Wiltshire Domestic Homicide Review

EXECUTIVE SUMMARY OF THE OVERVIEW REPORT

Into the homicide of Adult C

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Section One: Introduction

This Domestic Homicide Review examines the circumstances surrounding the death of Adult C.

1.1 This case came to the attention of the Police on Sunday 13th January 2013 via an out of area Police Control Room.

1.2 The Control Room received a call from the brother of the perpetrator. He told Police officers who attended his home address that Adult S had unexpectedly come to his house, and said he had killed his wife. Adult S gave his brother some photographs and money and said he was going to see their father. Their father had died some years previously and his ashes had been scattered on Exmoor.

1.3 Police despatched officers to the family's home address to check on Adult C's welfare. On their arrival the property was secure and following a forced entry, the body of Adult C was found upstairs.

1.4 Police began a murder investigation and over the next 24 hours there was an extensive search to locate Adult S.

1.5 The next morning Adult S turned up at his sister's address and asked her to call the Police. Police attended and he was arrested on suspicion of murder. He was taken to a local Police Station where he asked to see a doctor. When asked the reason, he showed a wound to his stomach. He was taken to hospital and kept in overnight and released the following day into Police custody.

1.6 Adult S was interviewed and gave an account of what happened. He claimed self-defence; Adult C sustained two stab wounds to the chest, one of which was the cause of her death. He claimed his injuries were caused during the same incident.

1.7 Adult S was charged with murder; after being treated for a mental disorder whilst remanded in custody, he pleaded guilty to manslaughter on the grounds of diminished responsibility. On 14th February 2014, his sentence was a hospital order with restrictions.

Section Two: The Review Process

2.1 This summary outlines the process undertaken by the Wiltshire Domestic Homicide Review Panel in reviewing the homicide of Adult C.

2.2. A Domestic Homicide Review (DHR) was recommended and commissioned by the Wiltshire Community Safety Partnership in line with section 9 of the Domestic Violence, Crime and Victims Act 2004 and the expectations of the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews 2011.

2.3. The Home Office was informed of the intention to conduct a DHR on the 25th February 2013

2.4. The process began with an initial Review Panel meeting on 21st March 2013 of all agencies that potentially had contact with the victim Adult C and the perpetrator, Adult S prior to the point of death.

2.5. The families of both the victim and perpetrator were contacted at the start of the Review. Adult C's mother asked that the Domestic Homicide Review (DHR) review the mental health provision the perpetrator received from 2010 when he moved to Wiltshire. Later friends and work colleagues of both the victim and perpetrator were contacted by the Review. The family of the victim were offered support from the support service AAFDA but declined as they were content with the specialist support being provided to them by the Homicide Support Service.

2.6 On 3rd March 2014 the victim's mother and step-father were shown the overview report. They said they took comfort from the thoroughness of the Review and from the actions which are being taken to address the lessons learnt as a consequence of their daughter's death.

2.7 The agencies participating in this case review are:-

- Avon & Wiltshire Mental Health Partnership NHS Trust (AWP)
- NHS Wiltshire CCG
- Relate Mid-Wiltshire
- Rhondda Cynon Taff Multi Agency Risk Assessment Conference (MARAC)
- Shropshire Council Children's Service
- South Staffordshire and Shropshire NHS Foundation Trust
- South Wales Multi Agency Risk Assessment Conference (MARAC)
- Splitz Support Service
- Shropshire Multi Agency Risk Assessment Conference (MARAC)
- Victim Support IDVA Service
- West Mercia Police
- Wiltshire Anti-Social Behaviour Risk Assessment Conference
- Wiltshire Council Housing Allocation and Options
- Wiltshire Council Safeguarding Adults
- Wiltshire Fire and Rescue
- Wiltshire Multi Agency Risk Assessment Conference (MARAC)
- Wiltshire Police
- Wiltshire Probation Trust

2.8 Agencies were asked to give chronological accounts of their contacts with the victim and perpetrator prior to the homicide. Where agencies had no involvement or insignificant involvement, they informed the Review accordingly. In line with the Terms of Reference (appendix one), the DHR has covered in detail the period from the 1st January 2005 (with the

exception of Wiltshire agencies, who commenced their research from 1st May 2008) and the death of Adult C that occurred on the night of the 12/13th January 2013.

