

Domestic Homicide Review
Joan/November 2015
Overview Report

Author: Paul Carroll CBE

Commissioned by:
Kent Community Safety Partnership
Medway Community Safety Partnership

Review Completed: 7th March 2017

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Domestic Homicide Review

Joan Baker

The key purpose of a Domestic Homicide Review (DHR) is to:

- a) Establish what lessons are to be learned from the domestic homicide, regarding the way in which local professionals and organisations work individually and together to safeguard victims;
- 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 these lessons to service responses including changes to inform national and local policies and procedures as appropriate;
- d) Prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;
- e) contribute to a better understanding of the nature of domestic violence and abuse; and;
- f) highlight good practice.

Scope

This report of a domestic homicide review examines agency responses and support given to Joan Baker a resident of Kent prior to the point of her death on the 19th November 2015.

On behalf of the members of the Domestic Homicide Review Panel, the individual organisations involved in this case and myself, as author of this report, I would like to express my sincere condolences for the tragic events that led to the death of Joan and the impact this has had on the wider family group.

In addition to agency involvement the review will also examine the past to identify any relevant background or trail of abuse before the homicide, whether support was accessed within the community 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.

This review examines the contact and involvement that organisations had with Joan Baker between 11th June 1996 and her death on 19th November 2015 at the hands of her Grandson, Simon Heath. In order to meet its purpose, this review also examines the contact and involvement that organisations had with the perpetrator.

The review has considered agency involvement with Simon Heath between the periods of January 1995 when he first committed an act of violence against his paternal grandmother for which he was originally subject to a Mental Health Order and November 2015, when his actions led to the death of Joan Baker.

Timescales

This review began on 17th December 2015 following the decision that the case met the criteria for conducting a DHR. Simon Heath was arrested on the day of Joan's death and was later charged with her murder. The Crown Prosecution Service did not request that the review was suspended pending the criminal trial, however they did ask that members of both Joan and Simon's families were not seen as part of the review until the trial was over. This was because there was a potential for family members to be called as witnesses. Due to this factor there was an initial delay in completion of the overview report, though collation of IMRs and other documentary evidence continued to be undertaken. In December 2016 new guidance issued by the Home Office borne out of findings and best practice from submitted DHR's, caused a review of this DHR. It was decided that the new guidance and advice provided be applied to this report. This has caused a delay in submission, but it was felt that the time delay was appropriate in ensuring this report was submitted in line with the current best practice expected. The review was completed on 7th March 2017.

1. Methodology

- 1.1 In accordance with Section 9 of the Domestic Violence, Crime and Victims Act 2004, a Kent and Medway Domestic Homicide Review (DHR) Core Panel meeting was held on the 17th December 2015. It confirmed that the criteria for a Domestic Homicide Review had been met.
- 1.2 That agreement was ratified by the Chair of the Kent Community Safety Partnership (under a Kent & Medway CSP agreement to conduct DHRs jointly) and the Home Office was informed.
- 1.3 Each of the following organisations completed an IMR for this DHR:
 - Kent and Medway NHS and Social Care Partnership Trust (KMPT)
 - NHS North Kent Clinical Commissioning Group (NKCCG)
 - Kent Police
- 1.4 Access to an internal NHS Trust Investigation was made available to the Chair of the Review Panel and considered in the writing of this report.
- 1.5 Information from meetings with family members was included in the completion of this review.
- 1.6 The terms of reference for this review are set out in [Appendix A](#) to this report.
- 1.7 A glossary of abbreviations, acronyms and terms used, which may be unfamiliar to those who are not professionals in the agencies concerned, is included at the end of this report .
- 1.8 This report has been anonymised and all the personal names contained within it, with the exception of members of the review panel, are pseudonyms.

2. Involvement of Family

- 2.1 The Review Panel considered which family members should be consulted and involved in the review process. The Panel was made aware of the following family members:

Name	Relationship to Joan Baker	Relationship to Simon Heath
Carole Heath	Daughter	Mother
Colin Heath	Son In Law	Father
Margaret Oliver	Daughter	Aunt
Stephen Heath	Grandson	Brother
Sarah Armstrong	None	Ex Wife
Louise Carter	None	Partner

- 2.2 The Independent Chairman wrote to family members on 6th May 2016 following the trial of Simon Heath. He offered to meet them to discuss the DHR process and listen to any views and concerns they had. The letters were sent by recorded delivery.
- 2.3 As a result the Independent Chairman met with members of Joan's family, namely Carole and Colin Heath (Parents of Simon and daughter and son – in – law of Joan) and Margaret Oliver (Daughter of Joan). They were able to provide background information about her, including an insight into her relationship with Simon which was not recorded or available to agencies. Where relevant to the Terms of Reference, this information has been included, but has not been attributed to an individual. Other members of the family who expressed a wish to contribute, such as Simon's brother and his wife were contacted through the family but ultimately decided to decline the opportunity to meet.
- 2.4 Meetings took place with family members on the following dates:
Carole and Colin Heath – June 2016.
Margaret Oliver – July 2016.
- Updated correspondence was sent to the family during the course of the review.
- 2.5. The family were not represented nor did they request the help of any advocate or specialist prior to or during the meetings.
- 2.6 Following the completion of the draft Overview Report, the Independent Chairman wrote to family members, offering them a further opportunity to meet, to allow them to discuss its contents, conclusions and recommendations. He again met with members of Joan's family on the 9th January 2017 (Carole and Colin Heath) and 6th March 2017 (Margaret Oliver). At these meetings the contents, recommendations and key issues from the Overview Report, were discussed allowing the family member concerned to ask questions and seek clarification on any points within the report. The

reason for the delay in publishing the report, as outlined earlier in this report, was also explained to them.

3. Contributors to the Review

3.1 Introduction

3.1.1 This Overview Report is an anthology of information gathered from Independent Management Reports (IMR) prepared by representatives of the organisations that had contact and involvement with Joan Baker and/or Simon Heath between 11th June 1996 and Joan's death on 19th November 2015.

3.1.2 An IMR is a detailed examination of an organisations contact and involvement with Joan and Simon. It is a written document submitted using a template. A member of staff from each relevant agency writes the IMR. That person will have had no involvement with anyone subject of the review. Once completed the review is signed off and approved by a Senior Manager of the organisation before being submitted to the DHR Review Panel.

3.1.3 Each of the following organisations completed an IMR for this DHR:

- Kent and Medway NHS and Social Care Partnership Trust (KMPT)
- NHS North Kent Clinical Commissioning Group (NKCCG)
- Kent Police

The authors of each individual IMR were independent and prepared by an appropriately skilled person who has not had any direct involvement with Simon Heath and who is not an immediate line manager of any staff whose actions are, or may be, subject to review within the IMR.

3.1.4 Access to an internal NHS investigation conducted by a Line Manager was given to the Chair of the review Panel and information therein considered in the completion of this review.

3.1.5 Enquiries were made via Kent Police to source records relating to Simon Heath with the Metropolitan Police in regard to related matters in the Metropolitan Police area in 1996.

3.2. The Review Process

3.2.1 The Review Panel

3.2.2 The Review Panel consisted of an Independent Chairman and senior representatives of the organisations that had relevant contact with Joan Baker or Simon Heath. It also included the Kent and Medway Domestic Abuse Coordinator and a senior member from Kent County Council Community Safety Teams.

3.2.3 The members of the panel were:

Kate Bushell – Designated Nurse for Safeguarding Adults,
North Kent Clinical Commissioning Group

Alison Gilmour – Kent & Medway Domestic Abuse Coordinator

Tina Hughes – Senior Operational Support Manager, National Probation Service

Carol McKeough – Safeguarding Adults Policy and Standards Manager, Kent Adult Social Services

Anne Lyttle – Service Director, Rising Sun Domestic Violence and Abuse Service

Paul Carroll – Independent Chairman

Shafick Peerbux – Head of Kent Community Safety, Kent County Council

Simon Wilson – Superintendent, Head of Continuous Improvement, Kent Police

Jessica Willans - Excellence and Effectiveness Manager (SPO), Kent Surrey and Sussex Community Rehabilitation Company

Cecelia Wigley – Head of Safeguarding, Kent and Medway NHS and Social Care Partnership Trust

3.3 Author of the Review

3.3.1 The Independent Chairman of the Review Panel is a retired Senior Civil Servant, having no association with any of the organisations represented. His career path was within HM Prison Service in which he served between 1977 – 2013, having been a Governing Governor, worked closely with Ministers in a Prison Service Headquarters setting and finishing his career as an Assistant Director responsible for oversight of 12 Prison establishments. His experience and knowledge include issues relating to domestic abuse and surrounding legislation. He has a clear understanding of the roles and responsibilities of those involved in working within a multi-agency approach required to deal with domestic abuse. He has a background of conducting formal reviews, investigations, and inspections, including the process of disciplinary enquiries. The Chair has no connection to the Community Safety Partnership and has never worked for any of the agencies involved with this review.

