

Domestic Homicide Review
Joan/November 2015
Executive Summary

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Commissioned by:
Kent Community Safety Partnership
Medway Community Safety Partnership

Review Completed: 7th March 2017

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

Section 1

1. The Review Process

- 1.1 This summary outlines the process undertaken by Kent Community Safety Partnership Domestic Homicide Review Panel in reviewing the homicide of Joan Baker who was a resident in their area.
- 1.2 The following pseudonyms have been used in this review for the victim, the perpetrator and other family members as per the table below. Pseudonyms have been used to protect their identities and those of their family members.

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

- 1.3 Criminal Proceedings were completed on 25th April 2016 and the perpetrator pleaded guilty to manslaughter by reason of diminished responsibility. The Judge accepted the plea and detained the perpetrator indefinitely by way of a Hospital Order under the Mental Health Act.
- 1.4 The process began with an initial meeting of the DHR Core Panel on 17th December 2015 and a decision to hold a domestic homicide review agreed. All agencies that potentially had contact with Joan Baker (victim) or Simon Heath (perpetrator) prior to the point of death were contacted and asked to confirm whether they had involvement with them.
- 1.5 Three of Three agencies contacted confirmed contact with the victim and the Perpetrator involved and they were asked to secure their files.

2. Contributions to the review

- 2.1 Each of the following organisations completed an IMR for this DHR:
- Kent and Medway NHS and Social Care Partnership Trust (KMPT)
 - NHS North Kent Clinical Commissioning Group (NKCCG)
 - Kent Police
- 2.2 Access to an internal NHS Trust Investigation was provided to the Chair of the Review Panel and considered by him in the writing of this report.
- 2.3 Information from meetings with family members was included in the completion of this review.
- 2.4 Each IMR was written by an independent person from within the organisation concerned. It is a detailed examination of an organisations contact and involvement with Joan and/or Simon. A member of staff from each relevant agency writes the IMR. That person will have had no involvement with anyone subject of the review. Once completed the review is signed off as approved by a Senior Manager of the organisation before being submitted to the DHR Review Panel.

3. The Review Panel Members

- 3.1 The Review Panel consisted of an Independent Chairman and senior representatives of the organisations that had relevant contact with Joan Baker and/or Simon Heath. It also included the Kent and Medway Domestic Abuse Coordinator and a senior member from the Kent Community Safety Team, Kent County Council.
- 3.2 The members of the panel were:
- Kate Bushell – Designated Nurse for Safeguarding Adults, North Kent Clinical Commissioning Group
- Alison Gilmour – Kent & Medway Domestic Abuse Coordinator
- Tina Hughes – Senior Operational Support Manager, National Probation Service
- Carol McKeough – Safeguarding Adults Policy and Standards Manager, Kent Adult Social Services
- Anne Lyttle – Service Director, Rising Sun Domestic Violence and Abuse Service
- Paul Carroll – Independent Chairman
- Shafick Peerbux – Head of Kent Community Safety, Kent County Council
- Simon Wilson – Superintendent, Head of Continuous Improvement, Kent Police
- Jessica Willans – Excellence and Effectiveness Manager (SPO), Kent Surrey and Sussex Community Rehabilitation Company
- Cecelia Wigley – Head of Safeguarding, Kent and Medway NHS and Social Care Partnership Trust

4. Author of the Overview Report

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

5. Terms of Reference for the Review

- 5.1 The terms of reference for this review are set out in [Appendix A](#) of the Overview report. However the specific issues and purpose of a Review are set out below.

5.2 Purpose of the Review

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

5.3 Focus of the Review

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

6. Summary of Chronology

- 6.1 This section sets out a summary of the key facts associated with the death of Joan Baker following a violent and fatal assault upon her at her home by Simon Heath, her Grandson, on the 19th November 2015. At the time of her death Joan was an 85 year old widow living alone in Kent.
- 6.2 Joan had very little contact with any of the agencies contributing to this review, although she was aware of the troubled history surrounding her Grandson's Mental Health and previous attacks he had made on members of the family. However, Joan's contacts were limited with agencies concerned and at the time of her death she was recorded as being in good health with every expectation of continuing to lead a full and healthy life.
- 6.3 The events leading to the death of Joan Baker occurred as a culmination of individual events linked by reoccurring themes triggered by a complex illness. This illness drove Simon Heath to consider that elderly relatives in his family were standing in the way of his progression in the family hierarchy. This created a resentment that provoked him to attack and seek to kill such relatives.
- 6.4 Simon's history of mental illness can be traced back to 1995, when after heavy use of drugs and alcohol he received treatment due to his deteriorating mental state. Despite such treatment, his condition led him to attack his paternal

grandmother in London in June 1996. His grandmother died some time later from pneumonia, but given the passage of time between the assault and her death no causal link between the two could be established, and as such, Simon was unable to be charged with Murder/Manslaughter. He was however detained in a Secure Unit under a Section 37/41 Mental Health Order.

