BROMLEY COMMUNITY SAFETY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

Overview Report into the death of Mary

August 2018

Independent Chair and Author of Report: Laura Croom

Associate Standing Together Against Domestic Violence

Date of final report – June 2020

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1. Preface

The Chair is very grateful for the time and assistance given by the family and friends who have contributed to this Review.

1.1 Introduction

1.1.1 Domestic Homicide Reviews (DHRs) were established under Section 9(3), Domestic Violence, Crime and Victims Act 2004.

1.1.2 This report of a domestic homicide review examines agency responses and support given to Mary, a British citizen residing abroad, prior to the point of her death by strangulation at the home of her son in August 2018, and to Simon, her son.

1.1.3 Mary had come from her home abroad to support Simon. During the previous week, Simon's mental health had deteriorated to the point that friends and family felt he should not be left alone. Simon had been taken to A&E earlier that week and on the day of the homicide as his family sought help due to his erratic behaviour. Both times he was given advice and sent home. On the night of the homicide, Simon's aunt and his mother, Mary, returned home from the hospital with drugs to reduce his anxiety. His aunt left and his mother stayed to help Simon. When Mary's other son, Stephen, rang later that night and asked to speak to their mother, Simon would not put Mary on the phone. Stephen threatened to call the police. Simon was very erratic and said that she was "sleepy sleep". Stephen then tried various ways to call his mother directly. Eventually Simon picked up his landline and said to Stephen, "She's gone." Stephen then heard the sound of Simon popping pills out of a blister pack. Simon then said goodbye and hung up.

1.1.4 Stephen was so worried that he rang the local police and asked them to attend the address. When they attended, Simon would not let them into the flat. They forced entry into the flat and found that Mary had been strangled. Simon was arrested and charged with her murder.

1.1.5 Simon's plea of guilty on the grounds of diminished responsibility was accepted by the court and he was sentenced in March 2019 to a hospital order, under S. 37 of the amended Mental Health Act 1983 (MHA). He has also been made subject to a Restriction Order under S. 41 of the MHA which adds additional restrictions, including requiring the Secretary of State for Justice to discharge Simon. This is added when the court thinks that the defendant is a risk to the public.

1.1.6 The Review will consider agencies contact/involvement with Mary and Simon (from 12 November 2015 to date of death in August 2018, inclusive.

1.1.7 In addition to agency involvement, the Review will also examine the past to identify any relevant background or trail of abuse before the homicide, whether support was accessed within the community and whether there were any barriers to accessing support. By taking a holistic approach the review seeks to identify appropriate solutions to make the future safer.

1.1.8 The key purpose for undertaking DHRs is to enable lessons to be learned from homicides where a person is killed as a result of domestic violence and abuse. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

1.1.9 This Review process does not take the place of the criminal or coroner's courts nor does it take the form of a disciplinary process.

1.1.10 The Review Panel expresses its sympathy to the family, and friends of Mary for their loss and thanks them for their contributions and support for this process.

1.2 Timescales

1.2.1 The Safer Bromley Partnership, in accordance with the December 2016 Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews

commissioned this Domestic Homicide Review (Review). The Home Office were notified of the decision in writing on 21 September 2018.

1.2.2 Standing Together Against Domestic Violence (STADV) was commissioned to provide an independent chair for this DHR on 30 November 2018. The completed report was handed to the Safer Bromley Partnership on date.

1.2.3 Home Office guidance states that the review should be completed within six months of the initial decision to establish one. There were some delays. The criminal trial was completed on 1 March 2019 when Simon was sentenced. Some IMRs were not received on time and Simon was undecided about participating in the review so he was given time to reflect and to approve the excerpts from his answers and from his psychiatric reports. The third meeting was moved to accommodate this. Finally, there was a delay as the Chair worked to get a shape on the final national recommendation about getting information to families early in a situation like this and then a small delay due to the COVID-19 pandemic.

1.3 Confidentiality

1.3.1 The findings of this report are confidential until the Overview Report has been approved for publication by the Home Office Quality Assurance Panel. Information is publicly available only to participating officers/professionals and their line managers.

1.3.2 This Review has been suitably anonymised in accordance to the 2016 guidance. The specific date of death has been removed, and only the independent chair and Review Panel members are named.

1.3.3 To protect the identity of the victim, the perpetrator and family members the following anonymised terms have been used throughout this Review:

1.3.4 The victim and mother of the perpetrator: Mary.

1.3.5 The perpetrator and son of the victim: Simon.

1.3.6 These pseudonyms were agreed by the family:

(a) Mary's sister and Simon's aunt is Sylvie.

(b) Mary's other son and Simon's brother is Stephen.

(c) Mary's husband and Simon's father is Foster.

(d) Simon's lifelong friend is Fred.

1.4 Equality and Diversity

1.4.1 The Chair of the Review and the Review Panel did bear in mind all the protected characteristics of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation during the Review process.

1.4.2 Simon was a white, single, heterosexual British male, aged 36, when he killed his mother. He did not have strong religious affiliations. His mother, the victim in the case, was 68 when she died. She was a white British married heterosexual woman. In domestic homicide reviews, sex is always a characteristic that needs particular consideration as 96% of those suffering serious injury or death due to domestic abuse are women.

1.4.3 *Sex*: Sex should always require special consideration. Recent analysis of domestic homicide reviews revealed gendered victimisation across both intimate partner and familial homicides with females representing the majority of victims and males representing the majority of perpetrators.[1] This characteristic is therefore relevant for this case as the victim of the homicide was female and perpetrator of the homicide was male.

[1] "In 2014/15 there were 50 male and 107 female domestic homicide victims (which includes intimate partner homicides and familial homicides) aged 16 and over". Home Office, "*Key Findings From Analysis of Domestic Homicide Reviews*" (December 2016), p.3.

"Analysis of the whole STADV DHR sample (n=32) reveals gendered victimisation across both types of homicide with women representing 85 per cent (n=27) of victims and men ninety-seven per cent of perpetrators (n=31)". Sharp-Jeffs, N and Kelly, L. "*Domestic Homicide Review (DHR) Case Analysis Report for Standing Together* " (June 2016), p.69.

1.4.4 Mary's role as Simon's carer might also have been significant as women are more likely than men to take on caring roles, with 58% of unpaid carers being women.[2]

1.5 Terms of Reference

1.5.1 The full Terms of Reference are included at **Appendix 1**. This Review aims to identify the learning from this case, and for action to be taken in response to that learning: with a view to preventing homicide and ensuring that individuals and families are better supported.

1.5.2 The Review Panel comprised agencies from Bromley, as the perpetrator had lived in this area his whole life. Mary had lived in Bromley for many years and moved abroad with her husband in 2006. Agencies were contacted as soon as possible after the Review was established to inform them of the Review, their participation and the need to secure their records.

1.5.3 At the first meeting, the Review Panel shared brief information about agency contact with the individuals involved, and as a result, established that the time period to be reviewed would be from November 2015, when Simon first contacted Bromley Healthcare about his mental ill-health, to the date of Mary's death at the end of August 2018. Later the Panel learned that Simon had attended a wedding in Turkey in the autumn of 2015 and had become so unwell mentally that his father had gone to collect him. To ensure no relevant contact was missed, the terms of reference asked that agencies summarise relevant contacts they had had with Mary or Simon prior to November 2015.

1.5.4 *Key Lines of Inquiry:* The Review Panel considered both the "generic issues" as set out in 2016 Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews[3] and identified and considered the following case

[2] Census 2011.

[3] See https://www.gov.uk/government/publications/revised-statutory-guidance-for-the-conduct-of-domestic-homicide-reviews

specific issues: Simon's participation in services from mental health agencies, compliance with medication and how Simon presented to different people.

1.6 Methodology

1.6.1 Throughout the report the term "domestic abuse" is used interchangeably with "domestic violence", and the report uses the cross government definition of domestic violence and abuse as issued in March 2013 and included in an appendix, to understand that domestic violence is not only physical violence but a wide range of abusive and controlling behaviours.

1.6.2 This Review has followed the 2016 statutory guidance for Domestic Homicide Reviews issued following the implementation of Section 9 of the Domestic Violence Crime and Victims Act 2004. On notification of the homicide, agencies were asked to check for their involvement with any of the parties concerned and secure their records. The approach adopted was to seek Individual Management Reviews (IMRs) for all organisations and agencies that had contact with the victim and or perpetrator. A total of fifteen agencies were contacted to check for involvement with the parties concerned with this Review. Seven agencies returned a nil-contact, five agencies submitted IMRs and chronologies. Due to the brevity of their contact, one agency supplied a letter of involvement, another provided a summary of engagement and a brief chronology, while the third provided a short chronology. The chronologies were combined with the information from the family and a narrative chronology written by the Chair.

1.6.3 The Chair considered requesting information from medical services regarding Simon and Mary accessed abroad but decided that such enquiries were unlikely to provide new information relevant to a domestic homicide review as Simon had limited contact there and no indications of a pattern of domestic abuse was found between Simon and Mary. Such enquiries would also have been likely to delay the process and add to the costs. The Panel agreed.

1.6.4 *Independence and Quality of IMRs:* The IMRs were written by authors independent of case management or delivery of the service concerned. The

IMRs received enabled the Panel to analyse the contact with the victim and perpetrator and to produce the learning for this review. Where necessary further questions were sent to agencies and responses were received. Four IMRs made recommendations of their own and evidenced that action on these is reflected in the action plan. They have informed the recommendations in this report. The IMRs have helpfully identified changes in practice and policies over time, and highlighted areas for improvement not necessarily linked to the terms of reference for this Review.

1.6.5 *Documents Reviewed:* In addition to the IMRs, documents reviewed during the Review process have included victim impact statements from the family, the eulogy for Mary, a written statement about Mary by her husband, Foster, and relevant research. Simon's family provided four psychiatrist reports on Simon that were made between the time that Mary was killed and Simon's trial.

1.6.6 *Interviews Undertaken:* The Chair of the Review has undertaken three interviews in the course of this Review. This has included two face-to-face interviews with family members and one telephone interview with a friend of the family. The Chair supplied written questions to Simon who responded with written answers. The Chair also welcomed the notes from the AAFDA support worker of her interview with another family friend.

1.7 Contributors to the Review

1.7.1 The following agencies were contacted, but recorded no involvement with the victim or perpetrator: Moat (housing association who own the housing block where Simon lived), Bromley Adult Social Care Services, Bromley and Croydon Women's Aid, National Probation Service, Bromley Community Rehabilitation Company, Bromley Drug and Alcohol Service, and London Borough of Bromley Housing Services.

1.7.2 Bromley Housing Services, having had no contact, decided that their participation was not required for the domestic homicide review panel

1.7.3 The following agencies and their contributions to this Review are:

Agency	**Contribution**
Bromley Clinical Commissioning Group: GP of Simon	IMR and chronology
Greenbrook Healthcare's Urgent Care Centres	IMR and chronology
Bromley Lewisham Greenwich Mind	Chronology
Bromley Healthcare	IMR and chronology
Oxleas NHS Foundation Trust	IMR and chronology
Metropolitan Police Service	Letter with analysis of two brief engagements and the night of the homicide
London Ambulance Service	Summary of engagement and chronology of brief contact
Kings College Hospitals NHS Foundation Trust – that includes Princess Royal University Hospital	IMR and chronology

1.8 The Review Panel Members

1.8.1 The Panel members for this review were:

Name	***Role and organisation***
Laura Croom	Independent Chair of this review, Associate of Standing Together
Robert Vale	Head of Trading Standards and Community Safety, London Borough of Bromley
Amanda Mumford	Community Safety Coordinator, London Borough of Bromley
Claire Lewin	Safeguarding Lead, Bromley Clinical Commissioning Group (CCG)
Dr. Tessa Leake	Named GP for Safeguarding Adults for Bromley CCG
Charlotte Dick	Named Safeguarding Adults Lead, Bromley Healthcare

Dr. Olaleye (Leye) Oginni	Clinical Director, Greenbrook Healthcare (Urgent Care Provider)
Heather Payne	Head of Adult Safeguarding, King's College Hospital NHS Foundation Trust
Dirk Holtzhausen	Development Manager, Adults Safeguarding Strategic and Business Support Services, London Borough of Bromley
Jane Wells	Director of Nursing, Oxleas NHS Foundation Trust
Dr. Abimbola Fadipe	Consultant Psychologist and Clinical Director, Oxleas NHS Foundation Trust
Nathan Rendell	Community Mental Health Services Manager, Bromley, Lewisham and Greenwich Mind
DS Helen Rendell	DS Serious Case Review Group, Metropolitan Police Service
Dawn Mountier	Safeguarding Officer, Quality and Assurance Directorate, London Ambulance Service NHS Trust
Constanze Sen	Chief Executive Officer, Bromley and Croydon Women's Aid

1.8.2 *Independence and expertise*: Agency representatives were appropriate in that they could speak for their agencies and provided the level of expertise and authority needed for the review. The Panel representative for BLG Mind line-managed those who attempted contact with Simon. The other Panel members were not involved in this case, nor were they line managers of those who were.

1.8.3 The Review Panel met a total of three times, with the first meeting of the Review Panel on the 12 March 2019. There were subsequent meetings on 20 June and 7 November. Between the 2nd and 3rd Panel meetings, the Chair met with Mary's husband and son who were back in the country briefly and sought to meet the perpetrator.

1.8.4 The Chair of the Review wishes to thank everyone who contributed their time, patience and cooperation to this review.

1.9 Involvement of Family and Friends

1.9.1 As there is no record that the Safer Bromley Partnership notified Mary's family when they decided to undertake a DHR of the case, there is a recommendation relating to this that can be actioned quickly as processes for DHRs in Bromley were being developed in the course of this DHR.

1.9.2 The Chair and the Review Panel acknowledged the important role the family could play in the review. The Chair of the Review sent introductory letters and Home Office leaflets through the MPS Family Liaison Officer in February 2019 and then brought the materials to her meetings with Mary's sister, Sylvie, (who took Simon to hospital twice the week of the homicide), Mary's husband, Foster, and Mary's other son, Stephen. Both Foster and Stephen had managed Simon during episodes of ill-health. Contact was sought with a cousin of Simon's and with a life-long friend of his, Fred, who had also seen Simon when he was unwell and had known the family for most of his life. A telephone interview was conducted with the friend. The Chair understood through the other family members that the cousin had decided not to be involved. The initial letter to family members outlined the process and invited them to be involved if they chose to but noted that this was voluntary, and they could do this in whatever way they chose. Family members were supported by the AAFDA support worker during the interviews.

1.9.3 The AAFDA support worker also spoke to a close friend of Mary's who had supported Simon in finding work and in the months leading up to Mary's death. The AAFDA worker provided the notes of this conversation to the Chair.

1.9.4 The Chair and Panel are grateful for the family's involvement, particularly given the circumstances of this tragic event. Foster and Stephen both live abroad and the Chair was grateful that they agreed to use some of their time when they were back in the UK to contribute to the review.

1.9.5 The Chair discussed the terms of reference with the family members, in particular the timeframe, the agencies involved and the questions this review might answer. The family have been updated through their AAFDA adviser who stayed in touch with the Chair.

1.9.6 The family were provided with the report on the 24th April 2020 and when the chair checked in with them two weeks later, they were ready to respond. Given the limitations on travel due to the COVID-19 pandemic, the Chair discussed the report with the three family members via video and audio-conferencing apps. The family's changes have been incorporated into the text. During this feedback, the family expressed concerns about Simon's current and future care and oversight. The Chair discussed these concerns with AAFDA who undertook to link them into further support.

Known in the review as	Relationship to victim, perpetrator or both	Means of involvement in review
Simon	Perpetrator and son of victim	Input on terms of reference Provided written answers to questions Provided consent for his answers and specific passages of psychiatrists' reports to be included
Foster	Husband of victim and father of perpetrator	Face to face interview Input on terms of reference Review of draft report Consented to the review seeing his Victim Impact Statement, the eulogy for Mary, and a statement he had written about his wife and her life
Stephen	Son of victim and brother of perpetrator	Face to face interview Input on terms of reference Witness statement Review of draft report

Sylvie	Sister of victim and aunt of perpetrator	Face to face interview Input on terms of reference Review of draft report
Fred	Lifelong friend of Simon and the family	Telephone interview

1.10 Involvement of Perpetrator

1.10.1 On 1 August 2019, the Chair sent a letter and consent form to the doctor responsible for Simon's care, outlining the DHR process and asking if it would be appropriate and possible for the Chair to speak to Simon about his experiences and use of services. The letter provided a Home Office leaflet on the process. The doctor requested and was sent a list of questions to assist them with their decision and to offer Simon another way of feeding into the review if he chose not to be interviewed.

1.10.2 Simon considered this for some weeks and chose to respond to the questions in writing, rather than being interviewed. His responses are noted in the chronology and in the overview and analysis. He was also asked for permission to use specific excerpts from the notes of psychiatrist reports completed after Mary's death. He consented.

1.11 Parallel Reviews

1.11.1 *Criminal trial:* Simon pleaded guilty to manslaughter by reason of diminished responsibility in January 2019. He was sentenced to a hospital order.

1.11.2 *No parallel reviews:* Following the completion of the criminal investigation and trial, there were no reviews conducted contemporaneously that impacted upon this review.

1.11.3 *Coroner*. Standing Together has been in touch with the coroner who, we understand, is waiting for our report before completing theirs.