3.4. Review Meetings

3.4.1 The Review Panel first met on 27th January 2016 to discuss the Terms of Reference, which were then agreed by correspondence. The Review Panel met on 19th May 2016 to consider the IMRs. The next meeting of the Panel was held on 14th September 2016, where the first draft of the Overview Report was reviewed, considered and amendments proposed. The panel met on the 16th December 2016 to consider the amendments made and agreed a form of words in regard to changes required to be made to the Conclusions section of the report, following disclosure of additional relevant information.

3.5. Parallel Reviews

3.5.1 There has been no Coroner's Inquest held into the death of Joan Baker and the family informed the author that they have been advised that there is no intention to hold one. The NHS Trust has conducted an internal investigation into the service provision to Simon after Absolute Discharge and the outcomes of that report have been used to draw conclusions and recommendations within this review.

3.6. Equality & Diversity

- 3.6.1. The review has considered the nine protected characteristics under the Equality Act 2010. The Panel considered that there were no relevant factors which impacted on the service delivery to persons involved in this review.

4. Background Information (The Facts)

4.1 Events Surrounding the Death of Joan Baker

- 4.1.2 Police attended the home of Joan Baker in Kent, where she lived alone, on the 19th November 2015 at approximately 09:00hrs. This attendance was following a phone call from both the perpetrator, Simon Heath, and from a neighbour who had seen Simon Heath at the house and heard loud noises causing her to seek assistance. Joan Baker had been assaulted with a blunt object causing serious injuries. Despite the efforts of Police and Paramedics Joan died in the ambulance that attended the scene.
- 4.1.3 Simon was present when police officers arrived at Joan's home. He was initially arrested on charges relating to assault but he was later re-arrested and charged with Murder following Joan's death on route to Hospital.
- 4.1.4 Joan died as a result of facial and chest injuries consistent with multiple blunt force impacts.
- 4.1.5 Simon was able to be interviewed by Police following consultation with Medical Staff. On the 19th November a Police interview occurred at which Simon was described as being mildly irritable, sweated excessively and often lost his train of thought. However, it was apparent that he was aware that he had been arrested for the murder of his grandmother and was able to provide sufficient details to the Police leading to Simon being charged with the murder of Joan and his subsequent detention in a secure unit.

4.2 Trial of Simon Heath

- 4.2.1 On 25th April 2016, Simon Heath pleaded guilty to Manslaughter by reason of diminished responsibility via video-link to the Crown Court.
- 4.2.2 The Judge accepted the plea and Simon Heath was detained indefinitely by way of a Hospital Order under the Mental Health Act.

4.3 Summary of Relevant History

4.3.1 Joan Baker

- 4.3.2 At the time of her death, Joan was an 85-year-old lady, living alone following the death of her husband. Joan was a white British national who was born in the U.K.
- 4.3.3 Joan was the mother to two children, both of whom lived locally and were in regular contact with her. Simon Heath, the perpetrator of the assault leading to her death was her grandson.

- 4.3.4 Joan was aware of the troubled history surrounding Simon's Mental Health and his previous attacks on elderly family members, including one such assault of her deceased husband.
- 4.3.5 Joan had little contact with any of the agencies in any formal manner and her Medical records indicate a lady of good health, with every expectation of continuing to lead a full and healthy life for the foreseeable future.

4.4.1 Simon Heath

- 4.4.2 Simon was a white British national, born in the U.K. He was one of two children. His childhood appears to have been happy within a family unit. His family believes that the onset of his mental health issues were due in part to alcohol and drug usage commencing during time spent working in Germany.
- 4.4.3 Being subject to a Section 37/41 Mental Health Order, which meant that for significant periods from 1996 onwards he was detained in secure hospital conditions. Simon's care within the community during this period allowed him the opportunity to make a relationship and ultimately marry in 2003, the couple becoming parents in 2004. This relationship ended in 2008 and later he established a further relationship with a woman and her two children, though this relationship has now ended.
- 4.4.4. Simon is a bricklayer by trade and has held down work in this field during his periods in the community.
- 4.4.5. Throughout the period covered by this DHR, Simon suffered significant mental health issues requiring medication to treat his symptoms.

5 Chronology/Overview of Events

5.1 Introduction

- 5.1.1 This section considers, in detail, the contact and involvement that both Joan and Simon had with agencies during the period covered by the Terms of Reference. The facts are based on IMRs submitted by organisations and information gathered from discussions with the family.
- 5.1.2 Each IMR included a detailed chronology of contact and involvement with Joan and Simon.
- 5.1.3 In the absence of information that Joan had anything other than limited contact with agencies, much of the focus of this section relates to the management and decisions relating to Simon.

5.2 Agency Involvement with Joan Baker

- 5.2.1 As previously stated Joan was an 85 year old widow at the time of her death. She was considered to be in relatively good health, with no serious diagnosed medical conditions, preventing her from being mobile and allowing her to lead a full and active life.

- 5.2.2 Joan was the maternal grandmother of Simon Heath and was aware of his mental health issues and of the assaults on his paternal grandmother (in 1996), which led to his being held under S37/41 of the Mental Health Act. Joan was aware that Simon posed a risk to her as he had attacked her late husband in 2005, an act that attracted a recall to hospital for Simon.
- 5.2.3 Joan was supportive of her family and their efforts to support Simon to lead as normal a life as possible. However, she was keen that any contact with Simon was subject to the presence of others given previous events.
- 5.2.4 It is apparent that Joan was not in contact with any of the agencies directly and appeared reliant for any information or risk evaluation being conveyed to her by other family members more closely involved with Simon.

5.3 Agency Involvement with Simon Heath between 1st January 1995 and 19th November 2015

January 1995 - May 2005

- 5.3.1 During research into Simon's behavior, following the events set out in 5.3.3, the Metropolitan Police discovered that Simon had worked in Germany as a bricklayer where he had started taking amphetamine (speed) which resulted in adverse changes to his mental state. Information from Simon's family indicates that in February 1995, an incident occurred when he banged on the door of his great grandparents' home, but they refused him access. His mother collected him, and Simon told her that had they let him in he would have beaten them to death. This matter was not reported to Police and is the first in a number of notable occasions where information was not shared with the Police. Having received a period of psychiatric assessment as a day patient, Simon was in September 1995, considered well again and no further action was taken and he was discharged. In June 1996 Simon had been on holiday with friends when an incident occurred in which Simon was described as engaging in a cocktail of hallucinogenic drugs mixed with alcohol, causing him to set fire to a mattress in his hotel room and then threatening to self-harm. Simon returned home early from his holiday due to these events.
- 5.3.2 On the 11th June 1996, Simon visited his paternal Grandmother, an 82 year old widow, who lived alone in South East London. Simon's illness caused him to hold the view that older family members were preventing others (namely Simon) from rising up the family hierarchy and therefore had to be removed.
- 5.3.3 Simon attacked his grandmother with a walking stick causing her significant injuries and the following day Simon was arrested and charged with assault by the Metropolitan Police. However, after an incident of self harm in Police cells, requiring Accident and Emergency treatment, Simon was admitted to a Mental Health Unit and progressively moved to a psychiatric intensive care unit, before finally being admitted to a Mental Health Secure Unit. Simon was charged with wounding and in October 1997 pleaded guilty to that offence and made subject to an S37/41 Hospital Order and returned to the Secure Unit. The grandmother later contracted pneumonia and on the 22/10/1996 she died. This however, given the passage of time between the attack and her contracting the fatal illness, did not result in Simon Heath being charged with murder/manslaughter.

