SAFER CORNWALL
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Safer Cornwall

DHR Overview Report Executive Summary

DHR 5

Independent Chair and Author

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Version 1.0 September 2016
Version 1.1 April 2017
Version 1.2 January 2018

1. Introduction

This Domestic Homicide Review (DHR) examines the circumstances surrounding the death of Adult A on 15 November 2013. The DHR was commissioned by Cornwall Council on behalf of Safer Cornwall (Cornwall's Community Safety Partnership).

The DHR was commissioned in autumn 2014 and the panel met for the first time in December 2014. On 15 November 2013, Adult B attacked and killed her husband Adult A by stabbing him once in the heart.

The report and this Executive Summary uses Adult A to denote the victim in this case and Adult B to denote the perpetrator.

2. The DHR process

A DHR was recommended and commissioned by Safer Cornwall in the autumn of 2014 in line with the expectations of the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews 2013. This guidance is issued as statutory guidance under section 9(3) of the Domestic Violence, Crime and Adults Act 2004.

A panel met for the first time in December 2014 following the appointment of an independent Chair, Dr. Jane Monckton Smith. In April 2015, Steve Appleton, Managing Director of Contact Consulting (Oxford) Ltd was appointed by NHS England South to provide additional mental health expertise and to assist the Chair in writing the Overview Report.

In October 2015, Dr. Monckton Smith withdrew as the Independent Chair and Steve Appleton took over the Chairing of the DHR and authoring of the overview report.

The DHR Panel received and considered Individual Management Reviews (IMRs) from the following agencies:

- NHS England – Primary Care
- Devon and Cornwall Police
- Cornwall Partnership NHS Foundation Trust

In addition the panel commissioned, with the support of NHS England (South) and independent forensic psychiatry report. The review was undertaken by Niche Patient Safety and was conducted by an independent forensic psychiatrist, Dr. John McKenna.

3. Views of the family

In conducting this review the panel has sought the views of family members in order to inform its understanding of the incident and the events that led up to it. The panel has sought throughout the review to ensure that the wishes of family members have informed its work and that their views are reflected in this Overview Report. In the full Overview Report the Foreword contains a statement from family members and an open letter that sets out their views about the DHR process, its findings and the DHR framework more broadly, including areas where the family disagree on specific aspects of the DHRs findings.

The engagement with family members of Adult A has taken place through email, telephone contact and face-to-face meetings.

The views of Adult A's family members were gathered through a face-to-face meeting with the Chair and they have been kept informed of progress with the DHR.

Foreword - Family tributes to Adult A

As part of the review, the chair met with members of Adult A's family. Throughout the process the panel sought to ensure that their voices were heard and that through them, Adult A was at the centre of our thinking. With this in mind, it was agreed that members of the family would have the opportunity to provide a written statement about Adult A as a foreword to the Overview Report. Their statement also sets out areas where the family disagree with some aspects of the reports findings. The family tributes are set out here in full and without editing by the panel or the author.

The report uses the terms Adult A to denote the victim in this case and Adult B to denote the perpetrator. The decision to adopt this approach was taken after discussion with family members and their advocate and was their request, rather than using initials or pseudonyms. It was taken to maintain

confidentiality but also to be more personal to him rather than using random initials or other forms of anonymisation.

A tribute to Adult A from his family

This is written in the hope you will gain an understanding into the person who has been killed and what he meant to us as a family. He wasn't a statistic or sad incident.

Anyone who knew him will smile just to think about him. He told such terrible jokes, and often thought our reaction was better than the joke itself. Even if you didn't want to laugh you couldn't help it as his chuckling was infectious.

He adored his wife and did all he could to protect and care for her. Coping with her illness can't have been easy but he was always loyal and loving. She was everything to him. As for his sons, you wouldn't find a prouder Dad. He'd drive hundreds of miles so they could compete in sporting challenges. Then he'd grin and do his American 'Spike the Bull Dog' impression (from Tom and Jerry) saying 'That's my boy!' He was a keen sportsman himself and really enjoyed competing, whether it was black run skiing or sailing.