- 6.5 During his period in the Secure Unit Simon continued to display violent outbursts and there are a number of incidents recorded of him assaulting other patients and members of staff.
- 6.6 Simon's treatment within the Secure Unit led to his release into the community in March 2000, but with conditions attached to his release. These conditions restricted where he could live and required that he take medication to control his illness. With the support of a range of clinical and social care professionals, Simon maintained his progress and was able to establish a relationship with a girl named Sarah, who would later become his wife. It seems that there was little or no knowledge of Sarah and her background or current circumstances other than she was now in a relationship with Simon. Given Simon's mental attitude to elderly people and the access he could have had to them through Sarah's work, see 6.8, there appears to have been a real need for greater research into the potential impact on Simon and his new associations following such a change in his circumstances.
- 6.7 Simon recognised that there was a need for regulation and indeed, when in July 2001 he admitted to drinking alcohol contrary to the terms of his release, he was informally returned to hospital for further assessment of his mental state, being released again in September.
- 6.8. In late September 2001, Simon began to have thoughts around killing an elderly person in a care home where his now girlfriend worked and was again re-admitted to hospital. During this admission, he also began to believe wrongly, that his girlfriend was having an affair with his father.
- 6.9 It is during this hospital admission that Simon was first treated with the drug Clozapine. This treatment for resistant schizophrenia, was to prove highly positive for Simon, allowing him to successfully balance his mental health and allow him to successfully live under monitoring in the community.
- 6.10 With the benefit of Clozapine treatment Simon was able to lead a stable life from December 2001 until December 2005. During this period he married his girlfriend Sarah and became a father. His illness was considered to be sufficiently stable that in May 2005 his care was transferred to the Local Community based Forensic Mental Health Team.
- 6.11 Simon met with his appointed Social Supervisor, Community Forensic Psychiatric Nurse and other supportive professionals on a regular basis during this period. On the 14th December 2005, when he met with the CMHT team, they detected no relapse indicators. However, during that month Simon

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

- 6.12 Simon was recalled to hospital following this attack and he later informed staff that it had been his intention to kill his grandfather. His early return to hospital saw him continue to verbalise aggression and indeed he assaulted another patient, a matter that was referred to the Police, who due to the mental state of both Simon and the other patient whom had been assaulted, the case was filed.
- 6.13 Simon remained in hospital until September 2007 as he was still considered a threat to elderly family members and possibly others. However, from May 2007, he was allowed time out of hospital as part of steps towards his rehabilitation. In September 2007 he was allowed Conditional Leave overnight with the strict condition that he was to have no unsupervised access to his grandparents.
- 6.14 On the 16th April 2008 his mental health had stabilised sufficiently to allow a Mental Health Review to authorise discharge back into the community.
- 6.15 In June 2008 Simon advised that he and Sarah were separating. Records show that he appeared to cope well with this change of circumstance and he remained on good terms with Sarah and maintained regular contact with his daughter.
- 6.16 The medication, support and supervision that Simon was receiving allowed him to lead a "stable" life throughout 2010 and 2011, holding down a job and doing well in maintaining as normal a life style as possible. However in 2012 Simon began to raise the issue of changes to his discharge conditions to allow him to partake in drinking alcohol and following a recommendation to the Home Office from the Mental Health Team, conditions were varied to allow him to drink two units per week.
- 6.17 During 2012 Simon also started a new relationship with Louise, whose two children were also in Simon's daughter's class at school.
- 6.18 On the 29th April 2014, Simon was granted an Absolute Discharge by a Mental Health Tribunal. Despite concerns raised by the family and a formal objection by the Secretary of State, the tribunal were not provided with any statement or documentary evidence that suggested they should not grant an Absolute Discharge, in the face of the evidence available to them of Simon's stable mental health over a prolonged period.
- 6.19 In May 2014 care of Simon was passed to the Community Mental Health Team and his GP advised accordingly. Simon continued to attend the Clozapine clinic but in November 2014 complained that his ability to work was being impaired due to the side effects of the drug. Adjustments were made around the nocte dose and a small reduction made when the pharmacist noted increased toxicity in his blood, which could have caused seizure if not addressed.

- 6.20. In August 2015, Simon reduced his medication dosage further to enable him to share the driving on a family holiday to Yorkshire. He did so without consultation with a doctor. The reduction in dosage appears to have continued until the 17th September 2015, when Simon himself informed his Care Coordinator by telephone. It however appears that the responsibility for ensuring Simon was seen by a doctor was not undertaken by the Care Coordinator but left to the Clozapine clinic nurse to arrange.
- 6.21 The care coordinator was a very experienced Social Worker, but he failed to engage with Simon or his family, with any form of contact being initiated by Simon. Simon's care plan review was overdue and significant doubts remain about the timing and quality of record keeping. Indeed the level of contact was described by KMPT as "ineffective".
- 6.22 During this period there is also evidence that following the removal of any Licence Conditions following his Absolute Discharge, that Simon was regularly using alcohol. Given the lack of contact with Simon by his social supervisor, this change in behaviour and the reasons behind them were not explored, and Simon provided with neither any form of support or challenge.
- 6.23 On the 19th November 2015, Simon attended the home of Joan Baker where he violently assaulted her which as a result later led to her death.

