarters

ICB - Integrated Care Board

IMHT - Integrated Mental Health Team

IDVA - Independent Domestic Violence Advisor

IMR - Individual Management Review

MAPPA - Multi-Agency Public Protection Arrangements

MARAC – Multi Agency Risk Assessment Conference

MASH - Multi Agency Safeguarding Hub

MHA - Mental Health Act

MS Teams - Microsoft Teams

NHS – National Health Service

NSIR - National Standards for Incident Recording

NWAFT – North West Anglia Foundation Trust

OWHR - Offensive Weapons Homicide Reviews

PACE - Police and Criminal Evidence Act

PTSD - Post-Traumatic Stress Disorder

PWS - Psychological Wellbeing Service

SI – Serious Incident (review)

SIO - Senior Investigating Officer

ToR – Terms of Reference

APPENDIX 2 – Accounts of Note

Account of Rebecca

I knew Marai for approximately eleven years. We met in late 2009 when we were both working at Hotel Chocolat. Over the years we became close friends and towards the end of Maria's life when Christopher became ill, we would speak on the telephone almost daily. Maria did not speak English very well and I would help her in this regard.

Maria was physically healthy and would regularly go running and boxing to maintain her fitness. She was a happy and kind person when she was away from her home, but when she was in her home, her mood would darken and she would be depressed.

Maria's home had a significant and obvious impact on her mood. She lived in a multi-occupancy block with other residents, one of whom she thought may have been alcoholic, as she would hear him making noises as though he was vomiting. Maria told me he this person was also noisy in other ways and often prevented her from getting to sleep or would wake Maria up in the middle of the night. This was reported by Maria on multiples of occasions to the council.

I helped Maria to write letters to the council, over a long period of time, to try and get her rehoused from where she was living. She was unhappy that her home was surrounded by fences and large trees, which caused her to feel uneasy and I understand she was later diagnosed with claustrophobia. I saw for myself, when visiting, that there was a lot of discarded rubbish around the block which was unpleasant and caused it to smell. Mara said she always felt there was something wrong with the house, as though there was a dark presence there.

As a consequence of my friendship with Maria, I also met Christopher on occasions, but Maria would talk about her children a lot, including Christopher. Maria told me that Christopher was a good man and a good husband and father, he was very quiet and sensitive. Maria said Christopher worked hard for his family, but he suffered with varicose veins and was unable to work for a period of time and money became scarce. She told me that she thought Christopher's wife believed that she could find someone better than him and that his wife left him during this period. I was aware Christopher and his wife had one child together.

Maria told me that Christopher used to smoke marijuana with his wife. I was also told by Maria that Christopher had to pay off a drugs debt to a local dealer at some point after his wife left him. I can't remember when this was, but I believe it was some years after he and his wife had separated. I know this had an impact on his finances at that time, but I don't

really have any further details on that. Because of this debt however, Christopher had little money left from his wages and this impacted on his capacity to sustain himself and Maria would often have to help support Christopher financially.

When Christopher's wife left him, she started to refuse him access to his son, whom Christopher and Maria both loved dearly. As a result of the debts, he was paying off, Christopher didn't have any money to engage legal representation to challenge his wife regarding access, and so Maria had to help him financially to contest the matter in court, but she didn't have enough money to get private legal representation, but she helped him financially to get some support in contesting the decision to refuse him access to his son, which Maria said had caused him to become depressed. After a long period of time, Christopher was allowed to have some access to his son.

In January 2021 Maria got a new job and was very happy with the appointment. Around about the same time, Maria first started to express significant concerns regarding Christopher's mental health.

On 22 January 2021, which is a day when it is a Polish tradition to celebrate Grandmothers, where as part of that tradition, grandchildren present their grandmothers with flowers on this day.

Maria told me that Christopher had come to her home with flowers and started dancing and talking to her like a child. She said EG was acting and talking like a child. She also told me that Christopher's eyes were different, they were not clear and were not how his eyes normally were, or were supposed to look. Maria told me that this was not Christopher and that he was not himself. She was very alarmed by his behaviour.

Over the next few days and weeks, Maria told me that Christopher was hearing and responding to voices. She told me that he said that God was speaking to him. Christopher was also saying other strange things including that Maria had brought the devil, and that people were hiding. Some of the other things she told me at that time were as follows.

Christopher had stopped going to work, but that Christopher believed he was still going to work and Maria continually made reference to Christopher's eyes.

