Surrey County Council: Safeguarding Adults Board

The death of Mrs A

A Serious Case Review

Professor Hilary Brown

Serious Case Review into the care and support offered to Mrs. A

Date of birth 22/02/1964

Date of death 24/01/2013

About this review

This review was commissioned by Surrey Safeguarding Adults Board to address issues that came to their attention about the care and support that partner agencies had been able to offer Mrs A during the period of 21/07/2011,when her friend disclosed details of abuse she had suffered (to the Surrey Police), until 24/01 2013 when she died. We also inquired into the support that was subsequently offered to her family and to other agencies and individuals with whom she was involved during that time.

Mrs A's death was widely reported in the media after her death. The Home Secretary announced a probe into the case in the House of Commons on 11th Feb 2013 and questions were subsequently asked of the Attorney General on March 3rd 2013. Concerns were being expressed about the police involvement in the case and the issue of whether someone waiting to give evidence in this situation should have been offered counselling as well as about the support that she had been given throughout the trial. The Director of Public Prosecutions conducted a Post-Conviction Case Review so that he could scrutinise the case. This Serious Case Review held under the auspices of the Surrey Safeguarding Adults Board addressed both those issues.

The review panel has been chaired by Helen Blunden, Designated Nurse for Safeguarding Vulnerable Adults in Surrey, hosted by Surrey Downs Clinical Commissioning Group and the report written by Prof Hilary Brown, Emeritus Professor of Social Care, Canterbury Christ Church University, working under the auspices of, and with the support of, Vic Citarella from CPEA.

About the process of serious case review

Serious Case Review in respect of a vulnerable adult is not yet a statutory responsibility, as it is in relation to children, but it is regarded as good practice and an essential source of learning and insight, on the basis of which health and social care services can make planned improvements. This case was referred to the Board's Serious Case Review Panel and accepted as the focus of such a review, meeting criteria set out in local and national protocols, namely that such a review should take place when

- An adult-at-risk dies or sustains potentially life-threatening injuries and
- Abuse or neglect is known or suspected and
- There are issues with the interagency working that would benefit from further investigation.[1]

The Surrey protocol sets out the criteria and process for a review of this kind whereby relevant agencies are asked to provide an account of their contacts and interventions with regard to the case, including a detailed chronology in the form of an Individual Management Review (IMR). Partner agencies were also asked to designate a senior person to attend meetings of the panel and to contribute to the deliberations of the group with a focus on learning, what went wrong and to making pragmatic improvements for the benefit of other vulnerable adults and their families in future. It was suggested that the designated person should be someone who was informed about, but not overly involved in the case, and that they should have sufficient seniority to take back lessons that emerge from this process of shared scrutiny and to oversee the implementation of an agreed action plan.

Meeting together for the first time in April 2013, the commissioning group agreed Terms of Reference for this review as set out below.

[1] ADASS (2011) Serious Case Review Safeguarding Advice Note 7

Terms of reference

Terms of reference were drawn up[2] and incorporated into a briefing letter that went out to all partner agencies[3] asking them to document, consider and reflect on

- their involvement with Mrs A and her family between the dates of 1976 - 21/07/2011, and 21/07/2011 – 24/01/2013, that is in the period leading up to the disclosure of the abuse to Surrey Police, and the period following on from this report
- the role and responsibility of (i) their agency and (ii) lead professionals within their agency, specifying timescales of their involvement.
- decisions that were made about Mrs A's (i) treatment as a survivor of sexual abuse (ii) vulnerability within the judicial process (iii) mental capacity (iv) support needs (v) legal and human rights.
- the adequacy of assessments undertaken, decision-making and planning concerning Mrs A and members of her family.
- how Mrs A's (i) medical diagnoses, (ii) mental health and (iii) care needs were addressed by each agency?
- whether and how her family's needs were addressed by each agency?
- the effectiveness of information sharing (i) within their own organisation (ii) with other agencies, (iii) with Mrs A and (iv) with her family.
- any organisational factors such as capacity and culture which may have impacted on practice in working with Mrs A.
- the extent to which each agency was aware of (i) historical issues (ii) and how this was and/or could have been conveyed through the Transition process between children's, young people's, mental health and safeguarding services and how these interfaces were managed?
- the effectiveness of each agency's response – its practices and internal processes as measured against the expectations set down in the multi-agency policies and procedures and (i) the agency's suggestions about ways in which practice could be improved within their own agency; and (ii) exactly how and within what timescales they will be enacted.

[2] By Surrey County Council, Christine Maclean, Senior Manager for Safeguarding, Adult Social Care, ; Helen Blunden, Chair of the Serious Case Review Panel, Vic Citarella and Hilary Brown, Independent author of the Serious Case Review report
[3] A list of agencies and their individual representatives can be found at Appendix A

- lessons to be learned from this case about the way in which professionals and organisations work individually and together
- how far each agency identified the support needs of Mrs A's family's between 21/07/2011 and 24/01/2013, and how each agency addressed those needs?
- whether each agency identified the needs of the family since Mrs A's death on 24/01/2013, and what they are currently doing to meet those needs?

The Panel also set in train enquiries to see whether any agencies were conducting formal reviews into related aspects of this case including whether Manchester Safeguarding Children's Board were conducting a formal review into the historical child abuse concerns at its heart; whether the Independent Schools' Regulatory Authority had and/or or were currently inquiring into Chetham's school[4], whether Surrey and Borders Partnership NHS Trust were conducting a formal suicide inquiry and/or when a Coroner's Inquest was likely to be held[5].

Mrs A is someone whose name is in the public arena and whose family are grieving for her as a wife and mother. This review has tried to balance its responsibility to discover all the facts in order to help other people who are potentially vulnerable as a result of similar events, while maintaining a proper respect for her, and her family's, right to privacy at this very difficult time for them. Mrs A's family were contacted and asked if they wished to contribute to this review. They declined to do so but the report will be made available to them and we hope it will stand as some kind of closure by restating the commitment of partner agencies to support people who are the victims of historical abuse and by exploring how, in day-to-day ways they might provide a more sensitive service in future.

[4] Manchester's Safeguarding Children's Board decided not to revisit these events but to carry out an inspection of the school as it currently operates: an investigation that they carried out jointly with the Independent Schools' Regulatory Authority

[5] New government guidance recommend that an inquest should take place within six months of a death, but the Surrey Coroner currently has a backlog and is running approximately 18 months behind

Outline of the events leading up to this review

This case concerns Mrs A, a woman who committed suicide after giving evidence against MB, her teacher and HKB his wife, who had both abused her while she was a young pupil studying music. Hoping to keep her mental distress and ill-health away from the court process, she did not seek counselling in the lead up to the trial although she did receive a mental health service in response to a series of suicide attempts, which led in some cases to hospital admissions, followed by assessment and management within the Home Treatment Team and Community Mental Health Recovery Service. Although at times she presented as being competent and in control of the high level of stress she was under, she also exhibited quite contradictory states and behaviours that were indicative of her history of abuse and mistreatment. The seriousness of her escalating suicide attempts was not properly calibrated and, believing her abusers had not been brought to justice, she took her own life in January 2013.

The historic abuse suffered by Mrs A

Mrs A's prior vulnerability

It is a matter of record that Mrs A alleged that she had been abused by a family member as a child and that she had experienced a troubled childhood and adolescence, offset by the fact that she was a very gifted musician. In order to develop her skills and progress her career, she left her adoptive home at the age of 14 and travelled away from home to attend boarding school.

In her evidence to the court about the abuse she suffered at school, Mrs A gave painful testimony about this previous history of (page 3 of Transcript of Cross Examination) physical and sexual abuse within her adopted family that had made her so vulnerable when she arrived at boarding school. She would have presented in ways that are typical of people struggling to deal with overwhelming experiences and traumatic sexualisation and her abusers were able to recognise this and exploit her understandable need for affection. In her evidence she spoke openly about her sexualised behaviours, and the lack of boundaries that left her unable to see until later that the "relationship" she had with MB was wrong and abusive. She gave evidence in court about how

challenging she had been as a teenager, for example visiting pubs with other school friends where she spoke to "*prostitutes"* (page 4 Transcript of Cross Examination) about their work, identifying with them because of her previous experiences of being sexually exploited. She spoke about how she became desensitised to sexual experiences and spoke about how she yearned to be part of MB's family even though he was abusing her. In her evidence, when challenged about why she sought out MB, she said that she "wanted the family that MB had and so I did what was necessary to be part of his family."

The account she gave has all the hallmarks of a vulnerable, already abused, young person, who was singled out because she did not have reference points or supportive adults around her who could have helped her to resist the process of grooming to which MB subjected her. She did try to voice what was happening to one of the house-mothers at the school (page 40 Transcript of Cross Examination), even though her previous attempts to tell her adoptive mother about the abuse she had suffered within the family had been met with hostility and rejection.

So Mrs A, as a child, had been doubly abused,- she arrived at Chethams School, recently bereaved having lost her adoptive father and having to cope with this previous abuse by a family member that had continued over a long period of time, a matter over which she had not been supported by her mother. Chethams school should have taken extra care of her, instead they seemed oblivious to her vulnerability. Her painful history goes some way towards explaining why she was targeted and so easily manipulated by MB. She spoke in her evidence about how she had not gone through with a previous complaint about him because at the time she still *"felt as if I was in a relationship, not being raped*", and later when MB had been made to leave the school because of his abuse of another girl, she described feeling "*gutted"* to realise that she was not the only one involved with him.

It was not within the remit of this review of adult safeguarding to inquire into the actions that Chethams took within local child safeguarding arrangements with regard to Mrs A or other pupils. However, it appeared to the Panel that, had Chethams been properly operating within local child safeguarding procedures, both her disclosure to the house-mother and her later complaint would and

should have triggered an investigation of concerns about her own welfare and about the safety other pupils. Mrs A could not have been expected to know how paedophiles operate at that stage in her life, or to understand that their offending usually conforms to a pattern of repeated and serial abusing against several victims. But local child protection professionals *would* have known this and, had they been alerted, they would have been able to launch appropriate inquiries into the welfare of Mrs A. They might have been able to establish whether others had been targeted and/or if further action was called for. This was also the case in regard to another music teacher (ML) about whom there were several allegations circulating. These were missed opportunities made worse by the fact that the school subsequently allowed Mrs A to go and live with MB in his family home despite her previous complaint, thereby both setting up the circumstances within which she was abused and allowed it to continue unchecked.

Particular environmental factors contributing to vulnerability

Music schools, in common with other "hothousing" establishments, create pressures that may have a particularly damaging impact on young people who are vulnerable and/or without parental support. These settings are competitive, and feed into expectations already placed on the young person to be "special" and to succeed. The adults around them, who are often prominent performers in their own right, are invested with exceptional power and influence and are in a position of trust from which they exert considerable leverage over whether their pupils achieve success in their chosen fields. The music world is not alone in this regard, -similar pressures arise in elite sports academies, boarding schools, ballet schools, cathedral and choir schools, drama and performing arts courses, art schools and other areas of endeavour that create a backdrop for this very particular and potent form of grooming.

Chethams School provided an ideal environment for this kind of abuse to occur. The school seemed unaware of the risks of sexual abuse and it does not appear to have proactively promoted a child protection agenda. Boundaries were blurred and some staff seemed at times to act with impunity. When, Mrs A was sent, as a teenager, to live with MB and his family it was effectively a private

fostering arrangement, put in place without any proper scrutiny or formal overview. The atmosphere of elite performance teaching created what one pupil described as a belief that you were "special"[6] and it placed teachers in an exclusive and powerful position in relation to their protégés.

In response to this case another music teacher (MR), a man who had acted as a whistle-blower, published an article offering a window onto the culture in these circles at the time we are speaking of from which it can be seen that Mrs A was not alone in being at risk from abusive sexual relationships and unprofessional behaviour. MR later said,

Music lessons are one-to-one… So, if you're determined to behave wrongly, there's the opportunity: "It's one of the easiest situations to abuse, I would have thought."

He further discussed how music teaching in particular, takes place in a context of emotional intensity and that pupils' crushes on staff are commonplace.

So this culture of sexualised behaviour between teachers and pupils that developed in the school at that time was, to some extent, known about and condoned. This culture may also have prevailed at the Royal Northern College of Music as there was considerable overlapping of staff, and this became the focus of contention specifically in relation to the appointment of ML to a senior post at the college. MR publicly confronted the principle of the college about the suitability of this appointment, given widespread allegations about ML's sexual exploitation of young women students, at considerable cost to his career[7]. When he made his concerns public, he received many letters of support from students disclosing past abuses and concerns. Mrs A was one such pupil/student. When his whistle-blower's warnings went unheeded, he recounted that

"Letters from pupils and professional musicians poured in, one was from [Mrs A] … She was a force to be reckoned with …"There was tremendous passion and anger." Chethams therefore represented a very particular context in which it was possible for MB to target and groom Mrs A from a

[6] http://www.guardian.co.uk/society/interactive/2013/apr/03/manchester-chethams-school-music-document accessed Oct 2013
[7] http://www.theguardian.com/uk/2013/feb/13/michael-brewer-rncm-teachers-story-martin-roscoe

position of trust, power and influence. Although it seems to have been common knowledge that some teachers within the music network around Chethams and the Royal Northern Music School had sexual relationships with their pupils this was not formally addressed.

1. THIS REVIEW DID NOT HAVE A MANDATE TO COMMENT ON ISSUES OF CHILD PROTECTION BUT URGES CHILDREN'S SAFEGUARDING BOARDS AND THE INDEPENDENT SCHOOLS INSPECTORATE TO PAY ATTENTION TO ALL SCHOOLS ESPECIALLY, BUT NOT EXCLUSIVELY, BOARDING SCHOOLS INCLDUDING THOSE CONCERNED WITH "SPECIAL" PUPILS OR THOSE THAT HAVE ELITE STATUS. THIS INCLUDES SO CALLED "FREE" SCHOOLS THAT EXIST TO SOME EXTENT OUTSIDE OF LOCAL NETWORKS.

The role of criminal justice agencies and services for victims

IMR's were sought and received from Greater Manchester Police and the Surrey Police. The Panel also received a report from the CPS in Manchester covering the North West area and from the Witness Support Service attached to The Three Crown Courts, Greater Manchester, that is provided by the charity "Victim Support".

Disclosure of the case to a third party and subsequent investigation

The particulars of the abuse perpetrated by MB against Mrs A came to light on 21/07/2011 through the intervention of a third party, a friend who attended a dinner party with Mrs A, to whom she confided the extent of the sexual exploitation she had been subjected to as a teenager and young woman. This person became alarmed that MB, the alleged perpetrator of this abuse, was still in a position of trust and influence and had access to other young aspiring musicians at national level. She reported the case to Surrey Police with a view to preventing further abuses of vulnerable young women. This led to an investigation by the Greater Manchester Police (GMP) in whose catchment area the crimes had taken place and in which area the perpetrators continued to reside. Surrey Police assisted GMP in that they interviewed Mrs A under 'Achieving Best Evidence' guidelines.

Surrey Police also knew about three of Mrs A's subsequent suicide attempts having been called to her home in these emergencies. Two of these incidents came to their attention as a result of GMP requesting Surrey Police attendance as a result of urgent concerns for Mrs A's welfare and a third incident was reported into them by the Crisis Helpline. But there was no overarching mechanism for this information to have been shared with GMP. The GMP IMR did consider whether having a single point of contact within the Surrey Force might have streamlined their communication but at the time considered this unnecessary.

This division of labour between the two forces created gaps, as well as boundaries, across which information did not pass. But this raises genuine ethical dilemmas about how far any one agency *should* have passed on information about Mrs A's mental health issues. It appeared to be her choice to go to court and to bear witness against the man who had abused her and therefore her right to keep other aspects of her life, including her mental health difficulties, out of this process. Despite this, as a matter of routine, her medical records up to the inception of the case *were* shared with the police bringing at least some of these concerns within their purview. A Serious Sexual Offences Unit has since been established within GMP (in 2012) but at the time this case was handled by CID who might have been inexperienced at recognising and managing symptoms that might helpfully be viewed as the legacy of these kinds of abusive experiences in childhood and adolescence. This unit should be tasked with compiling guidance on how to work collaboratively with other Forces, and for creating mechanisms for proper case coordination and witness support, across these boundaries.

Interim guidelines have recently been issued by the Director of Public Prosecutions (DPP) asking for a change in emphasis in the way historic and current cases of sexual abuse and exploitation are prosecuted requiring prosecutors to ***"…look at the allegation actually being made, rather than focusing too intently on the perceived weaknesses and vulnerabilities of victims."*** These guidelines call for better collaboration between forces and for evidence to be brought that dispels myths and stereotypes about victims of sexual abuse and exploitation. Its focus is on young witnesses but the ethos it

sets out is equally relevant to adult victims/survivors of historical child abuse. This guidance has since been issued in final form as "Guidelines on Prosecuting Cases of Child Sexual Abuse"[8] .

2. THE HOME SECRETARY AND THE COLLEGE OF POLICING WILL BE ASKED TO INITIATE THE DEVELOPMENT OF GUIDELINES ON HOW TO SHARE INFORMATION ACROSS POLICE FORCES WITH SPECIFIC REGARD TO HISTORIC ABUSE CASES.

3. BOTH POLICE FORCES AND CPS UNITS, IN ASSOCIATION WITH THE COLLEGE OF POLICING, SHOULD WORK TO IMPLEMENT THE CHANGE IN EMPHASIS OUTLINED IN RECENT GUIDANCE FROM THE CPS, TESTING THE ALLEGATION RATHER THAN CHALLENGING THE CREDIBILITY OF SURVIVOR WITNESSES OF CHILDHOOD SEXUAL ABUSE.

Investigating historical offences

Between July 2012 and 2013, 168 adults made allegations of historic sexual abuse to the GMP although this is likely to be considerably more than in previous years as a direct result of the publicity surrounding high profile cases that have featured in the media and around whom public opinion has crystallised.

Historic allegations of rape are investigated under the same guidelines as recent offences, a GMP protocol referred to as TALON (published in Jan 2013) which set out standards for that force, stipulating a management review of unsolved cases at 7 days, and every 28 days after that. Even though Mrs A's case came to the notice of GMP prior to the formal adoption of this policy, these timescales were observed. In Mrs A's case, both MB and HKB (the perpetrators) were arrested and on police bail within the first 28-day review period. The DCI reviewed the case after 90 days but there is no evidence of further management review after the offenders had been charged. Management review is anyway focused on investigation and evidence gathering rather than on victim support. In a subsequent review chaired by Keir Starmer QC, then Director of Public Prosecutions, it was emphasised that Mrs A contributed to discussions about how to charge the MB and was not in any

[8] http://www.cps.gov.uk/legal/a_to_c/child_sexual_abuse/

way a reluctant witness even though her hand had been somewhat forced by her friend's disclosure.

Recognising vulnerability within the Criminal Justice System

The officer-in- charge (OiC) was to some extent aware of Mrs A's mental state as her behaviour strayed outside what could be considered "normal" boundaries on several occasions. He became aware of one suicide attempt in May 2012 because Mrs A rang him directly and spoke to him late at night when he was on-duty at a time when she was very distressed. She seemed incoherent on this occasion, and possibly intoxicated, giving him sufficient cause for concern to make a request to Surrey Police to visit her in order to make a welfare check. Surrey Police duly did so and reported back to him that there was no cause for immediate concern as she was safely at home with her husband.

This Office telephoned Mrs A the following day and she was apologetic about making the previous call, seeming to realise that it had been inappropriate. She said that she had contacted the Surrey Rape and Sexual Abuse Support Centre (RASASC) to which he had previously signposted her but that they were unable to help her. He later rang them directly to clarify this and they said that they could help her if she wished to engage with them. The OiC was concerned that Mrs A was becoming confused about the parameters of their relationship because she signed her letters in a familiar way and was focussing on him for support that he was not in a position to give. After contacting RASASC, he called Mrs A again and she promised to ring them back. He tried to explain the demarcation between his responsibilities to the investigation and his concern for her as a victim/witness. He reiterated that she could contact specialist agencies that had been set up specifically to support people in her position and he also referred her to the Witness Care Unit (WCU) within the Surrey Police.

These incidents were part of an on-going and escalating pattern but there was no clear route that might have enabled him to feed this information into a formal risk management or care coordination process. Perhaps, in an attempt to respect Mrs A's confidentiality, they were not documented and did not become

part of the case record. These contacts did however provide an indication that all was not well in terms of Mrs A's mental health.

These were difficult judgment calls. The OiC did say that he had frank discussions about these matters with his seniors but there was no evidence that he received formal supervision to help him manage these breaches of his professional boundaries nor perhaps a shared understanding that these matters reflected re-enactments of boundary violations that Mrs A had suffered herself. Experienced officers and mental health professionals should have a framework for managing such difficulties with formal support from their seniors to protect them and to safeguard those to whom they have a duty of care, and it will help them to do so if they have a clear view that these ways of behaving are part of the legacy of childhood sexual exploitation.

His experiences echoed those of Mrs A's, male, GP who also experienced Mrs A as a person who found it difficult to stay within normal professional boundaries and who had been put in a position where he felt he needed to reassign her care within the practice. Both men felt uncomfortable as a result of Mrs A's behaviour but perhaps there was a tendency in both organisations to see these issues as a matter requiring personal rather than professional responses when actually these behaviours are typical and understandable presentations in someone who has been violated as Mrs A had been. Managing un-boundaried behaviours should be seen as a core task across all professions dealing with victims of sexual abuse.

Mrs A's GP took positive and timely action to transfer her care to a female colleague but what seems to have been missing is an acknowledgment, within the wider system, that this acting out was a source of information about Mrs A's instability and about the fragility of her mental state. The Panel wish to emphasise that we are not raising these issues in an attempt to "blame" Mrs A or to undermine her good name but because these are typical and understandable consequences of the abuse she had suffered in childhood. Diagnosis runs the risk of labelling and stigmatising people but it also names things and provides an explanatory framework, in this case one that would have linked aspects of Mrs A's difficulties to the abuse she had suffered as a girl.

These issues speak to the need for a special skill set and for diligent managerial oversight of these cases in the police force and in the medical profession, suggesting the need for specialised training that is informed by an understanding of the problems experienced by adults who have been abused as children. Officers currently complete a mandatory E-learning module on mental ill-health and learning disability, but it may be that this should be augmented with information specifically drawing links between prior abuse and difficulties later in adult life. Without these insights, the conditions and behaviours that tend to result from a history of childhood betrayal and exploitation, for example self-harming, sexualised behaviour, para-suicide and addictions, are trivialised and stigmatised. They often undermine the accounts of survivors when in fact they should be seen as validating them.

These symptoms are often wrapped up in a formal diagnosis of borderline personality disorder (a condition increasingly reframed as 'emotional intensity disorder'), which is widely understood to be a consequence of the fragmentation, trauma and the development of necessary but very stressful coping skills in a person who has been abused as a child. Had there been such a diagnosis in Mrs A's case, both men might have found it easier to escalate their concerns and to have them "seen" in their respective organisations. A formal diagnosis could also have lent weight to the GP's referral to the mental health team for urgent attention for Mrs A, and might have underpinned a more proactive approach to risk management, up to and including, assessment under the Mental Health Act.

4. MANAGING FRAGMENTED AND SOMETIMES UN-BOUNDARIED BEHAVIOURS SHOULD BE SEEN AS A CORE TASK ACROSS ALL PROFESSIONAL GROUPS DEALING WITH VICTIMS OF HISTORICAL SEXUAL ABUSE. NATIONAL BODIES SUCH AS ACPO, THE GMC (GENERAL MEDICAL COUNCIL), RCN (ROYAL COLLEGE OF NURSING). TEACHING AND SOCIAL WORK BODIES, AND OTHER NATIONAL ORGANISATIONS SHOULD BE ADVISED TO INCLUDE THESE ISSUES IN THEIR CURRICULA SO THAT THEIR MEMBERS ARE TRAINED TO RECOGNISE AND MANAGE THESE SYMPTOMS IN UNSTIGMATISING WAYS.