In a sympathy card a friend said she knew what he meant to us as a family. She had seen how our faces would light up when he came into the room. When he arrived the fun would start.

An open letter to the Home Office from the family of Adult A

The family of Adult A requested that an open letter to the Home Office be included in the Overview Report. It is produced here, unedited.

This commentary has been prepared by the elder son, daughter-in-law and six sisters of the victim of the crime which gave rise to this Domestic Homicide Review (DHR): Adult A. As his closest relatives we wish to offer some observations about the report – both its substance and the process involved in its preparation – and about the DHR process more generally. We hope that they will be found helpful: they are intended to be constructive.
We would like first to place on record the fact that, despite the shortcomings that we perceive in the process through which it was produced, we consider the final report to be a serious and honest effort to explore the issues raised by the case – in so far as they fall within the scope of a DHR. In our view it accurately identifies many of the key lessons to be learned from it. We are grateful to the author for inviting and paying attention to our comments on an earlier draft and for taking on board many of our suggested changes.

That said, we retain some important reservations about the overall process of review, of which this DHR report is the culmination. The nub of our criticism is that the approach to engaging us was throughout too reactive and insufficiently sensitive. In our view those carrying out not just the DHR itself but the contributing Internal Management Reviews (IMRs) should have sought from the outset to make early contact with family members and to agree with them the degree of involvement that they wished to have in the review processes. The aim at that stage should have been to establish trust and to engender confidence that any pertinent information and insights that we had to offer would be welcomed and taken into account.

This was not the sense that we got. In this respect things were not helped by the fact that in the first instance those conducting the Cornwall Foundation Trust (CFT) IMR seemed interested in dealing only with the “next of kin”, rather than the family as a whole. Whatever practical advantages this approach may seemingly have offered, in reality it gave the rest of us the feeling that we were being excluded. What is more, it risked loading all the responsibility of keeping the wider family informed and engaged onto one of the two members closest to the victim and thus most severely affected by the crime – his elder son. The fact that CFT appear to have offered support to their own staff involved in the case without extending a similar offer to the family, including the victim’s autistic younger son, served only to reinforce our impression that we were seen as not integral to the process.

Similarly the family were not given adequate opportunity to see and comment upon the IMRs at draft stage. As a result, the final versions contained some errors of fact which it was only possible to correct in the DHR report itself. Not only did this unnecessarily complicate and possibly delay the preparation of that report but it also perpetuated misunderstandings which could have been scotched much sooner.

As to the DHR itself, those conducting the review did not proactively contact us, explain the process and programme, or seek our input. Our request to meet, and ideally to sit on, the panel was not met. In the absence of any explanation, and despite the declared intentions of both the original and replacement chairs, we did not get the sense that our contribution was seen as an essential element of the exercise. The panel never actively solicited our knowledge and insights. Indeed it required great persistence on our part to secure the involvement that we did achieve.

It is true that from our standpoint part of the problem was that the DHR, and the IMRs previously, were in effect substituting for an open court criminal trial as a source of information about what actually happened immediately before and at the time of the homicide. Some of our relatively few outstanding criticisms of the report relate to the fact that, in the absence of evidence exposed and tested in court, the author – as he acknowledges - still relies heavily on the perpetrator's account of events. One observation not specifically relating to the DHR is therefore that even when there is an agreed plea, the victim's family and friends would still find it helpful for the court to establish formally the facts of the crime.

Although not strictly pertinent to the DHR, we would also like to note in passing that some of the failings observed in other public bodies, particularly an insensitivity to the feelings and expectations of a traumatised family, were at least equally characteristic of the conduct of the coroner's office. We are aware that a previous DHR in Cornwall has highlighted this lack of consideration for the bereaved and wish to underline the need for a change in attitude.