- 5.3.4 During his initial period in the Secure Unit, Simon participated in many therapeutic activities and commenced a medication regime. However, this did not appear to lower his risk as records show that during this time he assaulted a number of other patients and staff. None of these incidents were reported to the Police, therefore leaving their data on Simon limited. This may have impacted on the way in which they assessed ongoing risk.
- 5.3.5. Whilst at the Secure Unit, clear communication with Simon's immediate family continued and Simon admitted that his feelings also represented a threat to his mother as well as other wider elderly family members. It is not apparent whether these threats were considered as either a domestic abuse risk, or as a safeguarding concern by the Secure Unit. However, there was at this time no NHS Trust Policy or joint Kent and Medway policy for domestic abuse in place, which there is now. It is of concern that those potentially at risk were reliant on information from other family members close to Simon, rather than having the opportunity to be informed independently.
- 5.3.6 In March 2000, an Independent Mental Health Review Tribunal granted Simon a deferred conditional discharge, a mechanism that gives instruction as to what support and constraints must be in place for discharge to occur. After a period of living in a supported hostel, Simon moved into accommodation near his home, with his progress being closely managed by the forensic community team. By November 2000, Simon was reported as having lowered mood, but this was adjudged to have resolved itself quickly. In January 2001 Simon began to complain about the level of intrusion of regular injections. Agreement was made to increase the dose, but extend the frequency, thus removing such regular requirement for injection. In May 2001 Simon reported being in a relationship with a girl named "Sarah". It is not clear whether or not there was any review of the risk factors attached to Sarah. Whilst the evolving relationship was a matter of discussion at weekly review meetings, it is not obvious whether the discussions considered potential external risk, such as those surrounding her area of employment, working in an old people's home and how this may impact on Simon. It is not clear how much she had been initially told by Simon about his history and mental health issues, but as time passed it is apparent that there was disclosure, supported by Simon's parents and that Sarah became engaged with the team and attended assessment and review meetings on a regular basis. In July Simon admitted to consuming alcohol at a party and expressing concern about pressures on his relationship following him informing his girlfriend fully about his illness. Simon agreed that an informal admission to hospital and further assessment of his mental state was a suitable course of action.
- 5.3.7 In September 2001, after Simon returned from his hospital admission, he was living with Sarah in "supported" housing. However, the need to manage money and cope with difficulties in the neighbourhood added to Simon's feeling of stress. It was reported by Community Society the organisation that managed Simon's accommodation, that Simon informed them that he had been offered a gun, though it is not apparent for what purpose. It was reported to the Police by Community Society and is recorded on the Police intelligence database, all of which is positive practice. Simon is noted as having indicated that he would also be reporting this issue to his Social Worker. It is apparent that this conversation took place and Simon was advised to further contact the housing manager or the Police. There is no evidence to show what further action was taken to confirm or dismiss this

report and as such it appears that the Police were unable to do more than record this as useful intelligence.

- 5.3.8 In late September, Simon reported to the Forensic CPN, homicidal thoughts centered on a female resident of the nursing home where his girlfriend Sarah worked. Simon had thought through in detail how he would kill this particular person, describing his plan in some detail. Simon initially agreed to return to hospital on a voluntary basis but was later formally recalled to the Secure Unit given the thoughts expressed. The Police were not made aware of the recall or the circumstances surrounding it. It is a noticeable feature of this recall that upon admission a urine drug screen taken was positive for cannabis.
- 5.3.9 Simon remained in Hospital until November 2001. During this time his thoughts turned to his father, who he now believed to be having an affair with his girlfriend and he expressed a desire to kill his father. Staff in the secure unit were made aware and managed this risk, it is again not clear whether these risks were shared with other agencies in terms of considering safeguarding and future risks.
- 5.3.10 It is during this admission that Simon commenced Clozapine treatment as a treatment for resistant schizophrenia. This treatment was to prove highly positive for Simon, enabling him to successfully balance his mental health and allow monitoring in the community until such time as he felt empowered to vary his treatment, ultimately leading to the events triggering the assault on Joan Baker.
- 5.3.11 Simon's mental health was considered to have stabilised, following treatment with Clozapine and accordingly a Mental Health Review Panel granted a further conditional release in December 2001.
- 5.3.12 In August 2003, Simon married Sarah, and Simon appeared stable taking 550mg of Clozapine daily, having six monthly outpatient reviews and Care Plan meetings with the responsible clinician from Kent Forensic Psychiatry Service.
- 5.3.13 In May 2004, Simon discovered he was to become a father. There is evidence that those involved in his care plan considered the possible impact that a child may have on his mental health as they did not support the application made by Simon to have the restriction order lifted by way of Absolute Discharge.
- 5.3.14 Simon's family describe this period as settled and felt that their relationship with the Secure Unit allowed them to raise issues, discuss their concerns and where such concerns existed to have a point of contact to seek advice or discuss issues. Simon's parents have expressed their satisfaction with the service offered and the management of Simon up until this time.

5.4 May 2005 – April 2014

- 5.4.1 In May 2005 Simon's care was transferred to the Local Community Mental Health Team (CMHT). They met with Simon on the 14th December 2005, but did not detect any relapse indicators.
- 5.4.2 Medical records again inform us that in December 2005 Simon went to visit his parents. Whilst at his parents, his Mother expressed concern about the welfare of his grandmother who had recently been unwell. Shortly after, at his

request he and his mother went out to the local shops to buy some cigarettes and during this trip his mother indicated that she wished to quickly drop in to check on her mother Joan Baker. His mother expected Simon to wait outside but he followed her into the house and then attacked his grandfather who was asleep in his armchair. Simon placed his hands around his grandfather's throat and later admitted it was his intent to kill him. Serious harm to his grandfather was only averted due to the presence of Simon's mother who managed to wrestle him into the conservatory and lock the door, before calling her husband for further assistance. It is clear that his grandfather was very fond of Simon (as described by family members) and so he went to the conservatory to offer Simon re-assurance, upon which Simon said "I love you Grandad" before head butting him.

- 5.4.3 Records show that the incident was minimized to the Community Psychiatric Nurse, by Simon's close family in the form of Simon having "bad thoughts" and/or being "unwell". Family members also informed the author, that the grandfather was a retired Police Officer and in his concern that Simon receive help from the Mental Health Team, rather than report the matter to the Police and face further potential criminal charges he declined to inform the Police. This is a decision that one family member feels was a mistake in hindsight as not recording this as a crime may have had an impact on the significance and weight given to this event. Of course the fact that he was recalled to Hospital on the 18th December 2005 under the S37/41 order indicates action was taken, but this information was not shared with the Police.
- 5.4.4 Following return to Hospital Simon continued to verbalise aggression towards his grandfather and he focused this aggression onto another patient who he kicked and punched in the head. On this occasion the assault on the other patient was reported to Kent Police, who completed an investigation but due to the mental state of both Simon and his victim the case was "filed".
- 5.4.5 Throughout the period of recall until September 2007, Simon remained in Hospital, where records indicate he was still considered a threat to elderly family members and possibly others. However, in May 2007, it was assessed that Simon posed a low enough risk of violent behavior and could be considered for increased time out of hospital as part of his overall rehabilitation. Whilst this showed signs of progress, records show that in June 2007 overall the requirement was that Simon was deemed to need to remain on Section 37/41 MHA for a further 12 months. In July 2007 an internal KMPT Multi-Disciplinary team report expressed the view that the family perhaps did not recognise the risk Simon posed. However, whilst this appears to be a significant issue of concern, it is unclear as to what, if anything was done to address this.
- 5.4.6 In September 2007, given the views expressed in May relating to the reduced level of risk of violent behavior, the Ministry of Justice allowed Simon to have overnight conditional leave, which included having **no** unsupervised access to his grandparents. This release was notified to the Police, to ensure they were aware as was required by good practice. It appears that the sharing of this information was limited to Simon's parents only causing anxiety amongst the wider family.
- 5.4.7. In March 2008, Simon's mental health had stabilised and his progress had led to increasing periods of leave from Hospital, allowing a Mental Health Review to authorise discharge back into the community on the 16th April 2008.

- 5.4.8 It is at this point that an opportunity to link agencies in a coordinated fashion was missed.
- 5.4.9 MAPPA, or to give it its full title, Multi Agency Public Protection Arrangements, is a national initiative established to monitor High Risk offenders in the community, whether it be following release from custody or highlighted as a concern following appearance before the court. A fuller description of the MAPPA risk index and full guidance notes are available at <http://www.justice.gov.uk>offenders/>
- 5.4.10 When a potential MAPPA offender is released into the community then the local Policing area should be notified. In terms of Mental Health patients who are deemed a risk, the process is identical. If properly notified Simon would have become a Level 1 MAPPA nominal on VISOR (Violence and Sex Offender Register). If the individual poses a high risk of serious harm and therefore joined up multi agency working can assist in managing that risk then a Level 2 referral to MAPPA should take place. Such decisions should be considered by a formally constituted MAPPA panel, which would have agreed and recorded an appropriate course of management.
- 5.4.11 There appears to have been some considered discussion in regard to referral of Simon under MAPPA. Indeed on the 17th March 2008, correspondence was sent to the Chair of the Level 2 MAPPA Panel outlining the issues relating to Simon and expressing the opinion of the clinical team that MAPPA did not play a role, as the patient presented low risk of harm to the public and if such concerns arose, would be subject to recall to hospital. It is not clear, as records have been unable to be retrieved, whether or not a formal process around this correspondence took place. Given the clinical teams views and the safety net of potential recall, it is highly probable that the MAPPA team would have agreed that this case should be appropriately managed by way of a single agency management approach. It would seem appropriate to note that it should be good practice that any such discussion, be managed in a formal manner so that decisions and actions are appropriately recorded.
- 5.4.12 In June 2008, Simon advised that he and Sarah were separating. With the support of his parents and control of his medication, Simon appeared to cope with this change of circumstance well and it is accurate to record that he remained on good terms with Sarah having regular access to his daughter.
- 5.4.13 By the end of October Simon was taking 700mg of clozapine in divided doses, being monitored via a Care Plan approach and was noted as being symptom free enabling him to have regular contact with his family, including grandparents without incident.
- 5.4.14 Given the breakdown of his marriage Simon had been provided with accommodation near to both his estranged wife and to his parents, who were able to help provide meals and be on hand to support him. However, due to his independent living arrangements and the continued access to his daughter, it was appropriate for KMPT to refer this case to CAFCASS (Children and Family Courts Advice and Support Service) in accordance with KMPT Safeguarding policy. Whilst Kent Police were asked for their response in this review, it is evident that the intelligence they held was limited due to a lack of information shared with them. Given Simon's progress and stability,

CAFCASS concluded that any Social Services involvement between Simon and his daughter was unnecessary.