5. APPROPRIATE MANAGERIAL OVERSIGHT AND PROFESSIONAL SUPERVISION OF CASES INVOLVING PEOPLE ABUSED IN CHILDHOOD SHOULD BE PROVIDED TO

PRACTITIONERS IN THE POLICE FORCE, THE MEDICAL PROFESSION AND MENTAL HEALTH SERVICES.

6. ALL AGENCIES SHOULD HAVE GUIDELINES IN PLACE THAT HELP STAFF TO MANAGE INAPPROPRIATE AND/OR SEXUALISED BEHAVIOURS WHEN THEY ARISE IN THE CONTEXT OF THEIR WORK: THESE SHOULD ALLOW PRACTITIONERS TO ESCALATE CONCERNS ABOUT INAPPROPRIATE AND/OR UNBOUNDARIED BEHAIVOUR ON THE PART OF PATIENTS OR CLIENTS AND OFFER A ROUTE FOR CASE REASSIGNMENT AND/OR REDEPLOYMENT AS A MATTER TO BE MANAGED ON BEHALF OF THE AGENCY AS A WHOLE AND NOT LEFT AS SOMETHING FOR THE INDIVIDUAL PRACTITIONER TO MANAGE ALONE.

Legal definitions of vulnerability

Vulnerability is defined differently in different legal contexts. In adult safeguarding practice vulnerability the definition used is taken from "No secrets" that was first published in the 1997 document "Who decides," (one of the consultation documents leading up to the 2005 Mental Capacity Act); as "**a person who is or may be in need of community care services by reason of mental or other disability, age or illness, and who is, or may be, unable to take care of him or herself or unable to protect him or herself against significant harm or exploitation."** In the later context the eligibility for a Community Care Assessment was adopted as the threshold for assistance through safeguarding interventions.

The term "a vulnerable witness" refers to a wider group including people who are at risk of being intimidated. The 2005 Mental Capacity Act, by contrast, defines a group who lack capacity to make their own decisions which takes in a subset of vulnerable adults and witnesses.

GMP has its own hybrid definition as someone who **"may be vulnerable by virtue of age and/or their circumstances or who suffers from mental or physical disabilities, illness, or other such special feature which renders them either permanently or temporarily unable to care or protect themselves against harm or exploitation."**

The Chief Constables' order 2010/01 systematised a process of (risk) assessment and classified vulnerability in three bands,

⇒ Low were there may be a need for some additional services such as an assessment or truanting input

⇒ Medium whereby the child or adult is currently safe but where further non-urgent assessment and support is deemed necessary and

⇒ High where the person is in need of immediate protection

Recognising vulnerability is important evidentially because the Youth Justice and Criminal Evidence Act 1999 imposes a responsibility on investigating officers to interview a child or vulnerable adult in the presence of an "appropriate adult" whose role is to act as an advocate for the vulnerable person and as an intermediary during the examination process if they are a suspect. Vulnerability is also pertinent in a witness because this Act created a mandate for offering a range of assistance including intermediaries in court, screens, facility to give evidence-in-chief via video-link and onward referral to Victim Support Schemes. Mrs A *was* identified as vulnerable because she was a survivor of historic abuse and this was appropriately recorded alongside acknowledgment of her rights to seek access to these measures.

Mrs A's GP did not initially consider her to be a "vulnerable adult" within the terms of the government's guidance on abuse, "No Secrets" (DOH 2000) and did not consider making a referral under the Safeguarding Vulnerable Adults protocol. Nor did Surrey Police, as the first agency to come into contact with Mrs A in this context; they did not recognise her as a "vulnerable adult"within the safeguarding framework or consider making a referral through this route. Surrey Police did come to see her as vulnerable in terms of her mental health and referred her to mental health services (using a 39/24 form), but not through the adult safeguarding route.

No Secrets"sets the threshold for a safeguarding intervention at the level of eligibility for a community care assessment, stated in these terms, anyone who

⇒ may be in need of community care services by reason of mental or other disability, age or illness

⇒ is or may be unable to take care of himself or herself, or unable to protect himself or herself against significant harm or exploitation.

Mrs A might therefore have been seen to fall *within* the definition set out in this guidance in that she was mentally unwell at least to a threshold that would entitle her to seek assessment under the NHS and Community Care Act 1990 and could therefore have been seen as a vulnerable adult under this provision. Moreover, Surrey's Safeguarding Adults policy does include victims of historic abuse within its definition of a "vulnerable adult".

So, while Mrs A was not at risk of abuse as an adult, as a victim of *historic* sexual abuse she was vulnerable to being harmed by recalling these abusive experiences and at-risk of causing herself harm when the painful states she had experienced were reactivated as a result of giving evidence. She should therefore have been offered appropriate care coordination and mental health support. A multi-agency and multi-disciplinary approach *was* required and should have been provided either under the aegis of the CMHRS or within an Adult Safeguarding framework.

7. SAFEGUARDING PROCEDURES ACROSS OTHER LOCAL AUTHORITIES AND ACROSS SURREY'S PARTNER AGENCIES, SHOULD STATE PROVISIONS FOR VICTIMS OF HISTORIC ABUSE AND/OR CONTAIN INFORMATION ABOUT HOW TO SIGNPOST ALLEGED VICTIMS TO SERVICES THAT CAN ADVISE AND HELP THEM.

Police support for victims

Information regarding the measures taken by GMP to safeguard and support Mrs A was obtained from an interview with the officer in charge of the case, (OiC) and referenced against national guidance included in the following policy documents.

- The Criminal Justice System's (CJS) Witness Charter (2007)
- The Criminal Justice System's Code of Practice for Victims of Crime (2005)
- The Criminal Justice System's Rebuilding Lives Supporting Victims of Crime (2005)

- The Ministry of Justice Vulnerable and Intimidated Witnesses A Police Service Guide (March 2011).

The new Interim Guidelines (DPP 2013) also set out what **"support that victims can expect and make clear issues such as whether they can have counselling, whether they can know about other allegations and what support they might have at trial".** This document is, therefore, important to the way future cases are managed.

GMP currently use the "Assessment Framework for Information Sharing" (AFIS) and this should be continued however it is more geared to the sharing of intelligence about crime rather than welfare, with neighbouring forces. As a framework within which vulnerable people are managed across geographical boundaries (as often happens in relation to historical abuse) its use should be supplemented by strong partnership working with both Safeguarding Adults Boards, the one governing the area where the vulnerable person lives, and the area in which the trial is to be conducted which will host the investigation leading up to the prosecution. In this case the arrangements resulted in Mrs A having been shown round the court in Guildford, rather than the one in Manchester where she was due to give her evidence.

Supporting victims and witnesses is recognised as a discrete function within regular policing and the OiC did provide a great deal of direct support to Mrs A in the lead up to the trial. She had initially resisted referral to the charity "Victim Support" but after her suicide attempt in May 2012 he persuaded her to self-refer to the Rape and Sexual Abuse Support Centre based in Guildford.

So Mrs A *was* recognised as a "vulnerable and intimidated witness" in line with national guidance[9] and she *was* offered these special measures up to, and exceptionally even during, the courtroom process, but she was of the view, (expressed to her GP and to the mental health team) that if her mental instability became a matter of common knowledge, as she thought would happen if she accepted a screen in court, or if she had asked for the trial to be postponed on

[9] As stated in Equality and Human Rights Commission (EHRC) report Hidden in plain sight which requires that the police service "identify where special measures may be required as soon as possible in any investigation"

account of her mental ill-health, it would have undermined her credibility in front of the jury. She therefore seems to have made a principled decision to put her own wellbeing on hold in order to underline the clarity and, she hoped, the effectiveness of her evidence.

The Panel were strongly of the view that Mrs A's vulnerability and mental health difficulties did not, and should not, have framed her as an *unreliable* witness, instead the jury should have been appraised of the aetiology of her recent mental health difficulties and offered expert evidence as to her credibility. This would have been especially helpful in relation to Mrs A's difficulty in recalling dates and ordering events as demonstrated on page 13 of her cross examination when she tried to orientate herself by remembering how old MB's daughter was at the time of the offences. She became flustered and tried to explain to the barrister that she could not "remember" things in a systematic way but that her memories are of specific incidents, which psychologists refer to as "flashbulb" type memories that are typical in people who have suffered trauma.

Hiding mental health difficulties would not anyway have been a safe strategy for the prosecution because, under pressure of cross examination, Mrs A did regress somewhat. At times, she answered questions in a petulant or argumentative way, she was flustered when asked about dates or about her age, but notwithstanding this her account was rich in significant details and the felt experiences she had endured. The judge did try to clarify this for the jury, coming to Mrs A's assistance when her video evidence was being challenged. One telling extract from this evidence came when the barrister was asking her about her *first* memory of an incident in which MB had abused her, to which she had replied in her video interview by recalling the most intense. She recalled a time when MB had told her he did not like the way she smelled and that she must wash before he had oral sex with her. This she said was her most "**distinct memory…because it was something that was so horrible to me… it sticks out in my mind"** and when asked again why she had not responded with her **first** memory she said **"That is my strongest, saddest memory"** (p20 Court Transcript of the Cross Examination).

8. EXPERT WITNESS TESTIMONY AS TO A PERSON'S CREDIBILITY SHOULD BE OFFERED IN COURT TO EXPLAIN TO JURORS HOW CHILDHOOD SEXUAL ABUSE AFFECTS INDIVIDUALS BECAUSE THIS IS GERMANE TO THE WAY THEY ASSESS THE TRUTHFULNESS OF A VICTIM/ WITNESS'S ACCOUNT; THIS RECOMMENDATION WILL BE CONVEYED TO THE HOME OFFICE, THE DIRECTOR OF PUBLIC PROSECUTIONS AND TO THE COLLEGE OF POLICING

Mental Capacity and "special measures"

Surrey Safeguarding Adults policy (in Nov 2010) supported Mrs A's right to present herself in court without any concessions on the grounds that she was a vulnerable witness, stating that where a vulnerable adult who has capacity makes a decision that they do not want action to be taken, their wishes must be respected unless there are vital public interest considerations that weigh against this position. An important issue in this case is therefore whether Mrs A, at certain times, lacked capacity. If she had capacity she was entitled to make these choices for herself but if she did not have capacity or if it was compromised, for some or all of the time, it may have fallen to others to make decisions on her behalf and in her best- interests.

Although individuals and agencies were aware of her vulnerability, she chose to present herself as a capable, competent person to the Court even in the face of exacting cross -examination and goading/smirking from her abuser across the courtroom. Although the Officer in Charge had evidence that Mrs A did not have stable or appropriate sexual boundaries, he did not become aware of her suicidality until May 2012, but arguably Mrs A did not present in a manner that provided sufficient grounds to suggest that she did not have capacity despite this crisis. Nor should it have been the role of police officers to delve into her mental state but to act on the assumption that she had capacity to make her own decisions.

It is clear that Mrs A believed at some points, and according to the Press had told her family, that the Police were advising her not to seek therapeutic help prior to the trial but both police forces involved are clear that they did not give this advice - perhaps her belief reflected her own sensitivity to the possibility that she would have her credibility undermined in the court process. In fact,

Police often use counselling reports in support of the evidence in historic child abuse cases, but it was this conviction that underpinned her determination to stay strong in the lead up to, and then throughout, the trial. She was not consistent however, and on 5/11/2012 she had telephoned her GP to say that she wanted psychological help even if it did affect the court case and she had asked for this from the CMHRS during the course of an assessment they conducted at that time. She was in fact offered care coordination as a result of this assessment but not the psychological therapy she had specifically asked for.

Achieving Best Evidence in Criminal Proceedings Guidance March 2011 refers to therapeutic help for child or vulnerable adult and intimidated witnesses, stating only that,

"A child, vulnerable adult or intimidated witness may be judged by the investigating team and/or by those professionals responsible for their welfare, to require therapeutic help prior to giving evidence in criminal proceedings. It is important that professionals undertaking therapy prior to a criminal trial adhere to the official guidance: Provision of Therapy for Vulnerable or intimidated witnesses prior to a criminal trial" Practical Guidance (CPS and the DH with the Home Office 2011 para 3.133).

Given that there were no official barriers to Mrs A's receiving timely and appropriate help, providing pre-trial counselling hinged on whether she was making a fully *informed* and a fully *capacitated* decision in refusing to seek such input. Professionals from several agencies seem not to have challenged her view that it would damage her testimony and they all assumed that she had capacity to make this decision even in the stressful lead up to the court case. There is no reason why Mrs A could not have been supported to be more open about the legacy of the abuse she had suffered, in ways that would not have jeopardised her credibility in front of the jury[10].

9. POLICE, CPS AND MENTAL HEALTH PRACTITIONERS, SHOULD BE PROVIDED WITH ADDITIONAL TRAINING ON HOW TO ASSESS MENTAL CAPACITY AND SUPPORT ASSISTED

[10] Achieving Best Evidence in Criminal Proceedings Guidance March 2011 refers to Therapeutic help for child or vulnerable adult and intimidated witnesses.

DECISION MAKING; THEY SHOULD UNDERSTAND THE ROLE OF MENTAL HEALTH DIFFICULTIES AND EMOTIONAL DISTRESS IN SOMETIMES OVER-RIDING THE COGNITIVE PROCESSES NECESSARY FOR SOUND DECISION-MAKING.

10. WHERE A JUDGE IS OF THE CONSIDERED OPINION THAT A WITNESS IS VULNERABLE, EVEN IN CIRCUMSTANCES WHERE THAT WITNESS HAS REFUSED SPECIAL MEASURES, THE JUDGE SHOULD BE PROACTIVE BY INTRODUCING SPECIAL MEASURES THAT BOTH PROTECT THE PERSON DEEMED TO BE AT RISK OF PSYCHOLOGICAL OR PHYSICAL HARM *AND* THE QUALITY OF EVIDENCE PUT BEFORE THE COURT.

11. STEPS SHOULD BE TAKEN TO ENSURE THAT MENTAL ILL-HEALTH IS NOT SEEN AS A BARRIER TO PARTICIPATING IN AND/OR RECEIVING, JUSTICE INCLUDING FOLLOWING CPS GUIDELINES ON PRE-TRIAL COUNSELLING.

Mental Health Services

Services responsible for Mrs A's Mental Health Care

Assessment of Mrs A's mental health status fell clearly within the remit of statutory mental health services within the Surrey and Borders Partnership NHS Trust, guided by her GP practice with whom she was in regular contact. She was also taken to hospital as an emergency by the South East Coast Ambulance Service on seven occasions and was admitted as an in-patient to the Royal Surrey County Hospital (RSCH) during these episodes. Mrs A attended the same GP practice throughout that time but, as stated above, her named GP was reassigned after it became clear that she had crossed boundaries in contacting him out-of-hours, having tracked down his home number, and by acting inappropriately in some consultations. She was then allocated to a woman doctor within the practice who took over her care. A relatively seamless transition was achieved involving an extended joint handover appointment. The Panel considered that the GP himself and the Practice as a whole had acted appropriately in relation to this incident but registered that it was significant as an issue in relation to Mrs A's care.

Mrs A's mental health care prior to the trial

Mrs A had attended the Royal Surrey County Hospital (RSCH) as a patient since 2002 for a variety of health issues. She attended the accident and emergency department (A&E) following her first recorded overdose on 28th April 2012, and made a total of, seven attendances with overdoses in the subsequent 10 months before her death. When admitted, she received care for her physical condition and also an assessment of her mental health status. Three months before she died (24/1/2013) she received a diagnosis of anxiety and depressive disorder. These assessments were carried out by the Psychiatric Liaison Team (PLT), (within the RSCH), and the Home Treatment Team (HTT), both of which are provided by Surrey and Borders Mental Health NHS Foundation Trust (SABP). The PLT team operated during office hours, with the HTT providing cover for assessments requested during the evenings and at weekends.

The responsibility for Mrs A's *care coordination* rested with SABP who provide mental health services in this catchment area, however there were some gaps in their provision during this key period in Mrs A's life. Mrs A was first referred to CMHRS by the PLT on 20/10/ 2012 and, following a discussion in the multi-disciplinary team (MDT) on 24/10/2012, was provided with a "rapid" duty assessment on 31/10/2012. A plan was drawn up at this point to offer her care coordination to ensure coordinated support and assist with practical tasks. She was asking for psychological therapy at the time but this was not forthcoming. Initially the Panel thought that this was because there was a lack of resource but actually a decision was taken within the MDT that it would not be appropriate to offer her a psychotherapeutic intervention in the light of the impending court case. It was felt that Mrs A needed to be more emotionally stable to benefit from such treatment and therefore to wait until the risks had receded; they considered that it would be better to offer her one person to coordinate her care and to provide practical help and continuity. The Panel accepts that the team made what they considered to be a reasonable clinical judgment. Perhaps, with hindsight, it would have been helpful if Mrs A had received psychological help such as mentalisation based therapy or cognitive analytic therapy, that would have prepared her for the shock of the trial and directly addressed her instability at this time but we cannot know how or if that

would have worked out for her. What we can put on record is that in any future cases where a person is facing a court case of this nature therapy should at least be considered.

On November 5th 2012, the duty team telephoned Mrs A to confirm their decision that she would receive care coordination but that she would not be offered psychological input at that time. The CMHRS wanted to discuss their decision and their treatment plan with Mrs A's GP but although they tried to contact her, they kept missing each other and eventually made contact on December 13th 2012. On the 19th December Mrs A was seen by a psychiatrist but his letter to her GP was not sent until 31 December 2012 and was not received at the surgery until 7 January 2013. In this letter it was suggested that the GP review her medication and consider a referral to psychology. Mrs A was also seen by a psychiatrist on 9 January 2013, who referred her to the HTT, who saw her the following day. The letter setting out details of this second psychiatric review was typed up on 30th January 2013, after Mrs A's death, and not received at the surgery until early February. It is unclear to the Panel why a direct within-team psychology referral could not have been made by CMHRS to obviate this delay. The communication between the mental health and primary care practitioners during this time is summarised in the following extract from the overall chronology appended to this report.

5/11/2012	Rio patient record – progress notes	TC to Mrs A from CMHRS duty worker explaining plan for CMHRS to allocate care co-ordinator in next few weeks and to explore emotional regulation and distress tolerance work but not referral to psychology or psychotherapy until after the court case.	CMHRS tried to contact GP but not available. Message left for GP to contact CMHRS to confirm plan.	CMHRS to allocate care co-ordinator in next few weeks. Mrs A advised to contact Duty in meantime
6/11/2012	Rio patient record – progress notes	CMHRS called GP but not available so message left to contact. NB: report notes that CMHRS staffing levels were at critical point at this time and were	CMHRS attempted to liaise with GP.	Message left for GP to contact CMHRS to discuss plan.

		registered on the Trust's risk register as such.		
19/11/2012	Rio patient record – progress notes	Message from GP Surgery received by CMHRS on 16.11.12 advising that GP is on leave and will call back on 22.11.12	GP surgery communication with CMHRS.	Plan for GP to contact CMHRS on 22.11.12
13/12/2012	Rio patient record – progress notes	GP and CMHRS worker discussed the case by telephone. GP advised that CMHRS planned to offer regular sessions to help with distress tolerance and emotional regulation in the lead up to the court case. GP advised that this was required urgently with the court case only a month away.	Discussion between CMHRS and GP.	Need for urgent allocation to be discussed with CMHRS manager.

Mrs A was eventually allocated to the social worker who had been designated to be her care coordinator on 2/01/2013, over ten weeks after her initial referral to CMHRS. This time period is represented by the following entries in the overall chronology appended to this report.

14 Dec 2012	Royal Surrey County Hospital > Discharge summary Accident and Emergency notes Medical notes	3-day Admission after Insulin OD Known MH teams but not allocated key worker, seen MH teams in hosp Refusing to answer questions about intention Not being seen by MH team in the community, Ref to MH team when medically fit 15/12 DW HTT do not provide psychiatric review unless needs admission to psychiatric hospital Given number of crisis line and advised to	Discharge summary to GP Referred to HTT team Discussed with HTT team	Needs re-referral when medically fit For Mrs A to remain in hospital until seen by MH teams.

		contact duty team at FRH following week. Still not medically fit. 16/12 medical review - last seen by MH team 6/52 ago. She was promised they would follow her up but according to her this never happened. Very likely to re-attempt taking her own life. No MH bed available, crisis helpline team for Guildford said they don't review patients on the ward. If she feels suicidal, they will consider admission otherwise the patient will have to contact the community psych team herself. Registrar plan – cannot go home until seen by the psych team 17/12 PLN review - ongoing case, has court case 14th Jan 2013. Currently under Guildford MH team awaiting a psychotherapist and key worker to be allocated. Remains vulnerable and at risk of OD. Does not find HTT beneficial, wants to see a psychiatrist. Denies further <u>active</u> suicidal thoughts. Claims sons home from university (who are protective factor) Deemed safe to go home. Call from duty worker at Guildford MH team and appt (booked for 19/12/12)	Referred to PLN Referred to community MH services	Re-refer on next working day Seen by PLN, OPA for MH team booked

17/12/2012	Rio patient record – progress notes	Discussion in CMHRS MDT meeting regarding risk zoning. Identified that zoning had been red, high risk, on 31.10.12 but still not allocated. However, on CMHRS managers list was zoned as amber, medium risk so this was corrected to red, high risk		Urgent allocation of care co-ordinator to be made.
17/12/2012	Rio patient record – progress notes	Psychiatric Liaison Service at RSCH telephoned CMHRS to advise that Mrs A had been admitted to RSCH on 13.12.13 having taken a serious overdose of her husband's insulin medication. Mrs A assessed by psychiatric liaison. Said she felt overwhelmed by everything going on in her life and felt she had not received support from CMHRS. Psychiatric liaison service requested psychiatric outpatient appointment for Mrs A from CMHRS. This was arranged for 19.12.12. Mrs A also telephoned CMHRS upset that there had been no contact with her since assessment on 31.10.12.	Psychiatric liaison service contacted CMHRS and requested out-patient appointment.	Discharged home. CMHRS arranged psychiatrist out-patients appointment for 19.12.12. Mrs A advised of this appointment and that she was next on list for allocation of a care co-ordinator.
19/12/2012	Rio patient record uploaded GP letter	Mrs A saw psychiatrist at CMHRS outpatient clinic. Current stressors discussed – financial difficulties; husband's physical health problems; dealing with	Letter to GP with plan but not sent until 31.12.12 and received by GP on 07.01.13	Plan for urgent care co-ordination. No change to medication. Suggested referral to psychology.

		past sexual abuse issues. Not keen to continue with anti-depressants but advised to continue and to try to come off Diazepam. On-going suicidal ideation but no active plans or intent. (Recorded on RIO on 28.12.12)		
30/12/2012	Rio patient record – progress notes	Mrs A rang HTT and spoke to worker regarding high profile court case starting on 14/01/2012. Expressed need for help from mental health services but not getting the help needed. HTT worker advised her there was plan in place following appointment with psychiatrist on 19.12.12. and she was being offered services.		Plan in place to be followed.
2/01/2013	Rio patient record – progress notes	Allocation of social worker to be Mrs A's care coordinator by CMHRS		Care co-ordinator planned to see Mrs A as soon as possible.