Turning to the substance of the report, there are a few points on which we retain some concerns:

(i) we question its stated reluctance to make judgments based on hindsight when, for the purposes of learning lessons, hindsight is surely exactly what is required:

(ii) we fear that some participants in the review had lurking in their minds an anxiety that too explicit a finding of fault could have damaging consequences for the individuals or organisations whose actions they were reviewing. We see apprehensions of this sort as potentially deeply corrosive of the effectiveness of the DHR process. Its exclusive purpose must be, and be seen to be, forward-looking: to do everything possible to ensure that future practice minimises the risk of a criminal and personal tragedy of the type which occurred;

(iii) We note and endorse the criticisms of the support provided for her at home, and especially of the lack of continuity amongst the staff involved. But the more fundamental questions concern whether she had been correctly diagnosed, whether in the light of past experience it was wise to rely on her taking her prescribed medication (or on her husband to ensure her doing so) and whether, at the time of her release from Bodmin Hospital, it was appropriate to allow her home;

(iv) the above matters bear directly on the crucial question of whether the homicide could realistically have been prevented – an issue on which we note that the report reaches a conclusion slightly different from that of the forensic psychiatrist commissioned to review the case;

(v) despite the report's useful recommendations in regard to record-keeping and access, we do not feel that it fully lays to rest our suspicion that the confidentiality attaching to medical records can inhibit the sharing of information vital to treating physicians in their handling of a case, especially when a patient seeks actively to conceal his or her clinical history; and

(vi) however strong panel members' other credentials, we have doubts about their authority to adjudicate in matters of clinical judgment. In this particular case the accuracy of Adult B's diagnosis was clearly a critical issue. From our perspective the report commissioned from an independent forensic psychiatrist was accordingly the single most valuable element in the whole process. Yet a panel which lacked a member with similar qualifications was called upon to weigh up his judgments against those of the treating physicians and of the qualified psychiatrist who chaired the CFT's IMR. In our view the panel appointed to conduct a DHR in any case where mental illness has been a factor in a domestic homicide should include an experienced, professionally qualified forensic psychiatrist.

In relation to this last point, we recognise of course the difficulty of diagnosing definitively the mental condition of someone like Adult B. Although many of us had known her for over 30 years, we ourselves had no inkling that she was capable of the behaviour that she exhibited on this occasion. And as we understand things there remains even now, despite her detention and intensive observation and treatment for over two and a half years, considerable doubt as to her true condition – for example as to whether she suffers from a personality disorder or simply some form of psychosis.

In these circumstances we can well see that it would have been very hard to tell whether she was suffering from illusory fears of abandonment and bankruptcy or from delusional jealousy, or indeed from some combination of these conditions. We do note, however, that the forensic psychiatrist, Dr McKenna, said in his report that "I think it is very likely that at the times when she was severely depressed, Adult B's beliefs did at times include notions of infidelity that were delusional in nature". As indicated above, we do not seek a retrospective verdict on this matter; we merely wish to be reassured that in future all these possibilities – with their potential implications for treatment – will be properly considered.

Turning from this particular DHR to any lessons that it may hold for the DHR process generally, we offer the following observations:

(i) the concept of the DHR is fundamentally sound: performance across the organisations involved in cases of domestic homicide should be reviewed with the objective of learning lessons and improving future practice;

(ii) family members should be supplied with and given opportunity to comment on draft IMRs.

(iii) the involvement of the victim's family is crucial and should be pursued proactively by those conducting the review and before that by those preparing the IMRs that contribute to it;

(iv) family members should be given the opportunity, at the least, to meet panel members collectively and possibly to nominate one of their number to sit in on its deliberations as an observer;

(v) the chair of the DHR should be fully independent of the bodies whose performance is under review and to ensure this should be contracted and funded by a separate, central body (perhaps the Home Office) and ideally be drawn from a panel of trained professionals assembled for the purpose;

(vi) panel members should possess the expertise, skills and experience necessary to assess critically and comprehensively the evidence provided by the individual

organisational IMRs and from any other valid sources, including commissioned reports and family testimony;

(vii) where necessary further studies should be commissioned to supplement the information available from IMRs so as to enable the DHR to reach better founded conclusions about the lessons to be learnt from the case (as happened in this instance with the very helpful report from a forensic scientist); and

(viii) relevant information from the DHR should be drawn to the attention of, and made available to, those responsible for the custody and treatment of the perpetrator of the crime committed.