Christopher told her that he knew she had fallen out of a tree when she was a child and that God had given her invisible hearing aids.

Christopher told Maria that he had formed a new relationship with a woman who had a son. He said the woman's and child's names were the same as those of his ex-wife and child.

Christopher would stand at the window inside her home and look out into the darkness and say to Maria, "Look outside the window, no-one is there, they're scared, why did you bring the devil?"

Christopher would take wide strides towards her and say, "Ring the police, quickly."

Christopher was continually seeing things that weren't there and hearing and responding to voices that were not there.

Maria was extremely worried about Christopher, she told me that she knew he was ill as there had been a significant and disturbing change in his behaviour, which was continuing. Maria was so worried that she told me that she had tried to call Christopher's ex-wife to tell

her not to let Christopher see his son, as there was something wrong with him, but Christopher's wife never picked up. Maria told me that she feared that Christopher might do something to harm his son and said that she needed to make sure the child was safe.

Maria told me that she tried to get an appointment with her surgery in St Ives for Christopher to see a doctor, but the surgery would not see him, because he was registered at a surgery in Huntingdon. Maria was working and going to Christopher's GP in Huntingdon almost daily, trying to get some help for him. She told Christopher's GP that Christopher was sick and needed medication and a sick note, as he wasn't going to work. The surgery wouldn't help her and said that Christopher would have to come to the surgery. Maria told the GP that Christopher would not come to the surgery as he refused to believe that anything was wrong with him, but that she knew he was very unwell, as he was her son, and he needed medication. Maria was told that Christopher would have to come to the surgery before he could be given any medication. Eventually, Maria did manage to obtain a sick note from Christopher's Huntingdon surgery as she explained that Christopher was very unwell, wasn't attending work, and would lose his job and be destitute.

Maria tried to persuade Christopher to transfer from the Huntingdon surgery to the St Ives surgery, but Christopher refused, both because there was a Polish doctor he knew at Huntingdon, as well as him refusing to accept that there was anything wrong with him. Maria managed to obtain a form to enable Christopher's transfer to the St Ives surgery, but Christopher wouldn't sign it. In desperation Maria signed the form and took it to the St Ives surgery. She was asked who had signed the form, which she admitted she had and the form was refused.

Maria managed to obtain another transfer form and eventually persuaded Christopher to sign it. She reasoned with him that as he was living with her, he needed to have a GP to go to if anything happened, or he became sick.

Maria tried to make an appointment to see the GP at St Ives after the form had been signed. She managed to get a telephone appointment. During the telephone appointment Maria told me she told the GP that Christopher was very ill and needed medication, she told the GP that Christopher believed he was still going to work, but that he had not been to work for three weeks. Maria told me that the GP spoke to Christopher and asked how he was and Christopher responded that he was ok. Maria told the GP that he was not ok, he was ill, she was his mother and knew he was sick and that he needed help. She told the GP that she needed help as she had to work and Christopher was acting so strangely and was coming and going randomly, and she was very worried about him because she knew he was very sick. Maria told me that the GP was unable to prescribe any medication over the phone and would need to make an appointment for Christopher to see the GP.

Maria told me that she managed to make a further telephone appointment for Christopher, but on the day of the appointment, she was required to stay at work to complete some overtime as she needed the money. Maria told me that the GP had tried to call Christopher, but he hadn't picked up. Maria later spoke with the surgery, she tried to arrange a face-to-face appointment so the GP could observe EG. This appointment was originally offered for the following Friday, Maria requested an earlier appointment and it was made for the following Tuesday, which would have been the 23rd February.

Maria told me she rang 111 option 2 on a number of occasions, she told me she had explained her concerns to them and continually told them that she knew her son better than anyone, that he wasn't himself, and that she knew he was very sick and needed help.

I was told by Maria that the 111 operators came to see Christopher sometime in February 2021, but when they tried to speak to him, he became uncharacteristically loud and angry and shouted at them to get out of his house. Maria was upset that they didn't do anything in response to the strange behaviours she was telling them about, either in terms of giving him any medication or referring him to a doctor.