1.11.4 *Mental health review:* This case does not meet the threshold for a full independent investigation of mental health care that Simon received as he was not subject to a care programme approach, nor was he under the care of specialist mental health services in the six months prior to the homicide.[4] To determine this, the National Health Service England (NHSE) requested desk top reviews, a Level 1 review, from the GP surgery and Oxleas NHS Foundation Trust, in collaboration with the Bromley Clinical Commissioning Group shortly after Mary's death. This work informed the IMRs that were provided for this review.

1.11.5 Families are not involved in or notified of such reviews as they are undertaken to determine the most appropriate process for an enquiry. This will be returned to in the Analysis.

1.11.6 *Post mortem*. Completed in early September 2018 provided a provisional cause of death as compression of the neck and face consistent with strangulation or suffocation.

1.12 Chair of the Review and Author of Overview Report

1.12.1 The Chair and Author of the Review is Laura Croom, an Associate DHR Chair with Standing Together Against Domestic Violence (STADV). She is an independent consultant who has worked in the domestic abuse sector for 17 years and received Home Office DHR Chairs' training in 2013. She is currently chairing her thirteenth DHR.

1.12.2 STADV is a UK charity bringing communities together to end domestic abuse. STADV aims to see every area in the UK adopt the Coordinated Community Response (CCR). The CCR is based on the principle that no single agency or professional has a complete picture of the life of a domestic abuse survivor, but many will have insights that are crucial to their

[4] NHS's "Serious Incident Framework: Supporting learning to prevent recurrence" p. 47. Available at: https://improvement.nhs.uk/resources/serious-incident-framework/ [Accessed at 18.8.19]

safety. It is paramount that agencies work together effectively and systematically to increase survivors' safety, hold perpetrators to account and ultimately prevent domestic homicides.

1.12.3 STADV has been involved in the Domestic Homicide Review process from its inception, chairing over 70 reviews.

1.12.4 *Independence:* Laura Croom has no connection with the Safer Bromley Partnership or any of the agencies involved in this case. She had no prior contact with any of the friends or family of the victim or perpetrator.

1.13 Dissemination

1.13.1 The following recipients have received/will receive copies of this report:

- Panel members listed above
- Mary's husband, son and sister
- Standing Together Against Domestic Violence DHR Team
- Safer Bromley Partnership
- Bromley Council Executive

2. Background Information

2.1 The Homicide

2.1.1 Simon lived in a flat in Bromley. His mother, Mary, had come from her home abroad to support Simon. During the previous week, Simon's mental health had deteriorated to the point that friends and family felt he should not be left alone. Simon had been taken to A&E by his aunt, Sylvie, earlier that week and by his mother and aunt on the day of the homicide as his family sought help due to his erratic behaviour. Both times he was given advice about medications and re-directed to his GP and sent home. On the night of the homicide, Sylvie and Mary returned to Simon's flat from the hospital with additional medication and advice. His aunt left and his mother stayed to help Simon. When Mary's other son, Stephen, rang later that night and asked to speak to their mother, Simon would not let Stephen speak to her and replied that she was "sleepy sleep". Stephen was so worried that he rang the local police and asked them to attend the address. When they attended, Simon would not let them into the flat. They forced entry into the flat and found that Mary had been strangled. Simon was arrested and charged with her murder.

2.1.2 Simon's plea of guilty on the grounds of diminished responsibility was accepted by the court and he was sentenced in March 2019 to a hospital order, under S. 37 of the amended Mental Health Act 1983 (MHA). He was also made subject to a Restriction Order under S. 41 of the MHA as he was assessed as presenting a risk of serious harm to the public when mentally ill.

2.1.3 In interview on the night of Mary's death, Simon gave a confused and paranoid account of a game that he was in that would lead to horrible deaths for himself and his mother and Simon said that he had killed Mary to spare her that pain. He said he had considered taking his own life as well. He said, "I love her with all my heart, and I am sorry for doing that to her."

2.1.4 *Judge sentencing summary:* In sentencing, the Judge said that Mary "was killed because she came to your aid. When she heard you had relapsed, she

came from [abroad] to help you in any way she could. You, in your mentally deranged state, killed her."[5]

[5] www.bbc.co.uk/news.

3. Chronology

3.1 Chronology from year to year (timescales under review)

3.1.1 This chronology outlines the key events in this case, where Simon's mental health prevented him for carrying on his usual activities. The information is drawn from the agencies' IMRs and from interviews with Sylvie (Mary's sister), Stephen (Mary's other son) and Foster (Mary's husband).

3.1.2 There is also information provided by Simon in writing.

3.1.3 **2002 – Stephen, Mary's other son, moved a very long way away**

3.1.4 **2006 – Mary and Foster, Simon's parents, moved to a country in Europe**

3.1.5 **Autumn of 2015 – trip to Turkey with friends**

3.1.6 On 10 September 2015, Simon went to a wedding in Turkey. He was uncomfortable socially and was upset by seeing Syrian refugees. He drank heavily to manage his anxiety and had increasingly paranoid thoughts. Simon told this review that he was feeling overwhelming anxiety during this first episode of mental ill health. "I was not sleeping or eating well during my time in Turkey. I went to a hospital in Turkey where I was prescribed medication . . . but I can't recall the name of it." He later reported[6] that he had taken five Xanax in front of others at the wedding and they had taken the medication from him. Simon later told the Bromley Working for Wellbeing practitioner that he had taken the overdose because he wanted to go to hospital to feel safe. Simon was taken to hospital by friends several times while he was in Turkey. His family report that his behaviour was so concerning that eventually the friends rang Simon's parents. Simon's father, Foster, went to Turkey to get him out of hospital and brought him to their home abroad.

[6] To Wellbeing practitioner on 12 November 2015.

3.1.7 The family report that Simon saw a doctor there.

3.1.8 Simon returned to Bromley and saw his GP on 28 September 2015. He was diagnosed with generalised anxiety disorder following his panic attacks whilst in Turkey. He told the GP that he was started on Escitalopram (an antidepressant) while abroad. The GP advised him to continue with this medication.

3.1.9 Simon was reviewed several more times over the next few weeks by the GP when he reported feeling better on the medication. He was offered a referral to Bromley Working for Wellbeing for psychological therapy and counselling when he attended his follow-up appointment with the GP on 13 October 2015. He was provided with a "not fit for work" certificate with a diagnosis of anxiety and depression. (Bromley Healthcare's Wellbeing service later became Improving Access to Psychological Therapies (IAPT) services.)

3.1.10 On 3 November 2015, Simon saw his GP and said he had stopped the medication, felt well and was back at work. The GP recorded that Simon was back at work and due to start counselling soon. The GP did not recommend that Simon re-start his medications. On 12 November, Simon had an initial assessment by a Wellbeing practitioner. No indications of risk to himself or others were identified. His parents were noted as protective factors. No issues with abuse of substances were noted. Simon said his main problem was depression.

3.1.11 At a further GP review on 1 December 2015, Simon said he felt better and was waiting for counselling. He was given a further review date in February 2016.

3.1.12 Simon did not respond to an appointment for counselling and was discharged from counselling through a letter.

3.1.13 **July to August 2016 – deteriorating mental health. In-patient.**

3.1.14 Stephen was back in the country and staying with Simon in early July 2016. Simon was agitated and his mental health appeared to be deteriorating. Simon went to his GP for his low mood and anxiety. The GP restarted his

antidepressant and referred him to Bromley Healthcare's IAPT service for counselling. (This was cancelled later by a relative (unnamed) as Simon had been admitted to Green Parks House before an appointment was scheduled.)

3.1.15 At one point, Simon called to his brother and woke him up. Simon showed Stephen that he had cut his wrists. Stephen rang the ambulance and police, telling them that Simon wanted to commit suicide, felt violent towards himself, and had cut his wrists. The ambulance took Simon to the A&E at Princess Royal University Hospital (PRUH). Simon said harming himself was a mistake and "a cry for help". Simon was assessed by the Psychiatric Liaison Service (Oxleas NHS Foundation Trust) and then Simon and Stephen returned to Simon's flat.

3.1.16 Simon's mood was fluctuating from very high to very low. Simon then jumped from a first-floor window which he later explained in various ways to health professionals. His brother said that Simon had spread his arms and said, "I feel like I'm on top of the f***ing world" and then jumped out the window. After jumping from the window, Simon ran down the road to a railway station.

3.1.17 Simon was taken to A&E again. He had a comprehensive assessment including a risk assessment and he was admitted informally to Green Parks, the mental health facility at PRUH that is run by Oxleas NHS Foundation Trust (Oxleas), based on his presentation and a differential diagnosis[7] of possible psychotic/manic episode on 7 July 2016. He was screened for drugs as he indicated that he had used recreational drugs in the past. The screen was negative.

3.1.18 A few days later, it was found that he had a cuboid fracture of his foot which was then set in a cast. He also had fractured the head of the right radius (a bone in his forearm) and was treated at PRUH for this.

[7] A differential diagnosis is a series of potential diagnoses that could explain the symptoms a patient is experiencing, which can then potentially lead to the correct diagnosis. www.healthcareers.nhs.uk/glossary.

3.1.19 As Simon's behaviour changed over the time he was in hospital, a diagnosis was difficult to come to.

3.1.20 Simon became physically aggressive on the ward, damaging furniture and threatening staff. He dismantled his crutch and threatened staff with it. Another episode of aggression occurred on 14 July 2016.

3.1.21 On 15 July 2016, Foster recalls that he and Mary asked for a consultation so that they could understand Simon's care and diagnosis. They were told that the drugs were not working and therefore the medical professionals wanted to detain Simon for further tests. A Mental Health Act 1983 assessment was completed, and Simon was then detained under Section 5.2, then Section 2.[8] Sylvie, as Simon's nearest UK-resident relative, was informed. Foster and Mary were advised that staff were still assessing Simon and that they had a differential diagnosis that they were working towards.

3.1.22 Medical staff became concerned that there was a physical illness driving his aggressive behaviour and later that day, Simon was transferred from the mental health ward (Oxleas) to a general ward (Kings) in PRUH for a diagnosis and treatment. It was thought that his deterioration could be due to neuroleptic malignant syndrome (NMS), a rare but life-threatening response to anti-psychotic medication. Anti-psychotic medications were discontinued.

3.1.23 Simon had a possible seizure on 17 July 2016 which lasted for 5 minutes, after which he became agitated and disinhibited.

3.1.24 On 19 July 2016, the nursing levels for Simon increased to the need for two nurses to be with him at all times. This was a clinical decision based on risk. NMS no longer appeared to be an appropriate diagnosis. Further investigations suggested that he had developed an infection of his brain, either meningitis or encephalitis, most probably caused by a viral illness. After

[8] Section 5.2 allows a doctor or an approved clinician to keep someone in hospital because that professional thinks the person has a mental health problem and is not well enough to leave. A person can be detained for a maximum of 72 hours so that they can be seen by two doctors to decide if the person needs to be kept in hospital longer. Section 2 allows someone to be kept in hospital for up to 28 days to give doctors time to decided what type of mental disorder someone has, if they need treatment and the effect of that treatment on their health.

prescribing an anti-viral medication, his mental health and behaviour stabilised.

3.1.25 On 28 July 2016, Simon had an MRI. He continued to be agitated, disinhibited and aggressive. He had a lumbar puncture a few days later as the medical team continued to try to identify a physical cause for his presentation. The results led to more tests. The medical staff considered a diagnosis of mixed affective state with psychotic symptoms. Simon's mental health assessment was converted to a Section 2 of the MHA to a Section 3.[9]

3.1.26 Simon was reviewed again by a consultant psychiatrist on 4 August. Simon's behaviour had improved. The results of the lumbar puncture appeared to be insignificant. Simon expressed feelings of low mood and staff were concerned that he might self-harm.

3.1.27 Simon was transferred back to the mental health ward (Oxleas) on 5 August where he appeared more settled. He engaged with groups such as an emotional coping skills group and was referred to a group for anxiety, depression, affective disorders, personality disorder and trauma run by the community mental health team.

3.1.28 At a multi-disciplinary team (MDT) meeting on 8 August 2016 with Simon's parents, Simon's diagnosis and treatment were reviewed. Simon's presentation in Turkey in 2015 was noted and that he had been prescribed medication when staying with his parents at their home abroad, and he was not taking this medication. Simon complained of feeling low. On 8 August, Simon was reviewed at the ward round and his nursing observation level was reduced from Level 3 to Level 2 as a result of a reduced risk level. He was started on an antidepressant.

3.1.29 On 12 August 2016, another MDT noted an improvement in Simon's presentation and his compliance with medication. He was attending psychology-based groups. Simon was granted leave to visit his flat with his

[9] Section 3 of the Mental Health Act allows someone to be detained in hospital for up to six months to be given the treatment they need for a mental illness.

parents. The risk he presented to himself or other people was assessed as low.

3.1.30 There was a discussion with Simon and Mary on 15 August 2016 about how the leave had gone. Mary was given answers to her questions about the neurology follow-up. Referral to the Day Treatment Service (DTS) was proposed and accepted by Simon. The Care Programme Approach, the care coordinator, and the S117[10] meeting were explained to Simon.

3.1.31 On 23 August 2016, Simon was assessed by the DTS and was accepted for a 6-week programme post-release comprising daily meetings with various groups.

3.1.32 On 25 August 2016, a multi-agency team meeting with the community mental health team staff and the day treatment team created a plan for Simon.

3.1.33 Simon was discharged on 26 August 2016 with a diagnosis of mood disorder due to substance misuse and recurrent depressive disorder (severe episode) with psychotic symptoms. Simon's medications on discharge were mirtazapine (an antidepressant) and clonazepam (a sedative). Simon's illness was explained to Simon and his mother, Mary. The MDT explained that it was difficult to know if the condition would recur. Simon was advised to remain on the medications and avoid illicit drugs and alcohol. Simon was offered information on his illness and how to manage it. The team emphasised that he would need to continue on his medications for at least a year. His risk was reviewed and he was discharged to the care of his GP.

3.1.34 **After 26 August 2016 – 6-week post-hospital care in the community**

3.1.35 Simon was under the care of the DTS and attended for 6 weeks to transition him back to living in the community. He attended the following groups: person-centred planning to support him in setting out and

[10] Care Programme Approach (CPA) is a process where the patient's care from the mental health services and other agencies on leaving the hospital is coordinated by the care coordinator. The S. 117 meeting is required by the Mental Health Act 1983 to ensure that those who have been detained under S. 3 of the MHA have the care they need to remain well after leaving hospital.

achieving his personal goals. Simon wanted to return to work. He attended the Wellness Recovery Action Plan which is an evidence-based intervention developed to aid recovery from mental illness. He also went to the Positive Self which is a cognitive behaviour therapy-based approach to help deal with negative thoughts and an art therapy intervention. Throughout this time, he had regular one-to-one sessions with his keyworker and was reviewed by doctors on the team. He initially had some paranoid concerns but then returned to part-time work. The group work that Simon attended included information about medications. Finally, from October to December 2016 Simon attended an anxiety and stress management group.

3.1.36 On 12 September 2016, Simon attended his GP appointment with his mother. He was feeling anxious, low, and paranoid. His parents had gone out to dinner and when they returned, Simon was curled up in a ball. He described an evening where he felt he was in danger, that someone was trying to get into his flat and he was fearful of going out. Simon reported that he had reduced his anti-depressant to twice a day. The GP recommended that Simon increase his medication back to three times a day. It is not recorded why Simon had unilaterally reduced his medications.

3.1.37 The next day, Mary and Foster brought Simon back to the hospital, to the DTS. Simon told the day care team that he thought that people or a presence were after him. He denied having any hallucinations or being controlled. Simon was prescribed anti-psychotic medications as a result and his anti-depressants were changed (to sertraline). He seemed calmer after this.

3.1.38 On 20 September 2016, Simon went to stay for a week with his parents. The mental health team contacted his parents on 27 September who reported that everyone was fine.

3.1.39 On 30 September 2016 Simon was reviewed at DTS where a marked improvement was noted. His low mood had resolved. Mary was present for this review and it is noted that Simon's diagnosis was discussed with him and

Mary. Simon's medications were adjusted, and his risk assessment indicated that there could be a relapse in his mental state if he were to stop medication.

3.1.40 Simon attended the DTS until he was discharged on 12 October 2016. There was a meeting that day with Simon, Mary, his care coordinator and his keyworker. The on-going support was to help boost his self-confidence, help him gain coping skills and promote social inclusion. The team doctor noted that Simon was depressed, with psychotic symptoms.

3.1.41 **Maintenance of Simon's mental health**

3.1.42 Simon was discharged from the DTS to the Oxleas Community Mental Health Team (CMHT) in November 2016. Simon was then under the treatment supervision of the CMHT until 25 April 2017. From 12 October to 20 December 2016, Simon attended an anxiety and depression management group.

3.1.43 Simon was seen at follow-up appointments in the out-patients clinic in January and May 2017.

3.1.44 At the January 2017 follow-up with a doctor, Simon said that he had stopped the anti-psychotic medication for a period of time and the dark thoughts had returned so he had restarted these. He had stopped taking the medication partly because he had gained weight. Simon was advised not to stop taking his medication. The doctor gave him advice about the weight gain. Simon said he had agreed to join the Tai Chi club, as suggested by Sylvie. He had a psychological assessment and was recommended to take group or one-to-one psychology sessions.

3.1.45 In mid-February 2017, Simon was referred to Improving Access to Psychological Therapies (IAPT), Bromley Healthcare.