- 5.4.15 Simon continued his “stable” life throughout 2010 and 2011. In 2012 Simon began raising the issue of changes to his discharge conditions to allow him to have the “occasional” drink. His family recall, that in order to allow Simon to provide the appearance of full social normality, they would purchase and supply him with non-alcoholic beer to drink at social events such as family B.B.Q.’s or parties. Following a recommendation from the Mental Health Team, the Home Office agreed to vary Simon’s licence to allow him to consume two units of alcohol per week. Whilst this may have appeared to be the first step in returning normality to Simon, a member of the family expressed the view that this concession was likely to have been detrimental rather than helpful.
- 5.4.16 Simon continued to maintain his stable progression throughout 2012, maintaining contact with the Community Forensic Team, his daughter and holding down a job on building sites without issue. In late 2012 Simon revealed that he had started a new relationship with Louise Carter who had two children, one of whom was in his daughter’s class at school.
- 5.4.17 In January 2013, the Mental Health Team asked Simon if he had shared his Mental Health history with his new partner. Simon responded that he had broached the subject and that he had informed her that he had spent time in “a rehab mental hospital”. In ongoing meetings this issue was returned to by the team and in October 2013, Simon informed the team that he had disclosed his full history to his new partner.
- 5.4.18 This assertion by Simon was apparently untrue and was never confirmed with his new partner. Family members have advised that his partner was being “drip fed” information by Simon in response to her asking him why he was on medication and what it was for. It appears that this partner was only aware of the whole story shortly before the attack on Joan Baker and once known sought to end the relationship. It is apparent that Louise was never in a position to assess the risk to herself and her children. The recommendation outlined as Recommendation 2 would clearly have prevented such a difficult position for Louise to have existed.
- 5.4.19 In December 2013, the Responsible Clinician and Social Supervisor wrote a report to the Home Office recommending Absolute Discharge. It is a key action influencing the events that were to unfold.
- 5.4.20 The report compiled for the Mental Health Review Hearing held on 29th April 2014, provides a comprehensive background and clinical review of Simon’s history. It is supported by a social circumstance report that paints a positive picture. However, the report fails to investigate the concerns of the family or to establish whether his partner held any views, which in turn would have highlighted her lack of awareness of Simon’s past history. The family recalled that consultation with them was limited. Simon’s close family state that they were informed that an Absolute Discharge was being sought via the telephone. The family state they were opposed to the application as the licence conditions in place, were felt to be effective and good for Simon, to remove them would send him the wrong message.

- 5.4.21 A tribunal to consider Simon's request for Absolute Discharge met on the 29th April 2014. The panel consisted of a Judge, a medical member and a lay member. Whilst Simon Heath attended, neither a representative from the responsible authority or on behalf of the Secretary of State was in attendance. The tribunal reviewed and considered the patient's records and also written evidence from the Consultant Psychiatrist, Social Supervisor and from the Secretary of State. Oral evidence was provided by the Consultant Psychiatrist, Social Supervisor and by Simon himself.
- 5.4.22 The decision of the tribunal was that given all the facts and evidence presented to them an absolute discharge should be granted. It is noted from the Tribunal Hearing Decision that removal of conditions was opposed by the Secretary of State leading the Judge to observe as follows. *"The SoS comments that absolute discharge is premature at this time and that he has benefited from the structure of statutory supervision. They do not explain why"*. It is indeed of some concern why the SoS submitted comments without substantive supportive arguments, as much as it is that the view of the family was not heard and that any request for any input from the Police was seemingly not made.
- 5.4.23 On the 22nd April 2014, the issue of MAPPA monitoring is again considered. Correspondence was received by Simon Heath's solicitors from the Social Supervisor, confirming that following discussion with the MAPPA coordinator Simon did not meet the MAPPA threshold. There appears to have been no official review process and subsequent recommendations made in terms of Simon, only that informal conversations did take place. It is likely that the safeguards around his ongoing contact and care within the community and his long period of stable mental health would have influenced the outcome and that even if subject to MAPPA, supervision would have remained with the single agency. It would have been good practice, if with the benefit of hindsight, given the later events, that this decision had been recorded, either within the minutes of a MAPPA review or by exchange of formal correspondence rather than by an unrecorded telephone conversation. Therefore a learning point from this event is that all staff working within the supervisory setting should be reminded of their responsibilities under MAPPA and advised of the need for accurate record keeping of all contact between agencies and decisions agreed or actioned.

5.5 May 2014 - November 2015

- 5.5.1 Following the granting of the Absolute Discharge the care of Simon was passed to the Community Mental Health Team (CMHT) in May 2014 and his GP advised accordingly. In November 2014 Simon raised concerns at the Clozapine clinic that the side effects from his Clozapine medication was impairing his ability to work due to increased lethargy. Adjustments were made around the nocte dosing which appeared to be beneficial. Simon continued to attend the clozapine clinic where his medication levels were tested to ensure he was continuing to take the required level of treatment to keep him stable. A small reduction in the level of medication was made when the pharmacist noted increased toxicity in blood levels, which could have led to a seizure if not addressed.
- 5.5.2 In August 2015, the family took a holiday in Yorkshire, requiring some lengthy driving which Simon agreed to do his share. However, the family recalls that in order to be able to concentrate on driving such a long distance, Simon

reduced the amount of medication without medical consultation so as to remain alert and not suffer from lethargy, which is a side effect of his medication.

- 5.5.3 On September 17th some six weeks after reducing his medication, Simon made a call to his care coordinator informing him that he had reduced the medication. The responsible clinician was advised and a prompt appointment arranged.
- 5.5.4 Whilst at this time Simon was not showing any signs of relapse due to the reduction in medication, this change in circumstance was not shared with his partner despite consent having been given by Simon. On the 25th September there is evidence of a review meeting with Simon at which early relapse indicators were discussed and a care plan agreed that was entered in his Medical notes for presentation to services in case of crisis. The monitoring agreed included; ongoing review of his mental state; attendance at the Clozapine clinic monthly where his medication could be monitored; regular review with the Care Coordinator and CPA. It appears that the outcome of this review was not shared with either Simon's family or his partner.
- 5.5.5 Whilst the immediate family expressed their confidence in the care and communication provided by the team at the Secure Unit, they were highly critical of the care Simon received and the engagement with them following his transfer to the local CMHT. Indeed both parents raised the issue of never having contact with Simon's Care Coordinator or being provided with a contact point if they wished to raise concerns. They report that the only time they were engaged by the team was following the murder of Joan, when representatives of the CMHT, who they believe to have been the care coordinator and supervisor, attended his parent's home.
- 5.5.6 The feeling of the parents that Simon was not being properly supported by his Care Coordinator is clearly evidenced in the IMR of KMPT. Whilst there was contact between Simon and the Coordinator, this was often initiated by Simon. In order to understand why this apparent lack of engagement took place, enquiries were made as to whether the Care Coordinator had an extremely high case load, whether recruitment and retention were issues and if so could this account for the lack of apparent management. Whilst staff sickness was below Trust targets, vacancy levels were higher than normal. However, in the case of Simon's Care Coordinator, the panel were advised that his workload was not abnormally high.
- 5.5.7 Opportunities to meet with Simon were ignored, specifically after the reduction of his medication from 400mg to 200mg daily, initiated by Simon. There was no challenge or care plan meeting with the Care Coordinator. Indeed the Care Coordinator seems to have shown a lack of real urgency in managing a potentially dangerous situation and it was left to the clozapine clinic nurse, via email, to arrange an appointment to see a doctor.
- 5.5.8 Concern has to be raised about the lack of engagement with key family members to offer them support and advice and to involve them in care planning. Indeed the conclusion drawn by KMPT in their IMR is *"Information sharing and contact with the family post transfer to the CMHT was not as good as it was in the past..."* Again the Clinician who saw Simon in September 2015 post reduction in medication states that *"in hindsight she would have liked to get to know the family of Simon better"*.