Sometime between 6pm and 7pm on Tuesday 9 February 2021, my daughter rang (redacted number), I believe this number is Cambridgeshire County Council out of hours social services for adults. My daughter told the operator of our concerns regarding Christopher, she was told that someone would call her back. Sometime later that evening, someone did call back, after repeating the concerns regarding Christopher's behaviour over the previous two to three weeks, the operator provided an explanation as to how depression affected people differently. They said Christopher's behaviour could be a one-off event and advised my daughter that if his disturbing behaviour were to continue, we should call back and they would come and take him for an assessment. The operator explained that they weren't able to do anything the first time that these types of concerns were raised with them, as they might be a one-off. My daughter explained to the operator that 111 operators had been to see Christopher, but that he refused to talk to them, the operator said they were unable to see any record of the 111 visits. The operator reassured my daughter that if the strange behaviours continued and we had concerns, or Maria felt unsafe, we should call them and they would have the power to take him away to conduct a mental health assessment.

On Monday 15 February 2021, Maria told me that Christopher had turned up at her home at about 3am in the morning. She told me he had been discharged from Hinchingbrooke hospital after his landlady had called an ambulance, due to her concerns for his mental health. Maria didn't know why Christopher had been discharged. She said he had walked from the hospital to her house, which is a very long distance, and she said that he had nowhere to go, as he had been evicted from where he was living the day before, and she couldn't let him sleep outside.

The day before Maria died, I called the (redacted0 number again on Maria's behalf. I asked for the same person we had spoken to but this wasn't possible. I told the operator the background and asked them to come and get Christopher, as the behaviours we had described previously were continuous and getting worse. The operator told me, "It doesn't work like that." They told me that we would have to ring 111. I told them that Christopher refused to talk to 111 and that the previous operator told us, that if Christopher's strange behaviours continued, we should call this number and someone will come to take him for an assessment. I think this operator told me that they had a record of Christopher, but that we would need to re-contact 111 anyway. I repeated that Christopher refused to speak with the 111 operators but the operator insisted we had to contact 111 again.

On Sunday 21 February 2021, I called Maria and told her that she would need to call 111 again, but she told me that she would do it the next day as she was getting ready to go to see a room that Christopher had found to rent. She said that Christopher had come to her and asked for money to pay for the room. Maria said she had told Christopher that she would need to come with him and explain to the owner that he was sick and wasn't working,

to try and make sure that the owner knew all about his position and wouldn't evict him. Maria said that Christopher had been out on Saturday night and had arrived at her house late and kept her awake all night playing loud music. She told me that she had seen him sneaking out of the house in the early hours of the morning, but didn't know where he had been. I later learned from Maria that Christopher again left the house, whilst she was getting ready to go with him to see the room he had found. He did not return until Maria was called to go to the shop later that evening.

At 6.20pm on the evening of Sunday 21 February 2021, Maria called me, but I missed the call as I was at church. I called her back and she told me that she was at a shop because Christopher had taken a can of beer from the shop and believed he had won the lottery. She told me that the police were there, she also mentioned that Christopher had been to the shop earlier that morning and had taken a beer, which he hadn't paid for, and so the police had been called by the staff at the shop .

Maria asked me to speak to the police and she put me on the telephone with a female police officer. I told the officer that Christopher was not himself, that he was always really quiet and would never take beer or property, or claim to have won the lottery or be pretending to go to work if he was well. I told her that Christopher was very ill and that no one knew him better than his mum, and that it was clear that Christopher needed help.

I asked the police officer to take Christopher. I explained that Maria was scared and that Christopher needed to be in hospital. I explained that Maria was not scared that he would attack her, but she was scared Christopher would leave the gas on or burn the house down or flood the house, as he had previously showered in all of his clothes at his last residence. The police officer told me that they couldn't do anything.

I tried to convince the officer that Christopher was very sick and needed help, I told her that he was acting completely out of character, that he had twice stolen beer, which was a crime, which wasn't like him at all. I kept pleading with the officer that something was seriously wrong with Christopher and that he was in a different world, behaving completely out of character and that he was hearing and responding to voices, but the officer repeated there was nothing they could do.

It was clear the police knew there was something wrong, as I heard Christopher state that they are not real police and that he would call the real police and also stating that he'd won the lottery, but that Maria had changed his ticket. I told the officer that Christopher was following voices and that he'd claimed he was talking to God and accusing Maria of bringing the devil. I told her that Maria was scared and she had to go to work and wasn't able to sleep as she was so worried about Christopher. I pleaded with her, "Can you please take him?", the officer responded by saying something along the lines of, "Ok, we will talk to him." A short time later she came back on the phone and said there was nothing they could do. Christopher said that he wanted to go for a walk, but he walked back to Maria's home with Maria as she didn't want him walking around the streets.