3.1.46 Simon did not attend his IAPT appointment in March 2017, but it is not clear that the appointment letter was sent to him.

3.1.47 Simon was discharged from CMHT to his GP's care on 25 April 2017 with the following diagnoses:

(a) Recurrent depressive disorder, currently in remission

(b) History of mental and behavioural disorder due to the use of cannabinoids and alcohol misuse

(c) Had an acute psychotic episode or delirium secondary to viral or autoimmune encephalitis in July to August 2016

3.1.48 By May 2017, Simon's mental health was seen to have improved and he no longer presented with depression or psychotic symptoms. He was returning to full-time work. At an Oxleas outpatient clinic review, Simon was advised to continue with a lower dose of olanzapine (the anti-psychotic) for a further two months before ceasing it. He was advised to continue taking the sertraline (antidepressant) for six months and after this, the expectation was that the GP could reduce it further. Simon was discharged back to his GP.

3.1.49 In September 2017, the GP reviewed Simon and advised him to continue with the sertraline and to return in 2 months for a further review. There is no record that he returned for this review.

3.1.50 Simon's family say that he stopped taking his medications in December 2017. Simon thinks it was about a year after his admission to hospital, i.e. September 2017.

3.1.51 **August 2018 – Simon's mental health worsened**

3.1.52 Early in August 2018, Simon went to a music festival with Fred and others. The friends thought that Simon "wasn't himself". He was anxious, down and "weird". In the week before Simon killed his mother, Simon rang Fred and Fred went to see him. Simon was still anxious and down, worried about an imminent trip to see his brother and about a new relationship. There were further phone calls and Fred saw a serious deterioration in Simon's mental state. Simon talked about having "dark thoughts" but did not describe them further. Fred thought Simon might have been thinking of killing himself.

3.1.53 Simon texted his brother in a way that Stephen thought was a cry for help. Stephen told Simon to go to the GP and alerted the family. Mary spoke to Sylvie to say she was very worried about Simon.

3.1.54 A psychiatrist who spoke to Simon after the killing and before the trial recorded, “For about a week or two prior to the alleged offence the defendant started to suffer panic attacks again.” “The defendant was feeling increasingly anxious and panicky at work and found that he could not concentrate. He thinks he stopped work about a week prior to [Mary’s death]. He was not sleeping and was feeling increasingly anxious.”

3.1.55 **August 2018 – 3 days before Mary’s death.** Simon spoke to the mental health crisis line in the afternoon and they conducted a telephone assessment. That day, Simon attended A&E with Sylvie. Sylvie reported that Simon was very agitated in the car and said that the signs on the road were bothering him. She said it felt like hours before they were seen at hospital, though hospital records show that Simon arrived at 14:45 and was seen by the mental health team at 15:55. Sylvie said that they were seen in a room with a public address speaker that was constantly in use. Sylvie said it was very distracting and Simon was very unwell.

3.1.56 At the hospital, Simon described suicidal thoughts and anxiety. He said that he had ceased the anti-depressant nine months earlier. He was anxious about his planned trip to visit his brother which involved a long plane flight. Simon did not display psychotic symptoms. He was not consuming excessive alcohol or illicit drugs. He thought he might need to go to Green Parks, the mental health wing of the hospital, again. An assessment, including a risk assessment, was carried out. He was advised to re-start the antidepressant medication, sertraline. He was given an emergency appointment at a GP some distance from his flat. Stephen rang services from his home abroad and arranged for Simon to be seen by Simon’s own GP.

3.1.57 That night Simon spoke to Stephen (who was at his home abroad) and said that he wanted to take his own life.

3.1.58 **August 2018 – 2 days before Mary’s death.** Simon saw his GP and the antidepressants were recommended. He was advised to take diazepam before the long flight to visit his brother and to have promethazine tablets for

an emergency. Sylvie reported that he was advised to "go out in the sunshine".

3.1.59 **August 2018 – 1 day before Mary's death.** Mary arrived from her home abroad that evening. Sylvie had been with Simon all day, and some of Mary's friends, including Fred's brother, had come to help. Sylvie cleaned Simon's flat which she described as "disgusting". Friends went to do some shopping for Simon and made dinner. Mary told Sylvie that she was up most of that night trying to keep Simon in the flat. Simon kept trying to go talk to the neighbours. Mary said that she had stopped him taking an overdose the previous night.

3.1.60 **The day Mary was killed.** Simon had previously been given emergency numbers to ring. Mary called the mental health crisis lines the next morning and said Simon was agitated and expressing suicidal thoughts. He had been awake all night. Simon refused to talk to the mental health services on the telephone. Mary was advised to ring for an ambulance or to take Simon to A&E. Sylvie told this review that Simon's behaviour was very peculiar. For example, he was making sandwiches and then throwing them in the bin. Sylvie said that he was refusing to go to A&E or the GP. It took Sylvie and Mary two hours to convince Simon to go to the hospital.

3.1.61 Mary and Sylvie eventually managed to get Simon to A&E where Sylvie said that it seemed like they waited for several hours to be seen. Sylvie told this review that Simon appeared to deteriorate while they were waiting in A&E. She recalls telling the nurse that Simon "was getting more and more withdrawn as the noise and everything in A&E was obviously too much for him." (Hospital records show that they arrived at 11:04 and were seen at 12:10.) Eventually, Sylvie, Mary and Simon were seen in the room with the public address system in constant use. Sylvie could only stay 10 minutes as the parking was about to expire. It was noted that Simon was anxious and agitated with suicidal thoughts. He denied the use of alcohol or drugs. Mary said that she had cancelled the flights for his trip to visit his brother and that she would be staying with Simon. Simon was seen by a nursing staff member from the Oxleas mental health liaison team.

3.1.62 Oxleas undertook another comprehensive assessment and Simon was given 7 promethazine tablets to help him sleep (for his anxiety and agitation). He was advised to see his GP and to take the sertraline (antidepressant) in the morning so that it did not affect his sleep. He agreed to self-refer to a counselling service in Bromley for his anxiety and depression. He was given an urgent access line and Samaritan's card and discharged home with his mother. Sylvie thought the focus on when he was taking the medications was missing the point as he had only been on them since the hospital visit a few days before.

3.1.63 The diagnosis was that he was suffering a relapse of his depression and anxiety disorder following his ceasing sertraline in December 2017. When Sylvie met them outside, she says that Simon looked awful. Sylvie described him as looking like a little old man [he was 36 at the time], very withdrawn and very quiet. Sylvie thought he looked scared and Mary was holding his arm and helping him along.

3.1.64 They returned to the flat and Mary started to make dinner for Simon. Sylvie left, expecting to return the next day. She told Simon to be good to his mother.

3.1.65 In interview with the police, Simon reported that he thought that forces were going to overcome the Government and that these forces had plans to harm Mary and Simon in horrible ways. He wanted to protect his mother from this and therefore thought he had to kill her before they got to her. He tried several ways to kill her before he strangled her.

3.1.66 Stephen rang from his home around midnight and asked to speak to their mother. When Simon would not put Mary on the phone, Stephen threatened to call the police. Simon was very erratic and said that she was "sleepy sleep". Stephen then tried various ways to call his mother directly. Eventually Simon picked up his landline and said to Stephen, "She's gone." Stephen then heard the sound of Simon popping pills out of a blister pack. Simon then said goodbye and hung up.

3.1.67 Stephen was so worried that he rang the local police and asked them to attend the address. When they attended, Simon would not let them into the flat.

They forced entry into the flat and found that Mary had been strangled. Simon was arrested and charged with her murder.

3.1.68 Stephen spent the night ringing but was not told anything about what the police had found. When the UK family and friends woke in the morning and picked up his calls, several of them attended the flat and found the police there. Stephen's fears were confirmed by Sylvie when she rang him in the morning, UK time.

3.1.69 After an initial post mortem, where a cause of death was established, Simon was charged with the murder of Mary. Simon pleaded guilty to manslaughter on the grounds of diminished responsibility which was accepted by the court.

3.1.70 Simon was sentenced on 1 March 2019 to a hospital order, under S. 37 of the amended MHA 1983. He was also made subject to a Restriction Order under S. 41 of the MHA 1983.

4. Overview

4.1 Summary of information from family and friends about Mary

4.1.1 Mary was born and raised in Bromley with her sister, Sylvie.

4.1.2 Mary was passionate about dance. She started taking ballet lessons when she was three years old. Her sister remembers innumerable treks to watch Mary's lessons and performances as they grew up. Mary attended a dance school at the age of 15 and became an excellent dancer. She began her professional dancing career at the age of 18 in summer shows and pantomimes around England.

4.1.3 Sylvie describes her sister as a gentle woman, a bit of a worrier as a mother. She said that Mary looked after everyone. Simon described his relationship to his mother as "caring and loving and [she] did all the normal stuff for me growing up, including disciplining me when I was naughty."

4.1.4 Mary appears to have had a gift for friendship and, in addition to the family, several of Mary's friends helped out when needed when Simon was not well. Foster recalls that Mary always remembered everyone's birthdays – friends, nephews, nieces and grandchildren and sent cards. Foster recalls that she was constantly organising social events. She often played the role of mediator in wider family disagreements.

4.1.5 Mary met and married Foster in 1972. They lived in Bromley where their sons were born and raised. The couple also raised and showed pedigree dogs. They were married for 45 years.

4.1.6 Mary set up her own business in the 1970s and taught children the rudiments of ballet and tap dancing for 25 years. She also enjoyed competing with her dogs in shows for many years.

4.1.7 The family had summer holidays abroad and later bought a farmhouse in Europe that they refurbished. When Mary and Foster retired in 2006, they sold the farmhouse and realised a lifetime ambition to design and build their own home. They chose an area with good transportation links back to the

UK. While building the house, they took road trips in their sports cars. They developed friendships near their new home.

4.1.8 In 2002, Stephen moved a very long way away. He has two daughters whom Mary adored.

4.1.9 Foster and Mary had regular contact with Simon. They rang Simon weekly and returned regularly to the UK, returning more frequently when Simon's mental health problems became evident. Mary's sister reported that when Mary was in the UK, she took over Simon's care and wanted to handle everything herself. The family did not report that Mary felt she needed help or support herself.

4.2 Summary of information about Simon from him, from family and friends

4.2.1 As Simon was undecided about participating in the review, the Chair sent him a list of questions that would form the basis of the interview. Simon decided that he would like to participate in the review by answering those questions in writing. He was assisted by the mental health staff to do this and the Panel thank them for their support in this.

4.2.2 The Chair has also included information from friends and family that contextualises Simon's information.

4.2.3 Simon grew up in Bromley. Simon said that he had a family-orientated childhood. He described his family life as normal in that they ate meals and had holidays together. His brother went to live with relatives who lived closer to the college he attended when Simon was around 12. As a result, Simon said he spent his teenage years largely on his own. He said he thought he was a quiet but cheeky child and enjoyed computer games.

4.2.4 Simon said he was physically unwell as a child and was shorter than his peers. He thinks his small stature led to his being bullied, though he said this was not particularly traumatic.

4.2.5 His childhood friend, Fred, said that Simon had low self-confidence. Fred recalls that Simon always had a job: as a paperboy, in a shop, in a supermarket, and then his last job in IT. He saw that Mary cared for Simon

and they had a good relationship. Mary organised and sorted Simon out, even from a distance.

4.2.6 Simon attended a university in London where he obtained a degree in computer science. He lived away from home for a year or so and then moved back. He was not very good at living independently. His friend says that he was not very confident and was introverted, sometimes appearing more outgoing than he actually was.

4.2.7 Simon worked for an information technology company and played drums in a band. During his 20s and 30s, Simon was mostly solitary, but could be social at times. He had a wide circle of friends. Fred reported that during the last few years Simon was not good at getting in touch with his friends and sometimes "went off the radar". This made it hard to support him. Fred said that he had a mutual friend that worked in the same office as Simon and it was a very quiet office. The staff just came in and did their jobs as computer programmers and left.

4.2.8 In 2006 his parents moved abroad, and his older brother Stephen had already moved a great distance away. Simon moved into a flat on his own. Family and friends say that he found these changes difficult and felt abandoned and isolated following their moves.

4.2.9 When asked if he had experienced other episodes of mental ill health in addition to the three incidents described in this review, Simon said that he had not, though he had had a period of being "a bit moody and not recognising this as depression."

4.2.10 Simon reported to health professionals that he had used cocaine occasionally and cannabis socially. He had used LSD and MDMA at university. Simon reported that he had used nitrous oxide a few years before the homicide and had engaged in binge drinking to boost his social confidence. Fred recalls Simon having a poor reaction to MDMA in the past; it made Simon paranoid. He thinks that the reaction was so bad that Simon would not have used drugs again. Fred knew of no violent episodes in

Simon's past and was never frightened of him. He described Simon as a very placid person.

4.2.11 Simon's family say that Simon found various aspects of adult life difficult. His parents organised for him to buy his flat and his brother reported that he had organised Simon's job for him. Simon's parents were in touch regularly and often came back to the UK to see him and stayed with him.

4.2.12 It is notable that Simon's family understood his vulnerability. They reported that he rarely was the one to get in touch. Several reported that Simon was passive in his relationships. His father said that the family understood that they would have to advocate for Simon.

4.2.13 Several of those interviewed said that they felt that Simon, as an adult, was good at masking his depression until he got very sick. Fred says that he did not feel the "masking" was intended to be deceptive. Simon came to stay with Fred just before his hospitalisation in July 2016. It was clear that Simon was acutely ill, and Fred took him back to London the next day to see his doctor. After Simon came out of hospital later that year, he and Fred agreed that they needed to stay in touch more, as Simon needed to keep talking to friends. They agreed that when Simon was on his own too much, his mind would get stuck in a pattern.

4.2.14 Friends and family knew that Simon had a package of care when he came out of hospital in 2016. His friend did not know if the programme stopped or if Simon disengaged. His friends tried to stay closer to Simon after he came out of hospital, but it eventually appeared that he had made a good recovery, and his friends took a step back to let him get on with his life.

4.2.15 Simon's family continued to actively support him. His aunt, Sylvie, texted him weekly and took him to dinner monthly. His parents telephoned Simon weekly.

4.2.16 To those around Simon, he seemed stuck in a rut, continuing in a job that he did not like and continuing to live in the same place. Yet he seemed unable to effect change for himself. Simon's friend and family say that he had just

started a new relationship and the tension of this new relationship may have increased his anxiety.

4.2.17 One point that Simon's family and friends understood about Simon's mental health is that when he started to go downhill, he became very ill quickly and had irrational thoughts and delusions. They do not understand, given Simon's history, that he would have been sent home from the hospital twice that final week.

4.2.18 On reading the draft overview report, Foster said that the medical team did not use the word "psychosis" when describing Simon's mental health at the time. He says that, as a father, he is sure he would have remembered his son being diagnosed as "psychotic". Foster reiterated that he was not given a diagnosis and, having read the Overview Report, Foster does not think that he had enough information at the time about Simon's symptoms or diagnosis.

4.2.19 Simon was asked if there was anything, in hindsight, that might have helped. He found this a difficult question to answer. He said that being admitted to hospital during that last week could have helped. "I went to A&E on two separate occasions in a short space of time with the same problem but spoke to a different person each time. I might not have been very good at explaining my thoughts and might have been quiet and they kn[e]w I was going on holiday the next day. However, maybe I could have [been] probed for more information before discharging me."

4.2.20 Mary's family and friends have on-going concerns about Simon's release from hospital and the AAFDA support worker is finding appropriate channels for these concerns.

4.3 Summary of Information known to the Agencies and Professionals Involved

4.3.1 Greenbrook Healthcare

4.3.2 The Urgent Care Centre at Princess Royal University Hospital is managed by Greenbrook Healthcare and is co-located which means that patients can be appropriately streamed through to the Emergency Department (A&E) depending on the level of care that is required. Greenbrook had four contacts with Simon between 6 July 2016 (when he jumped out of the window) and 3 days prior to the homicide in August 2018. On each of those occasions, Greenbrook signposted Simon to other services in line with the protocol at the time that required those with significant mental health or trauma to be directly streamed to A&E.

4.3.3 **Kings College Hospital NHS Foundation Trust**

4.3.4 Kings College Hospital NHS Foundation Trust provides a full range of hospital services for people in the London boroughs of Lambeth, Southwark, Lewisham and Bromley as well as specialist services for patients across the South East and beyond.

4.3.5 Princess Royal University Hospital (PRUH) is one of the sites through which the Kings College Hospital NHS Trust operates. Patients are referred from Greenbrook Urgent Care to Emergency Department (ED) Triage service.

4.3.6 The Trust provided no health services for Mary within the timeframe of this review.

4.3.7 All contacts with Simon were at the PRUH site and all had to do with his mental health. The first contact with Simon was through the Emergency Department (or A&E) at the PRUH on the morning of 6 July 2016. Simon was seen at the PRUH A&E, having cut his wrist. He was seen by mental health services (Oxleas) where it was noted that he had undiagnosed mental health issues and he was discharged with GP follow-up.

4.3.8 Simon returned later that day after he had jumped out of a first storey window. He was referred directly to mental health services and was admitted to Green Parks, Goddington Ward which is run by Oxleas.

4.3.9 Simon was recalled to the A&E on 8 July after his x-rays had been reviewed and he was treated for a right cuboid fracture in his foot (one of the tarsal

bones towards the outside of the foot) that resulted from his jump the day before. Simon was delivered from Goddington Ward and returned there by ward staff.