One final point, arising from the last above, relates to the relationship between the health and justice systems in a case such as this, where someone who has been found guilty of a serious crime has been judged to have been mentally unwell at the time that he or she committed it. The appropriate treatment of such an offender raises issues quite different from those addressed by a DHR and relating to the extent to which he or she was responsible for his or her actions and poses a continuing danger to other members of society.

These are undeniably murky waters into which the bereaved relatives of a victim venture at their peril, given that they are inevitably less than wholly objective. It does seem to us, however, that at present there is too sharp a demarcation between the realms of justice and of health. Despite the efforts to forge a link (through for example the Section 37/41 Order made in this case), there seems to be an assumption that once someone has been assigned to hospital rather than prison, his or her care becomes essentially a medical task – one of cure rather than custody. Judgements about the patient's leave on release would appear to be made largely on the basis of the benefits that might accrue to the individual's treatment, with limited regard either to culpability for the original offence or even to the danger that he or she might pose to others when out in the community.

Surely this is too simplistic. Does the fact that someone is psychotic automatically absolve that person of all responsibility for his or her actions, however grave their consequences? And can even apparently successful treatment of their mental condition assure the public that they no longer constitute a danger, when they have previously shown themselves to lack the sort of inhibitions that prevent most humans from killing each other? The latter question is all the more pertinent when the individual's recovery may well be dependent on a regime of medication with which it is impossible to ensure that they will comply in a non-institutional setting.

We raise these questions because like the matters of practice addressed by the DHR, they underline the need for close collaboration between different arms of government to ensure that every case is handled in the way most appropriate to its unique circumstances and that the prospects of the most satisfactory achievable outcome are not jeopardised by inadequate communication between the various authorities involved.

4. Conclusions

Having reviewed and analysed the information contained within the IMRs and having considered the chronology of events and the information provided by family members, the panel has reached the following conclusions:

Knowledge of domestic abuse

Knowledge of domestic abuse and domestic violence, both in terms of the risks and the triggers was not of a sufficient depth and quality within the services that had contact with Adult B. The indicators of domestic abuse, particularly in relation to coercion and control, even in the context of a mental illness were not recognised and thus were not acted upon.

In addition, those agencies in contact with Adult B did not use routine enquiry in relation to domestic abuse as an approach in their interactions with her. This meant that information about potential risks and triggers was not gathered.

Risk assessment

Risk assessment was variable and focused primarily on Adult B's risk to herself. Risk to others and in particular to Adult A was not adequately considered or explored. This meant that those risks that can now be identified as a result of this review were not known and thus not acted upon. There are wider questions about lack of recorded risk assessments, the lack of risk assessment in the community while Adult B was on home leave and the adequacy of the risk assessments that were undertaken and these have been addressed within the IMRs.

Care planning and care co-ordination

Care planning and care co-ordination fell below the standard that should be expected. The lack of a written care plan, the lack of contact and the absence of the care co-ordinator in the months prior to the homicide represents a deficit in the care and support provided to Adult B or to her carer, Adult A, the victim of this homicide.

Record keeping and history taking

Record keeping fell below the standard that should be expected. The nature of the RiO[1] system did play some part in this, but the lack of up to date records represents poor practice. As highlighted in the Niche Review, this lack of records and history had the potential to increase the probability of unsafe care. The fact that a full history was not taken from Adult B contributed to the presence of gaps in the knowledge of her background, previous presentation, the genesis of her illness and is likely to have impacted the wider understanding of her condition.

Recognition of Adult A's need

It is evident that throughout Adult B's illness, Adult A attempted to care and support her as much as possible. He did so in the context of her delusional beliefs about their relationship and he sought to reassure her at all times, often without success. He willingly took on responsibility for caring for her, in at least one instance this willingness avoided a hospital admission.

Adult A did have good access to professionals working with Adult B, sometimes attending appointments with her and he does appear to have been kept informed about her care and treatment.

However there does seem to have been an over reliance on him and his ability to cope. This related to the inevitable pressures of caring for Adult B, especially in the context of the content of her delusions, but also to him having to monitor and alert services when help was needed. This placed particular demands on him which he was not provided with an opportunity to articulate confidentially to professionals.