2.9 Eighteen agencies/multi-agency partnerships were contacted about this review. Thirteen have responded as having had no contact with either the victim or the perpetrator.

2.10 The five organisations that completed either an Independent Management Review (IMR) or a report have responded with information indicating some level of involvement with members of the family.

2.10.1 **Avon & Wiltshire Mental Health Partnership NHS Trust (AWP**) treated Adult S after his discharge from a Shropshire mental health unit on 29th June 2009 where he had been treated for an acute and transient psychotic disorder.

- The initial AWP assessment noted that "he now presented very well and his wife supported this view". He said he did not want community psychiatric nurse (CPN) input as he felt well and wanted to spend time looking for work. Between 10th July 2009 and 17th January 2012, when he was formally discharged, following a "Care Programme Approach" (CPA) review, he had attended ten outpatient appointments with five different medical staff (four Consultants or Locum Consultants and a trainee doctor).

- Adult C accompanied Adult S to all of the appointments and up to January 2010 their relationship was reported as good. Adult C was also working full time and their financial concerns had been sorted out. In April 2010 Adult S lost his job because he was excessively slow and his wife expressed some frustration about how slow his thoughts and actions were. This was thought to be a side effect of the drugs he was prescribed and a slow reduction in the strength of the medication was agreed. By October 2010 he was reporting significant improvement in his symptoms, although Adult C said she needed to prompt him to help out at home and to take his medication.

- At his outpatient meeting on 7th July 2011 Adult S asked to come off the medication totally but Adult C expressed grave concerns as she felt she was the person who had to deal with him if he deteriorated. Consequently his medication was reduced rather than stopped.

- Two months later at the following meeting, it was noted that there was considerable marital tension. Adult C had stated that he was no longer the man that she had married. He was keen to stop his medication despite being aware that this would threaten any reconciliation between them. The Consultant encouraged them to seek counselling but neither of them was interested in doing so.

- Adult S made it clear he was going to stop taking his medication against the advice of the Consultant and that he did not want to continue to receive mental health services. The Consultant consequently decided there was no point in offering him any further appointments and he was formally discharged four months later in January 2012.

2.10.2 **NHS Wiltshire CCG**

- Medical records held in respect of both Adult C and Adult S from 2005 to 2013 were reviewed. They included medical contacts in the different parts of the country where the family had lived. Adult C was relatively healthy and rarely visited the doctor other than for asthma and hay fever problems. She last attended the GP's in September 2012 regarding her asthma.

- In relation to Adult S, his medical history showed that from 2005 he had three psychotic episodes in 2006, 2009 and 2013. His GP received regular reports from the mental health services about the progress of his treatment and subsequently of his discharge in January 2012. After his discharge he had one annual follow up with his GP. His only other visits were seven in 2012 relating to chest pains, there is no indication in his medical records that his mental health was discussed on those occasions.

2.10.3 **South Staffordshire and Shropshire NHS Foundation Trust.**

- Adult S was admitted to a mental health unit in Shropshire after being detained by the police under the Mental Health Act on 28th May 2009. He was treated for an acute and transient psychotic disorder. The hospital reported no problems relating to his childhood or education; that he did not drink or use illicit drugs but did smoke 20-30 cigarettes a day. He had at first been guarded and suspicious, refusing to sign documents about benefits or to assist his wife with documentation for their house move to Wiltshire. By the 22nd of June 2009 he was showing no signs of psychosis and following a period of leave he was discharged on 29th June 2009.

2.10.4 **West Mercia Police**

- West Mercia Police had four relevant contacts with the family during May and June 2009 when his mental health was deteriorating due to the stress of losing his job, after a second horse riding accident in which he was seriously injured. The first related to a call from Adult C that their son had gone missing. He was quickly traced to a friend's house celebrating the end of his exams. The police followed this up with a visit to the house and were satisfied that all was in order. Shortly after this, Adult C's mother raised concerns with the community health team, that Adult S had a history of mental health problems and had firearms in the house. This was reported to the police and the mother was contacted by telephone. She told the officer that the matter had been resolved as her daughter had the keys to the firearms cabinet and a visit from the police would only cause problems.