However, within a couple of days of this case allocation, the social worker went off on sick leave before seeing Mrs A. The following day (3/01/2013) Mrs A was admitted to Royal Surrey County Hospital (RSCH) following another overdose that she specifically linked to the stress of the upcoming court case. She was given the Crisis Line number and, after three days, discharged back to the Community Mental Health Recovery Service (CMHRS).

She was re-assessed by CMHRS specialty doctor on 9th January 2013 and referred to the HTT on 10th January 2013 when a host of stressors were made apparent to the team, the court case was at the top of this list but the family were also under stress in other ways, they were experiencing financial difficulties and Mrs A's recently discovered birth mother had cancer; also her

husband was extremely ill. Mrs A had earlier explained to her GP that she had searched out her birth mother, (she was adopted), who now lived in Canada, and who had been found to have cancer very soon after Mrs A had been able to make the journey to meet with her.

Mrs A was presenting as a tough resilient person at times but at other points she was clearly very vulnerable, stating her intention to commit suicide and actually making serious suicide attempts. Her periods of non-engagement should not have been taken at face value or to get in the way of her clinical needs being assessed. Her treatment should have been continually informed by what is known about the imprint of sexual abuse on a child or young woman. Behind her competent persona she was making lots of highly distressed phone calls, behaving strangely to the police officer in charge of her case, she claimed to be feeling numb (dissociated) and she was making suicide attempts that were growing in severity and frequency.

Mrs A's care therefore switched back and forth between the HTT/Crisis Team and the CMHRS during this very volatile period for her. The two services have different functions, with the crisis team providing urgent care and the recovery service seeking to provide a stable single contact for Mrs A. But the shifting of responsibility seemed to have inadvertently cut across the hoped-for continuity that had been planned in November 2012 before the trial commenced. By late January 2013, Mrs A was saying that the support of the HTT was not meeting her needs and she again stated that she needed therapy; she said she had been exceptionally tired and low since giving her initial evidential statements. She was not being offered treatment that was in any way specific to her experience as a survivor of sexual abuse even though this was prominent in her mind and she was naming it explicitly as the most pressing cause of her distress.

In SABP's first IMR it was stated that the crisis/HTT team did not have direct access to clinical psychology. The Panel were concerned whether they were alert enough to, and/or skilled enough in helping, Mrs A in relation to her experiences of the court case. If they had recognised her need for psychological support sooner, they might have revisited the MDT decision to delay offering her psychotherapeutic help and escalated her case on the basis of clinical

need. At the point of referral there was a specialist service for survivors of sexual abuse within the Trust to which CMHRS could have referred Mrs A for assessment and/or treatment[11], and/or consulted for expert guidance on the risks to Mrs A during the court case.

12. WORKERS WITHIN THE HTT AND CMHRS SHOULD BE OFFERED TRAINING ON THE SEQUELAE OF SEXUAL ABUSE AND ON MANAGING PRESENTATIONS MARKED BY INTENSE AND UNSTABLE MENTAL STATES.

13. WORKERS WITHIN THE HTT AND CMHRS SHOULD HAVE ACCESS TO A RANGE OF SPECIALIST SERVICES TO WHOM THEY CAN ONWARDLY REFER SURVIVORS OF PERSONAL OR SEXUAL VIOLENCE; A DIRECTORY OF SUCH RESOURCES SHOULD BE COMPILED.

14. NHS COMMISSIONERS SHOULD ENSURE THAT THERE ARE ADEQUATE SPECIALIST SERVICES WITHIN THEIR CATCHMENT AREA TO MEET THE NEEDS OF PEOPLE WHO ARE SURVIVORS OF CHILDHOOD TRAUMA AND ABUSE.

Organisational Problems

SABP's second IMR addressed more fully the difficulties that were being experienced by the CMHRS at this time, including the problems of recruitment and sickness that had led to gaps in coverage and delays in assigning care coordination roles. The Trust has various interlocking systems in place to identify teams in difficulty, presumably with a view to rectifying any systemic problems and restoring an adequate service to vulnerable people. There is an overarching Clinical Governance Meeting structure that monitors clinical practice, reviews incidents, collates benchmarks of national and local good practice and monitors the implementation of service improvement initiatives.

Critical incident reporting is one of these system checks. A routine multi-disciplinary "critical clinical incident review," internal to the department, was completed after Mrs A's death but the Panel were strongly of the view that this was inadequate and unsatisfactory and would not have helped in this process of identifying difficulties or service deficits since it neither recognised shortfalls

[11] For an account of the work of this service see Valerio, P. (2011) Who let the boys in? Discussion of an NHS mixed gender group for victims of childhood sexual abuse. British Journal of Psychotherapy vol 27, no 1, 2011 pp79-92 Blackwell Publishing Oxford

nor suggested remedies. Nor was this document referred to in any of the versions of SABP's IMR, suggesting that it had not been used or seen as an important trigger for learning. The template used for this process is superficial and needs to be revised. However, the panel does recognise that SABP have a Serious Incident investigation process which is used to identify root causes and lessons to be learned.

Each team also undertakes an annual "Periodic Service Review" that monitors its performance against agreed standards and targets. In the 17 months up to December 2012 supervision records within CMHRS show that there were problems with sickness and morale and by December there were 4.5 WTE vacancies out of an establishment of 23.64 FTE's. Contingencies, usually in place to cover for sickness, were not sufficiently robust in this team as a result of which regular supervision, appraisals and mandatory training slipped. Funding for locums was approved but suitable people could not be recruited. The team manager went off sick on 17/12/12. On 10/1/2013 the Community Services Manager called a meeting to discuss the impact of this and to approve some temporary redeployments to plug the most immediate gaps: it was after this meeting that the team was placed on the Trust Risk Register where it stayed until April 2013.

But despite these organisational difficulties, the IMR states that the team were not so lacking in resource that they were not in a position to conduct basic risk assessments and 'first aid". Nor do problems in the team provide sufficient explanation for the lack of attention that was paid to the links between Mrs A's distress and low mood and the end of the trial in which she had given her evidence.

Addressing mental health needs in relation to sexual abuse

A significant proportion of people using mental health services have been traumatised by early childhood abuse and sexual exploitation; this is a matter of record and should feature in the training of all mental health professionals. This service should have been clearer that Mrs A's recent ordeal in giving evidence in this high-profile trial was triggering intense feelings in her and they should have related her escalating suicide attempts and requests for help and

therapeutic support to the fallout from this. Although individual practitioners, and the team as a whole, were in constant contact with her, there should have been tighter care coordination to support Mrs A throughout this period, clearer coordination between the different mental health teams, clearer coordination between the acute hospital, (where Mrs A was admitted as an in-patient to stabilise her after her overdoses) and her GP surgery; and coordination between mental health services and primary care. The switching of her care between the intensive support of the HTT to the recovery service at this point did not contribute to the continuity or safety of her care and was not informed by a revised assessment of her needs and of the stress she was under.

It seems that the team were not fully appraised of the historic abuse that Mrs A had suffered other than by Mrs A herself and she seems to have been confused about what she could share while the trial was in process. But she disclosed enough to have flashed up red lights to the team that this was a woman facing down her demons in a very high-profile public arena, and in front of her adult son. Moreover, she was subject to the additional stress of press intrusion and was at risk of being put in a situation in which painful memories would inevitably be reactivated. Furthermore, as has been stated earlier, in November of 2012 and again at the conclusion of her time giving evidence, she was actively asking for psychological help.

Mrs A's mental health care after she had given evidence

On 11th January 2013 Mrs A had been seen at home with her son when medication was dropped off for her by the HTT team, she said then that she was not feeling suicidal, and that she had resumed her teaching work by that weekend. There was then a break in her contact with mental health services while she was in Manchester for the trial and the team expected her back on 17th January 2013 when they rang her to re-establish contact as planned. The court process had clearly left Mrs A feeling "down and fragile", it had gone on for longer than she had expected, she did not have clothes and personal things from home as she had not expected to stay overnight which added to her discomfort and that of her son who had accompanied her. As soon as her

evidence was completed on 17th January 2013, she was able to lower her defences and when she returned home she immediately telephoned the HTT to ask for more medication, which they delivered to her despite bad weather. Her prescription drugs at this point included a 7-day supply of Diazepam and Zoplicone, empty packets of these and other medications were found nearby Mrs A after her death, although her toxicology report post-mortem found low concentrations of these drugs that were consistent with therapeutic use. The provisional medical cause of death was stated as an acute overdose of Fluoxetine. [Date of Inquest still to be confirmed at the time of publishing this report]

Visits were to have resumed on an alternate day basis from 18th January 2013 when she returned to Surrey, but the weather was bad, and a planned visit had to be replaced by a phone call. The HTT made every effort to make sure that Mrs A received the medication she required even during this spell of extremely bad weather. On 19th January Mrs A was visited, on 21/01/13 she was phoned but declined a visit because she was still in court with her son, medication was dropped off in the evening, but Mrs A was not seen. She was rung on 22/01/13 but said she was tired, wanted therapy and had teaching to do after she had collected her daughter from school. She was rung again on 23/01/13 when her husband took the call - the following day she was dead.

It seemed as if Mrs A had stayed strong at her own emotional expense in order to maximise the chances of a conviction but once she got home she interpreted the press reports as saying that she had not been believed despite her best efforts and she declared herself “utterly traumatised”. The HTT did not specifically assess Mrs A’s suicide risk during this time nor how to mitigate it. There was no inquiry into whether she was stockpiling medication or into how she accessed her husband’s insulin. The escalation in her suicide attempts represented by her use of her husband’s insulin marks a shift away from any sense that these were “cries for help” as opposed to credible attempts to end her life. There seems not to have been an explicit discussion with Mr A about how his medication could have been kept securely locked away from Mrs A during this traumatic period. The team were able to prescribe limited amounts

of medication to her but not to control this additional source of risk. In the event she did not use insulin in her final suicide attempt.

HTT were monitoring Mrs A carefully during this time but it is not clear whether they were sufficiently alert to the crisis that might ensue if the verdict went against Mrs A. and/or whether they were engaging with the hidden distress that pulled Mrs A into these cycles of harm and suicidality. They seemed to have allowed themselves to take a step back when Mrs A appeared, on the surface at least, to be in a more optimistic frame of mind.

But behind Mrs A's more independent face she hid her turmoil and fragility. It is as if the team lost sight of how the outcome of the court case would inevitably be a critical factor in whether or not Mrs A overdosed again. An assessment under the Mental Health Act was not conducted and it seems that, despite Mrs A's explicit statements about making further attempts to end her life, it was not considered that she might reach the threshold for voluntary or compulsory in-patient treatment.

15. RECOGNITION AND INTERVENTION IN TEAMS THAT ARE FAILING SHOULD BE TIMELY AND WELL MANAGED.

16. SABP SHOULD REVISE THEIR CONTINGENCY PLANNING TO PROVIDE STAFFING COVER IN SUCH CIRCUMSTANCES IN FUTURE.

17. DESIGNATING A CARE COORDINATOR SHOULD BE SEEN AS A PRIORITY WITHIN THE CMHRS TEAM AND SHOULD BE EFFECTIVE FOR URGENT REFERRALS WITHIN 5 WORKING DAYS OF THE RECEIPT OF THAT REFERRAL.

18. THE INTERNAL CRITICAL INCIDENT REPORTING FORM USED FOR REFLECTION BY THE TEAM SHOULD BE SUBJECT TO REVIEW WITH A VIEW TO PRODUCING A MORE IN-DEPTH INITIAL ANALYSIS WHICH WILL INFORM THE SERIOUS INCIDENT INVESTIGATION REPORTING PROCESS.

19. TRAINING AND SUPERVISION SHOULD BE OFFERED TO ALL STAFF RESPONSIBLE FOR COMPLETING INTERNAL MANAGEMENT REVIEWS (IMR) THAT ARE COMPREHENSIVE, COHERENT AND THAT DEMONSTRATE GENUINE REFLECTION AND CONSIDERATION OF THE IMPLICATIONS OF SERIOUS CASES FOR ORGANISATIONAL AND INDIVIDUAL LEARNING.

Risk management

Following Mrs A's death, a departmental Multi-disciplinary Critical Clinical Incident Review was conducted as per the proforma (previously referred to as a Serious Untoward Incident Review) but it did not address the failings that had occurred in the coordination of Mrs A's care or the difficulties in sustaining engagement with Mrs A or her family when crises had abated. It focused on the last, and fatal, suicide attempt without linking this back to the long trajectory of her struggle with childhood abuse and its legacy. We understood later that there had been an additional internal review of the case, but the Panel were not appraised of this in the course of their review.

The Panel took the view that the initial IMR submitted by SABP did not wholly reflect other evidence submitted to the panel and that it was overly defensive, because it suggested that there had been adequate care coordination which was not in fact the case. Nor did this report identify the systemic pressures that had led to gaps in provision,- for example the high sickness rate or the lack of clinical psychology input, which might have had the potential to contribute to care planning on the basis of the evidence base pertaining to the sequelae of childhood sexual abuse and sexual victimisation, including its manifestation in presentations sometimes referred to as Borderline Personality Disorder[12]. An appreciation of multiple mental states and of the way people traumatised in childhood shift between states in order to cope, might have prevented the team from colluding with Mrs A's pattern of distancing herself from their support as soon as she felt back in charge, but then rapidly falling back down into a place where suicide seemed the only way out. Some key dates are listed below to show how Mrs A's suicidality escalated over the time leading up to the trial and a complete chronology is appended to this report.

Date	Event	Action/outcome
May 2011	Police investigation begins	
1/8/11	First disclosure to GP of history of sexual abuse	
Early 2012	Mrs A approaches RASASC service in Guildford	They have 5 month waiting list

[12] This condition marked by extreme, and sometimes unstable mental states is also referred to as Emotionally Unstable Personality disorder or using a less stigmatising label Emotional Intensity Disorder. It is widely understood to be a result of difficult and traumatic early experiences and a form of cumulative post-traumatic stress disorder in those subjected to on-going or repeated experiences of violence, assault or sexual abuse. Some references on this condition can be found at the end of the report.

28/4/2012- 1/5/2012	Mrs A took overdose of prescribed medication and wine (1)	Assessed by Liaison Psychiatry team. Referred to Home Treatment Team and given Crisis Line number on discharge on morning of May 1st 2012
1/5/12- 2/5/2012	Mrs A took another overdose in evening and was readmitted to A&E (2)	Discharged on May 2nd 2012 after psychiatric assessment and flagged as low risk
8/5/12	Mrs A reported to her GP that she had taken 4 overdoses in the previous week (3 and 4)	Assessed by psychiatric liaison team as not detainable "given everything she has gone through they can understand her overdoses"
18/8/12	Mrs A took another overdose and was seen in A&E (5)	Again she is assessed as low risk and deemed not to have any underlying "severe or enduring mental illness" and hence not eligible for case management by CMHRS
Aug 2012	Mrs A rings GP at home late at might	
12 /9/2012	Care transferred to second GP within the practice	
28/9/2012	Consultation with new GP	Referred to primary care counselling service
26/9/2012	Mrs A says she does not want counselling but pragmatic support with anxiety, panic and depression in the run up to the trial	Her dose of Fluoxetine is increased, Diazepam reduced because of its addictive properties and risk if used in overdose
20/10/2012	Mrs A takes another overdose of medication and alcohol and is taken to A&E (6) Mrs A says she plans to take further overdoses	Assessed by Psychiatric Liaison Service deemed to be at medium risk if intoxicated but at low risk of suicide or self-neglect, referred to CMHRS from HTT
22/10/2012	Consultation with GP, says she has again stockpiled medications	Mirtazapine prescribed instead of Fluoxetine as more sedative, Diazepam stopped
24/10/2012	Multi-disciplinary meeting of CMHRS agree to offer a duty assessment	Assessment arranged for 31/10/2012
24/10/2012	Primary care counselling service deems Mrs A as too high a risk for its service	Assessed as amber

27/10/2012	Another suicide attempt using her husband's insulin was not notified to GP or at any time entered on her medical record. Mrs A called the Crisis Line and they were able to trace her call so attended her at home where she had taken an overdose without her family being aware of it (7)	
28/10/2012	Assessed by psychiatric liaison	Deemed to be at high risk but discharged home and GP surgery not notified
31/10/2012	CMHRS team assessment	Deemed to be at high risk but again GP surgery not informed
	SABP IMR (second version) stated that Mrs A should have been seen as an urgent case from this date onwards and that she should have had an assessment within 5 days as stipulated in the operating guidelines, but her case did not lead to an escalation of concerns.	
3/11/12 and 14/11/12	Mrs A seeks help from GP practice to change medication back to Fluoxetine as too drowsy and putting on weight	
23/11/2012	Still waiting to be assigned CMHRS keyworker and a psychiatrist	Discussions between GP and manager of CMHRS who propose to offer "Distress tolerance and emotion regulation sessions" but not clear when these will start
14/12/2012	Very serious suicide attempt using husband's insulin (8)	Admitted to hospital for 3 days discharged 17/12/2012
17/12/2012	CMHRS "zoning" had incorrectly recorded Mrs A as amber not red	Case still not assigned
17/12/2012	Emergency appointment with GP	
19/12/2012	First appointment with psychiatrist	Urgency promised in appointing care coordinator, increased dosage of Fluoxetine
2/1/2013	Care coordinator assigned	
3/1/13	Another serious suicide attempt with husband's insulin (9)	Admitted for 3 days until 6/1/2013 again assessed as at low risk
5/1/13	Assessed by HTT	Mrs A did not want to engage
9/1/13	Reviewed by psychiatrist CMHRS appoint key worker but she goes off sick	Considered to be at high risk of "accidental" overdose

14/1/2013	Court Case due to start	Mrs A finishes her evidence on 17/1/2012
18/1/2013	CPN rings GP re prescription of 4 days Diazepam and Zopiclone, they get this to her despite very bad weather	Mrs A saying she was "utterly traumatised" by process of giving her evidence
19/1/2013	HTT visit	Mrs A says she is "numb"
21/1/2013	HTT drop off medication but do not see Mrs A in person as she refused to engage	She declines further visit as plans to be in Manchester while her son gives evidence
22/01/2013	Home visit from HTT, husband and son in court yesterday. Son now back at University in Cambridge. Slept last night but permanently exhausted. Talked about the court case and past abuse also by uncle when she was nine. Also referred to having been abused by her mother. Said she appreciated staff support but wanted proper therapy which would help her develop coping skills to deal with the abuse from the past. Had plans to sleep, collect daughter from school then has music lesson.	HTT to phone Mrs A on 23.01.12 and visit on 24.01.12.
24/1/2013	Mrs A makes final suicide attempt and dies at home (10)	

The panel considered that the risk assessments that were completed following Mrs A's suicide attempts were unfit for purpose. Mrs A was discharged home and deemed to be at low risk despite increasingly frequent and serious attempts to take her life. The "zoning" decisions that were part of the triage system for CMHRS, seem almost arbitrary and, even if the mistaken recording of amber instead of red on 17/12/12 is taken out of the equation, the subsequent low risk status assigned to Mrs A on 3/1/2013 appears to be completely unfounded. These were not teenage "cries for help' and, given that Mrs A was by this point using her husband's insulin, nor could her overdoses be framed as "accidental". SABP's secondary IMR stated that Mrs A should have been treated as an urgent case from 31st October 2012, with an assessment within 5 days, as stipulated in operating guidelines. The IMR stated that they were unclear why this did not lead to an escalation of concerns about the team at this point.

Additional information submitted to the Panel following SABP's IMR states that **"the team were responsive to each overdose" but that "on reflection there was insufficient longitudinal risk assessing and management planning"** which appeared to the panel to be somewhat of an understatement. Assessors should have been aware of the context within which these suicide attempts were being made, alert to the enormous strain the trial had put on Mrs A and to the likelihood that painful memories would resurface as she gave her evidence. They should have been aware that the sequelae of childhood sexual abuse includes patterns of symptomology sometimes referred to as "borderline" and that these were seen in Mrs A.

The team and all clinicians, should have been cautious because they should have known that a multiple states model predicts that this would include the ability to present in competent, and even sometimes grandiose, states but that at other times a person would experience the world from a position of feeling diminished and without hope, as the subsequent SABP IMR acknowledges **"She [Mrs A] presented as a strong person who did not see herself as a 'victim' and was keen not to be viewed as such by others".** But this was only one side of the story and the IMR states that the HTT were influenced, and possibly thrown off course, by Mrs A's volatility and tendency to fragment in this way.

These were not risks that have become clear as a result only of hindsight,- they were apparent at the time. Suicide attempts that are numbered 8,9, and 10 from early December onwards, should have been recognised as serious attempts by Mrs A to end her life and they presented risks that could have led to assessment under the Mental Health Act 1983. To be sectioned, three people (an Approved Mental Health Professional (AMHP) or nearest relative and two doctors) must be in agreement that a person is suffering from a mental disorder *and* needs to be detained for assessment or treatment, either **for their own safety** or the safety of others. Under section 2 of the Act, someone can be detained for up to 28 days for assessment; under section 3 a person can be detained for up to 6 months for treatment; section 4 is used in emergency situations for assessment over a period of 72 hours.

The mental health service, including the Psychiatric Liaison service should revisit and recalibrate their thresholds for applying the Mental Health Act, their assumption that Mrs A was not eligible for an assessment to be held on MHA section from December 2012 onwards is not congruent with the evidence seen by the Panel.

20. PRACTICE IN ASSESSMENT OF SUICIDE RISK MUST BE STRENGTHENED IN THIS TRUST AND BROADENED OUT TO INCLUDE

⇒ UNDERSTANDING OF THE CONTRIBUTION OF CHILDHOOD ABUSE AND TRAUMA

⇒ EVIDENCE ABOUT PARA-SUICIDE AS A PRECURSOR TO FATAL SUICIDE ATTEMPTS

⇒ LONGTITUDINAL ASSESSMENT OF RISK INCLUDING CHANGES IN FREQUENCY OR SERIOUSNESS OF SUICIDE ATTEMPTS

⇒ HOW TO INVESTIGATE AND ASSESS THE DEGREE OF PRE-PLANNING OF SUICIDE ATTEMPTS

⇒ HOW TO MANAGE MEDICATION IN THE CONTEXT OF REPEATED OVERDOSES

⇒ THESE CONSIDERATIONS SHOULD BE ADDED TO DOCUMENTATION THAT IS USED TO GUIDE CLINICIANS IN THE ASSESSMENT PROCESS.

21. TRAINING AND SUPERVISION SHOULD BE OFFERED TO MEDICAL STAFF COMPLETING SERIOUS INCIDENT REPORTS FOLLOWING SUICIDE SO THAT A REALISTIC ASSESSMENT OF FAILURES TO PREVENT SUCH EVENTS IS COMPILED AND FED INTO SERVICE IMPROVEMENT PLANS.

22. RISK MANAGEMENT STRUCTURES AND PRACTICES SHOULD BE OVERHAULED TO ENSURE THAT ZONING DECISIONS ARE TAKEN APPROPRIATELY OVER TIME, REVISITED ON A REGULAR BASIS, AND PROPERLY RECORDED.

23. THRESHOLDS FOR APPLICATION OF THE MHA SHOULD BE REVIEWED WITHIN SURREY MENTAL HEALTH SERVICES AND MONITORED AGAINST NATIONAL FIGURES.

Working with voluntary sector providers

Mrs A also tried to access a service from RASASC, a voluntary agency working within the Guildford area. Notwithstanding there being a five-month waiting list, this service did make time to see Mrs A but she later reported to her GP (in Sept 2012) that it had not been helpful. Following Mrs A's death this service was invited to contribute to the Serious Case Review but declined to do so. The

Panel, and partner agencies noted with concern that this agency refused to conduct an internal management review or engage with the issues that were put to them through this process. For example, this service publicises itself as offering a guarantee of confidentiality to victims of rape and sexual assault but when asked to provide information about their policies regarding exceptions to this rule of confidentiality, they declined. Most counsellors and therapists work within a voluntary professional code of conduct that would see them referring anyone with a high risk of suicidality to statutory mental health services where they could be comprehensively assessed within the terms of the Mental Health Act.