4.3.10 On Goddington Ward, Simon presented as hyper aroused and physically aggressive. His odd behaviour and increasing confusion raised concerns that there might be a physical cause driving these. As a result, Simon was moved from Goddington Ward to the Acute Medical Unit (AMU) at PRUH on 15 July for assessment and treatment. He was in PRUH for three weeks. During this time there were four recorded incidents of violence and aggression.

4.3.11 Records show that a meeting was held with Foster and Mary on 16 July where the incident from the previous September was detailed. The notes show that Simon was well supported by his family.

4.3.12 During the following 3 weeks, medical staff on the AMU and the psychiatric staff from Oxleas worked together to diagnose and manage Simon's presenting symptoms and behaviours. As Simon was on the AMU, the detail from those weeks is in this section of the report.

4.3.13 Arriving at a diagnosis was difficult. Initially it was thought that his deterioration could be due to neuroleptic malignant syndrome (NMS), a rare but life-threatening response to antipsychotic medication. Antipsychotic medications were discontinued.

4.3.14 He was also treated for autoimmune encephalitis. On 17 July, Simon experienced a possible seizure which lasted for five minutes and he was agitated and disinhibited afterwards. His behaviour continued to be disruptive and challenging. He assaulted staff and caused disturbance to other patients. This can occur when a patient develops aggression and confusion following a seizure. As a result, his nursing levels were increased so that 2 nurses were with him at all times (staff provided by Oxleas). AMU staff requested a medication review by Oxleas, and Simon was given Benzodiazepine, a medication that is used to treat seizures and can manage agitation and aggression.

4.3.15 On 19 July, there was a joint review by the medical and psychiatric teams, with an opinion from the neurology department. The multi-disciplinary team agreed that NMS was unlikely and moved towards a diagnosis of viral encephalitis as his blood results were improving following an IV of an antiviral. A lumbar puncture showed increased protein, but this was dismissed as likely to be insignificant a few days later. An MRI scan provided no further information.

4.3.16 Simon's presentation fluctuated. He was quite low in mood and his patient notes record that he had written a suicide note to his parents in late July 2016.

4.3.17 Simon had complained about pain in his arm and on 8 August he was found to have an un-displaced fracture of his radial head (the top of the radius bone, just below the elbow). The IMR writer noted that Simon's arm injury was treated but not formally reported. She is taking this up separately with the Trust.

4.3.18 At a review on 4 August 2016, Simon's marked improvement was noted. The antiviral was discontinued. However, Simon continued in a low mood and staff were concerned that he was making gestures suggesting he wanted to harm himself. His risk of self-harm was high but his risk to other people was reclassified as low to moderate as his behaviour had improved and his agitation had decreased. Simon was transferred back to Goddington Ward and the care of Oxleas.

4.3.19 Two years later, in August 2018, three days prior to the homicide Simon returned to A&E with Sylvie as she was concerned about his suicidal thoughts. He was referred to mental health services.

4.3.20 He was back to A&E with his mother and Sylvie 3 days later, the day of the homicide in August, again with suicidal thoughts. He was referred directly to mental health services in A&E.

4.3.21 **Oxleas NHS Foundation Trust**

4.3.22 Oxleas NHS Foundation Trust (Oxleas), formed in April 1995, is a provider of general mental health services for Bromley, Bexley and Greenwich. It is a specialist provider of Forensic and Challenging Behaviour services for Bexley, Greenwich, Lewisham, North Southwark, Bromley, and Learning Disability Services for Greenwich, Bexley and Bromley.

4.3.23 The Trust has expanded its services and now provides Community Health Services in Bexley and Greenwich and a wide range of prison/forensic services (physical and mental health) in Kent.

4.3.24 Simon was treated in Oxleas' Green Parks House that provides services for Bromley residents with mental health problems when inpatient assessment and/or treatment becomes necessary. There are three adult wards and Simon was treated in Goddington Ward. Simon initially was admitted as an informal (voluntary) patient, but when his behaviour became so disturbed, he was detained under the Mental Health Act, S. 2, and then under S. 3 (see footnotes on pp. 23 and 24 for explanation).

4.3.25 Oxleas first had contact with Simon when he attended A&E in July 2016 with his brother. He was seen by the mental health liaison team. Simon described being in low mood and had thoughts of self-harm. He had made superficial cuts to his wrist which he described as "a cry for help". He said that the symptoms had started in Turkey and the notes say that this was a few weeks before, whereas it was nine months before. He noted his use of alcohol to relieve his social anxiety. He said he had been admitted to hospital in Turkey three times. He noted that he had been prescribed medications abroad (an anti-depressant) but had not been compliant with them.

4.3.26 Simon had a full assessment that reviewed his symptoms to come to a diagnosis. There was also a risk assessment completed. It is worth noting that the risk assessment is designed to highlight any risks to others, including risk from domestic abuse.

4.3.27 The outcome of this visit was a diagnosis of depressive disorder and interventions that consisted of medication (anti-depressant) and a plan was

formulated with Simon and his family attending that he be referred for psychological therapy and to the CMHT.

4.3.28 Simon was discharged home but returned to A&E later in the day. His presentation had changed.

4.3.29 Simon was agitated, in a low mood, anxious and trying to contain these feelings. His family reported that he had jumped out of a first storey window. This presentation and information suggested that he should be admitted. Simon was assessed to have mental capacity and was admitted as a voluntary patient to the Goddington Ward.

4.3.30 The mental health team looked for symptoms of hyper mania or psychotic beliefs or ideas. As patients may mask symptoms, over time the diagnosis for patients may change.

4.3.31 On the ward, Simon's risk was reviewed and, as he had jumped out of window, his risk level to himself was raised. He was observed by nursing staff every 15 minutes. A drug screen showed nothing. At this point, the notes record that he appeared calm.

4.3.32 On the ward round (a multi-disciplinary team meeting), a diagnosis of a mood disorder was made. His risk of self-harm was seen as high due to his impulsivity and his actions to end his life (overdosing/cutting himself/jumping from the window). He was started on an anti-psychotic medication which is appropriate for those with mood disorders with associated bizarre beliefs and impulsivity.

4.3.33 When an x-ray revealed that Simon had fractured a bone in his foot, he was returned to A&E to have that set and a cast fitted.

4.3.34 Simon's mental health deteriorated between 12 and 14 July and he became quite agitated and aggressive towards staff, property and other patients. He had been very low in mood and then became hyperactive, negative and displayed childlike behaviour. Communication with him could be difficult as sometimes he would not answer questions, would adopt unusual poses, would answer questions by gestures or opening his eyes, would make

guttural or high-pitched sounds. Simon accepted tranquilisers which calmed him for a period of time, but he then became agitated and aggressive. He dismantled his crutches and tried to climb out of a window and was stopped by staff.

4.3.35 Staff responded to this dramatic change in his behaviour by increasing his nursing observations. A member of the nursing staff was within arm's length of Simon and could see him at all times. He was changed to a high observation room.

4.3.36 Simon's status as a voluntary patient was reviewed and he was then held on the ward under Section 5.2 of the MHA that allows someone to be held against their will for 72 hours. Simon's risk assessment was updated as a result of his agitation and aggression to property and staff.

4.3.37 Staff started to think that the change in behaviour might be secondary to a physical health problem, so a CT scan was requested.

4.3.38 An assessment under the Mental Health Act 1983 was completed on 15 July. The consultant psychiatrist met with Simon's parents to give them an update on his progress and the treatment so far. Though still formulating a diagnosis, the consultant psychiatrist told Simon's parents that they were working towards a diagnosis of severe depressive disorder with psychotic symptoms. On reading the report, Foster said that he does not recall ever hearing the words "psychotic" in relation to Simon.

4.3.39 On 16 July, Simon was moved to PRUH's Acute Medical Unit for further work to identify whether there was a physical cause of his strange behaviours. As noted above, doctors had several working diagnoses, and adapted Simon's medications in response to these diagnoses. There appeared to be a number of physical health problems that were expressed with psychiatric symptoms. Further tests were ordered.

4.3.40 Simon's continued disruptive behaviour led to his nursing observation levels being increased so that two nurses were with him at all times. The psychiatric team reviewed Simon's medications at the request of the AMU team who were managing Simon on their ward.

4.3.41 The 19 July review (noted above at 4.3.15) considered a diagnosis of viral encephalitis and, as Simon's behaviour continued to fluctuate, a diagnosis of auto-immune encephalitis was considered. The fluctuations in his mood could be explained as a delirium secondary to encephalitis.

4.3.42 Simon was moved back to Goddington Ward, a mental health ward, on 5 August as a result of a review by a consultant psychiatrist who noted that Simon's behaviour had improved substantially. He appeared calm with no psychiatric symptoms or signs. He was on the maximum dose for his benzodiazepine class of medication.

4.3.43 There was a review of his situation on 8 August with a multi-disciplinary team. Simon's parents attended. His history was reviewed and the diagnosis of a depressive disorder with psychotic symptoms was offered as the most definite in the context of his symptoms. Simon agreed to be assessed by the Drug and Alcohol Service. His nursing observations were reduced to once every 15 minutes.

4.3.44 It was noted that Simon was given a leaflet about the medication he was prescribed, though there were no notes that his diagnosis was discussed with him. He attended groups on the ward where diagnoses of anxiety and depression were discussed.

4.3.45 By 12 August, there was a marked improvement. A multi-disciplinary team met and agreed this and that he was taking his medications and attending groups for support. His parents were visiting, and it was explained to them that Simon was no longer expressing the wish to harm himself and the risk to himself and others was assessed as low. There was no indication that he presented a risk to anyone in his family and no indication of domestic abuse. Foster and Mary therefore requested temporary leave for Simon to go to his flat, supported by his parents. He was granted two days overnight leave with his parents.

4.3.46 When Simon returned to the ward, the leave was deemed a success though Mary thought Simon had been low during it. Mary asked about neurology follow-up. Simon was referred to the DTS to help him move from being an

inpatient to living independently again. The Care Programme Approach[11] was explained to Simon and his family. The role of the care coordinator and the Section 117 meeting were also explained.

4.3.47 Simon was assessed and accepted for a 6-week programme after he left hospital at the DTS. Goals around attendance were discussed and set with Simon. The DTS offers daily groups for patients, using the recovery-based model of care.

4.3.48 Mary attended the discharge meeting on 26 August 2016 with the community team manager and the ward MDT. It was noted that this was not Simon's first episode of depression, and he met the criteria for a diagnosis of recurrent depressive episode. Simon's presentation and behaviours led to a classification of this as a severe episode. The illness was explained to Simon and Mary. They were told that this could happen again and therefore Simon was to continue on his medication and avoid illicit drugs and alcohol as these could precipitate a relapse. Simon was offered information on his illness and self-management. A risk assessment was completed.

4.3.49 On 30 August he started with the DTS (the programme is outlined in the chronology, para 3.1.34) and participated well though was a bit quiet. Mary rang Oxleas a few days later and expressed some concern that Simon would ruminate on some of the issues raised at the DTS session and it would make him unwell again. This was discussed with her and she was reassured and given details on how to contact staff out-of-hours.

4.3.50 In September, Simon expressed some paranoia at a session with his keyworker and his parents said he had been paranoid about people in the street. He was given techniques to counter his negative thoughts and a psychological assessment was arranged. At the assessment, Simon expressed paranoid ideas and worried that there were people or a presence

[11] Care Programme Approach (CPA) is a process where the patient's care from the mental health services and other agencies on leaving the hospital is coordinated by the care coordinator. The S. 117 meeting is required by the Mental Health Act 1983 to ensure that those who have been detained under S. 3 of the MHA have the care they need to remain well after leaving hospital..

after him. There were no indications of illicit substances or alcohol. A diagnosis of depression with psychosis was made and was discussed with Simon and Mary. He was started on an anti-psychotic and his antidepressant was changed and increased after 7 days. By the end of the month, in a review with Mary present, it was noted that there was a significant improvement in Simon's low mood. His risk assessment indicated that there could be a relapse if he stopped medication.

4.3.51 Simon was discharged from DTS on 12 October and continued to attend some groups and accessed his prescribed medications from this GP throughout the autumn.

4.3.52 There is no standard recommendation regarding time frames to aid recovery following a mental illness. This is individualised for each person. Staff use a variety of objective methods to assess whether more support is needed, including observing any improvements in the patient's mental state, reduction in symptoms, re-engagement in social and work activities and information gained from the family.

4.3.53 In November, Mary rang the team, concerned that Simon had not been to work that week. They were able to reassure her that he had attended a group session a few days before. She rang back later to say that everything was fine.

4.3.54 Towards the end of December 2016, Simon attended the final core intervention group. An objective measure used showed an improvement in his depression.

4.3.55 When Simon saw an outpatient doctor in late January 2017, he reported that he had stopped taking his medication 2 weeks before but had noticed that his mood was low and the dark thoughts were returning and therefore had started his medications again. He reported feeling less anxious in social situations and had begun some new activities outside work. His anti-psychotic medication was causing an increase in his appetite and weight gain and Simon was given advice around this. The notes do not record any discussion regarding his compliance with his medication to his brief relapse.

4.3.56 In mid-February 2017, at a psychological consultation with the CMHT, Simon's depressive episode was seen to have been resolved and he was considered to be in remission. Simon wanted support to stop him reaching "rock bottom" again. It was decided at the consultation that he would benefit from some counselling sessions as required and did not need the extended period of intervention to continue. He was referred to Bromley Working for Wellbeing Service.

4.3.57 In early May 2017, Simon was reviewed in the outpatient clinic by a doctor he had not met before. He reported no problems, said he was taking his medications and was back at work. He was advised to reduce his anti-psychotic medications and then stop it after 2 months. If his dark thoughts returned, he should restart the medication. He was transferred back to his GP. There is a recommendation about changing medications at the point of discharge – the review returns to this below.

4.3.58 Oxleas then had no contact with Simon until the events of August 2018.

4.3.59 In August 2018, 3 days prior to homicide Simon rang the Crisis Line and talked about feeling anxious about the long trip to visit his brother. He did not report feeling low, nor did he report suicidal thoughts.

4.3.60 A few hours later, Simon came into A&E with his aunt, Sylvie, and was seen by a psychiatric liaison nurse. Simon described low mood and anxiety then and said he had stopped his antidepressant in December 2017 as he felt better and did not think he needed it. He had not talked to his GP about this. An assessment including a risk assessment was carried out. There were no psychotic components to his descriptions. A relapse in his depressive illness was suggested and a risk assessment was carried out. Simon was seen as a low risk to other people and medium risk to himself due to his past history of self-harm and suicidal ideation. He was prescribed medications for his anxiety and referred back to his GP to start his anti-depressants again. Medical staff thought it was likely that the relapse was due to his decision to stop his medication.

4.3.61 On the day of the homicide in August, when Mary called the Crisis Line, she said that Simon was agitated and that he had almost taken an overdose, but she had stopped him. He was refusing to see his GP. The advice was to call the London Ambulance Service for help in bringing him to the A&E.

4.3.62 Mary and Sylvie eventually got Simon to A&E. Simon was given a comprehensive assessment that included his past psychiatric history which would indicate that they had read his notes and were aware of his past history. Simon was given further medication and sent back to his GP.

4.3.63 Oxleas note that other responses were possible. The psychiatric liaison nurse might have noted that Simon's presentation was similar to his presentation in 2016. A medical review might have been called to start his antidepressant at that time rather than sending him back to the GP. The Home Treatment Team might have been considered to provide intensive support. Oxleas note that the risk assessment was comprehensive and there were no indicators that the risk to his family was imminent or high.

4.3.64 **Bromley Healthcare**

4.3.65 Bromley Healthcare is a social enterprise providing a wide range of community health care services to people in Bromley, Bexley, Croydon and Lewisham. It offers services in clinics, community settings, nursing homes and other venues. The services include district nursing and specialist therapy services, for example Improving Access to Psychological Therapies (IAPT). IAPT's predecessor, Bromley Working for Wellbeing was the service Simon was referred to in 2015.

4.3.66 IAPT offers a range confidential talking therapies and support for adults over age 18 who are registered with a GP in Bromley. The IAPT team includes psychological therapists, counsellors and psychological wellbeing practitioners. Bromley Healthcare describe their "stepped care approach" as one that is based on what the client tells them and then offers the least intensive level of therapy to help improve how clients are feeling. If that approach does not work for a particular client, then they can be offered more intensive support.

4.3.67 Bromley Healthcare did not have any face to face contact with Simon. He was contacted in November 2015 and had an initial telephone assessment by a psychological wellbeing practitioner. There were no significant concerns at the time, no current thoughts of suicide. He noted his parents as protective factors, that is, they were a support network for him to manage the symptoms of his illness. Simon described what had happened in Turkey and said that he took the overdose in front of others because he wanted to go to hospital to feel safe.

4.3.68 As Simon reported depression, he was assessed using the Patient Health Questionnaire 9 (PHQ 9) and recorded as having mild symptoms of depression. A follow-up telephone appointment was arranged for a week later. On that call, a risk management safety plan was agreed with Simon. This plan is a joint risk management plan and required active engagement, participation and input from Simon. Bromley Healthcare also sent a letter with the risk management safety plan. This case was discussed with a senior therapist to ensure it was thorough.

4.3.69 Simon did not keep the next treatment telephone session at the end of January. Appointment letters were sent that included other support options for Simon. When Simon did not respond to these, he was discharged from the service and his GP was informed, following service protocols.