- The only contact which indicated any suggestion of domestic abuse was not long after being told he was being made redundant. Adult S kept Adult

C and their son in the house against their will. He was not prosecuted for the false imprisonment but was sectioned under the Mental Health Act. Although Adult C told the police she never thought that Adult S would physically hurt her, she was provided with the details of domestic abuse support services which she did not use. Not long after this, while Adult S was still in hospital, she and her son moved to Wiltshire to be nearer to her parents.

2.10.5 **Wiltshire Police**

- Prior to the homicide, Wiltshire Police had only one further contact on 27th December 2011 at the family home involving the son.

Section Three: Key Issues

3.1 The DHR provided an opportunity to analyse information obtained from agencies and from the family, friends and work colleagues of both the victim and perpetrator.

3.2 The core issues related to Adult S's mental health up to the time of Adult C's homicide and the treatment he received from the mental health services. While there was no evidence of previous physical domestic abuse, he had stopped her and their son from leaving their home on one occasion whilst he was mentally ill. Adult C also complained about his lack of input into the family finances and that he was constantly following her.

3.2.1 Adult S was first diagnosed with an acute transient psychotic disorder in February 2006 when the family was living in Wales. He had been going through a period of stress because of an industrial tribunal in which he was involved and the trauma of a riding accident and post operative problems. He presented with paranoid symptoms, saying he felt persecuted and "being got at". His symptoms quickly deteriorated and in March 2006 he was sectioned under section 2 of the Mental Health Act. He was discharged a month later, although he remained under the care of a Consultant as an outpatient, for a further 15 months; after which he was discharged as his mental state returned to "normal".

3.2.2 In September 2008 while working as a huntsman in the Midlands he sustained serious injuries in another riding accident. As he could no longer carry out his work responsibilities he was made redundant in May 2009. The family were faced with financial worries and Adult S became mentally ill again. On the 28th May while still in possession of two firearms he held as part of his work as a huntsman, he refused to let his wife or son leave the house, holding them against their will. Adult C was able to text a message to her mother and the police were called. He was again sectioned under the Mental Health Act rather than prosecuted for false imprisonment as he had never threatened anyone with the firearms which had remained in the firearms cabinet throughout the incident.

3.2.3 He was successfully treated for his mental illness and discharged to join his wife and son who had already moved to Wiltshire to be near Adult C's parents.

3.2.4 Having been discharged from his section, he became a voluntary patient with the Avon and Wiltshire Mental Health Partnership NHS Trust and his treatment is summarised in paragraph 2.10.1 of this report.

3.2.5 Adult S was last seen by the Trust in September 2011 when contrary to medical advice he stated he wanted to stop taking medication and did not wish to continue to be treated. He was formally discharged in January 2012.

3.2.6 After his discharge he settled into regular employment and was well thought of by work colleagues, however, Adult C told friends she found him difficult to live with due to his poor hygiene and lack of financial support to the household. Their relationship continued to deteriorate and she considered leaving him, but could not bring herself to do so, as she thought he would be unable to cope on his own.

3.2.7 Adult C's parents, friends and work colleagues told the Review that it was only in the first weeks of January 2013 that Adult S's behaviour became so paranoid that Adult C suspected that his mental health was declining and she became worried that he might again keep her in the house against her will. She warned work colleagues of what action to take, if she did not turn up for work. Regrettably she did not share those fears outside her circle of family and friends.

Section Four: Lessons to be learnt

4.1 Four of the five agencies that had contacts with the family subject of this review have identified lessons they have learnt from the Review.

4.2 **Avon & Wiltshire Mental Health Partnership NHS Trust (AWP)**

4.2.1 While there has been a significant development of community services within AWP since Adult S was under the care of AWP services, the following issues have been identified as important lessons learnt;-

- Allocating a care co-ordinator to individuals.
- Seeing service users at home rather than offering an outpatient service.
- Ensuring that service users and carers are seen independently of each other and that both are asked about current as well as past abuse.
- Offering a broad care plan encompassing relapse management; stress management; carers' assessments; review of risks and crisis/contingency planning.
- Ensuring that robust relapse plans are in place prior to discharge.
- Recognising that risk assessments are a key way of recording and communicating concerns about risk.
- Recognising that it can be difficult for service users and their carers to engage with the service when there are repeated staff changes.