- 5.5.9 The Care Coordinator took responsibility for Simon on 1st July 2014 and up until the date of the murder of Joan Baker only saw him twice. These were not booked meetings but in response to requests from Simon to see him. The only other contact was to return two telephone calls, the last being on the 17th September 2015, to arrange to meet a doctor. Thereafter there was no further contact between them.
- 5.5.10 The KMPT IMR describes the Care Coordination as ineffective despite the fact that the Care Coordinator was a very experienced Social Worker. The role of the Care Coordinator was to offer support and advice to Simon in order to maintain his improved mental health and allow him to lead a normal life in the community. Within that role there was a requirement to ensure that Simon was coping with the demands of life, and to seek to identify trigger points that may show signs of increasing risk. In contrast the role of staff at the Clozapine clinic was to use clinical checks to ensure that Simon was adhering to his medication regime and also to ensure that what is a drug with potential harmful side effects, could be adjusted in consultation with his Doctor if and when required. It was not the role of these staff to manage Simon other than within this remit, however given the lack of contact with the Care Coordinator, staff at the clinic took it upon themselves to manage issues that needed immediate attention. This additional work and responsibility led to the inclusion in the IMR that, "*Simon Heath was effectively being managed by the staff of the Clozapine clinic.*"
- 5.5.11 The ineffective management of Simon is evidenced in regard to concerns about the level of care planning and record keeping. Care Programme Approach reviews were reviewed frequently whilst under the care of the Community Forensic Service. However, following discharge to the CMHT a care programme review was overdue at the time of the incident.
- 5.5.12 A care plan was available to view by the author of the KMPT IMR. The care plan consisted of 4 activities, including the reduction of medication and dated the 17th September 2015, when Simon had held a telephone conversation with his Care Coordinator. However, the Care Plan updates were not created on the computer system until the 19th November, the same day as the murder of Joan Baker, though they were dated with the September meeting date.
- 5.5.13 The evidence provided by examination of the Rio System (the Trust's current patient computer system) indicates that the care plans and risk assessment were written and entered onto the database after the alleged offence had taken place. Seeking to determine whether the Care Coordinator was aware of the death of Joan Baker is a matter upon which this review cannot be certain. Were the events coincidental, with the Care Coordinator being delayed in writing up case notes is a matter upon which this review can only conjecture as the Coordinator subsequently resigned from his post and was either unable or unwilling for interview. Given the apparent poor practice demonstrated by the Care Coordinator it is appropriate that his actions have been referred to his professional body.
- 5.5.14 The internal investigation conducted by the NHS Trust into the actions of the Care Coordinator, raise significant issues about the suitability of the individual allocated this case where it was clear from the outset that his motivation was significantly lacking, there were concerns over his health and it is of concern

that these issues being apparent did not lead to higher levels of supervision and governance.

- 5.5.15 Against this background it should be remembered that Simon had been given an Absolute Discharge and so took control of events in real terms. With clinicians meeting with Simon after the reduction in medication finding him apparently stable with no risk indicators present, there was no way, or indeed obvious need, of enforcing Simon to comply with medication as there appeared to be no evidence of risk to self or others.
- 5.5.16 It appears that Simon may have seen the Absolute Discharge as being a signal that requirements on him to continue to take his medication and moderate alcohol intake had been removed. This is borne out by family evidence, with accounts of him increasing his use of alcohol and indeed one anecdote is of him drinking heavily at a pop festival. Any significant increase in risk, such as behaviour change caused by dangerous lowering or non-administration of medication, could only have resulted in further intervention by professionals under the Mental Health Act as there were no constraints or license conditions applicable to him following his absolute discharge. The lack of any real care co-ordination with Simon or his family appeared to reinforce Simon's view that he was able to make his own decisions in regard to his care.
- 5.5.17 On the 19th November 2015, Simon Heath attended the home of Joan Baker, where he violently assaulted her and as a result led to her death. The report has considered whether there were any barriers presented to reporting that Joan may have had in terms of preventing this assault. Given all of the facts, it is clear that Joan was aware of Simon's history as were the wider family, that she was supportive of his care and treatment and that she felt that all necessary measures were in place to minimise the risk to her. It is not clear how much she had been told in regard to Simon's decision to amend his medication or the change in his life style, which may have influenced her decision to admit Simon on the day in question. However, it seems clear that Joan could have no prior knowledge of the attack that was to occur and therefore no opportunity to raise any fears with any agency or other members of the family.

6. Analysis

6.1 How and Why did these events occur?

- 6.1.1 The events leading to the death of Joan Baker occurred as a culmination of individual events linked by reoccurring themes triggered by a complex illness.
- 6.1.2 The illness drove Simon Heath to consider that elderly relatives in his family were standing in the way of his progression in the family hierarchy. As such this created a resentment that provoked him to attack and seek to kill such relatives.
- 6.1.3 Simon first manifested signs of this illness following heavy use of hallucinogenic drugs mixed with alcohol in 1995 and despite receiving treatment during 1995 his condition subsequently led him to attack his paternal grandmother in June 1996. His grandmother died some time later

that year of pneumonia, but due to the passage of time between the attack and the death there could be no causal link between the two and Simon was unable to be charged with murder/manslaughter. Simon was however detained in a Secure Unit under a Section 37/41 Mental Health Order.

- 6.1.4 During his period in the Secure Unit Simon continued to display violent outbursts and there are a number of incidents recorded of him assaulting other patients and members of staff.
- 6.1.5 Simon's treatment within the Secure Unit led to his release into the community in March 2000, but with conditions attached to his release. These conditions restricted where he could live and required that he take medication to control his illness. With the support of a range of clinical and social care professionals, Simon maintained his progress and was able to establish a relationship with a girl named Sarah, who would ultimately become his wife. It is a matter of concern as to the depth of the background investigation conducted by his Social Supervisor following Simon beginning the relationship with Sarah. It seems that there was little or no knowledge of Sarah and her life other than she was now in a relationship with Simon. Given Simon's mental attitude to elderly people and the access he could have had to them through Sarah's work, see 6.1.7, there appears to have been a real need for greater research into the potential impact on Simon and his new associations following such a change of circumstances.
- 6.1.6 Simon recognised that there was a need for regulation and indeed, when in July 2001 he admitted to drinking alcohol contrary to the terms of his release, he was informally returned to hospital for further assessment of his mental state, being released again in September.
- 6.1.7. In late September 2001, Simon began to have thoughts around killing an elderly person in a care home where his now girlfriend worked and was again re-admitted to hospital. During this admission, he also began to believe wrongly, that his girlfriend was having an affair with his father.
- 6.1.8 It is during this hospital admission that Simon was first treated with the drug Clozapine. This treatment for resistant schizophrenia, was to prove highly positive for Simon, allowing him to successfully balance his mental health and allow monitoring in the community.
- 6.1.9 With the benefit of Clozapine treatment Simon was able to lead a stable life from December 2001 until December 2005. During this period he married his girlfriend Sarah and became a father. His illness was considered to be sufficiently stable that in May 2005 his care was transferred to the Local Community based Forensic Mental Health Team. An issue of concern at this point is that as Simon entered parenthood, whether the risk to the child was subject to proper assessment. Whilst this would have been poor practice at that time, it should be noted that the introduction of measures under the National Patient Safety Agency in 2009, now make it a requirement for mental health professionals to be clear when service users are parents and consider the risk in terms of parenting and raise these accordingly.
- 6.1.10 Simon met with his appointed Social Supervisor, Community Forensic Psychiatric Nurse and other supportive professionals on a regular basis during this period. On the 14th December 2005, when he met with the CMHT team, they detected no relapse indicators. However, during that month Simon

attended his maternal grandparent's home and without warning attacked his grandfather. Fortunately his mother was in attendance and managed to wrestle Simon into the conservatory and lock him in before calling for assistance.

- 6.1.11 Simon was recalled to hospital following this attack and he later informed staff that it had been his intention to kill his grandfather. His early return to hospital saw him continue to verbalise aggression and indeed he assaulted another patient, a matter that was referred to the Police, who due to the mental state of both Simon and the other patient whom had been assaulted, the case was filed.
- 6.1.12 Simon remained in hospital until September 2007 as he was still considered a threat to elderly family members and possibly others. However, from May 2007, he was allowed time out of hospital as part of steps towards his rehabilitation. In September 2007 he was allowed Conditional Leave overnight with the strict condition that he was to have no unsupervised access to his grandparents. During this review the issue of who should have had knowledge of Simon's release was raised as an issue. Whilst it is not a requirement that wider family members should have been notified by the agencies involved, given the potential risk to grandparents, then it would seem to have been a matter of good practice to discuss with Simon's parents, the potential impact and concerns that such conditional leave might have within the wider family group and provide some support to address them.
- 6.1.13 On the 16th April 2008 his mental health had stabilised sufficiently to allow a Mental Health Review to authorise discharge back into the community.
- 6.1.14 In June 2008 Simon advised that he and Sarah were separating. Records show that he appeared to cope well with this change of circumstance and he remained on good terms with Sarah and maintained regular contact with his daughter.
- 6.1.15 The medication, support and supervision that Simon was receiving allowed him to lead a "stable" life throughout 2010 and 2011, holding down a job and doing well in maintaining as normal a life style as possible. However in 2012 Simon began to raise the issue of changes to his discharge conditions to allow him to partake in drinking alcohol following a recommendation to the Home Office from the Mental Health Team, conditions were varied to allow him to drink two units per week.
- 6.1.16 During 2012 Simon also started a new relationship with Louise, whose two children were also in Simon's daughter's class at school.
- 6.1.17 On the 29th April 2014, Simon was granted an Absolute Discharge by a Mental Health Tribunal. Despite concerns raised by the family and a formal objection by the Secretary of State, the tribunal was provided no evidence that suggested they could not grant an Absolute Discharge, given Simon's stable mental health over a prolonged period.
- 6.1.18 In May 2014 care of Simon was passed to the Community Mental Health Team and his GP advised accordingly. Simon continued to attend the Clozapine clinic but in November 2014 complained that his ability to work was being impaired due to the side effects of the drug. Adjustments were made around the nocte dose and a small reduction made when the pharmacist

noted increased toxicity in his blood, which could have caused a seizure if not addressed.