Maria called me again later that evening, I believe she was on her way home from the shop, as she had been to buy cigarettes for Christopher, as she didn't want him to go out, because she was so worried about him. She arrived home whilst we were talking on the telephone and she told me Christopher had left and had taken a bag of clothes.

Christopher arrived at her home whilst she was talking to me and asked her if she had got cigarettes, which I believe she gave to him, Maria told me that Christopher then went into the garden to smoke a cigarette. She said to me that she needed to check Christopher was still in the garden, which he was. She told me that Christopher was going somewhere, but he had a key, so she was going to try to sleep. Maria told me that she had to stop worrying about Christopher because she had work in the morning and needed to sleep. She said that because Christopher had a key, he could come and go, but that she needed to sleep. At the end of the call Maria told me that she was going to go outside to check that Christopher had a key and was then going to go to sleep.

Afterwards, I tried to call Maria several times, but there was no answer. Maria's daughter Grace called me from Poland and told me there had been a murder in her mum's home and that Christopher had been arrested by the police who had phoned her brother. Grace said that the family didn't know anything and asked if I could find out what was happening. I tried to find out, but I wasn't able to until I was contacted by the police major incident team who told me they had been given permission by Maria's children to speak to me. The police told me there had been a murder at Maria's address, but that they hadn't identified the victim. I met with the police when I arrived home from work and they took a statement from me over several hours. I quickly came to the conclusion, based on all the circumstances, that the victim was Maria.

The day after the homicide, a doctor called me and told me that they had permission from Maria's children to speak to me. They told me they had examined Christopher after his arrest. This doctor told me that Christopher was very ill. I told the doctor that we had known that, and that we had been telling doctors and 111 this for over a month and trying to get Christopher help. I told this doctor that if Christopher been given the help that Maria and others asked for, the homicide could have been prevented.

Account of Margaret

I knew Christopher for approximately two years. He was introduced to me by my next-door neighbour's son who knew him, as he was living close by on the next road and was looking for somewhere else to stay. He was the ideal tenant, he was very clean, tidy and hardworking, he worked all through the pandemic and would leave for work every day at 7.30 am and return home at about 6.30pm. He walked to and from work, where I believe he was well liked. I would describe him as being very quiet, someone who kept himself to himself and was always listening and even dancing to music.

It took Christopher a considerable time before he talked about his family. He told me about his son but added that he wasn't allowed to see him. He loved his mum dearly and he was a good cook, so he would make Sunday dinner for her every week.

He was very flamboyant and would dress in very bright, multi coloured clothes, which would frequently clash, he wore very skinny tight pants, leopard print leggings, frilly shirts and sequined jackets. He spoke a lot about friends, but I never really knew of any close friends, although there was an Eastern European man he used to talk to. He didn't have a girlfriend although he tried very hard to have a relationship, but he didn't speak English very well. I thought he might be gay, due to the attention he gave to his appearance and his fascination with, and the style of clothes he wore.

Whilst I have seen Christopher get angry, he was mostly meek and mild. During the covid pandemic, he was verbally aggressive with me because I had objected to him bringing his son and mum to the house, when we were in lockdown. I'd also heard Christopher sound verbally aggressive to his mum on the telephone, but he was never aggressive to her in person when I was there. Christopher and his mum similarly refused to acknowledge the threat from covid. I would describe her as being very blunt, but she didn't speak good English. I also met his wife around this time, as she was now allowing Christopher to see his son. I recall her saying that Christopher was "mad". But she never provided any rationale for this statement.

I believe Christopher used to occasionally smoke marijuana and he would be spaced out at times and at other times he would be hyperactive.

As I said, he was always eccentric and different, but in late 2020 and January 2021 I noticed his behaviour started to grow increasingly strange. He suddenly stopped going to work and kept telling me that he was on holiday, although this went on for several weeks. He also started drinking vodka, and would drink all weekend. He would drink vodka from a cup in the morning.

He started to continually wear a fleece with the hood up and would have earphones in and was continually talking and laughing, as if he was having a telephone conversation with one of his friends, but I believe he was talking to himself. Other times, he would be completely silent. At times he would be dancing without any music on and he had stopped eating as he normally would. I found it very strange being in the kitchen with him when he would be talking away to no one.

Christopher would light candles all around his bedroom and then leave them burning when he went out, which I told him was dangerous and asked him to stop. He would also get up for a cigarette in the night and leave a candle burning in the kitchen when he went back to his room. He had lots of fairy lights adorned around his room, it was like a grotto.