- Ensuring that robust early warning signs and relapse plans are developed in collaboration with the service user and their carer during the course of their care episode. All involved must have a copy of this and be familiar with it. At discharge, this will also outline the pathway back into care if there is a further relapse.
- Ensuring that an appropriate balance is maintained between seeking to engage people in services and allowing people to decline services if and when they have the capacity to do so.
- Ensuring that in letters to GP's, where there is an expectation that they will act on information provided in the letter, this is clearly expressed as such.

4.3 **NHS Wiltshire CCG**

4.3.1 From 2006 when Adult S was first treated for mental health issues, there was good communication between the agencies involved in Adult S's care and his GP.

4.3.2 During Adult S's time in Wiltshire between 2009 and 2013, the GP surgery received regular updates from AWP's Community Mental Health Team (CMHT). The GP Practice was notified Adult S was being discharged and was informed he had stopped his medication and had been advised to make contact with his GP; however, no follow up checks were made after his discharge.

4.4 **South Staffordshire and Shropshire NHS Foundation Trust.**

4.4.1 There is a need to ensure that when care is transferred to another area or organisation this is documented in the health record.

4.5 **West Mercia Police**

4.5.1 West Mercia Police did not refer Adult C's and Adult S's 16 year old son to Children's Services when he was reported as a missing person as he was found quickly. Following his return to his parents, a 'safe and well' check should have been completed. This is a basic requirement that provides the missing person, in particular a child, with the opportunity to express their concerns and anguish which has led them to take this course of action. Further it serves to provide information that may prove crucial in locating them should they go missing again.

4.5.2 Police records show details of the incident when Adult S held Adult C and their son at the home against their will were referred to the Children's Services, although Shropshire Children's Services have no records of this contact. While it is not considered that referrals in relation to the son would have provided a different outcome for Adult C or would have assisted her son, in these circumstances, but systems would have held more information to assist any subsequent assessment(s).

4.5.3 Improved communication between the police and the mental health unit may have provided an enhanced risk assessment for Adult S's return home.

4.5.4 Whilst suffering from mental illness, Adult S could possibly be classified as an adult at risk. There is no record on the police reports with regard to 'safeguarding of adults'. It would be normal for persons detained under section 2 of the Mental Health Act to have an appointed social worker and for that person to continue support upon release from the unit and throughout the duration of Adult S's treatment. West Mercia Police has no documentation referring to an appointed social worker nor, more importantly, of any contact between the Police and Social Services.

4.5.5 When the police attended Adult S's address and he was displaying mental instability, his firearms should have been seized. It was neither safe nor legal to leave the keys in the possession of a person not licensed to possess such weapons.

4.5.6 Adult S's familiarity with firearms and his mental illness should have prompted a closer liaison upon his release to ensure he was managed holistically across county borders by both police and medical staff in order that the opportunity for him to gain access to firearms in the future was carefully assessed against relevant information.

4.5.7 The National Firearms Licensing Management System (NFLMS) carried comprehensive notes on Adult S's movements and mental illness up until the revocation of his certificate. Had he made a subsequent inquiry for a firearms certificate re-issue then his antecedence would have been available regardless of where in the country he made such an inquiry.

4.5.8 Each call to the police, relating to the family prompted a positive response with direct engagement. Those interventions were proportionate and primarily in line with Force policy and procedures although there were a number of procedural breaches including; allowing Adult C who did not hold a firearm licence to retain the keys to the firearms cabinet, failing to interview the son after he went missing, and not recognising the purpose of the first telephone call from a Hospital informing the police that Adult S was being allowed home on day leave.

4.6 **Wiltshire Police**

4.6.1 Wiltshire Police policies for dealing with domestic abuse are up to date and in line with ACPO guidelines. There were no lessons learnt from their limited contact with the family in this case.

Section Five: Conclusions

5.1 In reaching their conclusions the Review Panel has focused on the questions:

- Have the agencies involved in the DHR used the opportunity to review their contacts with Adult S, Adult C and their son in line with the Terms of Reference (ToR) of the review and to openly identify lessons learnt?

- Will the actions they take, improve the safety of domestic abuse victims in Wiltshire in the future?
- Was Adult C's death predictable?
- Could it have been prevented?