6.1.19 In August 2015, Simon reduced his medication dosage further to enable him to share the driving on a family holiday to Yorkshire. He did so without consultation with a doctor. The reduction in dosage appears to have continued until the 17th September 2015, when Simon himself informed his Care Coordinator by telephone. It however appears that the responsibility for ensuring Simon was seen by a doctor was not undertaken by the Care Coordinator but left to the Clozapine nurse to arrange.

6.1.20 The Care Coordinator was a very experienced Social Worker, but he failed to engage with Simon or his family, with contact being initiated by Simon. Simon's care plan review was overdue and significant doubts remain about the timing and quality of record keeping. Indeed the level of contact was described by KMPT as "ineffective".

6.1.21 During this period there is also evidence that following the removal of any Licence Conditions following his Absolute Discharge, that Simon was regularly using alcohol. Given the lack of contact with Simon by his Social Supervisor, this change in behavior and the reasons behind them were not explored, and Simon was provided with neither support nor challenge around his behavior.

6.1.22 On the 19th November 2015, Simon attended the home of Joan Baker where he violently assaulted her which as a result later led to her death.

6.2.1 Key Considerations

6.2.2 Throughout this difficult case and over the whole period of time in which Simon has been known to the agencies involved, there has been a repeated lack of information being shared with the Police by the Mental Health agencies and also on one notable occasion from the family themselves. Whilst it is recognised that Simon may not have been in a mental state or it not be in the public interest to further charge him with offences following assaults on staff and patients within the Secure Unit setting, the reporting of any criminal act of assault is a matter that should be reported to and recorded by the Police as it may have influenced how they managed risk in the future.

6.2.3 Within the Secure Unit setting Simon was managed within a team based setting. This encouraged Simon's parents to engage in meetings and provided clear communication between them and staff. However, Simon did express a view that his feelings towards elderly members of his family extended also to his mother. It appears that at that time there was a lack of policy around potential domestic abuse and as such it is not clear if Simon's mother or other relatives were aware of the potential risk to them. It should be noted that this was a weakness in the organisational structure but there is now a formal policy in place to address this area of concern.

6.2.4 In 2001 Simon was living in the community and being supported as such. In May of that year Simon indicated he was in a positive relationship with a girl named Sarah. It is evident from the weekly team meeting notes that this relationship was discussed within the team. However there appears not to have been any real risk evaluation conducted in terms of examining her family background, where she worked, the possible risks and what Simon had told

her to prepare her for living with his illness. Whilst it appears that Simon did provide an extensive medical history to Sarah, her occupation working in a care home for the elderly saw Simon fantasise about killing an elderly resident which fortunately he reported to the Forensic CPN, leading to his recall to hospital. Once again the Police were not made aware of the recall.

- 6.2.5 In May 2004 Simon discovered he was to become a father. There is no record to show whether the impact of this responsibility and the risk to the child had been assessed. If it was there is no evidence of it having been recorded and as such was poor practice. It is therefore a matter of note that in 2009, introduction of measures under the National Patient Safety Agency now make it a requirement for mental health professionals to be clear when service users are parents and consider the risk in terms of parenting and raise these accordingly.
- 6.2.6 Following the assault on his grandfather in December 2005 neither Simon's family or the hospital reported the assault to the Police, nor was the subsequent recall shared with them. This is again a matter of significant failing in information sharing where a significant criminal act has occurred.
- 6.2.7 Following the recall after the assault on his grandfather in December 2005, Simon was again allowed overnight conditional leave in September 2007. This release led to concerns being raised by other elderly family members that they had not been made aware of Simon's release and fearing for their safety. Whilst on this occasion the Police were aware of his licenced release, their intelligence on Simon was far from complete and they had no reason, other than to note the release in case of any action needed, in managing Simon during that period. It appears that the sharing of this information was limited to Simon's parents, and whilst not under obligation to share this further, the risk evaluation would have been seen as a matter of good practice, if the issues around dissemination to other relatives prior to release had been discussed and actioned with Simon's parents.
- 6.2.8 Whilst the relationship between the Secure Unit of the hospital and Simon's close family is described by the family as good, with positive communication and regular meetings taking place, a comment made in a weekly team meeting should be noted. The comment relates to an expression of concern that the family perhaps did not recognise the risk Simon posed. This remark is neither further evidenced, nor more broadly explained. It is however a significant matter and it is unclear what, if anything was done to address such a concern. It is an observation that should have been pursued and addressed with the family, with actions and outcomes appropriately recorded.
- 6.2.9 On two occasions, one in March 2008 and again in April 2014, there were opportunities to review Simon under the Multi Agency Public Protection Arrangements (MAPPA). Evidence shows that there were on both occasions contact made between the Mental Health services and the MAPPA supervisor, though it is unclear what contact and decisions were discussed and made. Whilst it is likely that given the level of concentrated supervision Simon was being provided with, any MAPPA panel outcome would have considered supervision to be continued by that single agency. However, as a result of Simon's case failing to be formally considered by the panel to make such a decision, there appears to have been an opportunity for exchange of information on Simon which may have offered other agencies an insight into the risk involved. It is therefore important that staff in all relevant agencies are

reminded of the need to ensure that any referral on MAPPA issues are properly raised and recorded to ensure an accurate audit trail of action.

- 6.2.10 Following the separation from his wife in June 2008, Simon subsequently commenced a new relationship in late 2012. In January 2013 the Mental Health Team asked Simon if he had shared his medical history with his new partner. Whilst Simon informed them that he had told her he had spent time in a rehab mental hospital, the team continued to pose the question of how much he had told her. In October 2013 Simon informed the team that he had disclosed his full history to his partner. This assertion was never confirmed with his partner and was later found to be untrue. It seems evident that his partner (Louise) was never truly aware of the risk Simon posed, which would have allowed her to make decisions surrounding the continuation of the relationship. It is of note that she only became fully aware of the full nature of Simon's illness shortly before the death of Joan Baker and once aware sought to terminate the relationship.
- 6.2.11 Having been stable in terms of his mental health from 2008, Simon was seeking less in the way of restriction and discussed applying for an Absolute Discharge from his hospital order. This was supported by his responsible clinician and Social Supervisor who submitted a report recommending an Absolute Discharge in December 2013. The report was written following consultation with Simon but his parents record that there was minimal contact or consultation with them and that they were informed by telephone that an Absolute Discharge was being sought. They further record that they felt the lifting of restrictions imposed by his conditional discharge would be a negative step as to remove conditions would send Simon the wrong message, though it is not clear whether they raised this concern at that time.
- 6.2.12 The Tribunal met on the 29th April 2014 chaired by a Judge, a medical member and a lay member. Evidence was provided by way of patient records, and written submissions from the Consultant Psychiatrist, Social Supervisor and from the Secretary of State. Oral evidence was provided by the Consultant Psychiatrist, Social Supervisor and by Simon himself.
- 6.2.13 Given Simon's stable mental state over a period of years and the proposed care plan for him in the community, the Tribunal would have undermined Simon's patient rights, as there was little evidence or supporting facts to not approve the Absolute Discharge. Whilst there was an objection received from the Secretary of State, this was not supported by any formal presence or written statement to offer a rationale why the application should be declined. However, it does seem worthy of note that there appears to have been no opportunity for the panel to hear the views of the family, or indeed, whether they were invited to be in attendance. Furthermore, any social report would have provided a greater balance for the Tribunal panel against which to make a decision if there had been input from other concerned agencies, especially the Police, whose input was also not apparently requested. It would therefore seem appropriate to question whether current arrangements in providing Tribunals with the necessary breadth of information upon which to make their decision, are sufficiently robust.
- 6.2.14 Following the granting of his absolute discharge, transfer of his care was undertaken by the Community Mental Health Team and his GP in May 2014. It is apparent from much of the documentary evidence seen that it was at this stage that Simon and his family were most badly let down. At a time when

Simon needed to be engaged and supported, his social supervisor displayed little appetite for managing Simon and made little or no contact, unless initiated by Simon. Simon chose to reduce his medication and the frequency of use of alcohol increased. Whilst there were no relapse signals evident, the reduction in his medication was significant and when reported to his social supervisor, the follow up necessary did not occur. With relapse indicators which may have been presenting not able to be recognised by his partner and the ongoing lack of contact with the care coordinator, this meant that it was left to a lower banded nurse at the Clozapine clinic to make arrangements for Simon to be seen by an appropriate clinician.