4.3.70 There was a referral to IAPT from the GP in July 2016 based on the same symptoms: mixed anxiety and depressive disorder. Simon's non-compliance with medications was noted. This referral was cancelled by a relative of Simon's (no record of who this was), who said that he had been admitted to Green Parks House. This meant that he was not eligible for IAPT services and he was discharged, and the GP was notified.

4.3.71 On 24 February 2017, Oxleas referred Simon to IAPT for counselling to focus on questions about his life and relationships. The referral said, "no further suicidal ideation or thoughts about harming himself since his admission last year. There is no risk to others. Simon no longer drinks alcohol, which was a factor in last year's suicidality".

4.3.72 Simon's initial assessment was booked by IAPT for 22 March, but Simon did not attend. It is not clear from the files that the appointment letter was actually sent. Simon was discharged and the GP was notified, in line with the usual protocol.

4.3.73 **GP Surgery**

4.3.74 Simon has been registered with the surgery since March 2008.

4.3.75 Simon was seen at the surgery at the end of September 2015, following his panic attacks while at the Turkish wedding. He told the GP he had been prescribed Escitalopram while abroad and was advised to continue with this. He was reviewed four more times over the following six weeks during which he received a sickness certificate and was referred to Bromley Working for Wellbeing to be assessed for psychological therapy or counselling. It is standard practice, and consistent with NICE guidance, for patients with anxiety symptoms to be offered a combination of medication and talking therapy support.

4.3.76 On 3 November 2015, Simon reported that he had stopped taking the medication and felt okay and was due to start counselling soon. He was back at work and said his family were supportive. There was no note about why he had stopped taking his medication.

4.3.77 Simon was reviewed again in early December. He was still well and was waiting for counselling. He was asked to come back in 6 weeks which he did not do and he did not take up the offer of counselling and was discharged from that service.

4.3.78 When Simon returned with similar symptoms in July 2016, he was prescribed Escitalopram again and referred to counselling (Bromley Healthcare) again. He reported no suicidal escalation. No risk assessment was undertaken, nor was there a discussion of why he had stopped his medications and not taken up the counselling previously offered.

4.3.79 The GP spoke to Simon's parents after he was admitted to Green Parks House.

4.3.80 The GP stayed in touch with Simon while he was in hospital, reviewed his medications and provided a sickness certificate. He advised Simon to talk to his employer about a phased return to work and a review was arranged for after Simon was discharged from the hospital. It was recorded that Simon was attending community mental health services (CMHS).

4.3.81 Simon attended the GP surgery in mid-September 2016 and, though he was still feeling very anxious and low, Simon had reduced one of his medications. The GP recommended that he increase the medication back to the prescribed dosage. He was still under the care of the CMHS.

4.3.82 The GP notes show that Simon was reviewed at the end of September 2016 and that Simon was seen by the CMHS and he had been started on sertraline (an anti-depressant) and olanzapine (an anti-psychotic). During a review with his GP in October 2016, it was recorded that Simon's medications had been changed and he reported feeling shaky at times. He was still under CMHS care.

4.3.83 From the discharge information the GP received from the CMHT in late April 2017, the GP knew that Simon's diagnosis was recurrent depressive disorder, now in remission; a history of mental and behavioural disorder due to the use of cannabinoids and alcohol misuse; and an acute psychotic episode or delirium secondary to viral or autoimmune encephalitis. His medications on discharge from Oxleas CMHT were sertraline and olanzapine. Oxleas had determined that the olanzapine was to be reduced for a 2-month period and then discontinued.

4.3.84 Simon attended the GP surgery for a review of his medication in September 2017. He was seen to be well and was advised to continue the sertraline and return for a further review in 2 months' time which is standard practice.

4.3.85 The final contact the GP had with Simon was two days before the incident in August 2018 after Simon's aunt had taken him to A&E and been referred back to the GP. Simon's mental health had deteriorated. Simon reported being anxious about his planned visit to visit his brother. He was advised to start on sertraline again and to have diazepam before the flight. He was

given promethazine (an antihistamine sometimes used as a sleeping pill) in case of an emergency.

4.3.86 **Metropolitan Police Service (MPS)**

4.3.87 The MPS provided a letter outlining their involvement in this case.

4.3.88 The MPS had no records of any domestic abuse between Simon and Mary prior to the homicide in August 2018.

4.3.89 There were no records regarding Mary. Simon came to the notice of MPS on two occasions.

4.3.90 On 6 July 2016, police were called to Simon's flat by London Ambulance Service (LAS) to assist with a male armed with a knife and threatening to take his own life. When police attended the male no longer had the knife and had superficial cuts to his wrist. The male was taken to the hospital by LAS.

4.3.91 On 17 November 2016, a friend of Simon's rang the police as Simon had not attended an agreed meeting the day before and they were concerned as Simon had been diagnosed with depression and had tried to harm himself. Officers attended Simon's flat and found him there. He appeared safe and well and told police he had wanted to be alone so had not answered the door. A MERLIN Adult Come to Notice (CAN) was created and the risk was assessed as level one and no immediate safeguarding concerns were identified therefore this was not shared with Adult Social Care.

4.3.92 On the night of the homicide in August, Stephen rang the MPS from his home and told police about his worrying telephone conversation with Simon, that Simon said he had taken a lot of tablets and that Simon suffered from anxiety and depression. Stephen also expressed concern for his mother who was visiting Simon but whom Simon would not put on the phone. The police attended, forced entry when Simon would not let them in, and found Mary's body wrapped in a sheet.

4.3.93 **London Ambulance Service (LAS)**

4.3.94 LAS was called to Simon's flat on 6 July 2016. The report was that a male wanted to commit suicide and had a knife and had cut his wrists.

4.3.95 When they arrived, they were led to Simon by Stephen. Simon was in a chair with a towel around his wrist. Stephen explained the background, talked about the wedding in Turkey and its aftermath and said that Simon's health seemed to be declining again. It was reported that Simon had seen his GP the previous day and been prescribed medications and counselling.

4.3.96 The LAS crew found a small laceration to the inside of Simon's wrist and no other injuries or pain. The LAS took Simon to PRUH and handed him over to hospital staff.

4.3.97 The LAS was called on the night of the homicide, then cancelled and then requested to attend to pronounce Mary's life extinct. The LAS informed the police that they would need a forensic medical examiner to do this.

4.3.98 **Bromley Lewisham and Greenwich Mind (BLG Mind)**

4.3.99 BLG Mind's "Recovery Works" service was launched in September 2016. It is a third sector community service for adults, either diagnosed or self-identified as having mental health needs. It offers one-to-one work, employment support, courses and a befriending service.

4.3.100 Recovery Works was developed from existing services. Clients of the previous services had "front sheet" details uploaded to the new system for Recovery Works. Simon was one of those clients.

4.3.101 Simon was referred to Recovery Works in October 2016. His risk was described as "low. No current risk to self or others". Simon was in contact with Recovery Works and an appointment was made for him in January 2017 with the employment specialist. The records are not clear on this contact and it is thought some information may have been lost in the transfer of records.

4.3.102 Simon missed the January appointment. Three contact attempts were made and messages left for Simon to re-schedule an appointment. Simon did not get in touch. If requested by Oxleas, Recovery Works will let referrers know if a patient does not engage but that was not requested in this case.

4.3.103 As Simon had not responded, Recovery Works wrote to him to say that his case was closed to them but that he could contact them any time he wanted

to in the future. BLG Mind noted that for those interested in employment support, non-engagement is usually an indicator that the person has found employment.

5. Analysis

5.1 Domestic Abuse

5.1.1 Domestic homicide reviews were instigated to learn lessons from cases where someone is killed by an intimate partner or family member. In this case, when reviewing the information from agencies, family and friends for this DHR, the Panel found no evidence of domestic abuse. Family and friends report that Mary and Simon were close, that Mary looked after Simon and there was affection between them. The medical professionals noted that the family was supportive of Simon and they appear often in the records as attending meetings to discuss Simon and are often characterised as protective factors in his life.

5.1.2 At the criminal trial, Simon pleaded not guilty to murder but guilty to manslaughter and the court accepted that Simon had killed Mary while mentally ill.

5.1.3 In the course of their reviews, the agencies involved looked for and found ways that they could improve their practice.

5.2 Family questions

5.2.1 The family also had unanswered questions about the course of events and the decisions made. It is outside the scope of a domestic homicide review to review the medical decisions made. We have looked at the processes, the information known, and communications with the family to identify areas for improvement.

5.2.2 Mary and Simon's family and friends' central concern was to understand why the risk that Simon posed to Mary was not identified and addressed. They said that they did not know what Simon's diagnosis was and asked whether Simon was given his diagnosis and understood the importance of staying on his medications. They wanted to know how Simon's compliance with his medication was monitored. They wanted to know if the medical staff that

assessed Simon on the two attendances the week of the homicide knew and took into account his violent behaviour when hospitalised in the summer of 2016. They did not understand why the heightened concern of the family was not reflected in the medical response to Simon. They did not understand why Simon's previous pattern of rapid decline in psychosis did not inform the response to him in August 2018. They expected the medical staff to act in Simon's and their best interests. When Simon killed Mary, they felt that the medical staff had not taken the care they should have to protect Mary.

5.3 Analysis of Agency Involvement:

5.3.1 **Terms of Reference**

5.3.2 At the first Panel meeting, the Panel discussed the terms of reference and added the following issues as those that, on first scoping, appeared to be pertinent to this homicide: Simon's mental health, non-engagement with services, non-compliance with medication, and Simon's different presentations to different medical staff.

5.3.3 **Analyse the communication, procedures and discussion, which took place within and between agencies – Reviewing records**

5.3.4 Oxleas note that the Crisis Line interview in August 2018 might have been more thorough, but note that Simon was advised to see his GP urgently which he did, following some effort by his brother to get an appointment.

5.3.5 A key question for the family is whether the professionals that reviewed Simon during his two A&E visits in August accessed and considered information from his hospital admission in the summer of 2016. Oxleas' review of their records showed that those assessments included past psychiatric history, indicating that staff had read the notes and were aware of his past.

5.3.6 Oxleas provided an outline of their process when seeing a patient in A&E: Oxleas Mental Health services utilise an electronic patient record called "Rio"

to record and store all clinical information relating to a service user's care while they are open to Oxleas services. The Rio system enables staff to record notes detailing contacts and interactions and patient progress, care plans, risk assessments, clinical reports and summaries including patient personal and clinical history and diagnosis. Staff accessing the Rio patient record can see all relevant information from previous encounters, care and treatment periods that the service user has had within Oxleas services.

5.3.7 When a patient presents at the PRUH A&E with suspected mental health problems:

(a) The patient is triaged by A&E staff and if mental health concerns are present they make a referral to Oxleas Mental Health Liaison Team (MHLT) based in Green Parks House, opposite the PRUH A+E Department.

(b) The Psychiatric Liaison Nurse (PLN) based in the MHLT receives the referral and notes it in the Rio patient record, noting the referral source, the time of the referral, brief account of the reason for referral any other relevant information provided by the referrer.

(c) The assessment process starts with the PLN accessing the Rio case file system to establish if the patient is currently open to an Oxleas service or is previously known and to check on any relevant background information to assist the assessment process.

(d) The time necessary to undertake these checks and to start the face to face assessment is dependent on the amount of information available/that needs to be read through and whether the PLN is still seeing another patient.

(e) The PLN then meets with the patient to complete the assessment face to face to establish current mental state, any risks to self or others and needs

(f) Once the assessment is complete a plan is then agreed. The plan might include the following:

- Immediate prescribing with referral back to GP with advice on possible treatment / prescribing
- Support plan agreed with support network - family / carers

- Referral on to other services which may be appropriate to the identified needs
- Referral to a community mental health team for follow up in the community
- Admission to a mental health inpatient service either voluntarily or detention under the Mental Health Act.

5.3.8 The plan may involve a combination of the above and will be dependent on the needs of the patient and the presenting/assessed risk at the time of the assessment.

(a) The patient is then advised of the outcome of the assessment and the plan and the plan is set in motion.

(b) The face-to-face assessment is recorded on the patient's Rio case file and a brief summary of the assessment outcome/plan is recorded in the Rio progress notes.

(c) The assessment and plan is then discussed at the next referrals meeting with other multidisciplinary members of the team, including psychologists and doctors.

(d) A letter is sent to the GP accounting the contact with the patient and advising the GP pf the plan.

5.3.9 The Panel discussed whether enough time is allotted for frontline mental health staff to fully review previous medical records before seeing a service user. Oxleas reported that staff review the history of a case before seeing a patient with mental ill-health and that the time it takes to do that is factored into the time scheduled for each patient. They acknowledged that the patient (and family in this case) may not be aware of the time reviewing the file before seeing the patient.

5.3.10 When considering communication systems in this case, BLG Mind identified an internal issue from a change-over of systems when BLG Mind was launched in September 2016.

5.3.11 ***Recommendation for BLG****: For clients referred who have been Oxleas service users, staff to check that all the information from Oxleas has been transferred.*

5.3.12 **Analyse the opportunity for agencies to identify and assess domestic abuse risk and their responses to that risk, including accessing specialist domestic abuse agencies – Assessing risk**

5.3.13 The risk to Mary came from Simon, not as a result of a pattern of coercive and controlling behaviour, but as a result of his psychosis. Agencies involved with Simon, Mary and the wider family noted the support that he had and identified that Mary and Foster were protective factors for Simon regarding his mental health. Simon and his mother had a good relationship and Mary was protective of Simon. There were no indicators of an abusive relationship.

5.3.14 The question that wracks his family is whether risk should have been identified by medical staff during the two hospital visits the week that Mary was killed. In particular, the family thought that Simon's violent behaviour in 2016 should have informed the mental health risk assessments that week, resulting in his hospitalisation.

5.3.15 *Risk assessments*

5.3.16 The GP noted that when Simon attended on 5 July 2016 with symptoms of anxiety, low mood and panic attacks that he had no suicidal ideation. Simon was started back on Escitalopram and it was noted that Simon had not responded to the counselling that had been offered to him the previous autumn. No risk assessment was noted, nor any reason noted for Simon not attending the counselling.

5.3.17 In addition, the GP IMR made the following recommendation to ensure full documentation of a patient's substance misuse. In this case, alcohol and drug use were seen to be precipitating factors. The IMR author made a recommendation that was added to by the Panel to create the following recommendation:

5.3.18 **Recommendation: For CCG and Oxleas to jointly facilitate a learning event for GPs that will refresh their practice and explore specific learning from the findings in this DHR when working with patients with mental ill health. The learning would include:**

(a) **understanding of referral routes,**

(b) **reminding GPs of the resources available and**

(c) **encouraging enquiry about substance misuse in patients presenting with mental health problems**

(d) **encouraging GPs to document a patient's risk to self and others at every patient interaction**

(e) **liaising with the community mental health team whilst the patient is receiving services, to discuss a joint approach relating to his medication. In this case, Simon had a history of self-managing his medication.**

(f) **Recommending to GPs that where patients are suffering mental ill health and have not followed through with previous prescriptions, GPs should discuss with patients and record why they did not attend recommended therapeutic sessions and/or the patient's rationale for stopping or reducing their medications. The medical professional should record their advice to the patient regarding those patient decisions.**

5.3.19 During the second Panel meeting, the Oxleas Panel member explained that mental health services use a structured risk assessment that looks at a variety of factors in order to come to conclusions about risks to self and to others. The aim is to manage risk in the least restrictive way possible. The focus is on the client and if the client agrees to go home with a family member and receive support from the mental health team, then that is what is offered.

5.3.20 During Simon's hospital admission in 2016, the medical view of the basis for his aggression and violence continued to evolve. The diagnosis that Simon

left hospital with in August 2016 included “an acute psychotic episode or delirium secondary to viral or autoimmune encephalitis”, that is, it was thought to stem from an underlying physical ailment rather than from his mental illness. This was supported by the fact that Simon improved without antipsychotic or anti-depressant medication. Even when Simon was aggressive on the ward, he did not target anyone in particular and had never expressed any delusional beliefs in regard to his family. He always identified his family as part of his support structure.

5.3.21 As Simon had not been aggressive or violent to his family and friends, they were not seen to be at risk. His risk assessments reflected that he was a risk to himself and not to other people.

5.3.22 Mostly Simon’s family and friends feared that he would harm himself – as he had before when he had taken an overdose of pills (2015), cut his wrists and jumped out a window (2016). The family and friends were not frightened of Simon. He had not threatened them as he had staff members when he was on the ward. But they knew from that time that he was capable of aggression when unwell.

5.3.23 In that last week in August 2018 when Simon was taken to the hospital twice, his developing psychosis was not evident. On both occasions, he described his anxiety to staff but did not describe psychotic symptoms. The family and Simon’s friend thought that Simon sometimes disguised his symptoms so as not to appear as ill as he was. Simon himself wrote that “During the A&E admissions, I feel it might have been beneficial to be admitted to an inpatient setting. However, perhaps I was not explaining myself well enough and not explaining my thoughts properly.” This may have led to practitioners thinking that the alarm of his family at the A&E attendances in that last week was out of proportion to Simon’s presentation.

5.3.24 A mental health risk assessment includes reviewing previous risk to inform a formulation and management plan for current risk. The case system used by the Trust has a record for violent incidents. The Panel discussed flagging files and Oxleas provided the preceding explanation (see para 5.3.6) of what

practitioners see when they open a file such as Simon's, before they see the patient. The records show that Simon's history was reviewed at the pre-A&E attendance three days before the homicide, though it is not clear that it was reviewed on the day of the homicide. Oxleas reported that a review of previous risk assessments is a standard part of formulating a plan for any current risks.

