SERIOUS CASE REVIEW

SUBJECT: VA1

EXECUTIVE SUMMARY

Independent Chair:
Mr Andrew G Searle

Report on behalf of Manchester Adult Safeguarding Board, December 2009

1 Introduction

1.1 Manchester Safeguarding Adult Board commissioned a Serious Case Review after the killing of a 63 year old man on Monday 15th December 2008. The victim was killed, stabbed 17 times and then decapitated by his neighbour VA1.

1.2 VA1 had seen his GP earlier in the day and was known to have suffered depression and stress symptoms.

1.3 After the attack VA1 contacted the police admitting the killing saying he had cut a man's head off and put it in a wheelie bin outside the address along with the knife. He explained he had done this for his family and that he had a "calling".

1.4 The police attended the scene and VA1 identified himself to the Police Officer and said "It's me, his head is in that bin". VA1 was detained and subsequently arrested on suspicion of murder. A search of a nearby house, next door to that of the offenders address revealed the decapitated body of the victim.

1.5 During his arrest and interview at the police station the mental health of VA1 came into question. He was seen by medical professionals on a number of occasions whilst in custody, culminating in a decision that he was suffering from a mental illness. VA1 was subsequently detained under the Mental Health Act and taken from the police station to a medium secure unit.

1.6 A subsequent diagnosis of psychosis has been made however this did take some considerable time, due to the complexity of the issues.

1.7 On 27th July 2009 VA1 appeared at Manchester Crown Court where he pleaded guilty to manslaughter on the grounds of diminished responsibility. He was ordered to be detained indefinitely on a Hospital order.

2 Process

2.1 In line with the Multi Agency Policy of Manchester Safeguarding Adults Board MSAB a request to hold a Serious Case Review (SCR) in relation to VA1 was made by GMP. It was acknowledged that the case did not strictly meet the criteria for a serious case review but it was agreed that such a review would provide valuable learning and would test the effectiveness of the procedures. On the 20th February 2009 SCR panel was convened with an Independent Chair appointed. Other panel members consisted of representatives from:

Manchester City Council, Head of Safeguarding

Greater Manchester Police

NHS Manchester

The terms of reference were agreed as:

- To understand the context and processes that led to the serious incident.
- To obtain individual management reports from all agencies who had involvement with the subject
- To establish whether there are lessons to be learnt from the circumstances of the case about the way in which local professionals and agencies work together to safeguard vulnerable adults.
- To inform and improve local inter-agency practice.
- To improve practice by acting on learning (developing best practice).
- To prepare or commission an overview report which brings together and analyses the findings of the various reports from agencies in order to make recommendations for future action.

2.2 It was agreed the process would start following consultation with the Coroner and Crown Prosecutions Service, the panel not wishing to impact on either of the judicial processes.

3. Summary of events leading to the serious incident

3.1 VA1 was born in the Philippines and came to this country in October 2005 to be with his wife who had moved earlier in the year. A son was born to them in 2007. At the time of this incident VA1 was 31 years old.

3.2 It is significant that VA1 has strong religious convictions and joined the congregation of a local Roman Catholic Church becoming well known to the priest.

3.3 VA1 has had 21 contacts with health professionals, since his arrival in this country, one being his diagnosis of TB in July 2006. It is believed by Medical professionals, that he contracted TB when in the Philippines where he refused to take medication believing that "God would protect him and he did not need it". There are no medical records available from his home country.

3.4 In December 2007 VA1 attended his local GP for stress related matters involving work pressures and family pressures, following the recent birth of his son.

3.5 VA1 received counselling in the spring of 2008 after referral by his GP. Records confirm there were no concerns regarding VA1 and he responded well to advice given regarding diet, lifestyle and the counselling. Panel noted that the referral for counselling took in excess of 3 months,

3.6 In December 2008, VA1 was having problems sleeping. He confided in his wife and priest that he was hearing voices that were religiously based. The priest and VA1 could not discount this being a religious experience.

3.7 On 14th December 2008 VA1 attended mass at church. He became openly emotional standing up during the sermon, walking toward the altar, bowing and then collapsing to the floor. The priest described him as emotionally and physically drained. They spoke several times that day and the subject of hearing voices was again discussed.VA1 was advised by the priest to visit his Doctor. The priest was aware that he had received counselling earlier in the year which appeared to have helped, and believed his behaviour was no different to then. The priest informed him not to do anything the voices told him to do.

3.8 On the morning of 15.12.08 an appointment was made at the Dr's because VA1 was having problems sleeping, hearing voices and he had confided in his wife a few days earlier that he believed his neighbour was going to kill their family, especially their son.

3.9 Later that morning an incident took place between VA! and his neighbour resulting in the neighbour falling to the ground outside their front gates. He was helped by neighbours but declined to say what had happened. VA1 was taken into his house by his wife who only witnessed the neighbour on the ground. The police were not called by either party or neighbours.

3.10 VA1 and his wife attended an appointment with their GP at 3.30pm that day. Both VA1 and his wife discussed with the Dr that VA1 was having sleeping problems. The Dr described him as having a low mood and spoke to him about the benefits of Computerised Cognitive Behaviour Therapy (CCBT). VA1's wife recalls speaking to the GP about VA1 hearing voices at this consultation. The GP however is adamant that this was not mentioned. The GP made a further appointment to see VA1 the following day allowing VA1 time to read the information given to him regarding CCBT.