Other voluntary agencies such as Samaritans and Women's Refuges, drug and substance misuse agencies, and offender programmes, also have to manage this interface and it is of national importance that protocols and thresholds be agreed between statutory, private and voluntary bodies, whereby these services appropriately refer matters concerning potential child or adult protection matters, suicidality or potential offending to the relevant authorities. It might seem that flagging up these exceptions cuts across the confidentiality of patients/clients and that this in turn might prevent them from seeking much needed assistance, but this must be weighed against the public interest invested in protecting children and vulnerable adults, and considered against the backdrop of holistic strategies such as the "Think Family" approach to mental health care.

Moreover, this service took the unusual step of "advertising" their sympathy for Mrs A's family on their website after her death. They thereby breached her confidentiality by saying that they had worked with her in this very public forum and used this disclosure as a pretext to invite financial donations. The Panel considered this to be wholly inappropriate and the Chair of the Panel asked them to remove this from the website which they duly did. The Panel were left wondering about the level of skill and supervision in this service, about their policies governing confidentiality and the sharing of information and about the ethical basis of their fundraising. Commissioning and partner agencies were asked to take these matters up with them as part of the review process.

Surrey Safeguarding Adults Board and its partner agencies expect voluntary agencies to sign up to agreed local Safeguarding policies and multi-agency information sharing protocols. Where they are commissioning services, adherence to these policies should be stipulated as part of service level agreements, alongside expectations that practitioners working under their auspices would work within the official codes of conduct governing professional practice. Engaging with the safeguarding partnership would also have enabled this agency to access training on safeguarding and risk management. Operating outwith the Safeguarding Adults partnership places these agencies and their staff at risk of breaching their legal responsibilities to act with "due care". Because of the clear links between childhood sexual abuse, domestic violence and mental ill-health, assessing suicide risk should be considered part of the core business of these services and cannot be undertaken in isolation from statutory services.

24. COMMISSIONERS SHOULD ENSURE THAT ALL VOLUNTARY AGENCIES RECEIVING MONEY FROM PUBLIC FUNDS ARE BOUND BY THEIR LOCAL SAFEGUARDING ADULTS AND SAFEGUARDING CHILDREN PROCEDURES.

25. COMMISSIONERS SHOULD ENSURE THAT ALL VOLUNTARY AGENCIES RECEIVING MONEY FROM PUBLIC FUNDS ACTIVELY SUPPORT AND ENABLE PROFESSIONALS WORKING IN THEIR SERVICE TO ABIDE BY THEIR PROFESSIONAL CODES OF CONDUCT.

26 VOLUNTARY AGENCIES WORKING WITH SURVIVORS OF ABUSE SHOULD BE REQUIRED TO SIGN UP TO SAFEGUARDING PROTOCOLS AND INFORMATION/RISK MANAGEMENT PROCESSES: WHERE THEY ARE COMMISSIONED LOCALLY AND/OR RECEIVE SOME OF THEIR FUNDING FROM LOCAL STATUTORY AGENCIES THIS OBLIGATION SHOULD BE WRITTEN INTO SERVICE LEVEL AGREEMENTS.

Preventing suicide: a national priority

Would it have helped Mrs A if mental health workers had been more attuned to her past suffering and her present mental crisis as it was reactivated and made visible on a wider stage? The Panel thought that they should have conducted their assessments with these issues clearly in view. It was the view of the Panel that the risk-assessments that were carried out were more like separate snapshots rather than a linked-up story.

A nonfatal suicide attempt is the strongest known clinical predictor of eventual suicide,[13] and nearly half of all suicides are preceded by an attempt at suicide that does not end in death. People who self-harm are at increased risk of suicide[14] and a history of self-harm is found in 40–60% of suicides.[15] Substance abuse, especially alcohol, is highly associated with para-suicide and this was a feature of Mrs A's suicidality. The National Strategy does not make explicit the links between childhood sexual abuse and suicide attempts, but it does refer to self- harm as an indicator of risk. Women, (and men), with a history of childhood sexual abuse have a high risk of developing self-harming symptomology, as they struggle to manage intense and often dissociated self-states. On this basis we can infer that they are at increased risk of suicidal thoughts and behaviour. The National Strategy on suicide prevention does not address the fact that a history of sexual abuse often contributes to high risk of suicidality and accounts for presenting symptoms that might otherwise be trivialised or stigmatised.

Many researchers and commentators have argued that mental health services should be more explicit about the, often violent, backgrounds of their patients[16] [17]**because this dignifies their ways of coping and honours their resilience, as an alternative to pathologising their resultant distress**.

The government's own abuse strategy[16], issued in 2008, argued for making these links explicit, citing the evidence that violence and abuse is implicated in mental ill-health for 70% of women and significant numbers of men. This is a cross-national finding. Goode et al (2003)[18] working in the Republic of Ireland evidenced the very high levels of childhood sexual abuse histories amongst adults receiving services in Irish psychiatric settings. In the USA, Rose,

[13] Welch, SS (Mar 2001). "A review of the literature on the epidemiology of para-suicide in the general population". *Psychiatry Serv* **52** (3): 368–75. PMID 11239107

[14] Skegg, K. (2005), "Self-harm", *Lancet* **336**: 1471

[15] Hawton K., Zahl D. and Weatherall, R. (2003), "Suicide following deliberate self-harm: long-term follow-up of patients who presented to a general hospital", *British Journal of Psychiatry* **182**: 537–542, doi:10.1192/bjp.182.6.537, PMID 12777346

[16] NHS Confederation (2008) Iimplementing national policy on violence and abuse: a slow but essential journey NHS Briefing Paper No 162 June 2008 http://www.nhsconfed.org/Publications/Documents/Implementi ng%20national%20policy%20on%20violence%20and%20abuse.pdf accessed Sept 1st 2013

[17] Rose, S. Peabody, C. and Stratigeas, B. (1991) Undetected abuse amongst intensive case management clients. *Hospital and Community Psychiatry* , **42**, (5), pp 499-503

[18] Goode, H. McGee, H. and O'Boyle, C. (2003) Time to listen: Confronting child sexual abuse by Catholic Clergy in Ireland Royal College of Surgeons in Ireland Liffey Press Dublin

Stratigeas and Peabody (1991) [19] argued that the services which we label as "mental health services" are predominantly services for survivors of abusive childhoods and that many manifestations of mental illness and distress have their roots in such maltreatment. But as the DH's briefing set out,

There is a notable reluctance on the part of mental health professionals of all disciplines to routinely explore service users' experiences of abuse, and to directly affect their healing process if they are a known victim or survivor, particularly of child sexual abuse.

They explained this reluctance as being

due to the virtual absence of any reference to violence and abuse in pre-registration and post-registration training. In-service training typically relates to safeguarding children, protecting vulnerable adults and, sometimes, domestic abuse. Furthermore, whilst mental health providers are striving to deliver a 'hope and recovery model', the tendency of individual services is still to prioritise the symptoms and behaviours of their client group over the causes of their mental ill health.

The evidence from these studies suggests that violence and abuse should be made explicit in clinical assessment because, when obscured, it colludes with a view of the symptoms of mental ill health as pathology rather than as clumsy and sometimes no longer effective coping mechanisms. This can lead to victim blaming and compassion fatigue.

Similarly, inappropriate and sexualised behaviour may result as the person carries forward learned patterns of intrusive relating and this also needs to be managed without further damaging the patient. This was the case with the lead officer from GMP, and Mrs A's GP, who found themselves dealing with this kind of behaviour. They are to be commended for dealing with Mrs A's breaches of their professional boundaries with integrity, and it is appropriate that their personal responses should have been formally supported through supervision and organisational willingness to make appropriate arrangements in these

[19] Rose, S. Peabody, c. and Stratigeas, B (1991) Undetected abuse amongst intensive case management clients Hospital and Community Psychiatry **42**(5) pp499-503

circumstances. These are not issues that can, or should, remain the sole responsibility of individual practitioners, without proper oversight and governance.

DH policy is that, as an alternative to focusing exclusively on symptoms, individuals being assessed should be asked about abuse in assessments, after appropriate staff training, and that survivors of abuse should receive care that is tailored to their history as well as to their needs. Both elements of this strategy were missing in the mental health care that was offered to Mrs A,- the extent of the childhood abuse she had suffered was not sufficiently linked to her mental ill-health and nor did it trigger sufficient alertness and care to prevent her from taking her life. Moreover, although practitioners were aware of the court case Mrs A was dealing with, they did not appear to recognise the seriousness of its effect on her ability to manage.

Had it been the case that the mental health services in Surrey explicitly recognised the need for their services to be tailored to victims of childhood abuse they might have identified and referred Mrs A into a programme of care that could have helped her.

The National Suicide Strategy also argues for better services when people have been hospitalised on account of and/or are known to be at high risk of suicide. Although Mrs A was inconsistent in her engagement with services, she could not have been clearer about the stress occasioned by the “looming” trial or the distress caused by her experience of giving her evidence. She made numerous requests for help during this time. Moreover, she stated quite clearly on discharge (20/10/2013) that it was her intention to commit suicide, and yet she was assessed as being at low risk, and even when later she was flagged as high risk, this did not trigger an urgent or appropriate response. Her suicide attempts, listed previously, were becoming more serious and more frequent; she had the means to commit suicide using her husband’s insulin and/or her own medication and she showed that she was able to go through with serious attempts on her life on a number of occasions. NICE guidelines specify that people attending A&E after episodes of self-harm should receive a full psycho-social assessment and these guidelines must in future be adhered to.

The national strategy also urges Mental Health Trusts to provide support to families of people who are at risk of taking, or who have taken, their own lives. They recognise that suicide leads to particular forms of grief and despair. Mrs A's youngest child was assessed by Social Services, but no further action was taken or services offered. It is not known whether her husband, adult children or other members of her family have been able to access the support they need at this time.

27. MENTAL HEALTH SERVICES SHOULD IMPLEMENT THE GOVERNMENT'S ABUSE POLICY, MAKING A HISTORY OF ABUSE EXPLICIT IN CLINICAL ASSESSMENT AND ENSURING THAT CLINICIANS ARE ABLE TO ADDRESS SYMPTOMS APPROPRIATELY.

28. THE NATIONAL SUICIDE STRATEGY SHOULD BE TAKEN AS A DRIVER FOR TRAINING AND SERVICE IMPROVEMENT ACROSS ALL MENTAL HEALTH SERVICES AND NICE GUIDELINES ON ASSESSMENT OF PATIENTS REPORTING TO A&E AFTER SUICIDE ATTEMPTS SHOULD BE ADHERED TO.

29.ASSIST AND/OR ANOTHER EVIDENCE BASED SUICIDE PREVENTION TRAINING PROGRAMME SHOULD BE ROLLED OUT ACROSS THE SABP TRUST

Care of Mrs A as a witness during the trial

The courtroom

Were there ways in which the trial could have been made less distressing for Mrs A? As a vulnerable witness Mrs A had a right to "Special Measures" in court to assist her as she presented her testimony and to shield her when she came face to face with her abusers. These protections were offered to her before, and even during, the court case but Mrs A declined them, probably because she thought her evidence would carry more weight if the jury were not made aware of her mental ill-health. Given that there was a presumption that Mrs A had capacity under the terms of the Mental Capacity Act 2005, the police and CPS believed that she was entitled to refuse these measures and to keep her mental health history confidential and out of the courtroom. In fact her mental health history, counselling records and so on, could have been carefully admitted as evidence in that it supported her account of the abuse she had suffered and was indicative of its lasting impact on her. Moreover, although it

would have been exceptional, the Judge could have taken a decision in Mrs A's best interests, and in the interests of justice, to impose special measures or to remove the perpetrator from the courtroom when he began to "smirk" in an intimidating way during Mrs A's testimony[20]. In this context "smirking" *was* an act of extreme aggression and one demonstrating contempt for the legal process as well as for Mrs A.

Should the CPS have known about and/or been informed of Mrs A's mental fragility? Mrs A usually presented herself to them as someone who was clear and strong and who therefore wanted to face her abusers in open court without any protection. She did not disclose her mental ill-health because she thought, - and was probably right in thinking, that her credibility would be impugned if her mental distress was made apparent in the jury. The GMP IMR reports that Mrs A came across as very competent in Court, "**she was able to robustly give her testimony showing the ability to comprehend the questioning and respond accordingly"**. But there was also a different side to her, and we can see from the transcript that she did get confused and flustered, argumentative and unclear.

The judge did intervene on a number of occasions to assist her in sticking to the questions that she had been asked and in moving away from "sticking points" where she was being asked to remember things that she owned she could not recall clearly, including dates and the order of things. What she did do consistently in her evidence was point to contextual details that underlined the credibility of her account. Presenting differently, in different mental states, does not mean that a person is lying but that, as in this case, Mrs A had intense, and difficult to manage, feeling states accompanied by "shifts" in mood and behaviour. Her evidence conforms to what is known about the way disclosure of childhood sexual abuse and other forms of violence occurs.

The Mental Capacity Act 2005 (MCA) was designed to fill a vacuum that previously prevented adults with mental impairments from making decisions in some, even if not all areas of their lives. It is predicated on a presumption of capacity and a decision-specific, and time- specific, test of capacity that places

[20]This was the way Mrs A referred to the defendants behaviour in court during her testimony and is recorded in http://www.dailymail.co.uk/news/article-2275974/-Violinists-anguish-blow-blow-account-cross-examination-accusers-lawyer-branded-fantasist.html

an onus on any person seeking to make a decision on someone else's behalf, to make salient information about the matter at hand accessible and to provide assistance in making the decision if at all possible. Only if the person were not able to "understand, retain and use the information in weighing up their decision" would they be deemed to lack capacity to make a particular decision, in which case another person could, and should, make a decision on their behalf and "in their best interests".

Because Mrs A seemed able to make the decision to refuse special measures in Court, the CPS or other agents of the Court, would not have been prompted to question her capacity unless they had been in possession of detailed information about her mental ill-health. Even then the MCA and its guidance does not deal fully with the cognitive impact of mental illness as opposed to learning disability, acquired brain injury, dementia or other cognitive impairments. This is not to say that a mental health diagnosis, in isolation, implies a person may lack capacity, but that mental distress may cut across some areas of competent decision-making at particular points in time.

The mental health services did not consider that at any time during their contact with Mrs A where they should have been concerned about her decision-making capacity, and the same was true of the police and the CPS. However, viewed with hindsight it might be that Mrs A's capacity was, at some times, compromised in relation to these matters by the trauma of revisiting the abuse she had suffered in such a public arena and she was therefore entitled to all possible assistance and information to help her make these decisions and/or for some specific decisions to be made by others in her best interests.

The MCA needs to be applied in a nuanced way to such situations, because Mrs A's manifest instability might have cut across her decision-making capacity at key times during the time leading up to her death. Her shifting states, whereby she morphed from the strong confident person she portrayed herself to be in her dealings with the CPS, to the despairing person seen by the mental health team in the aftermath of her overdoses, might suggest that she was not able to make and/or act on fixed and settled decisions about particular aspects of her welfare. When she was in a confident state of mind, she was not able to be mindful of her fragility or to take into account how easily she collapsed into

vulnerability (see Brown 2011[21] for a detailed discussion of these issues). Assessing capacity in someone whose states fluctuate in this way is necessarily complex because the person may on the surface present as having capacity, while actually being overwhelmed by emotion and therefore unable to "think straight" in another context.

Mrs A's evidence

Courtroom procedures have evolved to strike a balance between the rights of victim/witnesses to be respected and protected and the right of defendants to test and challenge their evidence. Victims of sexual abuse are often presenting evidence in cases that rest solely on their personal testimony and this lays them open to being judged and discounted. A flavour of the cross-examination is included below taken from the Guardian's contemporaneous report of the trial.

> Mrs A was a combative, confident and emotional witness. When Kate Blackwell QC, Brewer's barrister, alleged her account of being raped by the B's at their house was "utter fantasy", Mrs A loudly replied: "Bollocks".
>
> "You have told this jury a complete pack of lies about the visit to this house," said Blackwell.
>
> Mrs A replied: "This is why cases don't come to court. This happened."
>
> "You spent the night lying next to two of your rapists?" asked the barrister, referring to Mrs A's account of sleeping three in a bed with the Brewers after she said they had raped her.
>
> Mrs A answered: "But this happened. I felt guilty, I did not know how to get out of it.
>
> "This is a lie," said Blackwell. "You could have left the house at any time."
>
> Mrs A replied: "You have got no idea clearly about what it is like to be raped. You have clearly no feminine understanding of what someone goes through like that. What shock your body goes through. How you almost feel you deserve it."

As Mrs A describes in this extract, overly assertive cross examination repeats a process of discrediting that victims of childhood sexual abuse have already experienced. Court officials should therefore pay more attention to the victim/witness's mental welfare and ability to make decisions about what

[21] Brown, H (2011) The role of emotion in decision-making Journal of Adult Protection vol 13 no 4 pp. 194-202 Emerald Group Publishing

special measures to accept, in cases of historic abuse and to the particular cognitive impairments that are a consequence of post-traumatic stress disorders (PTSD) and conditions that have, until recently, been labelled as Borderline Personality Disorder (BPD). It might be that a judge should take it upon her or himself to **impose** special measures and/or to remove the defendant where his or her behaviour seems to be undermining or intimidating a witness, even if this is through non-verbal means such as smirking, or making aggressive facial expressions or gestures. If the judge were to take responsibility in these situations the jury would not be left to infer that this was any reflection on the witness's credibility. In this case the Judge was clearly concerned enough to **offer** special measures **during** the court process even though Mrs A had previously refused them.

During her cross-examination, Mrs A had accused MB of smirking at her in the courtroom and it was this that had prompted the judge to offer her additional protection in the form of a screen which she refused. In this way it seems as if her courage was on trial but she did refuse to be goaded by MB into admitting any mental fragility, that she did so was a measure of her public spiritedness and wish that other young women would not be left at risk of harm from him as she had been.

Reporting of historic cases of child sexual abuse in the media

Before the Jury retired, the Judge had dismissed several of the charges on technicalities due to the fact that the Court did not have evidence to prove how old Mrs A had been at the time of the alleged offences. The Daily Mail duly reported this, and it was this article that Mrs A had open on her iPad when she died. The Panel felt that it was unhelpful that the case had been taken to court without these issues having been ironed out because this risked giving the impression that Mrs A was unreliable and/or that there was insufficient evidence.

This issue was addressed in detail in the post trial review chaired by the Director of Public Prosecutions (DPP) on March 12th 2013 and there was consensus in that meeting that Mrs A had been appropriately consulted about the charges and the way these were framed. The offences in childhood were noted as being

less firm as a result of confusion about dates but it was felt important to proceed despite this. It might have been possible for expert witness evidence to have been presented to the jury making clear the way that traumatic sexualisation cuts across ordered memory and that it would not be untypical of adults in this situation to find their recall of dates difficult as opposed to their ability to remember contextual details. There is precedence for this kind of evidence to be offered in support of someone whose mental fragility might otherwise suggest that their testimony is not reliable (see for example Neutral Citation Number: [2004] EWCA Crim 1294) a case in which two psychiatrists gave expert testimony about the mental state and evidential credibility of a woman with dementia). It might have been possible for the investigating officers to have drawn up a timeline with Mrs A based on her recollections and on the contextual information that she provided and/or to have called subsidiary witnesses that firmly located the incidents that she recalled in time. These details could have been corroborated by others and/or by reference to school records or other documentation.

As it was, Mrs A interpreted the dismissal of these charges to mean that she had not been believed which was particularly painful for her because it echoed her previous experience of not being believed or supported as a child. It is telling that she did not crumple in court under the strain of the cross-examination, even though this had included her being referred to as a liar and a fantasist,- it was the thought of the perpetrators being found not guilty that triggered her last, fatal, suicide attempt. The Panel thought that counsel should have maintained contact with Mrs A right up to the end of the trial, explaining legal issues through to the delivery of the verdict. This would have enabled them to explain, for example, the reasoning behind the decision to drop some of the charges, and any other process issues that could lead a witness to feel discounted or disappointed. The CPS and/or the OiC could also have kept in touch with Mrs A until the end of the trial and not left her to manage this disappointment or her return home without further assistance.

Reporting restrictions stayed in place until after the verdicts so that the jury were not aware that Mrs A had taken her life. She had not consented to be named during the trial process, but this protection only lasts for the duration of

a person's lifetime and therefore, when Mrs A died, the press broke her anonymity. Her family subsequently gave detailed information about her background to the media, including information about her experiences of having been adopted and of having been sexually abused by a family member from the ages of three until her teens. It is unclear whether they had qualms about opening up to the press about her in this way. In many ways it is helpful if the public are educated about the precursors to, and the lasting impact of, sexual exploitation in childhood or adolescence. It might be that their disclosures helped to portray Mrs A's childhood in a compassionate light eliciting understanding for her, and by association, for all victims of targeted abuse, and that this was indeed their intention. Nevertheless, such disclosure after death raises ethical issues.

The GMP IMR author agreed that it might have been helpful for a GMP officer to have liaised with Mrs A throughout the trial right up to this point, and to have allayed her fears that all charges would fall. A person from the witness service, provided by the charity Victim Support, stayed with her while she was giving her testimony, but the liaison stopped when she returned home. He therefore recommended that victims of rape or serious sexual assaults receive a daily call from the Officer-in-Charge right up to the end of a trial so that any legal issues can be accurately represented to the victim/witness and any fears allayed. This would be particularly important for someone involved in a case that does not reach a successful conviction on some or all counts, as occurred in this instance.

This continuity of care is also consistent with the revised Code of Practice for Victims of Crime, (the Victim's Code) that **"sets out the minimum standard of service and aims to ensure that victims of crime are provided with timely, accurate information about their case at all stages of the criminal justice process… The nature and sensitivity of child sexual abuse cases will inevitably mean that prosecutors (and the police) should go beyond the minimum requirements of the Victim's Code where appropriate to do so, and this should be agreed, recorded and actioned by the prosecutor and the police in the case".**

30. As part of the preparation for a trial a time-line should be constructed using various sources as corroboration so that an abused witness does not have to present details about times and dates in order to come across as a credible witness.

31. Mental health workers should be supported to develop their ability to make nuanced and well considered assessments of mental capacity in relation to specific decisions, including the application of special measures, where a person's cognitive functioning is temporarily or indefinitely affected by mental ill-health or distress.

32. The Crown Prosecution Service (CPS) and Police Witness Care Units (WCU's) should maintain contact with potentially vulnerable victims/witnesses throughout the whole course of a trial, beyond their own testimony, and right through the process of obtaining a verdict and sentencing, explaining to the victim/witness on what basis decisions have been made and helping the person to manage their reactions to the court's decisions.

33. All victims of rape or serious sexual assault, including historic cases, should receive a daily call from the OIC even after they have finished giving evidence so that, within the legal constraints of the judicial process, reassurance can be provided and any concerns identified and addressed, and if appropriate referred on to other services.

Concluding remarks

Turning concerns into change

Several of the agencies consulted have already used their internal review process to identify weaknesses in their current policies and practices and to suggest areas for improvement: these are summarised at the end of this document. This report has taken note of these recommendations but has made further suggestions about how each agency, and the partnerships between agencies, should improve their practice in relation to vulnerable adults who are survivors of childhood sexual abuse. We have been concerned that these lessons are learned especially in relation to victims who seek to get justice for

themselves and protection for others who might otherwise fall prey to those who have abused them. Those individuals and agencies charged with the care of people made vulnerable in this context should in future attend to their mental health and to their welfare more diligently.