5.3.25 The Panel discussed the use of flags on files to alert practitioners to a patient's history of violence or aggression. Oxleas said that they use flags to alert staff to a patient's violence. However, Simon's file was not flagged as the risk of violence would have been contextualised and, as Simon's previous aggression had not been attributed to his mental ill-health, but rather to his previous physical ill-health, that risk would have been seen to cease when his physical health improved.

5.3.26 In August 2018, as Simon was not describing psychotic symptoms and his previous violence was attributed to an underlying physical cause, his history and current presentation would not have increased his risk assessment or identified the risk to Mary. The family's contribution to the assessment is returned to below (5.3.48ff).

5.3.27 The Chair notes that it is beyond the scope of this review to critique the mental health risk assessments undertaken by the mental health professionals who saw Simon in August 2018. The review is reliant on the professional expertise of the Panel members in this matter.

5.3.28 **Analyse the co-operation between different agencies involved with Mary and Simon and the wider family**

5.3.29 The record of Simon's time in hospital in 2016, shows many multi-disciplinary meetings to determine the cause of his behaviour. The communication between the mental health team and the medical team seems to have been frequent and complementary.

5.3.30 The communication between the GP and the community mental health team is returned to with a recommendation below.

5.3.31 As there was no evidence of domestic abuse, the added time and cost of tracking down Mary's GP records abroad and synthesising them for this review was not felt to be proportionate. However, the IMR writer for the GP practice proposed the following recommendation for reviews where it would be proportionate to seek out this data.

5.3.32 **Recommendation: For the Home Office to explore an international data sharing agreement, especially regarding health care information, to facilitate the statutory responsibility of Community Safety Partnerships to complete domestic homicide reviews.**

5.3.33 **Communication with the family**

5.3.34 *Reviews*

5.3.35 For families who have been bereaved as a result of the actions of someone with mental ill health, the tragedy leads them to question what help the ill person received from mental health services. They want to know what was done and whether the risk was assessed and if so, why no risk was identified.

5.3.36 In this case, NHS England requested desk top reviews from the GP and Oxleas in collaboration with Bromley CCG, to establish if this incident was reportable under the NHS Serious Incident Framework 2015. The incident did not meet the criteria for reporting as a Mental Health Homicide under the 2015 Framework as Simon had not been in secondary mental health services for over 1 year at the time of the incident. Therefore, there was no Duty of Candour requirement as this incident did not meet the criteria for reporting. [12]

[12] From "A Duty of Candour" pamphlet produced by Action Against Medical Accidents and the Care Quality Commission: "The duty of candour is a statutory duty to be open and honest with patients or their family when something goes wrong that appears to have caused or could lead to significant harm in the future."

5.3.37 The Safer Bromley Partnership decided to undertake a DHR in September 2018 and it appears that the family were not advised of this at the time. The Safer Bromley Partnership is now developing a process for instigating and managing domestic homicide reviews in line with the 2016 Guidance. As evidence of this improved practice, for a subsequent DHR, the family was notified in line with the guidance.

5.3.38 **Recommendation: Safer Bromley Partnership to complete the development of their policy and practice for conducting domestic homicide reviews in line with the Home Office 2016 guidance.[13]**

5.3.39 Contact with the family about the DHR process was facilitated by the police's Family Liaison Officer and the Chair's letters to Mary's sister and husband were provided through the police FLO in early February 2019. At that point, the family had had information through the FLO about the criminal process, but they reported that they had had no information about the mental health assessment made on the day of the incident or how that assessment was made, or any further information from the mental health services.

5.3.40 In the Chair's experience of DHRs, this is a regular comment from families where there were concerns for the mental health of the perpetrator. In the first instance, they often simply want information. Even where there might be a delay in getting that information due to the needs of the criminal justice process, families would benefit from having answers to some basic questions about the diagnosis and care of their relatives as early as possible.

5.3.41 In discussions with the NHS Panel member for this DHR, the possibility of this being an early part of the DHR process was raised. For this case, for instance, the mental health trust might have accompanied the Chair to the meeting with family members so that basic questions could have been answered. Questions still unanswered at the end of that meeting, could have

[13] Home Office: (2016) Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews. [accessed on 14 April 2020 at https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575273/DHR-Statutory-Guidance-161206.pdfow

been addressed through the Trust's own processes or, where appropriate, by the DHR itself. Due to issues of confidentiality and consent, however, it is acknowledged that it would be difficult for health services to provide this without additional guidance about who should offer this information and when. The needs of the criminal justice system will have bearing on this but should not preclude this happening.

5.3.42 **National recommendation: That the Home Office work with NHS England to agree a process by which families bereaved through a domestic homicide, whose relative had mental health problems and was the victim or perpetrator of the homicide, can get information as early as possible about the diagnosis and care of their relative up to the time of the homicide. The needs of the criminal justice process should inform this work.**

5.3.43 In recognition of the greater scope for learning that these complex cases offer, the following recommendation is proposed.

5.3.44 **National recommendation: The Home Office to produce guidance on conducting joint DHR/MH/SCR reviews when the perpetrator and/or victim has a history of and/or current significant mental health concerns.**

5.3.45 *Understanding the diagnosis and how to help*

5.3.46 In the aftermath of the tragedy, Mary's family felt that they did not know what Simon's diagnosis was. The concern was that without knowing what the diagnosis was, it was difficult for them to understand what was dangerous or help Simon manage himself.

5.3.47 The records from Oxleas showed six meetings during July to September 2016 where Simon's presentation and the emerging diagnosis was discussed with him and family members. Mary was at all these meetings and other family members were at some of them. Meetings in August identified that Simon had a depressive disorder with psychotic symptoms. This was returned to in subsequent meetings. The records show that the diagnosis was discussed with Simon, as was the importance of staying on

his medications. It is both indicative of Mary's care for Simon and unfortunate, that the record suggests that she was the best informed of the family about Simon's diagnosis and medications.

5.3.48 The consultant noted that Mary was Simon's primary carer and the notes show discussions with both Simon and Mary about medications and diagnoses. Under the MHA, the nearest relative would be the nearest relative residing in the UK which would have been Sylvie. The consultant talked to the family members who were there, acknowledging Mary's role.

5.3.49 In the Panel discussion, it was noted that Simon's history suggested that any situation that was out of his usual routine would likely have prompted anxiety. As we know, the intended trip was disturbing him and he had started a relationship with a woman and there may have been additional disruptions in his routine. The potential for relapse following such changes would have been part of the advice Simon was given months before in discussions of relapse indicators, prevention and management. Mary was at a number of these meetings. It would have been useful to the wider family to understand that disruptions to his routine would be likely to cause him anxiety and/or a relapse. Knowing this might have helped them provide information to the medical professionals that Simon could not at the time.

5.3.50 **Recommendation: Oxleas NHS Foundation Trust and other mental health agencies to improve support for families and friends who are assisting or caring for someone with mental ill health, including safety advice for the carers and families. Oxleas and other agencies to have discussions with family and friends about what role they might have in the care of the person with mental ill health and provide support for them to do so.**

5.3.51 *The dilemma of the family*

5.3.52 In August 2018, the family were at the limit of their ability to cope with Simon's behaviours. They rang the crisis line, friends and family took shifts looking after him and staying with him, his brother tried to oversee arrangements from his own home. They could not account for Simon's

behaviour, but they had twice seen his mental health collapse frighteningly quickly and so they took him to hospital. His family note that Simon had little insight into his situation when he was deteriorating and therefore relying too heavily on his views at such times was ill-advised. To the family it was obvious that Simon needed urgent treatment. They observed Simon acting very strangely.

5.3.53 Family members said that they were not equipped to cope with Simon's behaviours and had no professional qualifications to assess the level of risk that Simon posed. The distress the family felt is well-illustrated by Sylvie's sense of time at the hospital. They relied on the mental health services to identify the risk and protect Simon and them from any danger he posed. When a mental health patient's behaviour becomes unpredictable and challenging, it is possible that they may hurt others, intentionally or unintentionally.[14] In such situations, it is often the case that the only people willing to take on that care are family members or close friends.

5.3.54 A 2014 study[15] looked at the role of informal caregivers in the care of people with psychosis. The researchers noted that aggressive behaviour in psychosis is not uncommon. The study found that 62.2% of the patient violence reported was towards the caregiver. "The findings suggested that . . . mental health staff need to be aware of the risks of such violence for caregivers of people with psychosis and consider appropriate procedures for minimising it."

5.3.55 Simon was not identifiably psychotic however, as the 2016 hospitalisation demonstrated, diagnosis is often an art rather than a science, and the uncertainty in any diagnosis has a parallel in the uncertainty in any risk assessment. As the Royal College of Psychiatrists' Assessment and management of risk to others: Good Practice Guide (August 2016) says that "A history of violence or risk to others is vitally important", it would be prudent

[14] Maden, Anthon. **Treating Violence: A Guide to Risk Management in Mental Health** [2007] Oxford University Press.

[15] Onwumere, J., Grice, S., Garety, P., Bebbington, P., Dunn, G., Freeman, D., Fowler, D., and Kuipers, E, "Caregiver Reports of Patient-Initiated Violence in Psychosis", The Canadian Journal of Psychiatry, Vol 59, No. 7, July 2014, p. 377ff.

to provide safety advice to family and caregivers where patients have been known to be violent.

5.3.56 The medical staff on the Panel found this a challenge as they would need the patient's consent to discuss the patient's risk and provide tailored safety advice to family members. From a domestic abuse perspective, the requirement of the potential perpetrator's consent to provide safety advice to a potential victim seems unnecessary and could, in itself, increase the risk. When providing safety advice in a domestic violence context, the victim's perception of risk is sufficient to provide the information. It is also possible to provide generic safety information in case it is needed.

5.3.57 The recommendation from this is included in the recommendation at 5.3.48.

5.3.58 The Panel discussed the medical practitioners' framework that focusses on patient presentation and consent and on the least restrictive option for the patient. This contrasted markedly with the family's expectations of the mental health services in A&E. The family were so distressed by the deterioration in Simon's mental health that they sought emergency help twice the week of Mary's death. The family say they trusted that the medical professionals understood the situation better than they did, would ask for the information they needed, and then would act in everyone's best interests.

5.3.59 There should be a way to bridge this practice framework and family expectations, for instance, with medical practitioners actively asking carers about the patient's behaviour, about their concerns, and active enquiry as to whether the current carers feel equipped to deal with the patient. This would be particularly useful when, as Simon reported after the homicide, that he was unable to express what was going on in his mind at the time.

5.3.60 Families and friends will have known the patient longer and be more aware of subtle changes in their behaviour and may provide valuable additional information to assist the mental health professional's evaluation. That it took Mary and Sylvie two hours to get Simon into the car for the second A&E visit, that he was making sandwiches and throwing them in the bin – this

information might have informed Simon's mental health assessment, though would not have changed the risk assessment.

5.3.61 **Recommendation: Oxleas NHS Foundation Trust to review how and when they gather information from the family and friends who are carers for patients who present to services with mental health problems.**

5.3.62 Professionals should not assume that families feel competent and safe to look after a mentally ill relative because they do not protest. It may be that families and friends provide such care out of a sense of familial duty and responsibility, regardless of the cost to themselves. The recommendation at 5.3.48 addresses this.

5.3.63 The Panel discussed that the London Ambulance Service has two or three people who offer specialist mental health advice to LAS staff. They are currently working in an office but are planning to roll this service out so that they are with ambulance crews attending a call-out for someone with mental ill health.

5.3.64 **Service participation**

5.3.65 Simon said that he had a card to contact Oxleas but when he did, following the incident in Turkey but before his admission to hospital, he said the response was not helpful. He said, "the person told me that I was being an attention seeker and so I did not want to use that service again."

5.3.66 Simon said his experience with MIND [likely these were the DTS sessions before he was passed on to MIND, as Simon did not engage with MIND] was "quite good but I was only able to attend the face-to-face sessions for a period of a couple of months and then it went to telephone contact. I preferred the face-to-face session[s] so I did not utilise the telephone service. However, I understand that MIND can only do so much, and I understood that the face-to-face session[s] could not continue."

5.3.67 Simon's friend asked if it would have been better to provide services to stop Simon deteriorating again. The record shows that Simon was offered a number of different services. When he left the hospital in 2016, he attended daily sessions at the DTS for many weeks.

5.3.68 Bromley Healthcare did not have a 'did not attend' policy for adults during the period that Simon was in touch with the service, though there were other policies in place that were followed. Since that time Bromley Healthcare has developed an organisation-wide No Access Visit/Did Not Attend Adult Policy. The policy requires that administrative staff will make two telephone calls to the patient to book the assessment and will agree with the patient how that appointment will be confirmed, that is, by letter, email, text or a combination of these methods. As a result of this DHR, the IAPT lead has advised all staff that if a patient does not attend an appointment to check that the appointment was confirmed with the patient.

5.3.69 ***Recommendation for Bromley Healthcare****: The IAPT clinical lead to ensure that all IAPT staff are familiar with the No Access Visit including Did Not Attend Adult Policy.*

5.3.70 To clarify the systems and response to people not attending appointments:

5.3.71 ***Recommendation for Bromley Healthcare****: The Named Adult Safeguarding Lead to discuss this case at Bromley Healthcare leadership meeting and use this as a learning tool in relation to a form of domestic abuse.*

5.3.72 ***Recommendation for Bromley Healthcare****: All IAPT staff to ensure that all patients are discussed with a supervisor prior to discharge following an initial assessment.*

5.3.73 **Patient medication choices**

5.3.74 While reviewing the events in this case, it is important to bear in mind two key principles of the Mental Capacity Act 2005:

(a) "S. 1(4) a person is not to be treated as unable to make a decision merely because he makes an unwise decision.

(b) S. 1 (6) Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action." Before doing something to someone or making a decision on their behalf, consider whether the outcome could be achieved in a less restrictive way."

5.3.75 Simon was asked in the written questions when and why he stopped taking his medications, whether he talked to his healthcare providers about this, their advice, the effect on his mental health, and his response to any changes he experienced. Simon said that he took himself off the sertraline ". . . in September 2017. This was because I thought that I was better and could deal with my mental health without medication." Simon said that he started taking sertraline again when it was prescribed by the GP in August 2018 two days prior to the homicide.

5.3.76 Simon felt that his mental health deteriorated gradually after he took himself off the sertraline "as it did before, leading up to the previous admission (Green Parks)." Simon said, "I did not notice any changes until I became anxious and panicky in late August 2018 . . . I was having unusual thoughts and feeling a bit nervous."

5.3.77 The family felt that Simon did not take his medications as prescribed and that his mental health suffered when he stopped taking his medications. They wanted to understand what process and who was responsible for overseeing this and whether action should have been taken when Simon was not compliant.

5.3.78 Oxleas explained that the standard practice when prescribing medications is to explain to patients why they have been prescribed the medication. When patients are resistant to taking medications, staff should listen and see what they can agree on and base the intervention on that agreement. Staff are trained in motivational interviewing skills. When someone has been in hospital as a result of mental ill health, it is essential that the medication is in

place for a period of time. Oxleas noted that the evidence shows that someone with depression should continue with their medication for 6 – 9 months after they feel better. If there is also an anti-psychotic prescribed, then the patient might be advised to carry on for another year. For someone with low mood and anxiety, the recommendation is usually a combination of therapy and medication. The therapy can assist patients to develop strategies. Simon did not carry on with the therapy and stopped his medications on five occasions.[16]

5.3.79 In early November 2015, Simon reported to his GP that he had stopped taking medications that he had only been prescribed six weeks before when visiting his parents. As it is best practice in these situations to offer a combination of therapy and medication, it would have been helpful for the GP to have a discussion with Simon about his decisions to stop medications and to decline counselling, especially following his recent episode of mental ill health.

5.3.80 Similarly, when Simon told his GP in September 2016 that he had reduced the dosage of one of his antidepressants, the GP recommended that he increase the dosage back to the prescribed level. It would have helped the GP's management of Simon to understand why he had reduced his medications again and to have liaised with CMHS to coordinate their approach. The Recommendation at 5.3.18e and 5.3.18f address this.

5.3.81 In January 2017, Simon had an outpatient appointment with Oxleas and admitted he had stopped his anti-psychotic medications but then restarted them when his mood dropped. There is nothing in the notes to indicate that the doctor had a conversation with Simon about compliance with his medicinal regime. This conversation shows that Simon did see how his mood deteriorated and linked this to his stopping his medications. Simon, on

[16] November 2015, September 2016, January 2017, November 2017, and December 2017.

that occasion reversed his decision and went back on his medications in order to improve his mental health.

5.3.82 When Simon was discharged back to his GP in May 2017, he was advised to continue with a lower dose of the anti-psychotic he was one for another 2 months before stopping it. If the dark thoughts returned, he was to go back on the anti-psychotic. He was advised to continue taking the antidepressant for 6 months after which the GP might reduce it further.

5.3.83 Oxleas says that it is not best practice to reduce medications at the time of discharge to the GP. It would have been better for the Oxleas outpatient clinic to have reviewed Simon again after the anti-psychotics were reduced.