Adult A's needs as a carer, and the impact of Adult B's illness and the content of her delusions were not adequately explored and he was not offered a carer's assessment.

Adult B's professional background and status

Adult B's professional status as a medically qualified, retired GP had some impact on the way in which she engaged with health care professionals. In the most part this manifested itself in her unwillingness to reveal aspects of her life that she considered private and to alter her medication regime and compliance with that medication based on her own medical background and knowledge.

[1] RiO is an NHS electronic recording system

The style of Adult B's engagement with health professionals appears to be consistent with that which might be expected in someone who is a physician patient. It does appear that her medical background influenced the degree to which she revealed information and the management of her medication, there is no evidence from the DHR or the Niche review that this unduly influenced or impeded the diagnostic conclusions of the treating Consultant Psychiatrist's or that their advice about her care was compromised by her professional status.

Adult B's mental health at the time of the homicide

Adult B had been diagnosed with psychotic depression and the conclusion of the panel, based on the information reviewed, is that this diagnosis was valid. It is also clear, based on the information reviewed that in the period leading to homicide, during the incident itself and for a period of time afterwards, Adult B was in all probability psychotic in the context of her severe depressive disorder.

Predictability and preventability

The review has not identified any evidence that indicates that physical violence had previously been a factor in Adult B's relationship with Adult A. There was evidence that in the context of her delusional beliefs about infidelity and estrangement, Adult B engaged in controlling behaviour, by requiring unreasonable levels of reassurance from Adult A about his whereabouts and activities, the kind of reassurance that would not have normally been expected.

The review has identified gaps and poor practice in the process of risk assessment but it is reasonable to conclude that there was an awareness of the risks Adult B posed to herself, particularly in relation to self-harm and thoughts of suicide, thoughts that she had come close to acting upon on more than one occasion. There was no evidence found in this review that Adult B had articulated plans for any act of violence towards Adult A or any other individual. Nothing was observed that led professionals to consider that Adult B was at risk of harming others, and in particular harming Adult A. Staff did not consider delusional jealousy and risk and this went unrecognised.

The Niche report also states that the internet searches conducted by Adult B prior to the homicide do not provide corroborative or substantive evidence that Adult B had planned the homicide in advance. Indeed the knowledge of these searches only came about during the police investigation. There are grounds however to conclude that, in large part, they may have related to her delusional beliefs at the time**.**

Coming to a view about the predictability of the homicide is necessarily a nuanced judgment. The panel has come to the conclusion that given the information available and Adult B's presentation at the time that the homicide was **not predictable**.

Turning to the matter of preventability, neither the police or health services received any information or calls around the time of Adult A's death alerting them to the fact that there was an immediate threat.

In the Niche report, Dr. McKenna highlights a number of areas that; had they been addressed could have prevented the incident. These include written risk assessment and risk management being properly implemented, addressing the matter of non-compliance with medication and treating this as a high risk issue, continuity of care within the HTT and their access to Consultant opinion and advice. Dr. McKenna draws a definitive conclusion that the incident **could have been prevented.**

The panel has considered this carefully and agrees that it can be argued that if more had been done to ensure compliance with medication, more effective monitoring, and improved risk assessment had been undertaken, these may have played a part in the possible prevention of the killing. Having said that, it is the view of the panel that it is not certain that it would have. As highlighted in the Niche review, this case is not one in which professionals could have been alerted to an increased and imminent risk by improved risk assessment at an individual level.

The deficiencies exhibited by mental health professionals involved in Adult B's care have been highlighted in this Overview Report and the CFT IMR. However, none of those failings can be conclusively proven to have had a direct causal link to the killing. As research quoted in the Niche report highlights "*… there are a substantial group of people who display none of the accepted indicators of violence before committing homicide"*[2]

Taking all of this into consideration and the lack of predictability it is the conclusion of the panel that if the matters highlighted within the Niche report had been properly addressed **Adult A's death may have been prevented.**

[2] Role of risk assessment in reducing homicides by people with mental illness Munro E and Rumgay J BJPsych Feb 2000

In conclusion, this was a particularly tragic case. The homicide occurred in the context of Adult B's mental illness, but it was an illness that presented in such a way that recognised risk factors that might have signaled the possibility of such an incident were only seen in the context of the presenting mental ill health. This is not to underplay the deficits that have been highlighted in this review, which demonstrate that in some instances the care provided to Adult B was not of the required standard, that the possibility of domestic abuse was not considered or recognised and that the effect of Adult B's illness upon Adult A was not fully explored or considered.