The Panel believes that Mrs A's abuse as a young woman at Chetham's School, the lack of attention that was paid to her safety and the failure to look into the protection of other young pupils who were also sexually abused by their teachers, marked a significant breach of child protection practice. We recognise that child safeguarding services have come a long way since then in recognising the damage done by the sexual exploitation of young people, but even taking account of the times in which these events occurred, it would appear that the school did not operate with sufficient accountability within local child protection procedures. Schools, even those catering for "special" pupils, should not cast themselves as, or ever be allowed to operate as if, they are above the law or outside the purview of the child safeguarding process.

We also believe that, as an adult survivor, Mrs A was let down by mental health services who did not appreciate how vulnerable she was throughout the process of bringing her abuser to justice and who did not put proper care coordination measures in place or adequately risk assess her increasingly serious suicide attempts. Although Mrs A presented in different mental states, sometimes competently and assuredly, while at other times showing great vulnerability and despair, this is territory with which mental health professionals should be familiar. Her apparent confidence should not have been allowed to undermine the intensity of the support that was offered to her or the urgency of attempts to engage with her.

The Panel considered that this was a suicide that could and should have been prevented. Mrs A had reasons to live and she continued to ask for help throughout this period. We therefore invite all the agencies concerned to take real and concrete steps towards improving their practice. When historic cases of sexual abuse come to court, we ask former victims to stand up and lay bare details about their lives that are painful and intimate. Criminal justice and mental health services should be able to provide a comprehensive and seamless support service to them throughout this process because, as this case

demonstrates, *historic* abuse is always a *present* source of difficulty and distress to those who have been victimised.

Specifically, we ask that

⇒ Criminal justice agencies improve their practice in supporting survivors of sexual abuse, in recognising the vulnerability of witness/victims as they face their abusers in court, and in acknowledging when victim/survivors might lack capacity to make decisions about special measures that would be in their own best interests. The police and CPS should *promote*, (not merely not dissuade), victims from seeking, timely counselling and they should stand alongside vulnerable witnesses in court, underlining their veracity to jurors by introducing expert witness testimony when they give their evidence. The media also has an important role to play in educating the public about the effects of childhood abuse, so that its consequences for a person's mental health, are understood by all, and so that jurors will take on their responsibilities from an informed position.

⇒ Mental health services should increase their alertness to the consequences of sexual exploitation and to the risks of suicidality and other forms of self-harming behaviour that are linked to it; they should work sensitively to make such histories explicit and to dignify a person's coping strategies. Commissioners and service managers should be much more informed and sensitised to the needs of people who have emotionally intense but unstable mental states[22] and to the skills required for engaging, properly assessing and containment of risk in these cases. They should recalibrate their application of the Mental Health Act to ensure that someone making repeated suicide attempts is appropriately assessed and reviewed.

⇒ The Press also has a role to play both during a trial and in relation to its broader remit of public education. Journalists, broadcasters and editors should be mindful of the way a person's mental health and their credibility are discussed throughout court proceedings, not only because they are obliged to avoid influencing a jury or the legal process, but out of respect for individual witnesses (who are not the ones on trial) and for their families.

[22] These conditions might previously have been referred to as Borderline Personality Disorder

Public education about the effects of childhood abuse on adult survivors may go some way towards de-stigmatising symptoms and behaviours such as self–harm, mental ill-health and eating disorders,- conditions that are otherwise used to blame and marginalise victims. This will, in turn, serve justice because juries are drawn from the general public and will be in a better position to evaluate abused victims and witnesses.

Taking action

Mrs A deserved support as a troubled teenager, and she most certainly deserved support again when, as a mature woman concerned for the safety of others, she stood up and faced her abusers in court. The Panel commend her bravery for taking a stand in this way. Those services, who held responsibility for her care, were found wanting in number of ways, and we hope that Mrs A's death will galvanise them to provide more coordinated and skilled care to other victims of historic abuse. Perhaps then, Mrs A's wish to protect other young people, can belatedly become a reality.

Summary of recommendations

1. This review did not have a mandate to comment on issues of child protection but urges children's safeguarding boards and the Independent Schools Inspectorate to pay attention to all schools especially but not exclusively, boarding schools, including those concerned with "special" pupils or those that have elite status. This includes so called "free" schools that exist to some extent outside of local networks.

2. The Home Secretary and the College of Policing will be asked to initiate the development of guidelines on how to share information across Police Forces with specific regard to historic abuse cases

3. Both police forces and CPS units, in association with the College of Policing, should work to implement the change in emphasis outlined in recent guidance from the CPS, testing the allegation rather than challenging the credibility of survivor witnesses of childhood sexual abuse

4. Managing fragmented and sometimes un-boundaried behaviours should be seen as a core task across all professional groups dealing with victims of historical sexual abuse. National bodies such as the College of Policing, the GMC (General Medical Council), RCN (Royal College of Nursing), Teaching and Social Work bodies, and other national organisations should be advised to include these issues in their curricula so that their members are trained to recognise and manage these symptoms in unstigmatising ways.

5. Appropriate managerial oversight and professional supervision of cases involving people abused in childhood should be provide to practitioners in the police force, the medical profession and mental health services.

6. All agencies should have guidelines in place that help staff to manage inappropriate and/or sexualised behaviours when they arise in the context of their work: these should allow practitioners to escalate concerns about inappropriate and/or unboundaried behaviour on the part of patients or clients and offer a route for case reassignment and/or redeployment as a matter to be managed on behalf of the agency as a whole and not left as something for the individual practitioner to manage alone.

7. Safeguarding procedures across other local authorities and across Surrey's partner agencies, should state provisions for victims of historic abuse and/or contain information about how to signpost alleged victims to services that can advise and help them.

8. Expert witness testimony as to a person's credibility should routinely be offered in court to explain to jurors how childhood sexual abuse affects individuals because this is germane to the way they assess the truthfulness of a victim/ witness's account in the light of their traumatic experiences; this recommendation will be conveyed to The Home Office, The Director of Public Prosecutions and to the College of Policing .

9. Police forces and mental health practitioners should be provided with additional training on how to assess mental capacity and support assisted decision making; they should understand the role of mental health difficulties and emotional distress in sometimes over-riding the cognitive processes necessary for sound decision-making.

10. Where a judge is of the considered opinion that a witness is vulnerable, even in circumstances where that witness has refused special measures, the judge should be proactive by introducing special measures that both protect the person deemed to be at risk of psychological or physical harm and the quality of evidence put before the court.

11. Steps should be taken to ensure that mental ill-health is not seen as a barrier to participating in and/or receiving, justice including following CPS guidelines on pre-trial counselling.

12. Workers within the HTT and CMHRS should be offered training on the sequelae of sexual abuse and on managing presentations marked by intense and unstable mental states

13. Workers within the HTT and CMHRS should have access to a range of specialist services to whom they can onwardly refer survivors of personal or sexual violence; a directory of such resources should be compiled

14. NHS Commissioners should ensure that there are adequate specialist services within their catchment area to meet the needs of people who are survivors of childhood trauma and abuse

15. Recognition and intervention in teams that are failing should be timely and well managed

16. SABP should revise their contingency planning to provide staffing cover in such circumstances in future

17. Designating a care coordinator should be seen as a priority within the CMHRS team and should be effective for urgent referrals within 5 working days of the receipt of that referral

18. The internal critical incident reporting form used for reflection by the team should be subject to review with a view to producing a more in-depth initial analysis which will inform the Serious Incident investigation reporting process.

19. Training and supervision should be offered to all staff responsible for completing internal management reviews (IMR) that are comprehensive, coherent and that demonstrate genuine reflection and consideration of the implications of serious cases for organisational and individual learning

20. Practice in assessment of suicide risk must be strengthened in this Trust and broadened out to include

- understanding of the contribution of childhood abuse and trauma
- evidence about para-suicide as a precursor to fatal suicide attempts
- longitudinal assessment of risk including changes in frequency or seriousness of suicide attempts
- how to investigate and assess the degree of pre-planning of suicide attempts
- how to manage medication in the context of repeated overdoses
- these considerations should be added to documentation that is used to guide clinicians in the assessment process

21. Training and supervision should be offered to medical staff completing Serious Incident reports following suicide so that a realistic assessment of failures to prevent such events is compiled and fed into service improvement plans

22. Risk management structures and practices should be overhauled to ensure that zoning decisions (that is the risk assessment decisions taken in mental

health care) are taken appropriately over time, revisited on a regular basis, and properly recorded

23. Thresholds for application of the MHA should be reviewed within Surrey mental health services and monitored against national figures

24. Commissioners should ensure that all voluntary agencies receiving money from public funds are bound by their local Safeguarding Adults and Safeguarding Children procedures

25. Commissioners should ensure that all voluntary agencies receiving money from public funds actively support and enable professionals working in their service to abide by their professional codes of conduct

26 Voluntary agencies working with survivors of abuse should be required to sign up to safeguarding protocols and information/risk management processes: where they are commissioned locally and/or receive some of their funding from local statutory agencies this obligation should be written into service level agreements

27. Mental health services should implement the government's abuse policy, making a history of abuse explicit in clinical assessment and ensuring that clinicians are able to address symptoms appropriately

28. The National Suicide Strategy should be taken as a driver for training and service improvement across all mental health services and NICE Guidelines on assessment of patients reporting to A&E after suicide attempts should be adhered to.

29. ASSIST and/or another evidence-based suicide prevention training programme should be rolled out across the SABP Trust

30. As part of the preparation for a trial a timeline should be constructed using various sources as corroboration so that an abused witness does not have to present details about times and dates in order to come across as a credible witness

31. Mental health workers should be supported to develop their ability to make nuanced and well considered assessments of mental capacity in relation to specific decisions, including a decision to disengage from services or to refuse

special measures, where a person's cognitive functioning is temporarily or indefinitely affected by mental ill-health or distress

32. The Crown Prosecution Service (CPS) and Police Witness Care Units (WCU's) should maintain contact with potentially vulnerable victims/witnesses throughout the whole course of a trial, beyond their own testimony, and right through the process of obtaining a verdict and sentencing, explaining to the victim/witness on what basis decisions have been made and helping them to manage their reactions to the Court's decisions.

33. All victims of rape or serious sexual assault, including historic cases, should receive a daily call from the OiC even after they have finished giving evidence so that, within the legal constraints of the judicial process, reassurance can be provided and any concerns identified and addressed, and if appropriate referred on to other services.

Lessons Learned/Recommendations from Internal Management Reviews

Agency	IMR Lessons Learned/Recommendations
Surrey and Borders Partnership Foundation Trust	**Lessons Learned** Good Practice:- Mrs A was assessed promptly by psychiatric liaison service and HTT on several occasions on presentation at RSCH following overdoses with plans put in place for follow-up when required HTT provided intensive community support from 10.01.13 to 24.01.13 with frequent contact and home visits, providing additional support and medication to help her at time of crisis including making arrangements to visit her and ensure that she had her prescribed medications in the period of heavy snow. Mrs A's family stated that Mrs A had appreciated the support she received from mental health services Psychiatrist from CMHRS had provided review appointments swiftly when requested The psychiatric liaison service, HTT and CMHRS communicated effectively between their services Practice Issues:- (i) Care Plan Issues – During assessments and contacts with the service, Mrs A had highlighted a Number of significant factors affecting her mental health including severe stress arising from the court case; financial problems; concerns and anxieties related to her year-old daughter; her husband's ill-health; impact of recent visit to see her birth mother and concerns about her mother's ill-health. Whilst she was given time to discuss these issues during assessments and appointments and given general support, there was no co-ordinated agreed care plan in place to assist her with these different issues. A care plan would have helped achieve clarity about the type and timing of any psychological treatment; advice regarding financial difficulties; offer of a carer's assessment and interim support during the court case. The CMHRS were not able to provide a care co-ordinator in a timely manner to develop a care plan in conjunction with Mrs A. Although Mrs A was ambivalent about her engagement with mental health services, she had highlighted difficulties with engaging with different staff from the HTT and an identified consistent care co-ordinator is more likely to have resulted in engagement and a clear care plan to meet the identified needs. (ii) Risk assessment and risk management issues – On several occasions in the months preceding her death, Mrs A had taken overdoses of her husband's medication which may have been a factor in her death(outcome of the coroner's investigation not known at this time. Additionally, Mrs A had identified that she hoarded medication. The manager of the CMHRS and the psychiatric liaison team both highlighted the need for risk assessments to lead to risk management plans that clearly address the risks associated with medicines not prescribed for the service user and how to improve their security and reduce the risks. Risk assessments did not fully

	consider the risk of overdose, the hoarding behaviour and access to her husband's diabetic medication and a specific risk management plan was needed to address these risks. (iii) Psychological Help for Survivors of Sexual Abuse – There was some initial lack of clarity regarding the most appropriate psychological help and treatment that needed to be offered to Mrs A before the court case and longer term. She had contacted RASASC herself regarding therapy in early 2012 but there was a long waiting list. She had also been referred by her GP to the IAPT service for short term work in October 2012 but was considered too high risk for their service. This issue was further complicated by Mrs A stating that she had been advised by the police against starting therapy before the court case. However, in early November 2012, the CMHRS did advise Mrs A that longer term psychotherapy would be beneficial once Mrs A was more emotionally stable and the immediate risks had reduced probably after the conclusion of the court case. In the meantime, she had been told that the CMHRS could explore emotional regulation and distress tolerance skills work to help her. The plan was for this to be discussed with the care co-ordinator once allocated. This plan was repeated in discussions between the CMHRS and GP in mid- December, but a care co-ordinator had not been allocated so this had not been progressed. This psychological help needed to be provided in a timely manner and referrals made for longer term psychological therapy as part of the care plan. Additionally, the HTT needs access at times to psychology to provide short-term psychological interventions where necessary. (iv) Liaison with other agencies regarding support needs related to court case – There was no evidence of communication between the mental health services and the police or criminal justice service despite the court case being such a major factor in Mrs A's life and problems. Mrs A had indicated concerns regarding information about her mental health problems being communicated to the police and may not have wanted the mental health services to contact the police liaison officer in Manchester. However, it seems this may not have been discussed with her and her consent sought. If she did not give consent, then advice could have been sought from the police victim support services and the local authority as to support available and whether there was information that agencies needed to know. **Recommendations** Mental Health teams to ensure that risk assessments and MDT reviews are recorded accurately in Rio records at all times and incorporate risk assessment and management plans related to specific risks identified. There should be evidence in the Rio record that these plans have been created and agreed with the person being supported by the service. Teams to ensure that psychological needs are fully considered and clarified in such cases with clear plans of how psychological therapy will be provided, by who, and when. Ensure referrals are made for appropriate psychological

	therapy at earliest stage possible so that when time is right it can be provided as quickly as possible. Teams to be made aware of the increased risk associated with being involved in court proceedings and ensure close communication with other agencies and plans in place to support people in this situation. Obtain advice from partner agencies and specialist support services to inform work with people in this situation who are in contact with mental health services. Teams to ensure that advice is sought from other agencies such as the police and court services to clarify support offered and any communication required or appropriate to support the service user in such circumstances Teams to ensure timely communication with GP's and ensure systems are in place for information to be sent to GP when they are unable to contact GP by phone. CMHRS to ensure that systems are in place to allocate a care co-ordinator in specified timescales where the need is urgent, to ensure interim contingency plans are in place pending allocation and to escalate any service delivery problems with allocation of urgent cases to senior managers.
Greater Manchester Police	**Lessons Learned** The Code of Practice for Victims of Crime makes it an implicit responsibility on the Police when dealing with sexual offences to ask victims if their details can be passed to the Victim Support Service, if that consent is denied, the Police must ensure that the victim can access information regarding local victim support services and provide the contact details of those agencies as soon as possible or in any case within five working days of the report being made. In this case this did not happen until the investigation had been transferred from the North Manchester to the South Manchester Division, a period of around three weeks. This was a simple oversight by the initial investigators who accept that they had erred on this occasion. The omission was rectified by the OIC as soon as he assumed responsibility for the investigation and, in the author's opinion, his approach to supporting Mrs A was exemplary. **Recommendations** The author believes that the Criminal Justice System guidance documents 'The Code of Practice for Victims of Crime' and 'Witness Charter' provide sufficient framework for the Police to instigate and manage support for both victims and witnesses involved in the judicial process. The evidence of this review has revealed minor individual oversight that is accepted by the officers concerned but it has not identified any systemic failings requiring remedial recommendations. However, the author is aware that on 11th June 2013, the government announced proposals to allow children and vulnerable adults to give their

	evidence and be cross-examined in advance of a trial starting thus taking them out of what the Justice Secretary describes as the *"cauldron of the courtroom"*. The Greater Manchester Police Commissioner Tony Lloyd said *"The tragic death of Mrs A demonstrates in the starkest terms how much of an ordeal giving evidence can be".* That the Public Protection Division Commander considers reviewing the 'Talon' policy document last published in January 2013 to include a process whereby all victims of rape or serious sexual assault receive a daily contact call during the trial process from the OIC so that, within the legal constraints of the judicial process, reassurance can be provided and any concerns they may have can be identified and addressed. (This recommendation was submitted in the further comments paper)
Surrey County Council Children's Services	**Lessons Learned** It is difficult to see into the future and easy to review a case when the reviewer is aware of one or more outcomes. To ensure that there is good communication between adult health services and children's social care where there are concerns about parents mental health impacting on the care of their children. **Recommendations** To ensure that there is good communication between adult health services and children's social care where there are concerns about parents mental health impacting on the care of their children. Managers to embed reflective supervision systems and to ensure a feedback loop is completed when one agency closes a piece of work.
SECAMB	The responses made to Mrs A by SECAmb were all clinically appropriate. Each call resulted in her being transported to hospital for further treatment. The PCRs were completed to a good standard, with clear information regarding the stress she was under, the difficulty of engagement with community mental health services (obviously from the perspective of the patient) and the nature of the of the self-harm and suicidal intention of Mrs A. This information would have been handed over to the receiving hospital at the time, which would have facilitated further investigation and treatment as appropriate. The nature of ambulance work, brief and intermittent interventions at crisis points does not enable a 'whole picture' approach to patient care. The escalating nature of Mrs A's suicide attempts would not have been identified through these interactions. However, making a report where children, or other vulnerable persons are identified as living in an environment where a parent or carer is making clear suicide attempts is very possible and action should be taken under these circumstances. Overall, the response from SECAmb was appropriate and whilst there was a lack of VP referrals being made following some of the contacts with Mrs A, I do not feel that this impacted in the eventual, sad outcome, which would have been very difficult for SECAmb staff to have anticipated.

	Recommendations 1. All staff directly involved in delivering care to Mrs A will have the need to safeguard vulnerable adults and children in similar circumstances highlighted and they will be reminded of their responsibility to report this. 2. All staff will be reminded of their responsibility to safeguard (as above) in an anonymised way.
Royal Surrey County Hospital	**Lessons Learned** It has been identified that there was not an information sharing form completed in relation to her youngest daughter and this has already been identified within the trust as good practice. There may have been lack of clarity about who was providing support to Mrs A coming up to and during the court case, which had already been identified as a major stressor. Also, although I don't think that it impacted on the outcome of Mrs A's case, there were delays in her being assessed by the MH teams as they were waiting for her to be medically fit for discharge rather than medically fit for assessment. **Recommendations** Staff working in the Accident and Emergency and Emergency Assessment units will be reminded to consider whether there are children at home when someone attends with self-harm or other mental health issue and whether there is need to complete an information sharing form if there are concerns. This will be raised by the Safeguarding Training Nurse with the matrons in both areas and posters will be made to display in staff areas. In situations where there are several agencies involved with providing care for individuals, we should be explicit about who is the lead agency for providing support or care in our correspondence, including discharge summaries. This improvement in communication would enable all agencies to be clear about where support There will be discussion between RSCH and SABP to formalise an agreement that MH assessments can be initiated when people are medically fit for assessment, rather than discharge. This will be for both the PLN and HTT teams.
Surrey Police	**Lessons Learned** While victim support and witness care for Mrs A was the responsibility of GMP it is felt that more accurate recording and appropriate sharing of information by Surrey Police following contact with Mrs A may have prompted additional support from other local agencies. Surrey Police could have made better use of CIS and 39/24s to record contact and share information concerning Mrs A. It is not felt that rectifying these administrative issues would have prevented Mrs A from taking her own life but it may have assisted in giving both GMP and Surrey Police more information to act upon. **Recommendations** The Head of the Contact Centre should ensure that all members of staff employed within the Contact Centre and Incident Handling Centre fully understand the policy around the recording of Out of Force crimes including what offences constitute a serious crime.

	The Head of the Contact Centre should ensure that the Customer Operations Desk staff record on the ICAD the details of where / to whom an ICAD has been shared. The Head of the Contact Centre should ensure that the Customer Operations Desk staff properly check the content of an ICAD and cross referenced ICADS ensuring all interested parties are updated prior to closure. The Head of the Contact Centre should ensure that all emails to external agencies are emailed from a group mailbox not from personal email accounts. The Head of Public Protection should remind all police officers and police staff through a force wide communication of the safeguarding requirement to complete a ZJ report and 39/24 following every contact with a vulnerable adult. The Head of Public Protection should ensure that staff within the CRU scrutinise the information recorded on all 39/24's and are sufficiently trained and aware of the appropriate agencies available that are best suited to offer support to individual circumstances. The Head of Public Protection should ensure that in the interest of completeness and future scrutiny staff within the Central Referral Unit annotates the 39/24 with details of the agencies with whom the form has been shared. The Head of Public Protection should consider utilising OF crimes for PPIU officers and staff to record all out of force requests. This would ensure all requests are formally recorded and filed centrally on CIS. The Head of Public Protection should ensure that all members of staff carrying out interviews of victims of rape and serious sexual offences discuss the issue of pre-trial therapy with the victim (appropriate adult) and make a record of the discussion. Staff should also confirm with the victim (appropriate adult) that they understand that should they receive any pre-trial therapy this will be disclosed to the Crown Prosecutor and will be subject to pre-trial assessment. This should also be recorded.
GP	**Lessons Learned** There was an evident need for better, timelier information sharing from the Duty Liaison Psychiatric team (RSCH, A&E department), HTT and CMHRS. There was no contact from police/CPS to ensure that Mrs A was receiving adequate support during the lengthy judicial process. There was no obvious system for information sharing with the police/CPS and no named police officer to contact to discuss the issue of counselling/therapy. Was it appropriate for the Police to advise Mrs A against counselling? The CMHRS did not seem to have any sense of urgency in setting up the counselling that Mrs A required nor assigning her a care coordinator. This lack of urgency persisted despite GP urging the service that her court appearance was rapidly approaching and despite the increasing frequency and seriousness of her overdoses. Mrs A was not assigned a case co-ordinator until much too late and, in any case the co-ordinator assigned was on sick leave so not accessible to the patient. In hindsight should we (the multi-agencies involved) have had a case conference involving our agency, the CMHRS, the HTT, Mrs A, Social Services

	and her family to try to safeguard her from herself – perhaps after the overdose on 20th October 2012 when the duty psychiatric service recognised her increasing risk (medium) to herself if intoxicated? Her increased risk now warranted management by the CMHRS and they would have been expected to lead on this.
Victim Support Organisation – Witness Service	**Lessons Learned** The detailed notes from our three volunteers (JW)(MB)(PB) identify the difficulties, emotional pain and exhaustion experienced by Mrs A over the three days of giving evidence at Manchester Crown Court. The Witness Service at Crown Court Crown Square delivered the best possible support service we could, as we do for each witness who attends our Court to give evidence. It is clear from the batting order and the need to obtain two consecutive further night's hotel accommodation and the note of volunteer (MB) and (PB) that neither Mrs A nor her son had brought sufficient changes of clothes with them or had anticipated that she would have to give evidence over so many days. In addition to the strains imposed by living away from home, whilst giving evidence, Mrs A was also concerned about her husband's ill health as noted by our volunteer (MB) in her notes of 13.2.13. At no time did the three volunteers in their February notes identify any concerns in relation to any indicators of self-harm/suicidal feelings by Mrs A. In relation to the two volunteers (JW) and (PB) both clearly state to-day 11th June 2013, that at no time during their respective days supporting Mrs A and her son on 15th and 17th January 2013 did they experience any indicators from Mrs A of self-harm or suicidal intentions. As a Witness Service we had no prior contact with Mrs A or her family or any direct contact with any member of any Agency preparing this case. Where we have referrals for individuals prior to trial we have the opportunity to start a detailed needs assessment which was not possible in this case. On the first day of trial we were faced with supporting Mrs A and her son, with no knowledge of her prior health needs, through a trial process which took considerably longer than she had anticipated completing her evidence. No special measures were applied for, for Mrs A prior to trial and they were offered and refused during trial. We would welcome: Every possible change, which would enable a detailed pre-trial assessment of health status to be made, where appropriate, to enable the preparation of a risk assessment in relation to whether or not an individual can withstand the demands of trial evidence giving. Appropriate Inter-Agency communication of detailed individual pre-trial needs assessment so that trial management is undertaken to reduce the exhaustion of that individual witness. As accurate or open communication of how many days any particular individual's evidence may take to complete. Avoidance of having to live away from home to give evidence if at all possible. Provision of post evidence-giving support based on pre-trial health needs

	assessment which is put in place before any evidence is taken and respects the impact of re-living traumatic past experiences in forensic detail during evidence giving. This should be based on individual need rather than crime type. Any contribution we can make to Inter-Agency training or advocacy on behalf of victims and witnesses.
CPS (No lessons learned/recommendations outlined in report)	N/A

Information and a short bibliography on emotional intensity disorder

Bateman, A. and Fonagy, P. (2006) Mentalization-based Treatment for Borderline Personality Disorder: A Practical Guide Oxford University Press

Fonagy, P Gergely, G. Jurist, E. and Target, M. (2002) Affect Regulation, Mentalisation and the Development of the Self Other Press New York

Howells, E, (2005) The dissociative mind The Analytic Press Hillsdale New Jersey USA

Miller, A. (1987) The drama of being a child: the roots of violence in child rearing Virago London

Mollon, P. (1996) Multiple selves, multiple voices: working with trauma, violation and dissociation Wiley Chichester

Ryle, A. Leighton, T. and Pollock, P. (1997) Cognitive analytic therapy and borderline personality disorder: The model and the method Hoboken, NJ, US: John Wiley & Sons Inc. (1997).