I have a friend who had a close relative who was diagnosed with schizophrenia, she had seen at first hand, the symptoms of this mental illness over a long period of time. She met Christopher at my home fairly early in his tenancy and told me that something wasn't right, she advised me to put a lock on my door. Initially I ignored this advice.

Sometime just before 10pm on Saturday 30th January 2021, I was sat watching TV when water started to come through the ceiling. I went upstairs and into the bathroom with my other tenant Peter where we found Christopher in the shower fully clothed, with shoes and socks on, looking totally bemused. I tried to ask him what he was doing, but he seemed totally vacant and I said to my other tenant, who was with me, "Oh dear, he has gone mad". We managed to get him out of the shower and I rang 111 at 2159 hours, according to my phone records. I told them what had happened and added and made reference to his other strange behaviour and told them that Christopher was acting as if he was "totally out of it". Someone called back from 111 at 2232 hours, according to my phone records, the caller was female who spoke Polish and she asked to speak with Christopher who told them he was alright now, although he hadn't felt well earlier but was now just tired. The caller only spent about five minutes on the phone with Christopher. Nobody attended my address as a result of this incident or called back to enquire further as to his condition or whether he had made a recovery.

After the call, Christopher just wandered off, my other tenant, Peter, cleared up the bathroom and took Christopher's sodden clothing and cleaned and dried them. When Peter went to return the dried clothes to Christopher the following day, Christopher denied they were his clothes.

On the evening of Tuesday 2nd February 2021, Christopher's mother came to the house. She knocked on the door and when I answered she told me that she had called some medical people to come and see Christopher, but that she didn't want him to know she had called them, or that they were coming to the house. She said they were supposed to come to the house at 8pm. She told me that he had been talking to imaginary children in her kitchen and that she was very worried about him. She said that these people were coming to see him as he needed help, she then hid awaiting their arrival.

A man and a woman arrived sometime later that evening. Maria and myself spent some time with them downstairs, telling them that Christopher was acting really strangely, including his failure to attend work and all the other things I have recounted. Maria told them he was seeing children in her kitchen and talking to them, she also said that he was her son and that she knew he wasn't right and needed help. She told them about him bringing flowers to her about the week beforehand, which was a Polish holiday I believe, and speaking to her like he was a small child, She poured her heart out to them, trying to convince them that Christopher needed help because he wasn't right. They asked Maria if Christopher had been ill before and she told them that he suffered from depression due to the separation from his wife. They made some notes whilst we were talking to them.

Whilst we were talking, Christopher came downstairs and went into the kitchen, without acknowledging us. I said to him, 'Some people want a word with you". He replied by saying something like, "I won't be a minute". Christopher then took some food and walked upstairs to his room. We continued to tell them that he had been acting really strangely. Christopher didn't come down from his room. The medical people went upstairs to his room, the female had a phone with her with an interpreter on I believe. Christopher was sat on his bed watching a movie, he told the female that he didn't want to talk to her and told her to, "go away". He then shouted, "Get out", very aggressively and continued shouting aggressively for about five more minutes.

Myself and Maria withdrew and came downstairs, to give them some privacy in doing whatever they needed to do with Christopher.

A short time later, they came downstairs and said there was nothing they could do. I was shocked and said something to the effect of, "You can do nothing"? They indicated that they would need to get a doctor to make an assessment, if we thought he wasn't right, as he wouldn't talk to them, so there was nothing they could do. I felt like the concerns Christopher's mum and I had both conveyed were just dismissed. It even crossed my mind that they weren't taking us seriously due to our advancing age.

They then spoke with Christopher's mother and repeated there was nothing they could do. They told her that if she wanted help, she needed to call a Peterborough telephone number. We kept telling them that he wasn't right, but they re-iterated there was nothing they could do and advised that we needed to call the Peterborough numbers they had provided. They really weren't very helpful.

For the first time, that night, I wedged a chair against the inside handle of my bedroom door due to concerns for my personal safety. The following day, I had a lock fitted on my bedroom door. I was becoming increasingly concerned about Christopher's behaviour and a day or two after this, I called his manager at work to verify that he was on holiday, as he had stopped going to work. His manager informed me that he was not on holiday, but that he had stopped attending work, without any explanation. He informed me that they had been trying to make contact with Christopher to check on his welfare, but they'd had no response to emails, phone calls and voicemail messages.