- 6.2.15 Simon's parents record that unlike the Community Forensic Mental Health Team, they had not had any contact with the Community Mental Health Team Social Supervisor, had no real emergency contact number which to call and felt isolated and uninformed. Indeed the IMR following the death of Joan, produced by KMPT, describes the care coordination as ineffective, despite the fact that the Social Supervisor was a very experienced Social Worker. Indeed the IMR concluded that "Simon Heath was effectively being managed by the staff of the Clozapine clinic". The contrast in the positive approach of the Secure Unit staff which was clearly good practice in engaging family members in Simon's care, appears lacking in the poor practice displayed by the Care Coordinator.
- 6.2.16 Care Plans were overdue but during investigation KMPT disclosed that a Care Plan dated the 17th September 2015 had been updated on the patient computer system "RIO". Further interrogation of the system revealed that these Care Plan updates had in fact not been entered onto the system until the 19th November, but dated with the September date. It has to be a matter of deep concern that the date of entry (19th Nov) also happens to be the date of the assault on Joan Baker and her subsequent death.
- 6.2.17 An internal investigation conducted by the NHS Trust following Joan's death explored issues with the Social Supervisor. It is evident from the report that there were real failings in the manner in which the Social Supervisor managed this case. However, there are also some areas of concern in the depth of governance of the Social Supervisor and it would be particularly appropriate if the systems and procedures for the management of high risk cases be revisited and reviewed.
- 6.2.18 This review has sought to meet the Focus and Specific Issues required to be addressed as set out in Sections 3 and 5 of the Terms of Reference attached as Appendix A.

7. Conclusions

- 7.1 This is a difficult case with a series of individual events linked by reoccurring themes triggered by a complex illness. This meant that when in relapse, there was a fixation upon elderly persons within the family group and possibly to others.
- 7.2 Could Joan Baker's death have been avoided? Based upon previous patterns of behavior when medication has been reduced or alcohol use has increased, there are instances of violent behavior towards elderly members of the family. Therefore predictive signs that were apparent, if acted upon, could have

prevented this death. If there had been stability in terms of the management of his medication, greater supervision and monitoring of his lifestyle, then active intervention may have been taken that allowed Simon to continue to function in the community but also have prevented the death of Joan Baker.

- 7.3 The lack of management of Simon's illness and failure to support his wider family by the Community Mental Health Team must be considered a key failing. It has to be concluded that after transfer to local CMHT, Simon and his family did not receive the level of care that was required.
- 7.4 Following the death of Joan an investigative review was conducted by the relevant NHS Partnership Trust. It is apparent from the review that the Social Supervisor asked to manage Simon's case was an experienced and qualified Social Worker.
- 7.5 The lack of engagement with Simon or his family, failure to respond to increased relapse indicators such as Simon's medication reductions, and the failure to update Care Plans regularly illustrate how the service provided fell short of expected standards. It is accurate to conclude that after all the work of many dedicated professionals, over many years, to establish a stable mental position for Simon, the break in the chain of continuity of supervision left Simon and his family vulnerable.
- 7.6 It is unclear to what extent the Social Supervisor was managed by Line Managers. There appears to have been an expectation that given his experience, the Social Supervisor should have managed and organised his own case load. The internal investigation provides evidence of a staff appraisal taking place, where there are also both motivational and health issues considered between the Manager and the Social Supervisor. Given these concerns and the recognition by managers that the Social Supervisor was reluctant to take on this case, it is unclear whether the investigative review considered whether supervisory oversight was suitably applied in regard to the management of Simon and as such poses an area of consideration in terms of process, from which lessons may be learned
- 7.7 It is entirely appropriate that the NHS Trust has referred the Social Supervisor to the Health and Care Professions Council.
- 7.8 The granting of the Absolute Discharge in 2014 has to be taken in context but is also a key milestone. The Tribunal fulfilled its role fully, given the need to balance the evidence available with the requirement to meet the patient's rights and consider wider public protection. In this case the Absolute Discharge appears to have acted as a signal to Simon that he was free of constraint and could lead his life normally as he perceived others appeared to do. This saw an increased level of alcohol consumption, reduction in the level of medication that had served to stabilise his mental health and coupled with the lack of appropriate supervision, must be considered a contributory factor in the death of Joan Baker.
- 7.9 Given the concerns of the family, the lack of opportunity for them to have input into the Tribunal process, plus the lack of availability of any rationale from the Secretary of State objecting to the Absolute Discharge, the question must be posed as to whether or not the process surrounding Tribunal hearings in cases such as these provide the breadth of information and allow for family

input, to provide the Tribunal with wider background information to consider in reaching its conclusions.

- 7.10 Communication is vital in managing complex cases such as Simon's. Events surrounding Simon were not always evident to the Police, especially when the family chose not to report a significant assault by Simon to them. The incidents of criminal assaults committed by Simon whilst in hospital which were not reported to Police again led to their intelligence being incomplete. Whilst it is recognised that it may not be possible to investigate matters to a conclusion within a mental health environment given the limits on how investigations are able to proceed, it remains that good practice requires that any criminal act that occurs in such establishments should be reported to the Police.
- 7.11 A further example of where communication was unclear relates to the two opportunities for other agencies to be made aware of Simon's full history through the formal MAPPA process. It is apparent that Simon's case was raised with MAPPA coordinators on two occasions, once in written format (2008) and again rather more informally by telephone in 2014. On both occasions the recommendations by clinicians was that he did not meet the threshold although this view was less strongly advocated in 2008 than in 2014. There appears to have been a lack of formal recording on both occasions. Whilst it must be acknowledged that a MAPPA panel would have more than likely decided to refer the case for single agency management, in this case mental health, a formal discussion of his case would have brought to light information for all agencies that may have later been available to the Mental Health Tribunal and would certainly have provided a clear record of decisions taken and why.
- 7.12 This case highlights a difficult area in relation to safeguarding. It appears from the evidence that Simon was able to engage in two relationships and to be a responsible adult for children, whilst certainly in the case of his relationship with Louise Carter, she was unaware of his full history and the possible risks. Whilst there remains the issue of what should be disclosable and what should require a patient's permission, it seems that where a person with Simon's background has a significant change in their relationship, then there should be a mechanism to ensure that the other party in the relationship has had disclosure of the background so as to assess risk. This surely should have been an area of consideration for his Social Supervisor. Recommendation 2 is made as a result of these concerns.
- 7.13 Decisions taken in the care of Simon were all within the established policies of the respective agencies. Agencies worked within parameters to seek to manage Simon, but as can often occur in organisations dealing with multi-faceted demands, communication becomes stretched. In this case, communication within each agency was largely managed well internally, but the opportunities to share were missed on a formal basis leaving more speculation as to possible determinations rather than recorded outcomes. Finally, it is often a view of families involved within the Criminal Justice and Mental Health systems that their voice is not heard. Whilst in Simon's case the family expressed the view that they felt very much part of the team whilst Simon was in the secure unit, they do not do so in relation to the decisions taken around the events leading up to the granting of the absolute discharge and to the quality of care given to Simon thereafter by the CMHT. It is to be

hoped that lessons may be considered to seek improvements in regard to these issues.

8 Lessons Learned

- 8.1 This DHR has considered all of the information available to it, particularly the NHS Internal Trust Report. This report has utilised the identified gaps in procedures in identifying and learning from the issues within this case so as to identify lessons that relate to many cases of domestic abuse or homicide in terms of cross and inter agency relationships. This is of particular importance in regard to information sharing, supervision and governance of staff and the requirement to maintain accurate records of decisions and outcomes. NHS England has furthermore confirmed that all of the recommendations and actions required within its internal report remain under review and subject to internal audit. Whilst not all recommendations have yet been fully implemented NHS England are taking positive steps to do so. However, the contents and recommendations within this report have been fully informed utilising the findings of the NHS internal report.
- 8.2 The need to ensure that appropriate governance, support and supervisory procedures are followed in regard to staff whose case load includes a potentially high risk client. Regular oversight should be maintained with any aspects of concern appropriately recorded and action taken to manage the risk. It is a concern that such good practice did not occur in regard to the supervision of Simon Heath.
- 8.3 Further lessons should be learnt from this review in regard to communication and information sharing and how these are translated in terms of multi-agency working and ongoing engagement with family members to inform key decisions and safeguard others. It is clear that many of the issues raised in the review have been addressed by way of National or Local protocols, but it would be good practice for agencies to consider and review staff awareness of such protocols, particularly in relation to reporting criminal acts in secure hospitals to the Police and ensuring proper documentation of contacts between agencies.
- 8.4 Six recommendations have been made arising out of the information that has been provided by agencies that had involvement with Joan and/or Simon.