Scott Peck, M. (1985) People of the lie: the hope for healing human evil Simon and Schuster New York

Winston, A. (2000) Recent developments in borderline personality disorder Advances in Psychiatric Treatment (2000) 6: 211-217

Blog on Emotional Intensity Disorder accessed Dec 2013 http://forums.psychcentral.com/personality-place/49734-emotional-intensity-disorder-bpd.html

DSM-IV-TR (2004) Criteria for Diagnosis of Borderline Personality Disorder

BPD is manifested by a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

Frantic efforts to avoid real or imagined abandonment.
A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation. This is called "splitting."
Identity disturbance: markedly and persistently unstable self-image or sense of self.
Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating). Note: Do
Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior.
Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days).
Chronic feelings of emptiness.
Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights).
Transient, stress-related paranoid ideation or severe dissociative symptoms.

Glossary of Acronyms

ASC	Adult Social Care
BPD	Borderline Personality Disorder, now also referred to as Emotional Intensity Disorder
CMHRS	Community Mental Health Recovery Service
CPS	Crown Prosecution Service
DH	Department of Health
DPP	Director of Public Prosecutions
FTE	Full time equivalents
GMP	Greater Manchester Police
GP	General Practitioner
HTT	Home Treatment Team
IMR	Internal Management Review
NICE	National Institute of Clinical Excellence
PLT	Psychiatric Liaison Team
RSCH	Royal Surrey County Hospital
SAB	Safeguarding Adults Board
SABP	Surrey and Borders Partnership NHS Foundation Trust

Complete chronology

Name: Mrs A

Dates covered by Chronology: 1976 - 21/07/2011, and 21/07/2011 – 24/01/2013

Organisation
Surrey Police
Greater Manchester Police
Royal Surrey County Hospital
Surrey and Borders Partnership
Victim Support Organisation
CPS – Witness Support
SCC Children's Service

GP did not supply a separate chronology. Contact information was embedded within the written text of the IMR report.

Date	Source of Information	Brief description of contact (include time if relevant)	Involvement of & communication with other agencies	Outcome &/or Response
March / April 2002	Royal Surrey County Hospital > Letter to GP	Letter regarding Fractured left ankle	Letter sent to GP	
01 Oct 2002	Royal Surrey County Hospital > Letter to GP	Letter regarding antenatal testing in 4th pregnancy	Letter sent to GP	
01 Feb 2003	Royal Surrey County Hospital > Letter to GP	Letter regarding USS results showing her baby was small	Letter sent to GP	
01 Sep 2003	Royal Surrey County Hospital > Letter to GP	Letter regarding ruptured ectopic pregnancy	Letter sent to GP	
01 Jun 2004	Royal Surrey County Hospital > Letter from GP	Letter about pain from surgery for ectopic pregnancy	Appointment given for OPA	Appointment given
01 Aug 2004	Royal Surrey County Hospital > Letter to GP	Letter to say Mrs A DNA her OPA	Letter sent to GP	
01 Mar 2009	Royal Surrey County Hospital > Letter from GP	Referral for abdominal pain	Appointment given and seen in OPA	Appointment given
01 Mar 2009	Royal Surrey County Hospital > Letter to GP	Letter re. OPA, plan for cholecystectomy	Letter to GP	Put on waiting list for surgery

Date	Source of Information	Brief description of contact (include time if relevant)	Involvement of & communication with other agencies	Outcome &/or Response
01 May 2009	Royal Surrey County Hospital > Letter to GP	Letter re: op delay for cholecystectomy as possible anaesthetic risk	Letter to GP	Surgery rescheduled
01 Sep 2009	Royal Surrey County Hospital > Letter to GP	Discharge letter following ruptured ectopic pregnancy	Letter sent to GP	
01 Oct 2009	Royal Surrey County Hospital > Letter to GP	Discharge letter following cholecystectomy	Letter to GP	
01 Nov 2009	Royal Surrey County Hospital > Letter to GP	Histology report on gall bladder - Normal	Letter to GP	
01 Feb 2010	Royal Surrey County Hospital > Letter to GP	Letter re. fractured ankle	Letter to GP	Follow up appointment
01 Aug 2010	Royal Surrey County Hospital > Letter to GP	Letter re. possibility of renewed fracture of the ankle	Letter to GP	Follow up appointment
01 Sep 2010	Royal Surrey County Hospital > Letter to GP	Letter re. fractured ankle	Discharge Letter to GP	
21 Jul 2011	Surrey Police > 14:10 ICAD P11209795	Dr W attended Guildford Police Station to report third party a historic rape of a friend Mrs A by her former Music Teacher – MB. Mrs A used to be a pupil at Chethams School, Manchester where MB was a teacher and where incidents of abuse took place. Dr W stated that she and the victim were concerned that MB still had access to children and feared others could be suffering abuse.	Greater Manchester Police (GMP)	A member of staff on the Front Desk explained that as the offence had occurred in the Greater Manchester area it was a matter for Greater Manchester Police to investigate. He stated that he would arrange for a police officer to attend her address and take further details. Appointment made to see informant on 22/07/2011. PC attended the address and details of the offences were obtained. Mrs A was not seen at this time, but Dr W stated she would be happy to speak with an officer. Details of the offences which included rape and other serious sexual offences were added to the ICAD and passed (emailed) to Greater Manchester Police (GMP) to investigate.
21 Jul 2011	Greater Manchester Police > Surrey Constabulary CAD P11209795 24/07/11. &	The witness JW approached Surrey Constabulary and provided a third-party report of child sexual exploitation (CSE) and rape by a former teacher	This report was recorded by Surrey Constabulary and transferred to GMP for investigation.	GMP accepted responsibility for the investigation.

Date	Source of Information	Brief description of contact (include time if relevant)	Involvement of & communication with other agencies	Outcome &/or Response
	Integrated Criminal Justice System database (ICIS) MG 11 Witness Statement from JW.	at Chetham's School of Music.		
22 Jul 2011	Surrey Police > 18: 47 ICAD P11211265 Caller: Crime Input Unit, GMP	Call from GMP stating that they could not record a third-party allegation and needed an officer to make contact with the victim.	GMP	Appointment made to see Mrs A on 23/07/2011. Mrs A seen by PC at 15 Aldersey Rd, Guildford. Brief details of the allegations were obtained and placed on the ICAD. The ICAD was transmitted to GMP. At 17:25 on 23/07/2011 GMP acknowledged receipt of the ICAD and provided their crime reference number - 126062K/11. No statement taken
23 Jul 2011	Greater Manchester Police > GMP Operational Policing Unit System(OPUS) - Crime report 126062K/11	From the details provided by Surrey Constabulary, GMP recorded a crime report for rape of a female over 16 years of age at Chetham's School of Music between 01/01/1977 and 31/12/1980.	Head of the Board of Trustees of the National Youth Choir of Great Britain (NYCGB) Durham Local Authority Designated Officer (LADO)	GMP commenced an investigation. The Head of the Board of Trustees of the NYCGB was told that MB should not have any access to any person under the age of 18 until the matter had been investigated.
26 Jul 2011	Greater Manchester Police > OPUS - Crime report 126062K/11	Mrs A was contacted by the initial investigators Detective Sergeant and Detective Constable amongst other information told that there would be a requirement for her to be interviewed and that it would be recorded using audio/ video equipment. They also identified other potential witnesses who may have provided corroborative evidence. However, the officer cannot remember giving Mrs A advice regarding victim support between 26/07/11 and 16/08/11.	N/A	Evidence gathering process was initiated. No evidence that advice was provided regarding VSS.

Date	Source of Information	Brief description of contact (include time if relevant)	Involvement of & communication with other agencies	Outcome &/or Response
27 Jul 2011	Greater Manchester Police > OPUS - Crime report 126062K/11	Mrs A was interviewed by DC K from the Surrey Constabulary with the process being recorded using audio / video equipment.	N/A	The interview was passed to GMP as evidence for the investigation.
28 Jul 2011	Surrey Police > Telephone call from DC A GMP to DS DUGUID, PPIU (W)	DC A requested Surrey Police PPIU officers to obtain a victim statement from Mrs A	GMP	On 28 July 2011 Mrs A was video interviewed by DC K, PPIU (W). Statements were also recorded from Dr W & Mr A. Evidence package forwarded to GMP.
16 Aug 2011	Greater Manchester Police > OPUS - Crime report 126062K/11	Because the offence of rape had been committed at the home of MB and HKB the investigation was transferred from the North Manchester to South Manchester Division and the OIC became DC MA.	Durham Local Authority Designated Officer (LADO)	Durham LADO updated regarding the progress of the investigation
16 Aug 2011 – 22 Aug 2011	Greater Manchester Police > Interview with OIC	The OIC made telephone contact with Mrs A and discussed his planned approach to the investigation; including his intention to arrest and interview both MB and HKB along with the probability that they could spend some time on police bail until the investigation was completed and the CPS had made a charging decision. The OIC passed on contact information about Surrey VSS and the services they might provide to both Mrs A and her family.	N/A	N/A
22 Aug 2011	Greater Manchester Police > Integrated Criminal Justice System (ICIS) database	MB was arrested and interviewed in relation to the offence of rape. He denied the allegations and was bailed until 12/11/2011 with strict conditions restricting	N/A	N/A

Date	Source of Information	Brief description of contact (include time if relevant)	Involvement of & communication with other agencies	Outcome &/or Response
	OPUS custody information EDL Log B1055722011	unsupervised access to any child under 17 years of age. The OIC telephoned Mrs A and informed her of the outcome.		
06 Sep 2011	Greater Manchester Police > ICIS OPUS custody information EDL Log B1060752011	HKB was arrested and interviewed in relation to the offences of rape and gross indecency. She denied the allegations and was bailed until 14/11/2011. The OIC telephoned Mrs A and informed her of the outcome.	N/A	N/A
12 Nov 2011	Greater Manchester Police > OPUS custody information EDL Log B1055722011	MB's bail date was extended to 06/01/2012 to allow for Mrs A to be re-interviewed. The OIC telephoned Mrs A and informed her of the outcome.	N/A	N/A
14 Nov 2011	Greater Manchester Police > OPUS custody information EDL Log B1060752011	HKB's bail date was extended to 06/01/2012 to allow for Mrs A to be re-interviewed. The OIC telephoned Mrs A and informed her of the outcome.	N/A	N/A
15 Dec 2011	Greater Manchester Police > ICIS MG6C - Unused material disclosure schedule	The OIC and a colleague travelled to Surrey and conducted a second interview with Mrs A. The OIC discussed support and counselling that could be available through the VSS for both her and family and the benefits of applying to the courts for 'Special Measures' to help her present her evidence. Mrs A revealed that Surrey Police had advised her against counselling as it might taint her evidence and in any case she did not feel that she needed that level of support. She	N/A	N/A

Date	Source of Information	Brief description of contact (include time if relevant)	Involvement of & communication with other agencies	Outcome &/or Response
		declined special measures as she wanted to confront her abusers with her evidence in court.		
01 Jan 2012	Greater Manchester Police > Interview with the OIC	In the early hours of New Year's day the OIC received a telephone call from Mrs A on his mobile, she was intoxicated and incoherent causing the OIC sufficient concern for him to contact Surrey Constabulary and request that they attend at her home address and check on her welfare. The OIC was later informed there was no cause for concern, that she was safe and well with her family. Later the same day the OIC called Mrs A to check on her welfare himself and establish why she had made the call. Mrs A was apologetic and knew she should not have made the call but explained that she'd had a drink and wanted to talk about the case. The OIC once again discussed the services that VSS could provide to both her and her family.	Surrey Constabulary	There was no cause for concern.
02 Jan 2012	Surrey Police > 00:10 - ICAD P12000967 Caller: DC A, GMP	DC A informed Surrey Police that he is the OIC for a rape investigation involving victim Mrs A. He had just received a call from Mrs A who sounded very distressed and he requested Surrey Police to carry out a welfare check.	DC A was updated. 39/24 shared with Mental Health	A police unit was deployed. Mrs A was seen no need for medical assistance. Mrs A explained that she was not coping with having to resurrect the abuse she was subjected to as a child. She was agitated that a complaint had been made on her behalf. She stated that if she did not have her children, she would have no reason to live. She stated that she felt depressed.

Date	Source of Information	Brief description of contact (include time if relevant)	Involvement of & communication with other agencies	Outcome &/or Response
				Mrs A was left in the care of one of her adult sons. 39/24 completed and submitted to Mental Health. No further Police action
03 Jan 2012	Greater Manchester Police > OPUS custody information EDL Logs B1055722011 & B1060752011	MB's and HKB's bail date was extended to 31/01/2012 pending CPS review. The OIC telephoned Mrs A and informed her of the outcome.	N/A	N/A
31 Jan 2012	Greater Manchester Police > OPUS custody information EDL Logs B1055722011 & B1060752011	MBs and HKB's bail date was extended to 27/02/2012 to allow for CPS to come to a charging decision. The OIC telephoned Mrs A and informed her of the outcome.	N/A	N/A
27 Feb 2012	Greater Manchester Police > OPUS custody information EDL Logs B1055722011 & B1060752011	MBs and HKB's bail date was extended to 28/03/2012 to allow for CPS to come to a charging decision. The OIC telephoned Mrs A and informed her of the outcome.	N/A	N/A
28 Mar 2012	Greater Manchester Police > OPUS custody information EDL Logs B1055722011 & B1060752011	MBs and HKB's bail date was extended to 26/04/2012 to allow for CPS to come to a charging decision. The OIC telephoned Mrs A and informed her of the outcome.	N/A	N/A
26 Apr 2012	Greater Manchester Police > OPUS custody information EDL Logs B1055722011 & B1060752011	MB and HKB answered bail. MB was charged with 6 specimen offences of indecent assault on a female under 16 years of age and one offence of rape of a female over 16 years. HKB was charged with one offence of indecent assault on a female under 16 years and one	Crown Prosecution Services. Manchester and Salford Magistrates Court. Head of the Board of Trustees of the National Youth Choir of Great Britain.	The prosecution process was instigated. The Head of the Board of Trustees of the NYCGB and the Durham LADO were updated in relations to the charges that had been brought.

Date	Source of Information	Brief description of contact (include time if relevant)	Involvement of & communication with other agencies	Outcome &/or Response
		offence of rape of a female over 16 years. Both were bailed to appear at Manchester and Salford Magistrates Court on 07/06/2012. The OIC called Mrs A and informed her of the outcome.	Durham Local Authority Designated Officer (LADO)	
28 Apr 2012	Royal Surrey County Hospital > Discharge Summary Medical Notes Nursing Notes	3/7 admission mixed OD Seen by MH team fit for discharge for follow up by HTT (to contact her that night), given crisis number. Record in notes that had been raped in the past (30 years ago ? by uncle Knew depression not under control, uncle and wife don't believe her, does not want to see psychiatrist as does not want to confront issue. PLN referral Discussed pending court case and media hounding with SpR, concern that OD will be seen as mental instability. 29/4 Keen to see psychiatry but not medically fit HTT seen but not assessed as not medically fit 30/4 MH team 15.55 ref to HTT 20.20 HTT will not see until medically fit, needs blood checking. V distressed on ward as had been called by police about court case. 1/5 fit for discharge, no reply from PLN Seen by PLN team, frustrated with delay to be seen to be followed up by SW HTT, given their 'phone number and	Discharge summary to GP Referred to HTT services Seen PLN, referred to HTT Referred to PLN Seen by PLN	For re-referral when medically fit For re-referral when medically fit Seen PLN Referred to HTT

Date	Source of Information	Brief description of contact (include time if relevant)	Involvement of & communication with other agencies	Outcome &/or Response
		crisis line number. Client has not got immediate plans to kill herself but needs short crisis intervention		
28 Apr 2012	Greater Manchester Police > ICIS - MG 2 Witness assessment for special measures (Information required for an application to the court by the CPS). Interview with the OIC.	The OIC once again discussed Special Measures procedures with Mrs A and how they might assist her to present her evidence at court. She maintained her earlier position saying that she wanted to confront her abusers with her evidence.	CPS	There was no application for Special Measures.
30 Apr 2012	Greater Manchester Police > Interview with the OIC	Mrs A sent the OIC an email asking if he was on duty. The OIC called her back immediately to be told that she was in hospital in Guilford having attempted to take her own life. The OIC once again advised Mrs A regarding the availability of counselling. He then spoke to Surrey Victim Support Services and they gave him the contact number for Surrey Rape and Sexual Abuse Support Centre (RASASC) who were the agency to provide specialist counselling services to survivors of rape and sexual abuse in Surrey. The OIC contacted RASASC and in general terms discussed Mrs A's situation with them. They were positive they could help an individual in Mrs	Victim Support Services. Rape and Sexual Abuse Support Centre (RASASC) Guilford.	Mrs A was provided with the specific details of the RASASC, the agency who could provide local specialist counselling services.

Date	Source of Information	Brief description of contact (include time if relevant)	Involvement of & communication with other agencies	Outcome &/or Response
		A's circumstances. Consequently, the OIC passed their contact details to Mrs A and strongly advised her to self-refer to them. Upon being discharged from hospital the OIC says that the NHS put in place regular visits to Mrs A's home address by their Home Treatment Team to check on her wellbeing.		
30/04/2012	Rio patient record – progress notes	Liaison Psychiatry - Assessment at RSCH following OD of prescribed medication taken with 2 bottles of wine. Mrs A identified precipitating factor of overdose was media reports regarding sexual abuse case going to court.	Referral to SABP Home Treatment Team (HTT)	To be assessed by HTT.
01 May 2012	Royal Surrey County Hospital > Accident and Emergency notes	Brought to A&E by ambulance having taken mixed OD, only discharged same day from EAU. Seen PLN and HTT, risk remains moderate to high, f/u by HTT, home visit this afternoon	Referred to MH team	Seen by PLN and HTT
01/05/2012	Rio patient record – progress notes	Liaison Psychiatry – now fit for discharge from hospital	Referral to HTT and given Crisis Line phone number	Discharged home from RSCH
01/05/2012	Rio patient record – progress notes	Later that day contacted at home by HTT no answer – left message Time 20.12 Mrs A phoned HTT at 21.02. Reported feeling ok in mood. HTT arranged to visit on 02.05.12		HTT arranged to visit at home on 02/05/2012
01/05/2012	Rio patient record – progress notes	Time 23.45 – Mrs A taken to A&E, RSCH after taking a further overdose.	Mrs A had informed police liaison officer in Manchester who	Admitted to RSCH for medical treatment and assessment.

Date	Source of Information	Brief description of contact (include time if relevant)	Involvement of & communication with other agencies	Outcome &/or Response
			contacted ambulance service	
01 May 2012	Surrey Police > 22:32 - ICAD P12123216 Caller: DC A, GMP	DC A expressing concern with regards to Mrs A and requesting a welfare check be carried out. Mrs A had been taken to hospital this morning for a suspected overdose. She had been discharged but had been in contact with the officer and her demeanour caused DC A to be concerned as to her current welfare. DC A stated there may be 3 children at the address between the ages of 10-18.	DC A was updated with outcome of welfare check.	Police unit deployed to (address). Officers spoke with Mr A who confirmed that his wife Mrs A had been in hospital. It is not recorded how long she had been in hospital of when she had been admitted. Mr A stated that Mrs A had felt she had been discharged from hospital too soon as she was having great difficulty getting to sleep. He told the officers that she was in bed and had just managed to fall asleep. Mrs A was not seen by the officers as they felt that insisting on seeing her may exacerbate the situation. They had no reason to question what Mr A had said or had any concerns about leaving Mrs A in her husband's care. No further Police action.
01 May 2012	Greater Manchester Police > Interview with the OIC	During the evening of the 01/05/2012 whilst the OIC was on duty at Elizabeth Slinger Road police station, Mrs A telephoned him on his office number. She was once again intoxicated and incoherent resulting in the OIC making another request that Surrey Police undertake a welfare check at her home address. Surrey's response was that again there was no cause for concern and that she was safe and well with her husband.	Surrey Constabulary	There was no cause for concern.
01 May 2012	SABP > Rio patient record – progress notes	Time 23.45	Admitted to A&E at RSCH	
02 May 2012	Greater Manchester Police >	The OIC called Mrs A to check on her welfare and establish why she had called him the previous	RASASC Surrey joint Police / CPS Witness Care Unit	The OIC believes that Mrs A self-referred to the RASASC who then supported her up to and including the trial.