5. DHR Recommendations

Many of the issues raised in the IMRs that have been analysed and commented upon in the Overview Report are subject to recommendations within those IMRs. In addition, there are some similar features within this DHR that have been revealed in another recent DHR in Cornwall. With this in mind there is necessarily some congruence between the recommendations in this report.

The DHR panel offers the following overarching recommendations for local action:

1. We recommend that there should be a clear and robust domestic abuse policy in place at each GP surgery in the county. These policies should be regularly reviewed by practice managers and subject to audit at regular intervals. Such a policy should be distinct and separate from policies relating to Safeguarding.

2. We recommend that a training needs analysis for GP's, mental health workers and others should be conducted to identify which staff would benefit from training in recognising markers for domestic abuse. Further work should be undertaken across local agencies to ensure the dissemination of regular training and information in relation to domestic abuse. In particular the use of a specialist package like IRIS to support GPs in their responses to domestic abuse should be used.

   Work should also be undertaken in relation to training in recognising signs of and risks of coercion and control, which has recently been legislated for.

   All training should highlight the fact that domestic abuse may be perpetrated by women on men as well as vice versa.

3. We recommend that direct enquiry into domestic abuse is used by all agencies in any assessment or risk assessment process. Direct enquiry should be considered as part of the tool kit of skills and interventions to be utilised within statutory organisations.

4. We recommend that assessment and risk assessment processes be reviewed to ensure clearer guidance about the need to consider and respond not only to the risks of harm to the individual, but also to others including spouses, partners and children.

5. We recommend that a programme of work be undertaken in relation to the provision of carer's assessments. There is a statutory requirement to offer a carer's assessment. Work is required to ensure that this duty is being met and it should be regularly audited.

6. We recommend that training be put in place to develop the skills and expertise of health care professionals in working with physician patients or those who may have health care expertise and experience

7. We recommend work be undertaken to develop further skills in risk assessment and risk management to ensure that methods and approaches are consistent with current standards in specific organisations and that in particular, professionals routinely consider the potential for risk to others, whether or not this is articulated by the individual being worked with.

8. We recommend that a process and protocol be put in place to guide practitioners and managers about how best to ensure continuity of care provisions, most notably, continuity of worker. Recognising the constraints of workforce capacity and workload, it is nevertheless important to place emphasis on the need to provide continuity wherever possible. Such a protocol should include guidance about decision making relating to the appropriate use of qualified and non-qualified staff.

9. We recommend that a process and protocol be put in place across Cornwall to ensure the timely and appropriate notification of GP's about care plans, current treatment and changes to that, including hospital discharge by secondary care NHS Trust providers.

10. We recommend a programme of work to review recording processes and an associated regular audit of recording practice. In particular this should focus on the requirements to ensure written care plans are in place, that risk assessments are properly recorded and appropriately reviewed and updated. In addition, focus should be given to ensuring that staff working in local organisations fully understand how to utilise the electronic recording systems that are currently used in statutory organisations.

In addition, the matters relating to missing or incorrectly coded medical records should be subject to review by CFT to establish the reasons for the lack of historical notes and measure put in place to ensure CFT request copies of all historic mental health care notes from the GP to be uploaded into the current clinical record.

11. We recommend that a focused themed review of previous DHRs in Cornwall be undertaken to identify common themes and issues, from which focused learning and practice development can take place with local organisations. We make this recommendation in the context of there having been previous DHRs in Cornwall where the quality of risk assessment in the wider context of an individual and the effect this may have on understanding whether they pose a risk to others is an area of practice that should be considered for wider learning and practice development. There may be other commonalities and it would be of benefit to the local system to know and understand these so that a co-ordinated approach to learning and development can be undertaken in response to DHRs undertaken as a whole rather than seeing each in isolation.