3.11 Later that evening the incident occurred in which VA1 killed his neighbour. There is no information leading up to the actual attack.

4 Summary of agencies involvements:

4.1 The following agencies and individuals were contacted and invited to participate in the SCR process. Agencies which had knowledge of VA1 were asked to complete an Individual Management Review (IMR).

- Greater Manchester Police
- Manchester City Council Adult Services

- Manchester City Council Children Services
- Manchester City Council Housing
- NHS Manchester
- Manchester Mental Health and Social Care Trust
- Manchester Community Mental Health :Primary Care Mental Health team
- Pennine Acute Hospitals :NHS Trust North Manchester General Hospital
- Priest of VA1
- Consultant Psychiatrist – (in confidence)
- VA1 (declined to be involved)
- Wife of VA1 (declined to be involved)
- Family of deceased (declined to be involved)

4.2 It is established that since their arrival in the Country neither VA1 nor his family had any contact with Children's or Adult Services, Housing or the police until the incident on 15.12.08.

4.3 Two in depth IMRs have been received by the SCR panel, one from the Police the majority of which relates to VA1's time spent in custody. VA1 remained in custody for interviews and received regular medical assessments until 18.12.09.

4.4 On the evening of 18.12.08 it was established that VA1 was suffering from a mental illness which required treatment. He was subsequently admitted to a medium secure unit under Section 2 of the Mental Health Act.

4.5 **The Police** have complied throughout with the Police and Criminal Evidence Act which outlines the treatment of all prisoners including vulnerable adults.

4.5.1 One area of concern to the panel was the time delay in the initial "police doctor" attending after request. This is made the subject of a recommendation in this report.

4.6 **NHS Manchester** provided in depth information from several Health professionals detailing the engagement VA1 had with his local GP surgery and Community Mental Health Team regarding stress related problems. It has been established that prior to events in December 2008 VA1 had 21 contacts with Health professionals. VA1's presentation was such that no "red flags" were evident. No information was shared by VA1 regarding 'hearing voices" to enable healthcare professionals to adapt their treatment plans accordingly.

4.6.1 NHS Manchester highlighted "obtaining consent" for VA1's medical records as being a factor delaying the investigation process. They also highlighted the GP's initial concerns about engaging in the SCR. The GP was unsure of the process and had concerns regarding a possible disciplinary element to this investigation. A further issue expressed was the lack of systems in place to provide support for GP's involved in such incidents. These points are subject of recommendations.

4.7 A subsequent diagnosis of psychosis has been made whilst VA1 has been detained in a secure Mental Health Unit. It is noted however this diagnosis did take some considerable time due to the complexity of the issues.

4.8 VA1's priest and the last GP from VA1's surgery to see him were interviewed by the Independent Chair of the panel. Independent expert advice was sought in confidence from a Consultant Psychiatrist. VA1 himself, the deceased's family, and wife of VA1 were invited to participate in the serious case review but they declined.

5 Conclusion

5.1 The underlying question for this Serious Case Review is whether or not the serious incident could have been prevented by agencies that had contact with VA1.

5.2 Very few professionals were in contact with VA1, and of those that were, all were from a health background. It is clear that, after investigation, no professionals individually or collectively, were ever presented with the information which would have enabled them to take action to prevent this tragic occurrence.

5.3 Without the opportunity to affect the outcomes the effectiveness of the multi agency policy has not been tested in relation to this case

5.4 After the incident, clinical and judicial processes have taken place, resulting in an acceptance that significant mental illness has been a factor.

5.5 The timescales initially set by the SCR panel were in hindsight extremely ambitious and unattainable. NHS Manchester highlighted issues surrounding confidentiality and consent being one reason for the extended enquiry. A further issue was the initial concern of the GP to engage in the process due to their lack of understanding of the SCR process.

5.6 A number of issues have been highlighted as a result of this process and these are included in the recommendation section of this report in order to assist inter agency working.

6 Recommendations

6.1 It is recommended that GMP review the systems in existence regarding on call Forensic Surgeons attending police stations to ensure expectations relating to speed of response are explicit.

6.2 It is recommended that NHS Manchester reviews the opportunities to secure a more robust and objective review of "Significant Event Analysis" ensuring a greater degree of impartiality.

6.3 NHS Manchester to ensure there is a system in place to address and resolve issues of consent and information sharing at the start of any Serious Case Review.

6.4 NHS Manchester to enter into dialogue with the Local Medical Committee to set up a system to identify and support GP's who encounter difficult or stressful situations.

6.5 Manchester Safeguarding Adults Board to consider opportunities to engage with "Faith Groups" to raise the profile of safeguarding adult's responsibilities and procedures.

6.6 Manchester Safeguarding Adults Board to consider cascading safeguarding adults awareness training to all GP surgeries, to include responsibilities regarding the preparation of Internal Management Reviews and participation in Serious Case Reviews.

6.7 Manchester Safeguarding Adults Board to review its processes for setting up and managing Serious Case Reviews and revise where appropriate, in the light of the experience of this first serious case review

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