9. Recommendations

- 9.1 The Review Panel makes the following recommendations from this DHR:

No.	Para. No.	Recommendation	Agency
1	5.3.4	Secure Units and other similar establishments should ensure that there is a process of effective communication between them, the Police and other appropriate agencies regarding reporting assaults in their establishments. This must include the local authority where assaults occur in hospitals between patients.	NHS England

2	5.3.8	Whenever there is a significant change of circumstance, such as a change of relationship, or any significant change of circumstance for those under supervision on conditional discharge, then a multi-agency meeting should be initiated and as a result to take and record any action that is required, the person(s) responsible for actions and time scale for completion.	NHS England
3	5.4.5	Where there are concerns in regard to family members raised within a team meeting or any other internal setting then those issues should be clarified. The proposed course of action to manage this position should be set out in the form of an action plan, which should indicate the action required, the responsible member of staff, timescale for action and thereafter feedback on the engagement with the family and the outcomes recorded.	KMPT
4	5.4.22	That the process of Mental Health Tribunal Review hearing applications for Absolute Discharge be reviewed to ensure that current arrangements are adequate to provide the panel with the appropriate breadth of information needed to reach their decision. Such changes should also consider how best to receive intelligence/information from the family.	SoS
5	5.4.22	Where an agency expresses a view as to the decision a Mental Health Tribunal should consider, then, such a view must be supported with a rationale, either in person or in the form of documentary evidence.	SoS
6	6.6	That the NHS Trust, in light of the findings of their investigation, further consider whether the management and governance arrangements currently in place were effective and consider how lessons learnt from this review can be applied for the future.	NHS England

Appendix A

Victim – Joan Baker

DHR Terms of Reference

1. Background

- 1.1 On 19th November 2015, police officers attended an address in Kent, the home of Joan Baker. They found that the victim had been assaulted with a stool, sustaining head injuries from which she subsequently died.
- 1.2 Simon Heath (her grandson) was arrested for murder and was subsequently charged and remanded in custody.
- 1.3 In accordance with Section 9 of the Domestic Violence, Crime and Victims Act 2004, a Kent and Medway Domestic Homicide Review (DHR) Core Panel meeting was held on 17th December 2015. It confirmed that the criteria for a DHR had been met.
- 1.4 That agreement has been ratified by the Chair of the Kent Community Safety Partnership (under a Kent & Medway CSP agreement to conduct DHRs jointly) and the Home Office has been informed.

2. The Purpose of DHR

- Establish what lessons are to be learned from the domestic homicide, regarding the way in which local professionals and organisations work individually and together to safeguard victims;
- Identify clearly what those lessons are, both within and between agencies, how, and within what timescales they will be acted on, and what is expected to change as a result;
- Apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;
- Prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a coordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;
- contribute to a better understanding of the nature of domestic violence and abuse; and
- highlight good practice.

3. The Focus of DHR

- 3.1 This review will establish whether any agency or agencies identified possible and/or actual domestic abuse that may have been relevant to the death of Joan Baker.
- 3.2 If such abuse took place and was not identified, the review will consider why not, and how such abuse can be identified in future cases.
- 3.3 If domestic abuse was identified, this review will focus on whether each agency's response to it was in accordance with its own and multi-agency policies, protocols and procedures in existence at the time. In particular, if domestic abuse was identified, the review will examine the method used to identify risk and the action plan put in place to reduce that risk. This review will also take into account current legislation and good practice. The review will examine how the pattern of domestic abuse was recorded and what information was shared with other agencies.

4. DHR Methodology

- 4.1 Independent Management Reports (IMRs) must be submitted using the templates current at the time of completion.
- 4.2 This review will be based on IMRs provided by the agencies that were notified of, or had contact with, Simon Heath in circumstances relevant to domestic abuse, or to factors that could have contributed towards domestic abuse, e.g. mental health and alcohol or substance misuse. Each IMR will be prepared by an appropriately skilled person who has not any direct involvement with Simon Heath, and who is not an immediate line manager of any staff whose actions are, or may be, subject to review within the IMR.
- 4.3 Each IMR will include a chronology, a genogram (if relevant), and analysis of the service provided by the agency submitting it. The IMR will highlight both good and poor practice, and will make recommendations for the individual agency and, where relevant, for multi-agency working. The IMR will include issues such as the resourcing/workload/supervision/support and training/experience of the professionals involved.
- 4.4 Each agency required to complete an IMR must include all information held about Simon Heath from 6th October 1997 to 19th November 2015. If any information relating to Simon Heath's victim(s), or Simon Heath being a perpetrator, of domestic abuse before 6th October 1997 comes to light, that should also be included in the IMR.
- 4.5 Information held by an agency that has been required to complete an IMR, which is relevant to the homicide, must be included in full. This might include for example: previous incidents of violence (as a victim or

perpetrator), alcohol/substance misuse, or mental health issues relating to Simon Heath. If the information is not relevant to the circumstances or nature of the homicide, a brief précis of it will be sufficient (e.g. In 2010, X was cautioned for an offence of shoplifting).

- 4.6 Any issues relevant to equality, for example disability, cultural and faith matters should also be considered by the authors of IMRs. If none are relevant, a statement to the effect that these have been considered must be included.
- 4.7 When each agency that has been required to submit an IMR does so in accordance with the agreed timescale, the IMRs will be considered at a meeting of the DHR Panel and an overview report will then be drafted by the Chair of the panel. The draft overview report will be considered at a further meeting of the DHR Panel and a final, agreed version will be submitted to the Chair of Kent CSP.

5. Specific Issues to be Addressed

- 5.1 Specific issues that must be considered, and if relevant, addressed by each agency in their IMR are:
 - Were practitioners sensitive to the needs of Simon Heath, knowledgeable about potential indicators of domestic abuse and aware of what to do if they had concerns about a victim or perpetrator? Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?
 - Did the agency have policies and procedures for the ACPO Domestic Abuse, Stalking and Harassment and Honour Based Violence (DASH) risk assessment and risk management for domestic abuse victims or perpetrators, and were those assessments correctly used in the case of Simon Heath? Did the agency have policies and procedures in place for dealing with concerns about domestic abuse? Were these assessment tools, procedures and policies professionally accepted as being effective?
 - Did the agency comply with information sharing protocols?
 - What were the key points or opportunities for assessment and decision making in this case? Do assessments and decisions appear to have been reached in an informed and professional way?
 - Did actions or risk management plans fit with the assessment and decisions made? Were appropriate services offered or provided, or relevant enquiries made in the light of the assessments, given what was known or what should have been known at the time?

- Were procedures and practice sensitive to the ethnic, cultural, linguistic, religious and gender identity of Simon Heath (if these factors were relevant)? Was consideration of vulnerability and disability necessary (if relevant)?
- Were senior managers or other agencies and professionals involved at the appropriate points?
- Are there ways of working effectively that could be passed on to other organisations or individuals?
- Are there lessons to be learned from this case relating to the way in which an agency or agencies worked to safeguard Joan Baker, Simon Heath's daughter, the two children of Sarah Armstrong (Simon Heath's common law wife at the time of the offence), as well as any other family members, and promote their welfare, or the way it identified, assessed and managed the risks posed by Simon Heath? Are any such lessons case specific or do they apply to systems, processes and policies? Where can practice be improved? Are there implications for ways of working, training, management and supervision, working in partnership with other agencies and resources?
- How accessible were the services to Simon Heath?
- To what degree could the death of Joan Baker have been accurately predicted and prevented?

6. Document Control

- 6.1 These Terms of Reference form one document, on which will be marked the version number, author and date of writing/amendment.
- 6.2 The document is subject to change as a result of new information coming to light during the review process, and as a result of decisions and agreements made by the DHR Panel. Where changes are made to the document, the version number, date and author will be amended accordingly and that version will be used subsequently.
- 6.3 A record of the version control is included in the appendix to the document.

Appendix B – Glossary

Abbreviation	Description
DHR	DOMESTIC HOMICIDE REVIEW
IMR	INDEPENDENT MANAGEMENT REVIEW
CSP	COMMUNITY SAFETY PARTNERSHIP
KMPT	KENT & MEDWAY NHS & SOCIAL CARE PARTNERSHIP TRUST.
NKCCG	NHS NORTH KENT CLINICAL COMMISSIONING GROUP.
CMHT	COMMUNITY MENTAL HEALTH TEAM
MAPPA	MULTI – AGENCY PUBLIC PROTECTION ARRANGEMENTS.
VISOR	VIOLENCE AND SEX OFFENDER REGISTER.
CAFCASS	CHILDREN AND FAMILY COURTS ADVICE AND SUPPORT SERVICE.
SOS	SECRETARY OF STATE
GP	GENERAL PRACTITIONER (DOCTOR)
CPA	CARE PROGRAMME APPROACH
CFPN	COMMUNITY FORENSIC PSYCHIATRIC NURSE.