5.3.84 ***Recommendation for Oxleas NHS Foundation Trust****: Clinical Directors to discuss and provide guidance to mental health staff about changing medications at the point of discharge. Primary care physicians will be advised to continue on the medication and to seek the support of the community mental health team if a reduction of medications is being considered.*

5.3.85 On Simon's release from the hospital in August 2016, his diagnosis was explained to him and the need for him to continue on his medications and to avoid the use of illicit drugs and alcohol. He was told that he could relapse.

5.3.86 **Analyse the policies, procedures and training available to the agencies involved on the domestic abuse issues.**

5.3.87 There was no evidence presented to agency staff to suggest that Mary was suffering domestic abuse at the hands of Simon. The Panel took this opportunity to review their domestic abuse training.

5.3.88 For Bromley Healthcare, all relevant clinical staff should access domestic violence training every 3 years. Their notes clearly record that Simon did not pose a risk to himself or others. A risk assessment is a mandatory part of the IAPT service. There are safeguarding processes in place if there are concerns and these were not activated as there were no concerns.

5.3.89 For Oxleas. Training on domestic violence is mandatory for all clinical staff so that they are able to recognise signs and enquire further. This training is refreshed at least every 3 years as part of Safeguarding Adult and Safeguarding Children training. It is also available as a standalone training.

5.3.90 For GPs: The IRISi scheme[17] is available for GP surgeries in Bromley. IRISi (Identification and Referral to Improve Safety interventions) delivers training targeted at primary care staff to improve referrals to specialist domestic abuse services. 66% of the Bromley GP practices are fully IRIS-accredited; the remaining GP practices are being invited to undertake IRIS training with the majority taking up the opportunity. In addition, the CCG have allocated further resources to deliver this service.

5.3.91 Given the pressure on health and other services during the time of the COVID-19 pandemic, the Chair did not pursue information on the remaining service's domestic violence policies or training and recommended that this information is provided to the DV lead so that a comprehensive view of local agencies' response can be compiled.

5.3.92 **Recommendation: Panel members supply Safer Bromley Partnership with their agency's domestic abuse policies and information about their domestic abuse training for their staff.**

5.3.93 **Good Practice**

5.3.94 In the review of information from agencies, there were examples of good practice by agencies. The lead GP had built up a good relationship with Simon, and he was well-known at the surgery. The GP stayed in touch with Simon when he was in hospital.

5.3.95 During Simon's 2016 admission, there were many multi-disciplinary meetings at the hospital to get the widest possible understanding of Simon's condition when in hospital in 2016. There was evidence of good collaboration between

[17] IRISi is a third sector organisation that delivers IRIS training which is a specialist domestic violence and abuse training, support and referral programme for GPs that has been positively evaluated in a randomised controlled trial.. From www.irisi.org./iris/about-the=iris=programme. [Accessed 3 March 2020.]

the medical and psychiatric staff as they tried to identify the underlying cause of Simon's behaviour.

5.3.96 Kings College Hospital staff took a detailed history from Simon's parents when he was moved to the Acute Medical Unit in 2016.

5.3.97 The Oxleas staff had a number of meetings with Simon's parents during the earlier part of his hospitalisation in the summer of 2016. These meetings recorded which family member was there and what was discussed.

5.4 Equality and Diversity:

5.4.1 Simon was a white, single, heterosexual British male, aged 36. He did not have strong religious affiliations. His mother, the victim in the case, was a 68-year-old white British married heterosexual woman. In domestic homicide reviews, sex is always a characteristic that needs particular consideration as in three-quarters of domestic abuse-related offences, the victim was female (75%)[18]. The factors of pregnancy and gender reassignment do not pertain in this case.

5.4.2 There is no indication that either Simon or Mary received a response from agencies that was affected by these characteristics. It is noticeable that when Simon's mental health was deteriorating that those around him were the ones to get him the help he needed: his friends in Turkey in the autumn of 2015, his family and friends in July 2016 and August 2018.

5.4.3 Any barriers that Simon had in accessing mental health services were more likely due to his mental ill health.

5.4.4 Though sex is a characteristic of particular note in domestic homicide reviews, there has been no indication of any abusive behaviours from Simon

[18] Data on domestic abuse by sex of victim. From 'Domestic Abuse in England and Wales: year ending March 2018' on www.ons.gov.uk. Data from 28 police forces that supplied data on the sex of the victims. [Accessed 24.10.19]

towards Mary. Simon had had a few relationships with women and there was no indication of any abusive behaviours in those relationships either.

5.4.5 As noted at the opening of this review, women are more likely than men to take on caring roles. Where there is a risk in those situations then, it may be that women are more at risk. However, the evidence in this case does not suggest a wider application and a brief review of research suggests there is, as yet, limited academic work identifying women as being at greater risk in these situations and therefore we have drawn no specific conclusion or made recommendations.

5.4.6 Mary was 68. Research has noted that "Aging parents of adults with serious mental illness are often called upon to provide long-term or even life-long assistance to their disabled children . . . The complex and debilitating problems experienced by these adult children, and their continued dependence, may have serious negative consequences for their aging parents. The on-going assistance that these aging parents are frequently called upon to provide comes at a time when they are often struggling to deal with issues and challenges related to their own aging . . . Despite an increasing number of intervention studies that have targeted families of adults with serious mental illness, there has been little research that has focused exclusively on developing interventions to address the unique needs of aging parent caregivers of this population.[19]

5.4.7 Foster noted, on reading the report, that describing Mary required details that would make it easy to identify this case locally as her business and their breeding dogs meant that they were well-known locally. In addition, concerns were raised by the Panel about Simon's confidentiality if this full report was published. As a result, there is a recommendation about the publication of this report and a national recommendation for the Home Office

[19] Kaufman, A. V., Scogin, F., MacNeil, G. , Leeper, J., and Wimberley, J, "Helping Aging Parents of Adult Children with Serious Mental Illness", J Soc Serv Res. 2010 Oct; 36(5): 445-459.

to provide further guidance about how to meet the requirement to publish DHRs and to also protect the confidentiality of its subjects.

5.4.8 **National recommendation: For the Home Office to provide more guidance for domestic homicide reviews regarding the legal obligation to protect sensitive personal information such as medical information and the obligation to publish domestic homicide reviews.**

5.4.9 **Recommendation: Safer Bromley Partnership to only publish the learnings and recommendations as Simon will be released eventually and his confidentiality should be respected.**

6. Conclusions and Lessons to be Learnt

6.1 Conclusions

6.1.1 Communication with family: helping them understand the patient's behaviours and keep themselves safe

6.1.2 A key aspect of domestic abuse work is helping those at risk of domestic abuse keep themselves safe. Though there was no domestic abuse identified in this case, there are parallels with helping families to understand the situation and to keep themselves and their loved ones safe.

6.1.3 The family did not feel they had been given the information they needed to understand Simon's behaviour and to understand the risk to themselves. In conversation for this review, his family and friends identified strange behaviours by Simon that, if discussed more with Simon and then shared with the mental health professionals, might have supported a different approach.

6.1.4 The families of those suffering from mental ill health need to be part of the information gathering and care planning. The challenge in this situation was that Mary was accurately seen as Simon's primary carer yet she lived abroad and therefore was not in a position to oversee Simon's medications or attendance at services continually. Given her faithful attendance at meetings with medical staff about Simon's situation, she appears to have had information about Simon's diagnosis, but the wider family were not aware of this. This supports the application of the MHA definition of closest relative that would have alerted Sylvie to the detail of Simon's diagnosis which might have enabled her to advocate more for Simon's hospitalisation.

6.1.5 There also needs to be an acknowledgement that, even if the mental health patient is content to be cared for by their friends and family, that the friends and family need active support to do this and they need to know they have the option to decline this responsibility.

6.1.6 Time and information available to mental health professionals to make decisions in A&E

6.1.7 The family were concerned that the mental health professionals who saw Simon on the two attendances the week of the homicide in August did not know about Simon's aggression when in hospital in 2016 and therefore did not have all the information they needed to make a reliable risk assessment.

6.1.8 The family also thought that the hospital consultations on the two August 2018 attendances were too brief to be able to see past Simon's efforts to mask how ill he was. His aunt felt that he covered up his symptoms when talking on the phone to professionals, though she assumed at the time that the medical professionals were well able to understand what was going on and see through the masking.

6.1.9 The procedure when assessing a mentally ill patient in A&E is to review the file before seeing the patient. Previous risk assessments are clear on the file but would not have triggered particular concerns in this case because Simon's previous aggressive behaviour had been attributed to a physical cause rather than to his mental ill health.

6.1.10 At his A&E attendances the week Mary was killed, Simon presented with anxiety, suicidal thoughts and not sleeping. Staff did not see his more extreme behaviours and there is no record that family were asked for or provided further detail.

6.1.11 Simon's medication choices

6.1.12 In conversation with the family, they understood that Simon had unilaterally stopped his medications on a number of occasions. They were concerned that he did not know the consequences of this and that Simon's non-compliance was not explored by the medical professionals.

6.1.13 The records of Simon's time in hospital show that before he was released, he was talked through his diagnosis and his medications. He was told that the episode could recur, and he was told to stay on his medications and stay away from illicit drugs and alcohol as they appeared to have had a role in his

deterioration in 2015 and 2016. It is also recorded that Simon told professionals that he had come off his anti-psychotic medications in January 2017 and had had dark thoughts so had gone back on them, so he was aware of the link between taking the medications and the deterioration in his mental health.

6.1.14 Simon had sought to come off his anti-psychotic medications because he was gaining weight. This is common and mental health staff had discussed this with him at the time.

6.1.15 Simon also told his friend Fred that he was having dark thoughts earlier in August 2018, but Simon did not seek to go back on the medications then.

6.1.16 Working within the principles of the Mental Capacity Act 2005 noted above, GPs and mental health staff need to ask questions to explore non-compliance and to understand why a patient chooses not to take their medications so that they can use motivational interviewing techniques to encourage compliance.

6.1.17 <u>Assessing risk in situations of mental ill health</u>

6.1.18 The professionals assessed Simon as a low risk to himself and others on the night he killed Mary. It may be that the professionals took full account of Simon's history and still assessed him as low risk because the violence had been attributed to an underlying medical, rather than psychiatric, problem.

6.1.19 Though Oxleas have identified other actions that the medical professionals could have made on the August presentation, the risk assessment was comprehensive and indicated no historic or immediate risk to his family.

6.1.20 However, it is difficult not to link Simon's history of violence during his 2016 admission to Simon's aggression towards his mother on the date of the homicide in August. Though Simon's actions that night were unprecedented and unpredictable, his diagnosis when he left hospital in 2016 included a caution that the illness could recur. In such circumstances, more information and support for his family and some guidance on managing him to keep him

and themselves safe might have helped them advocate for the hospitalisation that they felt he needed.

6.2 Lessons to Be Learnt

6.2.1 Communication between mental health services and the GP need to improve in order to ensure that the care is coordinated and consistent.

6.2.2 Information and support for families. Professionals need to empower families and carers to understand a diagnosis, to work with them, and to hear when families and friends do not feel they can support a family member with mental health problems.

6.2.3 Families bereaved through domestic homicides should be provided at the earliest opportunity with information about the mental health diagnoses and care that their family member received.

7. Recommendations

7.1 IMR Recommendations

7.1.1 **BLG MIND**

7.1.2 *For clients referred who have been Oxleas service users, staff to check that all the information from Oxleas has been transferred.*

7.1.3 **Bromley Healthcare**

7.1.4 *The IAPT clinical lead to ensure that all IAPT staff are familiar with the No Access Visit including Did Not Attend Adult Policy.*

7.1.5 *The Named Adult Safeguarding Lead to discuss this case at BHS leadership meeting and use this as a learning tool in relation to a form of domestic abuse.*

7.1.6 *All IAPT staff to ensure that all patients are discussed with a supervisor prior to discharge following an initial assessment.*

7.1.7 **Oxleas NHS Foundation Trust**

7.1.8 *Clinical Directors to discuss and provide guidance to mental health staff about changing medications at the point of discharge. Primary care physicians will be advised to continue on the medication and to seek the support of the community mental health team if a reduction of medications is being considered.*

7.2 Domestic Homicide Review Recommendations

7.2.1 The recommendations below should be acted on through the development of an action plan, with progress reported on to the Area Community Safety Partnership within six months of the review being approved by the partnership.

7.2.2 **National recommendations**

7.2.3 **National recommendation 1:** For the Home Office to encourage agencies to develop information systems that allow for easier sharing of information, particularly about risk.

7.2.4 **National recommendation 2:** For the Home Office to provide more guidance for domestic homicide reviews regarding the legal obligation to protect sensitive personal information such as medical information and the obligation to publish domestic homicide reviews.

7.2.5 **National recommendation 3**: For NHS England to explore if an international data sharing agreement could facilitate a statutory review process should the information be deemed necessary as indicated by a Domestic Homicide Terms of Reference.

7.2.6 **National recommendation 4:** That the Home Office work with NHS England to agree a process by which families bereaved through a domestic homicide, whose relative had mental health problems and was the victim or perpetrator of the homicide, can get information as early as possible about the diagnosis and care of their relative up to the time of the homicide. The needs of the criminal justice process should inform this work.

7.2.7 **National recommendation 5: The Home Office to produce guidance on conducting joint DHR/MH/SCR reviews when the perpetrator and/or victim has a history of and/or current significant mental health concerns.**

7.2.8 **DHR Recommendations for Bromley Agencies**

7.2.9 **Recommendation 1:** Safer Bromley Partnership to complete the development of their policy and practice for domestic homicide reviews in line with the Home Office's 2016 guidance.[20]

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[20] Home Office: (2016) *Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews.* [accessed on 14 April 2020] at https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575273/DHR-Statutory-Guidance-161206.pdf.

7.2.10 **Recommendation 2:** CCG and Oxleas to jointly facilitate a learning event for GPs that will refresh their practice and explore specific learning from the findings in this DHR when working with patients with mental ill health. The learning would include:

(a) understanding of referral routes,

(b) reminding GPs of the resources available and

(c) encouraging enquiry about substance misuse in patients presenting with mental health problems.

(d) encouraging GPs to document a patient's risk to self and others at every patient interaction.

(e) liaising with the community mental health team whilst the patient is receiving services, to discuss a joint approach relating to his medication. In this case, Simon had a history of self-managing his medication.

(f) Recommending to GPs that where patients are suffering mental ill health and have not followed through with previous prescriptions, GPs should discuss with patients and record why they did not attend recommended therapeutic sessions and/or the patient's rationale for stopping or reducing their medications. The medical professional should record their advice to the patient regarding those patient decisions.

7.2.11 **Recommendation 3:** Oxleas NHS Foundation Trust to review how and when they gather information from family and friends who are carers for patients who present with mental health problems. Family and friends will have known the patient longer and be more aware of subtle changes in their behaviour and may provide valuable additional information to assist the mental health professional's evaluation.

7.2.12 **Recommendation 4:** Oxleas NHS Foundation Trust and other mental health agencies to improve support for families and friends who are assisting or caring for someone with mental ill health, including safety advice for the carers and families. Oxleas and other agencies to have discussions with family and

friends about what role they might have in the care of the person with mental ill health and provide support for them to do so.

7.2.13 **Recommendation 5:** Panel members supply Safer Bromley Partnership with their agency's domestic abuse policies and information about their domestic abuse training for their staff.

7.2.14 **Recommendation 6:** Safer Bromley Partnership to only publish the learnings and recommendations as Simon will be released eventually and his confidentiality should be respected.

Appendix 1: Domestic Homicide Review Terms of Reference

Case of Mary

This Domestic Homicide Review is being completed to consider agency involvement with Mary and Simon following the death of Mary in August 2018. The Domestic Homicide Review is being conducted in accordance with Section 9(3) of the Domestic Violence Crime and Victims Act 2004.

Purpose of DHR

1. To review the involvement of each individual agency, statutory and non-statutory, with Mary and Simon during the relevant period of time 12 November 2015 to date of homicide in August 2018 (inclusive). To summarise agency involvement prior to 12 November 2015.

2. To 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.

3. To 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.

4. To apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate.

5. To prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity.

6. To contribute to a better understanding of the nature of domestic violence and abuse.

7. To highlight good practice.

Role of the DHR Panel, Independent Chair and the Safer Bromley Partnership

8. The Independent Chair of the DHR will:

a) Chair the Domestic Homicide Review Panel.
b) Co-ordinate the review process.
c) Quality assure the approach and challenge agencies where necessary.
d) Ensure the family is invited to contribute to the review.
e) Produce the Overview Report and Executive Summary by critically analysing each agency involvement in the context of the established terms of reference.

9. The Review Panel:

a) Agree robust terms of reference.
b) Ensure appropriate representation of your agency at the Panel: Panel members must be independent of any line management of staff involved in the case and must be sufficiently senior to have the authority to commit on behalf of their agency to decisions made during a Panel meeting.
c) Prepare Individual Management Reviews (IMRs) and chronologies through delegation to an appropriate person in the agency.
d) Discuss key findings from the IMRs and invite the author of the IMR (if different) to the IMR meeting.
e) Agree and promptly act on recommendations in the IMR Action Plan.
f) Ensure that the information contributed by your organisation is fully and fairly represented in the Overview Report.
g) Ensure that the Overview Report is of a sufficiently high standard for it to be submitted to the Home Office, for example:
    - The purpose of the review has been met as set out in the ToR;

- The report provides an accurate description of the circumstances surrounding the case; and
- The analysis builds on the work of the IMRs and the findings can be substantiated.

h) To conduct the process as swiftly as possible, to comply with any disclosure requirements, Panel deadlines and timely responses to queries.
i) On completion present the full report to the Safer Bromley Partnership.
j) Implement your agency's actions from the Overview Report Action Plan.