5.2 The IMRs and reports have been detailed and open. The organisations have used their participation in the review, to identify lessons learnt from or in connection with their contacts with the family in line with the Terms of Reference. The Review while focusing on Adult C's and Adult S's domestic situation, acknowledged that although there was evidence of emotional and coercive domestic abuse, the homicide related more to Adult S's mental health. This corresponds to the conclusions reached at Adult S's criminal trial, where his plea of guilty of manslaughter on the grounds of diminished responsibility was accepted by the Crown.

5.3 The Review Panel is satisfied that the agreed recommendations reflect the needs identified in the lessons learnt. Provided they are fully and promptly implemented, they will improve the safety of individuals suffering from mental health problems, their families and domestic abuse victims in Wiltshire in the future. The Panel also recognises that the Wiltshire Community Safety Partnership and the individual agencies working in the County have comprehensive domestic abuse strategies and polices, while NHS England is increasing Clinical Commissioning Groups and Area Teams awareness of mental health homicides though a series of workshops.

5.4 The Review Panel, in considering all of the information provided, does not believe that, at the time it occurred, Adult C's death was predictable to agencies.

5.4.1 Adult C was always perceived as the stronger partner, who "did everything for him" and was known to stand up to him. In a debrief to police after the incident in 2009 when Adult S had kept Adult C and their son in the house against their will, she said told officers that he had not threatened her with a gun and it was not physical abuse but mental abuse she feared when he was ill. Later relatives and friends told the Review that Adult C was not afraid of Adult S physically abusing her, but was afraid that he would try and keep her in the house against her will as he had done this in the past.

5.4.2 After Adult S was last seen by the mental health service in September 2011 there were no episodes of mental illness reported to either Adult S's GP or to the AWP mental health team up to the date of the homicide some 16 months later. While a formal risk assessment was not carried out at the time Adult S was discharged from AWP services, the Consultant was aware from the risk history that Adult S's previous episodes of illness had been related to stress. The consultant told him, in the presence of Adult C, that he could return directly to AWP if his mental health declined and should in any case report to his GP. Adult S had been a voluntary patient and agencies were not aware of any reason to consider that he should be sectioned under the Mental Health Act after his discharge.

5.4.3 Since Adult C's death, members of her family and friends, have said that it was only in the weeks leading up to her death that Adult C spoke about a decline in Adult S's behaviour and stated that this was similar to the run up to the previous times when he had been sectioned. She described him to them as bad-tempered, suspicious and generally unpleasant. Sadly these concerns were never raised with any of the agencies involved in this Review.

5.5 Could Adult C's death have been prevented? In the Review Panel's opinion there was no information available to agencies, at that time, to have enabled them to take any action to prevent it.

5.5.1 After Adult S was last seen by the mental health service in September 2011, he attended his GP seven times in 2012, regarding chest pains; Adult C also attended the GP for asthma. There is nothing in their medical notes to indicate that either mentioned any kind of concern regarding Adult S's mental health on these occasions.

5.5.2 Although Adult C's parents and friends have said, that in the weeks before her death, she had spoken to them about a sharp decline in Adult S's behaviour; neither Adult S nor Adult C sought any help although she knew about domestic abuse support services and the availability of mental health services.

Section Six: Recommendations

6.1 **National recommendations**

6.1.1 Individuals who have been under Community Mental Health Teams (CMHTs), either long term or on more than one occasion should have yearly mental health reviews with their General Practitioner post discharge.

6.1.2 That the Department of Health review its Guidance "Investigations of Adverse Events in Mental Health Services", in particular the criteria relating to when an independent investigation should be undertaken. Currently it is limited to "when a homicide has been committed by a person who is or has been under the care, i.e. subject to a regular or enhanced care programme approach, of specialist mental health services **in the six months prior to the event**".

6.1.3 Police Firearms Licensing Departments should notify GPs of any patient applying for a firearms certificate and request medical information to inform their decision.

6.1.4 If the decision is taken to issue a firearms certificate the GP should be requested to flag the patient's electronic medical record. So that the Police can be notified if the patient at a later date suffers from any illness which may potentially endanger the certificate holder or any other person if he/she has access to firearms.