7. Key Issues Arising from the Review

- 7.1 The key issues arising from this review are as follows and further detailed in Section eight below.
- Lack of appropriate management of Simon once his care was transferred to the local Community Mental Health Team.
 - The level of governance in place in regard to the management of the Social Supervisor, especially given indicators of performance and personal issues available to Line Managers.
 - Lack of engagement with Simon or his family, leaving a gap in the chain of continuity of supervision of which Simon had become reliant upon over a number of years.
 - Clarity relating to action to be taken relating to recording assaults with the Police, where they occur in a Mental Health setting such as a secure hospital setting. All such incidents whether on another patient or any member of staff should be reported.
 - Where any concerns are raised in regard to the understanding or actions of family members of a patient held under Mental Health action, should be recorded and appropriate action taken to manage the risk associated to the concern raised.

- The need to clarify what information is available to a Mental Health Tribunal and the breadth of information it needs to be able to come to appropriate evidence based decisions in regard to granting an Absolute Discharge. This should include utilising intelligence available from family members to inform such a decision.

8. Conclusions

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

- 8.5 Given the concerns of the family, the apparent lack of opportunity for them to have input into the Tribunal process, plus the lack of availability of any rationale from the Secretary of State objecting to the Absolute Discharge, the question must be posed as to whether or not the process surrounding Tribunal hearings in cases such as these, provide the Tribunal with the required breadth of information needed. It also poses the question as to how do procedures allow for family input, to provide the Tribunal with wider background information to consider in reaching determinations.
- 8.6 Communication is vital in managing complex cases such as Simon's. Events surrounding Simon were not always evident to the Police, especially when the family chose not to report a significant assault by Simon to them. The incidents of criminal assaults committed by Simon whilst in hospital which were not reported to Police again led to their intelligence being incomplete. Whilst it is recognised that it may not be possible to investigate matters to a conclusion within a mental health environment given the limits on how investigations are able to proceed, it remains that good practice requires that any criminal act that occurs in such establishments should be reported to the Police.
- 8.7 A further example of where communication was unclear relates to the two opportunities for other agencies to be made aware of Simon's full history through the formal MAPPA process. It is apparent that Simon's case was raised with MAPPA coordinators on two occasions, once in written format (2008) and again rather more informally by telephone in 2014. On both occasions the recommendations by clinicians was that he did not meet the threshold although this view was less strongly advocated in 2008 than in 2014. There appears to have been a lack of formal recording on both occasions. Whilst it must be acknowledged that a MAPPA panel would have more than likely decided to refer the case for single agency management, in this case mental health, a formal discussion of his case would have brought to light information for all agencies that may have later been available to the Mental Health Tribunal and would certainly have provided a clear record of decisions taken and why.
- 8.8 This case highlights a difficult area in relation to safeguarding. It appears from the evidence that Simon was able to engage in two relationships and to be a responsible adult for children, whilst certainly in the case of his relationship with Louise Carter, she was unaware of his full history and the possible risks. Whilst there remains the issue of what should be disclosable and what should require a patient's permission, it seems that where a person with Simon's background has a significant change in their relationship, then there should be a mechanism to ensure that the other party in the relationship has been had disclosure of the background so as to assess risk.

9. Lessons to be Learned

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

10. Recommendations from the Review

- 10.1 **Six Recommendations** have been made from the review they are:-

1) Secure Units and similar establishments should ensure that there is a process of effective communication between them, the Police and other appropriate agencies regarding reporting assaults in their establishments. This must include the local authority where assaults occur in hospitals between patients.

2) Whenever there is a significant change of circumstance, such as a change of relationship, or any significant change of circumstance for those under supervision on conditional discharge, then a multi-agency meeting should be initiated and as a result to take and record any action that is required, the person(s) responsible for actions and time scale for completion.

3) Where there are concerns in regard to family members raised within a team meeting or any other internal setting, then those issues should be made clear. The proposed course of action to manage this position should be set out in the form of an action plan, which should indicate the action required, timescale for action and thereafter feedback on the engagement with the family and the outcomes recorded.

4) That the process of Mental Health Tribunal Reviews hearing applications for Absolute Discharge, be reviewed to ensure that current arrangements are adequate to provide the panel with the breadth of information needed to reach their decision. Such changes should also consider how best to receive intelligence/information received from the family.

5) Where an agency expresses a view as to the decision a Mental Health Tribunal should consider, then such a view must be supported with a rationale, either in person or in the form of documentary evidence.

6) That the NHS Trust, in light of the findings of their investigation, further consider whether the management and governance arrangements currently in place, were effective and consider how lessons learnt from this review can be applied for the future.