Safer Bromley Partnership:

a) Translate recommendations from Overview Report into a SMART Action Plan.
b) Submit the Executive Summary, Overview Report and Action Plan to the Home Office Quality Assurance Panel.
c) Forward Home Office feedback to the family, Review Panel and STADV.
d) Agree publication date and method of the Executive Summary and Overview Report.
e) Notify the family, Review Panel and STADV of publication.

Definitions: Domestic Violence and Coercive Control

10. The Overview Report will make reference to the terms 'domestic violence' and 'coercive control'. The Review Panel understands and agrees to the use of the cross-government definition (amended March 2013) as a framework for understanding the domestic violence experienced by the victim in this DHR. The cross-government definition states that domestic violence and abuse is:

"Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse: psychological; physical; sexual; financial; and emotional.

Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim."

This definition, which is not a legal definition, includes so-called 'honour' based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group."

Equality and Diversity

11. The Review Panel will consider all protected characteristics (as defined by the Equality Act 2010) of both Mary and Simon (age, disability (including learning disabilities), gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation) and will also identify any additional vulnerabilities to consider. The Review Panel identified the following protected characteristics of Mary and of Simon as requiring specific consideration for this case: sex.
12. The following issues have also been identified as particularly pertinent to this homicide: mental health, non-engagement, non-compliance with medication, and different presentations to different medical staff.
13. Consideration will be given by the Review Panel as to whether either the victim or the perpetrator was an 'Adult at Risk' Definition in Section 42 the Care Act 2014: "An adult who may be vulnerable to abuse or maltreatment is deemed to be someone aged 18 or over, who is in an area and has needs for care and support (whether or not the authority is meeting any of those needs); Is experiencing, or is at risk of, abuse or neglect; and As a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it."

    Abuse is defined widely and includes domestic and financial abuse. These duties apply regardless of whether the adult lacks mental capacity.

    If it is the case that any party is an adult at risk, the review Panel may require the assistance or advice of additional agencies, such as adult social care, and/or specialists such as a Learning Disability Psychiatrist, an independent advocate or someone with a good understanding of the Mental Capacity Act 2005.

    The Care Act 2014 states; "Safeguarding means protecting an adult's right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, while

at the same time making sure that the adult's wellbeing is promoted including, where appropriate, having regard to their views, wishes, feelings and beliefs in deciding on any action. This must recognise that adults sometimes have complex interpersonal relationships and may be ambivalent, unclear or unrealistic about their personal circumstances."

14. *Expertise:* The need for additional expertise on the Panel was considered at the first Panel meeting. Given the characteristics of the victim and perpetrator, and the issues found to be particularly relevant here, the Panel identified no agencies that might bring additional expertise to these issues. The expertise on the Panel was felt to be commensurate to the case.
15. The Safer Bromley Partnership and Chair of Review will make the link with relevant interested parties outside the main statutory agencies.
16. The Review Panel agrees it is important to have an intersectional framework to review Mary and Simon life experiences. This means to think of each characteristic of an individual as inextricably linked with all of the other characteristics in order to fully understand one's journey and one's experience with local services/agencies and within their community.

Parallel Reviews

17. If there are other investigations or inquests into the death, the Panel will agree to either:
    a. Run the review in parallel to the other investigations, or
    b. Conduct a coordinated or jointly commissioned review - where a separate investigation will result in duplication of activities.
    c. It will be the responsibility of the review Panel chair to ensure contact is made with the chair of any parallel process.

Membership

18. It is critical to the effectiveness of the meeting and the DHR that the correct management representatives attend the Panel meetings. Panel members must be independent of any line management of staff involved in the case and must be sufficiently senior to have the authority to commit on behalf of their agency to decisions made during a Panel meeting.

19. The following agencies are to be on the Review Panel amend as appropriate:
    a) Bromley Clinical Commissioning Group

b) Bromley Healthcare
c) Bromley Lewisham and Greenwich MIND
d) Kings College Hospital NHS Foundation Trust
e) Oxleas NHS Foundation Trust
f) Greenbrook Healthcare
g) National Health Service England
h) Metropolitan Police Service
i) Bromley Community Safety
j) London Borough of Bromley Adult Safeguarding

20. Mary lived abroad and there were no circumstances in this case that required information from her local services.

Role of Standing Together Against Domestic Violence (Standing Together) and the Panel

21. Standing Together have been commissioned by the Safer Bromley Partnership to independently chair this DHR. Standing Together have in turn appointed their DHR Associate (Laura Croom) to chair the DHR. The DHR team consists of two support officers and a DHR Manager. The DHR support officer (Amy Hewitt/Helena Canavan) will provide administrative support to the DHR and the DHR Team Manager (Gemma Snowball/Hannah Candee) will have oversight of the DHR. The manager will quality assure the DHR process and Overview Report. This may involve their attendance at some Panel meetings. The contact details for the Standing Together DHR team will be provided to the Panel and you can contact them for advice and support during this review.

Collating evidence

22. Each agency to search all their records outside the identified time periods to ensure no relevant information was omitted and secure all relevant records.

23. Chronologies and/or Individual Management Review (IMRs) will be completed by the following organisations known to have had contact with Mary and Simon during the relevant time period: 12 November 2015 to date of the homicide in August 2018.

a) GP of Simon
b) Greenbrook's Healthcare Urgent Care Centre
c) Bromley Healthcare
d) Oxleas NHS Foundation Trust
e) Kings College Hospitals NHS Trust – including Princess Royal University Hospital
f) Bromley Lewisham and Greenwich MIND
g) Metropolitan Police Service
h) London Ambulance Service

24. Further agencies may be asked to completed chronologies and IMRs if their involvement with Mary and Simon becomes apparent through the information received as part of the review.

25. Each IMR will:
    - Set out the facts of their involvement with Mary and/or Simon;
    - Critically analyse the service they provided in line with the specific terms of reference;
    - Identify any recommendations for practice or policy in relation to their agency;
    - Consider issues of agency activity in other areas and review the impact in this specific case.

26. Agencies that have had no contact should attempt to develop an understanding of why this is the case and how procedures could be changed within the partnership which could have brought Mary and Simon in contact with their agency.

Key Lines of Inquiry

27. In order to critically analyse the incident and the agencies' responses to Mary and/or Simon, this review should specifically consider the following points:
    a) Analyse the communication, procedures and discussions, which took place within and between agencies.
    b) Analyse the co-operation between different agencies involved with Mary / Simon [and wider family].

c) Analyse the opportunity for agencies to identify and assess domestic abuse risk.
d) Analyse agency responses to any identification of domestic abuse issues.
e) Analyse organisations' access to specialist domestic abuse agencies.
f) Analyse the policies, procedures and training available to the agencies involved on domestic abuse issues.

As a result of this analysis, agencies should identify good practice and lessons to be learned. The Review Panel expects that agencies will take action on any learning identified immediately following the internal quality assurance of their IMR.

Development of an action plan

28. Individual agencies to take responsibility for establishing clear action plans for the implementation of any recommendations in their IMRs. The Overview Report will make clear that agencies should report to the Safer Bromley Partnership on their action plans within six months of the Review being completed.

29. Safer Bromley Partnership to establish a multi-agency action plan for the implementation of recommendations arising out of the Overview Report, for submission to the Home Office along with the Overview Report and Executive Summary.

Liaison with the victim's family and [alleged] perpetrator and other informal networks

30. The review will sensitively attempt to involve the family of Mary in the review, once it is appropriate to do so in the context of on-going criminal proceedings. The chair will lead on family engagement with the support of the police and AAFDA.

31. Simon will be invited to participate in the review, following the completion of the criminal trial.

32. Family liaison will be coordinated in such a way as to aim to reduce the emotional hurt caused to the family by being contacted by a number of agencies and having to repeat information.

33. The Review Panel discussed involvement of other informal networks of the Mary and Simon and agreed it was proportionate to the DHR to invite the following persons: Mary's husband and other son, her sister and a friend of Simon's. Additional information from other interviews with friends was provided by AAFDA.

Media handling

34. Any enquiries from the media and family should be forwarded to the Safer Bromley Partnership who will liaise with the chair. Panel members are asked not to comment if requested. The Safer Bromley Partnership will make no comment apart from stating that a review is underway and will report in due course.

35. The Safer Bromley Partnership is responsible for the final publication of the report and for all feedback to staff, family members and the media.

Confidentiality

36. All information discussed is strictly confidential and must not be disclosed to third parties without the agreement of the responsible agency's representative. That is, no material that states or discusses activity relating to specific agencies can be disclosed without the prior consent of those agencies.

37. All agency representatives are personally responsible for the safe keeping of all documentation that they possess in relation to this DHR and for the secure retention and disposal of that information in a confidential manner.

38. It is recommended that all members of the Review Panel set up a secure email system, e.g. registering for criminal justice secure mail, nhs.net, gsi.gov.uk, pnn or GCSX. Documents will be password protected.

39. If an agency representative does not have a secure email address, then their non-secure address can be used but all confidential information must be sent in a password protected attachment. The password used must be sent in a separate email. Please use the

password provided to you by the Standing Together team. They should be reminded that they should remove the password and only share appropriate information to appropriate front line staff in line with the DHR Confidentiality Statement and the specific Terms of Reference.

40. If you are sending password protected document to a non-secure email address it must be a recognisable work email address for the professional receiving information. Information from DHR should not be sent to a gmail / hotmail or other personal email account unless in rare cases when it has been verified as the work address for an individual or charity.

41. No confidential content should be in the body of an email to a non-secure email account. That includes names, DOBs and address of any subjects discussed at DHR.

Disclosure

42. Disclosure of facts or sensitive information will be managed and appropriately so that problems do not arise. The review process will seek to complete its work in a timely fashion in order to safeguard others.

43. The sharing of information by agencies in relation to their contact with the victim and/or the perpetrator is guided by the following:
    a) The Data Protection Act 1998 governs the protection of personal data of living persons and places obligations on public authorities to follow 'data protection principles': The 2016 Home Office Multi-Agency Guidance for the Conduct of DHRs (Guidance) outlines data protection issues in relation to DHRs(Par 98). It recognises they tend to emerge in relation to access to records, for example medical records. It states 'data protection obligations would not normally apply to deceased individuals and so obtaining access to data on deceased victims of domestic abuse for the purposes of a DHR should not normally pose difficulty – this applies to all records relating to the deceased, including those held by solicitors and counsellors'.
    b) Data Protection Act and Living Persons: The Guidance notes that in the case of a living person, for example the perpetrator, the obligations do apply. However, it further advises in Par 99 that the Department of Health encourages clinicians and health professionals to cooperate with domestic homicide reviews and disclose all relevant

information about the victim and where appropriate, the individual who caused their death unless exceptional circumstances apply. Where record holders consider there are reasons why full disclosure of information about a person of interest to a review is not appropriate (e.g. due to confidentiality obligations or other human rights considerations), the following steps should be taken:

- The review team should be informed about the existence of information relevant to an inquiry in all cases; and
- The reason for concern about disclosure should be discussed with the review team and attempts made to reach agreement on the confidential handling of records or
- partial redaction of record content.

c) Human Rights Act: information shared for the purpose of preventing crime (domestic abuse and domestic homicide), improving public safety and protecting the rights or freedoms of others (domestic abuse victims).

d) Common Law Duty of Confidentiality outlines that where information is held in confidence, the consent of the individual should normally be sought prior to any information being disclosed, with the exception of the following relevant situations – where they can be demonstrated:
   i) It is needed to prevent serious crime
   ii) there is a public interest (e.g. prevention of crime, protection of vulnerable persons)

44. The chair, police and CPS will be minded to consider the confidentiality of material at all times and to balance that with the interests of justice.

Appendix 2: Glossary of drugs and abbreviations

Word or abbreviation	Definition or meaning
Acyclovir	Antiviral
Anxiolytic	Drugs used to reduce anxiety
Benzodiazepines	A class of drugs used as a sedative, used for sleeping problems and anxiety
Bromley Working for Wellbeing	This is the same as the IAPT, Improving Access to Psychological Therapies.
Clonazepam	Anti-depressant
CMHT	Community Mental Health Team
CPA	Care Programme Approach
DTS	Day Treatment Service
Denzapine	Anti-psychotic medication
Diazepam	A benzodiazepine used to treat anxiety, alcohol withdrawal and seizures.
Escitalopram	Anti-depressants
Goddington Ward	Mental health ward in Green Parks, the mental health facility run by Oxleas at PRUH
IAPT	Bromley Healthcare's Improving Access to Psychological Therapies
Lorazepam	Medication used to treat anxiety
MDT	Multi-disciplinary team meeting
Mirtazapine	Anti-depressant
NMS	Neuroleptic Malignant Syndrome
Olanzapine	Anti-psychotic medication
Promethazine	An antihistamine sometimes used as a sleeping pill
PRUH	Princess Royal University Hospital, run by Kings College Hospital NHS Foundation Trust

Sertraline	Anti-depressant prescribed to Simon after 2016 hospitalisation.
Xanax	Proprietary name for alprazolam that is used to treat anxiety and panic disorders. A benzodiazepine.

Appendix 3: Action Plan

Bromley DHRCL2018 Action Plan

The reference is drawn from the “Recommendations for Bromley DHR CL” paper
Key:

- IMR Recommendations,
- ORN – Overview Report National Recommendations,
- ORL – Overview Report Local Recommendations.

REF	RECOMMENDATION	LEAD AGENCY	ACTION	LEAD PROFESSIONAL	OUTCOME	MONITORING	TIMESCALE	COMMENTS
IMR 1.1.2	For clients referred who have been Oxleas service users, staff to check that all the information from Oxleas has been transferred.	BLG MIND						
IMR 1.1.4	The IAPT clinical lead to ensure that all IAPT staff are familiar with the No Access Visit including Did Not Attend Adult Policy.	BROMLEY HEALTHCARE						
IMR 1.1.5	The Named Adult Safeguarding Lead to discuss this case at BHS leadership meeting and use this as a learning tool in relation to a form of domestic abuse.	BROMLEY HEALTHCARE						
IMR 1.1.6	All IAPT staff to ensure that all patients are discussed with a supervisor prior to discharge following an initial assessment.	BROMLEY HEALTHCARE						
IMR 1.1.8	Clinical Directors to discuss and provide guidance to mental health staff about changing medications at the point of discharge. Primary care physicians will be advised to continue on the medication and to seek the support of the community mental health team if a reduction of medications is being considered**.**	OXLEAS						

ORN1 1.2.3	For the Home Office to encourage agencies to develop information systems that allow for easier sharing of information, particularly about risk.	HOME OFFICE						
ORN2 1.2.4	For the Home Office to provide more guidance for domestic homicide reviews regarding the legal obligation to protect sensitive personal information such as medical information and the obligation to publish domestic homicide reviews.	HOME OFFICE						
ORN3 1.2.5	For NHS England to explore if an international data sharing agreement could facilitate a statutory review process should the information be deemed necessary as indicated by a Domestic Homicide Terms of Reference.	NHS ENGLAND						
ORN4 1.2.6	That the Home Office work with NHS England to agree a process by which families bereaved through a domestic homicide, whose relative had mental health problems and was the victim or perpetrator of the homicide, can get information as early as possible about the diagnosis and care of their relative.	HOME OFFICE & NHS ENGLAND						

ORL1 1.2.8	Safer Bromley Partnership to complete the development of their policy and practice for domestic homicide reviews in line with the Home Office's 2016 guidance.	SAFER BROMLEY PARTNERSHIP						

ORL2 1.2.9	CCG and Oxleas to jointly facilitate a learning event for GPs that will refresh their practice and explore specific learning from the findings in this DHR when working with patients with mental ill health. The learning would include: (a) understanding of referral routes, (b) reminding GPs of the resources available and (c) encouraging enquiry about substance misuse in patients presenting with mental health problems. (d) encouraging GPs to document a patient's risk to self and others at every patient interaction. (e) liaising with the community mental health team whilst the patient is receiving services, to discuss a joint approach relating to his medication. In this case, Simon had a history of self-managing his medication. (f) Recommending to GPs that where patients are suffering mental ill health and have not	CCG & OXLEAS						

	followed through with previous prescriptions, GPs should discuss with patients and record why they did not attend recommended therapeutic sessions and/or the patient's rationale for stopping or reducing their medications. The medical professional should record their advice to the patient regarding those patient decisions.							
ORL3 1.2.10	Oxleas NHS Foundation Trust to review how and when they gather information from family and friends who are carers for patients who present with mental health problems. Family and friends will have known the patient longer and be more aware of subtle changes in their behaviour and may provide valuable additional information to assist the mental health professional's evaluation.	OXLEAS						

ORL4 1.2.11	Oxleas NHS Foundation Trust and other mental health agencies to improve support for families and friends who are assisting or caring for someone with mental ill health, including safety advice for the carers and families. Oxleas and other agencies to have discussions with family and friends about what role they might have in the care of the person with mental ill health and provide support for them to do so.	OXLEAS						
ORL5 1.2.12	Panel members supply Safer Bromley Partnership with their agency's domestic abuse policies and information about their domestic abuse training for their staff.	ALL						
ORL6 1.2.13	Safer Bromley Partnership to only publish the learnings and recommendations as Simon will be released eventually and his confidentiality should be respected.	SAFER BROMLEY PARTNERSHIP						