Date	Source of Information	Brief description of contact (include time if relevant)	Involvement of & communication with other agencies	Outcome &/or Response
	Interview with the OIC	day. Again, she apologised and said she had been drinking and wanted to talk about the case. The OIC was becoming concerned that Mrs A was focussing on him for the support that should have come from the VSS and RASASC. It also appeared that she was becoming confused about the parameters of their relationship because she would sign her emails as one would with close friends i.e. *"love ...."* and including kisses. During this call she told him that she had spoken with the RASASC but did not intend to use their services. This concerned the OIC and so he called them himself and was informed that they had indeed spoken to Mrs A and that they believed they would be able to help her if she so wished. The OIC called Mrs A back and explained to her the demarcation between his responsibilities to the investigation and to her as the victim and the specialist agencies that had been set up specifically to cater for the support and counselling needs of victims and witnesses. Mrs A apologised and agreed to ring them back.		The OIC did not receive any further spontaneous incoherent telephone calls from Mrs A beyond this date.

Date	Source of Information	Brief description of contact (include time if relevant)	Involvement of & communication with other agencies	Outcome &/or Response
		The OIC referred FA to the Surrey joint Police / CPS Witness Care Unit.		
02/05/ 2012	Rio patient record – progress notes	Time 08.27 - Mrs A not currently fit for discharge	HTT advised of re-admission.	To be assessed prior to discharge.
02/05/ 2012	Rio patient record – progress notes	Time 15.50 Psychiatric Liaison team and HTT Joint assessment at RSCH	Communication between psychiatric liaison and HTT services	Mrs A offered but declined informal admission to Psychiatric inpatient ward and accepted alternative of HTT support at home. Discharged home.
02/05/ 2012	Rio patient record – progress notes	Time 20.44 HTT undertook home visit – had got back from RSCH half an hour earlier – in bed.		HTT to visit at home on 03.05.12
03/05/2 012	Rio patient record – progress notes	HTT HV by Staff grade psychiatrist and Student Nurse. Poor health of husband and financial difficulties discussed. Plan agreed for HTT to visit daily, assess risk and monitor mental state.		Risk of self-harm assessed as low. Anti-depressant medication prescribed. HTT arranged to visit again on 04.05.13
04/05/ 2012	Rio patient record – progress notes	HTT HV Nurse – unsteady on feet, no medication at present. Plan to start medication tomorrow, HTT to visit daily, monitor mental state		HTT to visit on 05.05.12
05/05/ 2012	Rio patient record – progress notes	HTT HV Mrs A said difficult to speak to a different person each day and expressed need to have opportunity for in-depth conversation with one person and build relationship with that person Expressed wish for 1:1 counselling but said police had advised her not to see a counsellor before the court case in case it jeopardised the case.		Plan for HTT to discharge care back to GP.

Date	Source of Information	Brief description of contact (include time if relevant)	Involvement of & communication with other agencies	Outcome &/or Response
		Denied suicidal thoughts and did not want any further help from HTT		
06/05/ 2012	Rio patient record – progress notes	Time 14.15 HTT rang – no answer – no message facility		HTT to continue to try to contact.
06/05/ 2012	Rio patient record – progress notes	Time 19.41 HTT rang as above – tried mobile - no answer		Plan for HTT to possibly discharge on 07.05.12.
07/05/ 2012	Rio patient record – progress notes	Time 11.09 HTT rang mobile and landline – no answer		HTT to continue to try to contact.
07/05/ 2012	Rio patient record – progress notes	Time 20.37 HTT rang again on both numbers – no answer		To contact on 08/05/2012 and arrange psychiatric review
08/05/ 2012	Rio patient record – progress notes	HTT HV by staff grade psychiatrist and psychiatric nurse. Mrs A stated she did not need further HTT input. Assessed as low risk	Mrs A had seen GP who had prescribed Diazepam and changed anti-depressant medication. HTT sent discharge letter and recommendations to GP	HTT discharged from service and back to care of GP with recommendation for referral for counselling or psychology help
10 May 2012	CPS Witness Support > B vs B chronology of Contact	Case Allocated	.	
11 May 2012	CPS Witness Support > B vs B chronology of Contact	Contacted OIC by email to check it was appropriate to make contact with the victim, Mrs A directly or if he wanted to make contact first and inform her that I would be her WCO. Officer informed me a few days later that he had spoken to the victim and contact could be made directly.	.	
14 May 2012	CPS Witness Support > B vs B chronology of Contact	Message left with victim on home answering machine by the allocated Witness Care Officer. The message left by the Witness Care Officer was introducing herself to the victim, providing contact details and	.	

Date	Source of Information	Brief description of contact (include time if relevant)	Involvement of & communication with other agencies	Outcome &/or Response
		asking the victim to call back. (Victim did not return call) Contact is usually made by letter, however, due to the serious nature of the offence contact was made by phone. Further contact would not be made by the Witness Care Officer until the date of the next hearing. As per the Victims Code of Practice.		
07 Jun 2012	CPS Witness Support > B vs B chronology of Contact	Introduction call made. The Witness Care Officer explained to the victim what her role would be during the proceedings (to keep the victim informed of what happens after each hearing). Victim was informed that the case had been sent to the Crown Court and the next hearing (the Preliminary Hearing) was going to be on the 28th June 2012. Support was discussed in the form of Victim Support and Rape Crisis; **(this was declined by the victim.)** Witness Care Officer informed the victim that should she require any help or assistance at any stage then she should contact the Witness Care Officer. Victim informed WCO that she would like to be addressed as Mrs S in any future correspondence and not Mrs A **(victim details amended).** Contact is only made with the victim once a hearing has taken place as per the Victim Code of	.	

Date	Source of Information	Brief description of contact (include time if relevant)	Involvement of & communication with other agencies	Outcome &/or Response
		Practice. There was nothing further to update the victim on at this stage		
04 Jul 2012	CPS Witness Support > B vs B chronology of Contact	Post preliminary letter dispatched after hearing which requested the victim availability for trial and that a provisional trial date had been set by the court of the 14th January 2013. Contact is only made with the victim once a hearing has taken place as per the Victim Code of Practice. Again there was nothing further to update the victim on at this stage	.	
02 Aug 2012	CPS Witness Support > B vs B chronology of Contact	Phone call made to the victim by WCO, providing an update. It was explained to the victim that an application for AVT was being made on the 07/08 and the WCO obtained the victim's availability for trial. Victim was informed that she would be updated of the AVT application at the earliest opportunity.	.	
08 Aug 2012	CPS Witness Support > B vs B chronology of Contact	The Victim was informed by the Witness Care Officer that the trial date of the 14th January 2013 remains in the court list and that a formal warning letter will be sent out in due course.	.	
09 Aug 2012	CPS Witness Support > B vs B chronology of Contact	Warning letters dispatched providing victim of the date and time of the trial and asking for the reply slip to be returned. Letter highlighted to the victim that if she had any concerns or wanted to discuss what will happen	.	

Date	Source of Information	Brief description of contact (include time if relevant)	Involvement of & communication with other agencies	Outcome &/or Response
		at court to the Witness Care Officer on the contact details provided in the warning letter. **(Reply slip NOT returned by the victim nor did victim call the WCO).**		
18 Aug 2012	Royal Surrey County Hospital > Discharge summary Accident and Emergency notes Medical notes	2/7 admission mixed OD Seen by MH team, fit for discharge given crisis line number Court case going on all 2012, very stressed because of this. 20/8 Seen PLN did not want to go into details of court case supported by police + GP. Given crisis line number	Discharge summary to GP Referred to MH services	Seen by PLN
20/08/ 2012	Rio patient record – core assessment	Mrs A admitted to RSCH following overdose of Diazepam and her husband's diabetic medication. Had just returned from seeing her birth mother in Canada who had advanced cancer. Seen by psychiatric liaison nurse but refused full assessment and wanted to go home to be supported by GP and police. Did not want contact with husband or other referrals to be made. Assessed as having capacity to make this decision. Risk assessed as low.	Letter sent to GP by psychiatric liaison service	Discharged home from RSCH to care of GP.
03 Oct 2012	Greater Manchester Police > ICIS MG6 Confidential information document	At the request of the CPS the OIC once again contacted Mrs A to discuss the benefits of applying for 'Special Measures'. Mrs A declined and the OIC reported back to the CPS in the following terms: **"She is willing to give**	Crown Prosecution Service	Special Measures were not applied for.

Date	Source of Information	Brief description of contact (include time if relevant)	Involvement of & communication with other agencies	Outcome &/or Response
		her evidence in court and would like to see the defendant as she gives her evidence so does not require screens. What is very important to (Mrs A) is that her identity is not reported in the press."		
16 Oct 2012	CPS Witness Support > B vs B chronology of Contact	Chaser call made to victim seeking confirmation and **to complete the needs assessment,** to discuss support and special measures – no response received by the Witness Care Officer by telephone. A further letter was dispatched to the victim asking for an urgent response to the court warning and again the letter highlighted to the victim that she could ring her Witness Care Officer should she wish to discuss what would happen of the day of the trial. **(Reply slip NOT returned by the victim nor did victim call the WCO).**	.	
20 Oct 2012	Royal Surrey County Hospital > Accident and Emergency notes	Mixed OD, disclosed childhood sexual abuse and upcoming court case. Seen HTT in A&E, noted to have capacity and that stress has increased due to court case due in January. Referred to Community MH services and advised to attend GP for change to antidepressant	Referred to HTT team Referred to Community MH team, advised to contact GP	Seen HTT and referred to community team
20/10/ 2012	Rio patient record – progress notes	Admitted to CDU at RSCH following overdose of Diazepam with alcohol. Assessed by HTT who cover psych	Referral to CMHRS by HTT (for psychiatric liaison service).	Follow up call made by HTT. Referral made to Guildford CMHRS, Recommendation to GP to review anti-depressant medication, and refer to IAPT

Date	Source of Information	Brief description of contact (include time if relevant)	Involvement of & communication with other agencies	Outcome &/or Response
		liaison service at times out-of-hours. Overdose reportedly triggered by looming court case taking place in January 2013. Risk assessed as medium when intoxicated but low risk of suicide.	Assessment and risk assessment faxed to GP.	service, and advising of referral to CMHRS.
21/10/ 2012	Rio patient record – progress notes	HTT contacted Mrs A to advise of plan and referral to CMHRS		Plan to refer to CMHRS
22/10/ 2012	Rio patient record – progress notes	HTT contacted CMHRS	HTT discussed referral with CMHRS.	CMHRS to discuss referral at MDT meeting on 24.05.13
23 Oct 2012	CPS Witness Support > Bvs B chronology of Contact	Rang victim and discussed the following: Confirm with the victim that she had received her court warning and confirmed her attendance for the trial on the 14th January 2013. At no point did the victim express any reluctance to attend court. Offer a pre-court visit at Guildford Crown Court **(declined by victim).** Discussed with the victim what would happen on the day, including the role of Witness Service and the entrance to the Witness Suite. The WCO explained that the Witness Suite was for prosecution witness only and that the victim would be assigned a member of the Witness Service staff to look after her during the trial. Explained to the victim that she would be given a copy of her statements on the morning of the trial and that Counsel would come and speak	.	

Date	Source of Information	Brief description of contact (include time if relevant)	Involvement of & communication with other agencies	Outcome &/or Response
		with her before the trial started. The victim was informed that when she was required to give her evidence, a member of the Witness Service staff would take her down to the court room. Victim was also informed that she could bring someone with her to court for support. Discussed Special Measures with the victim, including video-link and Screens. (**Both were declined by the victim**). Witness Care Officer informed the victim that travel, and accommodation arrangements will be made nearer the time.		
24/10/ 2012	Rio patient record – progress notes	Referral discussed at CMHRS MDT meeting		Mrs A to be offered a duty assessment with CMHRS
25/10/ 2012	Rio patient record – progress notes	Message left for Mrs A to book duty appointment with CMHRS. Mrs A called back to arrange		CMHRS duty assessment arranged for 31.10.12
26/10/ 2012	Letter to report author in response to penultimate draft of the SCR report	Multi-disciplinary team assessment of Mrs A		
27/10/ 2012	Note on uploaded Police report received on 31.10.12 – no record on Rio	A female telephoned the SABP Trust Crisis Line saying she was not feeling safe and would die if she hung up the phone. Phone then cut off. Crisis Line obtained telephone number and advised police who undertook a welfare check where Mrs A was found to have taken an overdose.	Crisis Line contacted police.	Mrs A taken to RSCH for medical treatment and assessment.

Date	Source of Information	Brief description of contact (include time if relevant)	Involvement of & communication with other agencies	Outcome &/or Response
27 Oct 2012	Surrey Police > 02:11 - ICAD P12314248 Caller: Mr S, Crisis Helpline, Redhill GD/12/9709 – Non-Crime Vulnerable Adult Investigation	Call from Crisis Helpline, they had received a call from a female who wanted to speak to a female. She stated that she was not in a safe place and if she hung up she would die. Contact was the lost. Mr S was able to provide a telephone number for the female caller.	39/24 shared with Mental Health.	Enquiries traced the call to the home address of Mrs A. Call Handler aware from research of previous welfare concerns. Police unit was deployed. Officers were let in by son. Mrs A was found asleep and was woken by officers. She stated that she had stabbed her-self in the stomach several times with her husband's Insulin pen and had been drinking. An ambulance was called and conveyed Mrs A to the Royal Surrey County Hospital. At the hospital Mrs A informed the officers that she cannot cope with the pressure and stress of going to court in January 2013 as the victim of sexual abuse when she was a child. She stated that she just wanted to die and had tried placing a plastic bag over her head (a bag was found in bed with Mrs A). 39/24 completed.
27 Oct 2012	Royal Surrey County Hospital > Accident and Emergency notes Medical Notes Nursing Notes	Mixed OD (with Police) Several ODs in last year – since big trial about child abuse when she was younger. Felt overwhelmed following discussion about Jimmy Saville. Unsure of wish to end life. 28/10 fit for psych assessment (TAG score 9) Seen by HTT, denies further intent to harm herself. Has appointment to see duty CPN on 31/10/12	Referred to MH services Seen HTT	 Seen HTT, given follow up appointment
28/10/ 2012	Rio patient record – progress notes	Assessed by Psych Liaison at RSCH following overdose including husband's insulin. The insulin had been injected directly into her stomach.	CMHRS to follow up and assess as planned. Ambulance service vulnerable person report received by CMHRS.	Discharged home for follow up by CMHRS at planned assessment appointment on 31.10.12.

Date	Source of Information	Brief description of contact (include time if relevant)	Involvement of & communication with other agencies	Outcome &/or Response
		Mrs A made link to finding out that birth mother in Canada has bowel cancer, daughter's referral and assessment by CAMHS (no follow up needed) and revelation by her husband regarding their finances. Assessed as high risk.	Police Adult at Risk (39/24) form received by CMHRS.	
30 Oct 2012	CPS Witness Support > B vs B chronology of Contact	Reply slip confirming attendance received from victim. The Witness Care Officer called the victim to confirm receipt of the confirmation. During the conversation the victim disclosed that her husband was ill and the fact that he may not be able to travel to Manchester for the trial. E-mail dispatched to the caseworker informing him of the potential issues with attendance and asking for consideration to be given for a video-link for Mr A from Guildford. The victim was informed by the Witness Care Officer that she would contact her again after Christmas to discuss her husband's conditions, to inform her what day she will be required to attend court and to arrange travel and accommodation. The Witness Care Officer stressed to the victim should she have any questions or concerns in the meantime she would contact the Officer. **(Victim again did not display any reluctance to attend court nor did she ring the WCO at any stage)**	.	

Date	Source of Information	Brief description of contact (include time if relevant)	Involvement of & communication with other agencies	Outcome &/or Response
		As above no further communication required as per VCOP.		
31 Oct 2012	SCC Children's Service > Police	Mrs A, 9-year-old child's mother had stabbed herself with the father's insulin in her stomach and also drunk alcohol in what would have been a fatal dosage. She also had a plastic bag in bed with her. She reported depression and stress and was due for mental health assessment. She reported 19-year-old son has an illness which is genetic. Presumably dad is diabetic. According to further ambulance report it appears the other adults were in the household asleep and unaware of what had happened. Mrs A called 999 and put phone down.	Social worker visit to the home, parents and child spoken to. School and health checks completed in respect of child. GP reported concerns regarding family and advised that referral to CMHT had been made. School did not report concerns with regard to child.	At time of Initial Assessment of daughters needs parents reporting Mrs A feeling better in herself, but it was recognised that forthcoming court case and other factors were clear stress indicators for her. CMHT referral had been made by GP and assessment had been undertaken. It was acknowledged that there was a risk that daughter could be exposed to high levels of stress in the household and Mrs A's mental health. However, Mrs A was presenting as meeting daughters need and was presenting well in regards to her mental health. Both Mr and Mrs A were aware of the need to protect daughter from being exposed to harm and daughter's older brothers were also able to care for her and protect her from being exposed to harm. It was suggest that the school offer the support of the Home School Link worker to be a professional outside of the family with whom daughter can speak to about anything that is concerning her because this intervention worked in the past when daughter was having friendship difficulties.
31/10/ 2012	Rio patient record – progress notes	Duty assessment at Guildford CMHRS. Described being overwhelmed by events over past year including court case related to sexual abuse, husband's poor physical health, financial problems, and relationship issues with nine-year-old daughter. Reported hoarding high doses of Diazepam and		Assessment discussed in CMHRS MDT meeting. Risk of suicide assessed as high by CMHRS and rated as "Red" zone (High Risk) Plan – care-coordination to be offered by CMHRS to help with practical strategies to manage emotions. Duty worker to contact Mrs A to discuss this proposal

Date	Source of Information	Brief description of contact (include time if relevant)	Involvement of & communication with other agencies	Outcome &/or Response
		Temazepam prescribed by GP. Mrs A expressed wish skilled therapist to help her to manage her emotions.		
5/11/ 2012	Rio patient record – progress notes	TC to Mrs A from CMHRS duty worker explaining plan for CMHRS to allocate care co-ordinator in next few weeks and to explore emotional regulation and distress tolerance work but not referral to psychology or psychotherapy until after the court case.	CMHRS tried to contact GP but not available. Message left for GP to contact CMHRS to confirm plan.	CMHRS to allocate care co-ordinator in next few weeks. Mrs A advised to contact Duty in meantime
6/11/ 2012	Rio patient record – progress notes	CMHRS called GP but not available so message left to contact. NB: report notes that CMHRS staffing levels were at critical point at this time and were registered on the Trust's risk register as such.	CMHRS attempted to liaise with GP.	Message left for GP to contact CMHRS to discuss plan.
12 Nov 2012	Victim Support Organisation - Witness Care Officer for City of Manchester CPS Witness Care Unit	We received a Witness Referral Form; a completed pro-forma by secure e-mail asking us to arrange and undertake a pre-court visit for a witness in the trial of MB and HKB starting 14/01/2013 NOT MRS A. We contacted and arranged a Pre-Court visit for this witness on 03/01/2013 at 1pm.	No other involvement with other Agencies	
19/11/ 2012	Rio patient record – progress notes	Message from GP Surgery received by CMHRS on 16.11.12 advising that GP is on leave and will call back on 22.11.12	GP surgery communication with CMHRS.	Plan for GP to contact CMHRS on 22.11.12
30 Nov 2012	SCC Children's Service > School	School spoke to contact centre to ensure that information of mothers self-harm attempt has been reported to SCS.	.	Contact centre advised school that assessment had been completed. No referral made.

Date	Source of Information	Brief description of contact (include time if relevant)	Involvement of & communication with other agencies	Outcome &/or Response
13/12/ 2012	Rio patient record – progress notes	GP and CMHRS worker discussed the case by telephone. GP advised that CMHRS planned to offer regular sessions to help with distress tolerance and emotional regulation in the lead up to the court case. GP advised that this was required urgently with the court case only a month away.	Discussion between CMHRS and GP.	Need for urgent allocation to be discussed with CMHRS manager.
14 Dec 2012	Royal Surrey County Hospital > Discharge summary Accident and Emergency notes Medical notes	3-day Admission after Insulin OD Known MH teams but not allocated key worker, seen MH teams in hosp Refusing to answer questions about intention Not being seen by MH team in the community, Ref to MH team when medically fit 15/12 DW HTT do not provide psychiatric review unless needs admission to psychiatric hospital Given number of crisis line and advised to contact duty team at FRH following week. Still not medically fit. 16/12 medical review - last seen by MH team 6/52 ago. She was promised they would follow her up but according to her this never happened. Very likely to re-attempt taking her own life. No MH bed available, crisis helpline team for Guildford said they don't review patients on the ward. If she feels suicidal, they will consider admission otherwise the patient will have to contact the	Discharge summary to GP Referred to HTT team Discussed with HTT team Referred to PLN Referred to community MH services	Needs re-referral when medically fit For Mrs A to remain in hospital until seen by MH teams. Re-refer on next working day Seen by PLN, OPA for MH team booked

Date	Source of Information	Brief description of contact (include time if relevant)	Involvement of & communication with other agencies	Outcome &/or Response
		community psych team herself. Registrar plan – cannot go home until seen by the psych team 17/12 PLN review - ongoing case, has court case 14th Jan 2013. Currently under Guildford MH team awaiting a psychotherapist and key worker to be allocated. Remains vulnerable and at risk of OD. Does not find HTT beneficial, wants to see a psychiatrist. Denies further active suicidal thoughts. Claims sons home from university (who are protective factor) Deemed safe to go home. Call from duty worker at Guildford MH team and appt (booked for 19/12/12)		
17/12/ 2012	Rio patient record – progress notes	Discussion in CMHRS MDT meeting regarding risk zoning. Identified that zoning had been red, high risk, on 31.10.12 but still not allocated. However, on CMHRS managers list was zoned as amber, medium risk so this was corrected to red, high risk		Urgent allocation of care co-ordinator to be made.
17/12/ 2012	Rio patient record – progress notes	Psychiatric Liaison Service at RSCH telephoned CMHRS to advise that Mrs A had been admitted to RSCH on 13.12.13 having taken a serious overdose of her husband's insulin medication. Mrs A assessed by psychiatric liaison. Said she felt overwhelmed by everything going on in	Psychiatric liaison service contacted CMHRS and requested out-patient appointment.	Discharged home. CMHRS arranged psychiatrist out-patients appointment for 19.12.12. Mrs A advised of this appointment and that she was next on list for allocation of a care co-ordinator.

Date	Source of Information	Brief description of contact (include time if relevant)	Involvement of & communication with other agencies	Outcome &/or Response
		her life and felt she had not received support from CMHRS. Psychiatric liaison service requested psychiatric outpatient appointment for Mrs A from CMHRS. This was arranged for 19.12.12. Mrs A also telephoned CMHRS upset that there had been no contact with her since assessment on 31.10.12.		
19/12/ 2012	Rio patient record uploaded GP letter	Mrs A saw psychiatrist at CMHRS outpatient clinic. Current stressors discussed – financial difficulties; husband's physical health problems; dealing with past sexual abuse issues. Not keen to continue with anti-depressants but advised to continue and to try to come off Diazepam. On-going suicidal ideation but no active plans or intent. (Recorded on RIO on 28.12.12)	Letter to GP with plan but not sent until 31.12.12 and received by GP on 07.01.13	Plan for urgent care co-ordination. No change to medication. Suggested referral to psychology.
30/12/ 2012	Rio patient record – progress notes	Mrs A rang HTT and spoke to worker regarding high profile court case starting on 14/01/2012. Expressed need for help from mental health services but not getting the help needed. HTT worker advised her there was plan in place following appointment with psychiatrist on 19.12.12. and she was being offered services.		Plan in place to be followed.
2/01/ 2013	Rio patient record – progress notes	Allocation of social worker to be Mrs A's		Care co-ordinator planned to see Mrs A as soon as possible.