On either the 11th or 12 February 2021, Christopher's manager came to the house. But Christopher had gone out. I rang him back when Christopher came home and he came back to the house and spoke to Christopher. I would describe Christopher as being tolerant towards his manager, but not friendly. He asked Christopher to come back to work as he didn't want him to lose his job, but Christopher kept saying he'd go back to work, but he never did and had stopped paying his rent the week before the shower incident.

The rent was always paid two weeks in advance and Christopher had always paid his rent on time. He used to borrow money from me in between his salary payments, but he always paid it back. He was quite a heavy smoker and he sometimes borrowed money to purchase cigarettes.

Due to the rent arrears, coupled with my increasing concerns regarding his behaviour and for my personal welfare, I made up my mind to evict Christopher and told him that I couldn't afford to let him stay, as I needed the rent, he was due to leave on Sunday 14 February 2021, he would have had at least one weeks' notice of his eviction.

During his final week of tenancy, his strange behaviours continued, he stopped going out and spent most of the time in his room, without music or TV. Whenever I did see him, he had his hood up and didn't speak to anyone.

EGs behaviour was becoming increasingly troubling, so on Thursday 11 February I called the police non-emergency number, as I was becoming increasingly concerned for my own personal welfare, especially when my other lodger, Peter, was working nights, which he was. I was put on hold for so long, I gave up and went online and made a report. In the report I told the police about Christopher's behaviours, the results of his recent interactions with medical and 111 staff and my increasing worries for my own personal welfare when alone in the house. I also told them that Christopher was being evicted on 14 February and wanted them to log this information in case there were any problems. I later received an email response from the police. Nobody from the police called me or attended my address to assess my situation.

He spent the week packing his belongings in boxes which he stored under the breakfast bar. During this week Christopher's mum came around and we had a coffee together, she told me that she was unable to accommodate Christopher as she was moving. I believed this was said with a view to me changing my mind about Christopher's eviction, but I told her that I couldn't be responsible for her son.

On the day Christopher was due to be evicted, he went to his mum's for lunch and returned about 6pm and went outside to the back garden and started smoking a cigarette, I went out to him and reminded him that he had to leave that day as I had a new lodger moving in. Christopher became emotional and upset and asked me if he could stay if he got some

money. I had to say, “no” to him, but I was so concerned about him, I asked him, “If I get you an ambulance, will you speak to them”? It was clear to me that he needed help and he agreed.

I rang for the ambulance and I explained that they may have a record of Christopher refusing speak to them, but I reassured them that he was agreeable to speak to them today.

The ambulance arrived shortly after I called with two female paramedics, one of whom spoke Polish. They were at my home for quite a while examining and talking to Christopher. I told them about the strange behaviours I had witnessed him displaying and about what his mum had mentioned to me and the 111 operatives. I asked one of the paramedics if Christopher might have bi-polar disorder and she responded by saying she thought it might be more serious than that. I just want to add that I didn’t tell anyone that Christopher had expressed suicidal thoughts, I only reported his strange behaviours.

The paramedics checked Christopher’s blood pressure, pulse and his eyes. They tried to engage him in conversation, but he was mostly vacant. I told them that he was being evicted today and he couldn’t come back to stay at my address. One of the paramedics told Christopher they were going to take him to get assessed by a doctor, she repeatedly asked him where he was going to go after he was released from hospital as he couldn’t come back here. It just didn’t register with Christopher what she was saying, she kept asking him and he kept looking vacantly at them. They reiterated to him that he couldn’t come back here and asked where he was going to go repeatedly, but it didn’t register nor did he respond in any meaningful way. They asked him if he had taken drugs or drank alcohol and I believe Christopher said he’d had a. “little bit”.

As they were leaving with Christopher, I told the paramedics that I needed his key, as he was being evicted. The paramedic again made clear to Christopher he couldn’t come back and he handed over his key. They then put him in the ambulance.

About tea time the following day, Monday 15 February 2021, Christopher turned up at my house. I was quite shocked to see him as I expected him to be in hospital. He told me they had released him in the early hours of the morning and he had walked back to his mums, which is a bit concerning as this is a considerably long walk and he clearly wasn’t well.

On Friday 19 February 2021, the boxes containing Christopher’s belongings were in the back bedroom and he came to the house and was pulling them apart looking for his passport, which I recall he needed to register at the GPs surgery.

On Sunday 21 February Christopher was ringing the doorbell constantly picking up the boxes of his belongings, he was backwards and forwards about a dozen times and wouldn’t accept any help. I later learned he had dumped all the boxes in the local park. He had left one suitcase, which he left outside which he said he would pick up the following day, but I never saw Christopher again.