Date	Source of Information	Brief description of contact (include time if relevant)	Involvement of & communication with other agencies	Outcome &/or Response
		care coordinator by CMHRS		
03 Jan 2013	Royal Surrey County Hospital > Discharge Summary Accident and Emergency notes Medical Notes	3-day admission after mixed OD. Reviewed by MH team, low risk for follow up by CMHT given no. of crisis line if further thoughts of self-harm Self-harm mark on L arm. Referred MH team 4/1, will see when medically stable. 5/1 Seen MH team (HTT). Denied active suicidal thoughts, could not tell if she will do this again as she still had fleeting thoughts mainly for DSH. Advised to contact crisis line.	Discharge summary to GP Referred to MH services	Seen by MH teams
3/01/ 2013	Rio patient record – risk assessment	Mrs A admitted to RSCH following further overdose of husband's insulin.		Admitted to RSCH for medical treatment and further assessment.
5/01/ 2013	Rio patient record – progress notes	Assessed by HTT at RSCH. Mrs A reluctant to engage with assessment. Referred to anxiety and distress related to court case involving abuse suffered as child at music school in Manchester. Distressed at being referred to as a "victim" when all her life she had refused to be weak. Had recently self-harmed by cutting her arms, stomach and thighs, she said this was the first time she had done this since she was 17. Assessed as high risk of further overdose or accidental harm.	CMHRS informed of assessment at RSCH and plan.	Plan:- Mrs A to engage with CMHRS, call Crisis line if necessary, son home from university and to support Mrs A through court hearing, HTT to phone next day and then discharge.
6/01/ 2013	Rio patient record – progress notes	HTT tried to call Mrs A but no answer.	HTT liaised with CMHRS.	Discharged by HTT back to CMHRS

Date	Source of Information	Brief description of contact (include time if relevant)	Involvement of & communication with other agencies	Outcome &/or Response
07 Jan 2013	CPS Witness Support > B vs B chronology of Contact	The Witness Care Officer rang the victim to inform her that a batting order would be obtained by Wednesday (09/01) and to ascertain if her husband could travel to Manchester or would he require a video link. Again a pre-court visit was offered to the victim **but was declined. The victim informed the Witness Care Officer that she had been through the support measures with the OIC and did not want any.**	.	
7/01/ 2013	Rio patient record – progress notes	CMHRS admin staff called Mrs A and arranged out-patient appointment with same psychiatrist on 09.01.13 as care co-ordinator was off sick		Mrs A to attend out-patient appointment with psychiatrist on 09.01.13
09 Jan 2013	CPS Witness Support > B vs B chronology of Contact	The Witness Care Officer rang the witness to inform her on which day she would be needed and to discuss her travel and accommodation arrangements. Victim stated that she would like her son to travel with her as he would be supporting her throughout her time in Manchester.	.	
9/01/ 2013	Rio patient record – progress notes	Review with psychiatrist at CMHRS. Mrs A advised that she needs to attend court on 15.01.13 to give evidence at court hearing in Manchester. Her son would be accompanying her. Expressed continued suicidal thoughts but no active plans. Assessed as at high risk of accidental	CMHRS referred to HTT	Referred to HTT. HTT to assess. Diazepam prescribed for seven days to help manage stress of court hearing. Care co-ordinator to contact FA as soon as back at work.

Date	Source of Information	Brief description of contact (include time if relevant)	Involvement of & communication with other agencies	Outcome &/or Response
		overdose. Psychiatrist decided to refer to HTT in view of current presentation, risks and court case.		
10 Jan 2013	CPS Witness Support > B vs B chronology of Contact	The Witness Care Officer spoke to victim and informed her that WC Manager had authorised for her son to travel with her and we would cover the cost of travel and accommodation. Travel and accommodation documents sent to victim by email as agreed NO FURTHER CONTACT WITH VICTIM	.	
10/01/ 2013	Rio patient record – progress notes	HTT assessed Mrs A at home. Issues identified - mother's cancer, debt, court hearing, recent overdose		HTT psychiatrist prescribed additional medication for one week to help with sleep. HTT planned to visit on 13.01.13 Mrs A to attend court in Manchester from 14.01.13 to 16.01.13. HTT to visit on 17.01.13
Prior to 11 Jan 2013	Victim Support Organisation - Witness Care Officer for City of Manchester CPS Witness Care Unit	We received by secure e-mail a list of Witnesses Attending Court for this trial these forms are known as LWACS. It is a typed list of witnesses attending a trial date for the case name which is the defendants names with the CPS Caseworker's name who prepared the list also included. This is the first time we had sight of a list of witnesses' names. We prepared our normal written materials for the volunteers who deliver our Service each day. A Case summary sheet listed 9 Civilian Prosecution witnesses from the LWAC with Mrs A as the first witness.	No other involvement with other Agencies.	

Date	Source of Information	Brief description of contact (include time if relevant)	Involvement of & communication with other agencies	Outcome &/or Response
11 Jan 2013	Victim Support Organisation - Witness Care Officer for City of Manchester CPS Witness Care Unit	We received a list of the trial day-by-day order of witnesses, known as the 'batting order' of witnesses, by secure e-mail which had been prepared by the CPS Caseworker. The list showed Mrs A and her husband as first and second witnesses to the trial attending on Tuesday 15/01/2013 and a note explaining that Monday 14/01/2013 would be for Legal Arguments. The Batting Order and the Pre-Court visit pro-forma were attached to our Case Summary Sheet ready for the volunteers delivering the Service during the trial	No other involvement with other Agencies	
11/01/ 2013	Rio patient record – progress notes	HTT visited and dropped off medication. Her son was with her and reported she was ok with no suicidal thoughts, Mrs A requested call on 13.01.13		HTT to call on 13.01.13
13/01/ 2013	Rio patient record – progress notes	HTT called and spoke to husband as Mrs A was out teaching – he would ask her to call		FA to call HTT.
14 Jan 2013	Surrey Police > BBC news site and PNC	Trial commenced of M**B** and ex-wife HKB at Manchester Crown Court OIC DC A GMP	No involvement from Surrey Police	Mrs A gave evidence and was cross examined. She declined the use of special measures and chose to give her evidence in open court.
BY THE 15 Jan 2013	Victim Support Organisation - Service Delivery Manager for Crown Court Crown Square Witness Service	Special Delivery Manager had handwritten a note on our Case Summary Sheet for the trial: 'Wit 1 No Special Measures' relating to Mrs A.	Special Delivery Manager enquired of, Witness Care Officer for City of Manchester CPS Care Unit, whether or not any other Special Measures had been applied for other than the remote link for Mrs	

Date	Source of Information	Brief description of contact (include time if relevant)	Involvement of & communication with other agencies	Outcome &/or Response
			A's husband. Our volunteers were aware that Mrs A was not using Special Measures to give evidence.	
15 Jan 2013	Victim Support Organisation - Crown Court Crown Square Witness Service Volunteer written notes and Service Delivery Support written notes	10.45 a.m. Mrs A and her son arrived at the Witness Suite entrance at Crown Square which is in a different road to the main Court entrance and were familiarised with Court procedures and given support prior to starting to give evidence after lunch. Witness Service Manager made arrangements for a side room to be made available for Mrs A and her son, prior to Mrs A and her son going into Court and during any breaks. Mrs A's son accompanied his mother into Court and sat next to our volunteer. Our SDS received a further night's hotel booking for Mrs A and her son by secure e-mail from WCO and passed it to Mrs A. Arranged for a taxi to transport Mrs A and her son to the hotel having discussed payment arrangements with WCO.	We informed the CPS Caseworker at Court that Mrs A's husband would be giving evidence via Live Link from Guilford Crown Court. Prior to entering the Courtroom, a Police Officer in the case stood with our volunteer Mrs A and her son talking with them. Mrs A's needs were met as they arose and Mrs A and her son thanked Witness Service Volunteer on leaving for her support saying it had helped a lot.	
15/01/ 2013	Rio patient record – Clinical coding.	Entry made in clinical coding section of Rio – providing diagnosis of Mixed Anxiety and Depressive Disorder. It is likely that this followed after her appointment on the 9/01/13		Comment : This is the only reference to Diagnosis being made in her records.
01 June 2012 –	Greater Manchester Police >	The OIC kept in contact with Mrs A by telephone on a monthly basis to establish if she had any	.	

Date	Source of Information	Brief description of contact (include time if relevant)	Involvement of & communication with other agencies	Outcome &/or Response
15 Jan 2013	Interview with the OIC	needs and answer any questions she might have. She gave him no cause for concern during this period.		
15 Jan 2013	Greater Manchester Police > Interview with the OIC	The trial of MB and HKB commenced at Manchester Crown Court. As the OIC was also a prosecution witness communication with Mrs A was restricted. She was supported by the VSS and Manchester Witness Care Unit during the process	N/A	N/A
16 Jan 2013	Victim Support Organisation - Crown Court Crown Square Witness Service Volunteer written notes	Mrs A and her son arrived at the Witness Service at Crown Court Crown Square from their hotel at 10.00a.m and were accompanied by our volunteer back to Court 14 to continue giving evidence	Following a short adjournment His Honour Judge Rudland explained to Mrs A that she could apply to him for Special Measures, namely live link or a screen. Mrs A said she would continue her evidence in open Court. The CPS Caseworker asked the Witness Service Manager to pass on to Mrs A and her son confirmation of a further night's hotel booking received on secure e-mail from the Witness Care Officer. Witness Service Volunteer called a taxi for Mrs A and her son to return to their hotel. Mrs A and her son were supported throughout the day in and out of Court however they had not anticipated that they would have to stay so many days away from home.	

Date	Source of Information	Brief description of contact (include time if relevant)	Involvement of & communication with other agencies	Outcome &/or Response
17 Jan 2013	Victim Support Organisation - Crown Court Crown Square Witness Service Volunteer written notes.	Mrs A and her son were introduced to our volunteer at the end of the evidence giving on Wednesday 16/01/2013 in anticipation of the volunteer supporting them on their return to Court on Thursday 17/01/2013.	The side room arranged with the Court Service for Mrs A and her son to wait, just prior to entering the courtroom and during any breaks, was one of the video conferencing rooms on the 3rd floor close to Court 14 but far enough away to ensure she had no direct visual or verbal contact with the defendant's family or friends or legal representatives and Mrs A and her son did not leave this room until the usher called them into Court. Mrs A's son was very supportive of his mother. During cross examination by Defence Counsel His Honour Judge Rudland intervened on a number of occasions. During a mid-morning break a Police Officer in the case had a brief word with Mrs A at the request of the Court. At the end of the second cross examination His Honour Judge Rudland asked Mrs A if she was still ok to concentrate for re-examination or would she prefer to finish for the day and resume on Friday. Mrs A said she was fine to carry on and wanted to finish so she could go home. Her evidence concluded around	

Date	Source of Information	Brief description of contact (include time if relevant)	Involvement of & communication with other agencies	Outcome &/or Response
			4.50pm. Mr C Prosecuting Counsel and the CPS clerk came down to the Witness Suite to see Mrs A and her son and thank her for attending. The Witness Service Manager arranged a taxi to take Mrs A and her son to Piccadilly Railway station to get a train home. Mrs A and her son expressed their thanks to our volunteer and the Witness Service for looking after them. Mrs A also stated that she felt Judge Rudland had been very fair with her and said on more than one occasion that she liked him.	
16 Jan 2013 – 17 Jan 2013	Greater Manchester Police > Interview with the OIC	Mrs A presented her evidence in chief and was cross examined by defence counsel. At one point during the cross examination the Judge brought up the subject of special measures and asked Mrs A if it would help her if she did not have to look at the defendants. Mrs A once again declined.	N/A	N/A
17/01/ 2013	Rio patient record – progress notes	HTT MDT discussion regarding discharge planning	HTT discussed plan to discharge with CMHRS.	HTT plan to discharge back to CMHRS if risk remains unchanged following visit today. CMHRS psychiatrist to undertake seven-day follow- up as care co-ordinator still off sick.
17/01/ 2013	Rio patient record – progress notes	HTT made several calls to Mrs A with no answer.		HTT to visit Mrs A on 18.01.13

Date	Source of Information	Brief description of contact (include time if relevant)	Involvement of & communication with other agencies	Outcome &/or Response
		Visit to home but Mrs A not there as still in Manchester Mrs A called asking for visit on 18/01/2013		
18/01/ 2013 - SNOW	Rio patient record – progress notes	Adverse weather conditions Telephone call from F Mrs A advising unsafe driving conditions near her house. Reported feeling '"utterly traumatised' by giving evidence, was called a liar and a fantasist by the lawyer in court. Reported poor sleep, low mood, denied suicidal ideation. Said she was a survivor and would see case through. Mrs A had run out of medication, unable to get to GP due to road conditions. HTT arranged for medication to be picked up from local chemist by Mrs A.	HTT advised GP of medication being prescribed by HTT and plan for HTT to prescribe any additional medication.	HTT arranged for collection of medication and prescribed additional medication to help Mrs A through court case. Plan for HTT to visit on alternate days.
18/01/ 2013		Time 20.42 HTT called Mrs A – she could not talk but confirmed she had got medication from chemist but wanted something stronger. Discussion about when appointment with psychiatrist could be arranged – earliest was following week. Requested a visit on next day, sounded calm		HTT arranged to visit on 19.01.13
19/01/ 2013	Rio patient record – progress notes	HTT visited Mrs A at home. She was described as pleasant and welcoming, low mood, described feeling numb. Talked about the sexual abuse she had suffered and the on-going court case and feeling bad because everything was now in		HTT to visit again on 21.01.13.

Date	Source of Information	Brief description of contact (include time if relevant)	Involvement of & communication with other agencies	Outcome &/or Response
		the open. Concerned that the court may not believe her. Difficulties sleeping. Taking medication as prescribed. Denied plans to self-harm. Husband and children supportive. Requested psychology treatment.		
21/01/ 2013	Rio patient record – progress notes	HTT called Mrs A. Advised she and husband both giving evidence in court that day. Reported feeling well aside from the anxiety and trauma of the court hearing. Medication required so HTT arranged to visit late evening to deliver medication.		HTT visited and delivered seven day's supply of Diazepam and Zopiclone medication. HTT to visit on 22.01.13
22.01. 2013	Rio patient record – progress notes	Home visit from HTT, Husband and son in court yesterday. Son now back at University in Cambridge. Slept last night but permanently exhausted. Talked about the court case and past abuse also by uncle when she was nine. Also referred to having been abused by her mother. Said she appreciated staff support but wanted proper therapy which would help her develop coping skills to deal with the abuse from the past. Had plans to sleep, collect daughter from school then has music lesson.		HTT to phone Mrs A on 23.01.12 and visit on 24.01.12.
18 Jan 2013 – 23 Jan 2013	Greater Manchester Police > Interview with the OIC	On three occasions during this period the OIC was asked by Prosecuting Counsel to contact Mrs A by telephone to clarify issues that had cropped	N/A	N/A

Date	Source of Information	Brief description of contact (include time if relevant)	Involvement of & communication with other agencies	Outcome &/or Response
		up during the evidence of other witnesses. On each of these occasions the OIC found that, although naturally anxious about the outcome of the trial, Mrs A was busy getting on with her life i.e. shopping, driving her son back to university and taking her husband to hospital. There was nothing about her demeanour that gave him any cause for concern.		
23.01.2013	RIO patient record – progress notes	HTT called Mrs A but husband said she was asleep and didn't want to be disturbed. The plan was to visit the next day.		The plan was for the HTT to visit on the 24th January 2013. The HTT was advised by the CMHRS on the 24th January that they had been informed by the police that Mrs A had taken her own life.
24 Jan 2013	Surrey Police > 08:18 – ICAD P13023824 Caller: SECAmb (Ambulance Ref: 21632768) GD/13/640 – Non-Crime Suspicious Incident	Call from Ambulance that a unit had attended (address) and Mrs A had been declared dead as a result of a suicide bid.	GMP and CPS made aware of death	CID attended no suspicious circumstances. Full report being made to HM Coroner as trial still in process. Mr A informed police that his wife had returned from the trial in Manchester feeling quite depressed. She had been advised to stay in bed by the Home Treatment Team and had been given a course of Diazepam and Zopiclone tablets. She had remained in bed since returning and only got up to eat. He stated he last saw his wife alive at 20:30 on 23 January 2013. Around 08:00 he found his wife in bed – she was very cold and rigid. A number of empty packets of prescription and non-prescription drugs were located near to Mrs A. *MB had just begun to give his evidence and in view of the evidence given by* Mrs A *the judge had directed the jury to return not guilty verdicts on five*

Date	Source of Information	Brief description of contact (include time if relevant)	Involvement of & communication with other agencies	Outcome &/or Response
				of the charges as they fell outside the statute of limitations. The trial was adjourned *On 26 March 2013 MB was sentenced to 6 years imprisonment having been found guilty of 5 counts of indecent assault against* Mrs A*. HKB was also found guilty of I count of indecent assault and sentenced to 21 months imprisonment.* No date yet set for HM Coroner's Inquest.
24 Jan 2013	Greater Manchester Police > Terms of reference	Mrs A was found dead at her home address in Surrey having taken what is suspected to have been a fatal insulin overdose.	N/A	N/A
26 Mar 2013	Victim Support Organisation - Account of Service Delivery Manager The Witness Service The Three Crown Courts in Greater Manchester Anne Gaunt was on annual leave	Mrs A's son and other Family members attended the sentencing of the two defendants at Crown Court Crown Square	Police Officers transporting and supporting the family brought the family to the Witness Service entrance and they were supported in our family room which is available for bereaved families with our volunteer D. D and the support Police Officer explained that we could make onward referrals for any family member to our Victim Care Units in their home locality. All family members very much appreciated the offer but declined. Special arrangements were made to escort the family, to and from the Court where the Sentence was to take place, along the secure corridors. Family members and the supporting Police	

Date	Source of Information	Brief description of contact (include time if relevant)	Involvement of & communication with other agencies	Outcome &/or Response
			Officers thanked us for the support on this day.	
29 Apr 2013	SCC Children's Service > Police	Police advised contact centre of mother's death.	.	

Appendix A List of participating agencies and their representatives

Panel

Helen Blunden (Chair)	Hosted by Surrey Downs CCG, Designated Nurse for Safeguarding Vulnerable Adults in Surrey
Stewart Leahy	Surrey Police, Detective Inspector
Julian Gordon-Walker	Surrey County Council, Children, Schools and Families, Head of Safeguarding
Paola Valerio	Surrey and Borders Partnership NHS Foundation Trust, Trust Lead for Safeguarding, Domestic Abuse and Prevent
Sue Boakes	Kingston Advocacy Group, Deputy Director
Andy Butler	Surrey County Council, Adult Social Care, Principle Social Worker/ Senior Practice Development Manager.
Karen Devanny	NHS East Surrey Clinical Commissioning Group, Director of Quality and Nursing
Justine Hillier	Ashford and St Peters Hospitals NHS Foundation Trust, Associate Director of Nursing Medicine

SCR Support

Support was provided to the Review Panel from the Senior Lawyer at Surrey County
Council, the ASC Senior Manager for Safeguarding at Surrey County Council and the
Surrey Safeguarding Adults Board Administrator.

List of documents submitted to the Panel

Internal Management Reviews (IMRs) Submitted by:

Surrey and Borders Partnership NHS Foundation Trust
Crown Prosecution Service
Surrey Police
Greater Manchester Police
GP
Surrey County Council, Children's, Schools and Families
South East Coast Ambulance Service
Victim Support
Royal Surrey County Hospital NHS Foundation Trust

Appendix B

Interim Guidelines on Prosecuting Cases of Child Sexual Abuse - Summary

Issued by the Director of Public Prosecutions on 11 June 2013

- **Application:** These guidelines set out the approach that prosecutors should take when dealing with child sexual abuse cases.
- **Allocation:** All child sexual abuse cases must be dealt with by specialist prosecutors based in the CPS Rape and Serious Sexual Offences Units which have now been established in each CPS Area. Advocates presenting these cases in court must be specialists.
- **Early consultation:** In large or complex child sexual abuse cases, there should be early consultation between the police and the CPS. Joint case review meetings should take place periodically so that progress can be checked and advice on case issues given.
- **Support:** Victims and witnesses should be made aware from the outset of the investigation exactly what is expected of them, particularly in terms of attending court and giving evidence, and they should be offered support to help them in the process. There is no bar to a victim seeking pre-trial therapy or counselling and neither the police nor prosecutors should prevent therapy from taking place prior to trial.
- **Identifying risk:** Prosecutors should be aware of typical vulnerabilities exhibited by children who may have been abused. These include but are not limited to: being missing from home, school, or care; drug or alcohol misuse; being estranged from family; self-harm; being involved in offending; and physical injury. Prosecutors should have regard to the list of signs and behaviors typically seen in children who are being sexually exploited which was published by the Office of the Children's Commissioner in England in 2012.
- **Credibility:** When assessing the credibility of a child or young person, police and prosecutors should focus on the credibility of the allegation, rather than focusing solely on any perceived weaknesses in the victim. In particular, police and prosecutors should avoid making assumptions about victims. A reluctance to co-operate with those in authority, failure to report allegations of abuse swiftly, and providing inconsistent accounts are not uncommon in victims of child sexual abuse, especially during initial interviews.
- **Taking the victims account:** Particular care should be exercised when deciding how to take the victim's account. A video recorded interview is often the most appropriate means but may not always be so. Consideration should be given to the use of a Registered Intermediary at an early stage.

Prosecutors should be familiar with police ABE procedures and mindful of the need for a clear and focused ABE interview to be presented at the trial.

- **Other allegations:** There is no rule which prevents victims being told that they are not the only ones to have made a complaint of abuse. Victims can be told that the suspect has been the subject of complaints by others. Doing so may strengthen their resolve to continue their engagement with the criminal process. But this should usually only be done after the victim's account has been given and the details of other allegations should not be disclosed.

- **The suspect:** In child sexual abuse cases, the account given by the suspect must be considered as intensely as the credibility of the complainant. Prosecutors should ensure that the police investigate all background issues of relevance, including intelligence, previous allegations (even if no prosecution resulted), any relevant child abduction warnings, third party accounts, and the suspect 's associations.

- **Third party material:** Third party material should be sought at an early stage, preferably pre-charge. Examples of third-party material which may be relevant include: medical notes; social services/children's services material; education notes; counselling/therapy notes, and information or evidence arising in parallel family/civil proceedings. Police and prosecutors should handle requests for Local Authority material in accordance with any applicable local or national protocol to ensure that the Local Authority makes disclosure to the full extent permitted by law.

- **Support at court:** Prosecutors should discuss with the police at an early stage what special measures should be used to support a victim at court. The views of the victim should be taken into account as well as the type of offending alleged. The use of Registered Intermediaries should also be considered. Prosecutors are advised to keep special measures under review as the date of the trial approaches so that they remain appropriate and the most effective support is given to the victim.

- **Cross examination:** Ground rules hearings about cross examination in court are recommended in any young witness trial but required in any intermediary cases. This includes the defense agreeing who will be the lead counsel to put questions to the victim in cases with more than one defendant and the length of time given to the cross examination. The ground rules hearings should take place in advance of the day of the trial so that everyone, particularly the victim, is aware of what to expect and how long the proceedings in court should take.

- **Challenging myths and stereotypes:** Prosecutors should challenge myths and stereotypes at court. In appropriate cases, prosecutors should consider adducing expert evidence or inviting the trial judge to give specific directions to the jury.

- **Sharing information:** Prosecutors who receive relevant cases from the police should check with the police that they have complied with their statutory duties to share information with Local Authorities and any other relevant bodies. CPS case files should not be closed until this confirmation is received. Prosecutors must be proactive in highlighting to police officers information which is of concern to them. If it is not possible to prosecute a case, but information available causes concern to the prosecutor, they should ensure that this is brought to the attention of the relevant investigating police officers, so that they can in turn share this with the relevant agencies including Local Authorities.