6.2 Cross agency recommendations

6.2.1 In order to share information about adults and children at risk, Wiltshire organisations are exploring the feasibility of establishing a MASH (Multi Agency Safeguarding Hub) for children and adults; however, this is still at an early developmental stage and agreement has yet to be reached on what form it may take, if it is proceeded with at all.

6.2.2 All organisations will support the work of the Wiltshire Domestic Abuse Reduction Group, and identify an agency champion for domestic abuse.

6.3 Individual agency recommendations

6.3.1 Avon & Wiltshire Mental Health Partnership NHS Trust

The following changes were made to AWP services after Adult S was discharged by the Trust, but before the homicide occurred. They are not in response to this incident, but explain, why no further action is planned in relation to some of the lessons learned.

As part of the implementation of the "Recovery Model of Care", services now routinely offer:

- The allocation of a care co-ordinator and the use of a community based model of care in preference to outpatient services – with the agreement of the individual service user.

- A recovery care plan encompassing relapse management; stress management; carers' assessments; review of risks and crisis/contingency planning.

- Closer scrutiny of:
  - Team caseloads and discharge arrangements
  - Care planning, risk assessments and plans to manage risk
  - The use of carers' assessments and relapse plans.

Recommendations arising directly from the lessons learnt from this incident:-

- Practitioners should ensure that they have completed work on early warning signs (particularly focusing on possible risk) and that they have developed a full crisis and contingency plan, involving the carers and the GP, before discharging someone who has full capacity and who it is believed will stop their prescribed medication following discharge.

- Routine case note audit and management supervision by team managers should be used as a way of checking that cases are allocated appropriately; that carers' needs are assessed and that relapse planning is routinely undertaken.

- Practitioners should always seek to interview service users and carers independently from each other at some point in the assessment process and subsequently, at intervals.

- Trust CPA/risk guidance should explicitly state that where risk behaviour has previously been targeted at a family member/carer, staff should periodically seek assurance from them (independent of the service user) about the current level of risk.

- The AWP Critical Incident Overview Group should consider how the learning from this incident can be shared with clinical teams.

6.3.2 **NHS Wiltshire CCG**

NHS Wiltshire CCG believes it is important to raise the profile of domestic abuse within Wiltshire General Practices, to ensure they understand how they can support victims and what support agencies are available locally. This in turn will lead to early identification of abuse. Training will be essential in abuse signs, the DASH, MARAC referral process. A way forward would be the introduction of the "CAADA Responding to Domestic Abuse: Guidance for General Practice".

6.3.3 **South Staffordshire and Shropshire NHS Foundation Trust (SS&S NHS Foundation)**

SS&S NHS Foundation has introduced "Rio" (Electronic Patient Record) which will ensure staff are prompted to complete the transfer of care process. This process is currently being implemented and will be completed by 31st March 2014.

6.3.4 **West Mercia Police**

It is imperative that once a person is entered onto the "COMPACT"[1] system that the necessary and relevant tasks are completed to the benefit of all concerned, including safe & well checks and partner agency referral. Supervisory staff should be reminded of the importance of completing tasks set within "COMPACT". Whilst some generic tasks might be suspended, post incident debriefs with the missing person and liaison with partner agencies cannot be suspended and should be completed in order to reduce future risk and best inform staff dealing with recurrent absences.

A force wide circulation has been sent out by the head of the Firearms Licensing Department to remind officers that:-

a) Circumstances will prevail where the firearms are held as part of the individual's terms of employment and that full inquiries should be made with the firearms licensing unit to establish whether an entitlement to

[1] *(Note. Compact - Persons reported as missing to the West Mercia Police are recorded onto a computer system referred to as COMPACT. This system generates tasks to assist officers in locating the missing person. This is not a National system, although several police forces use the COMPACT systems.)*

hold the weapon/ammunition remains when the individual's employment ceases.

b) The firearm certificate holder is the key-holder and for another person to hold the key, they too must hold a certificate upon which the authority to have possession of those weapons exist. It is neither safe nor legal to leave the keys with an unlicensed family member. If in doubt the firearms and certificate should be seized whilst inquiries and/or revocation is considered.

Currently there is no system established for police to be notified when a mental health sectioned patient is due for release. To build on the good practice in this case, the Police Protecting Vulnerable Adults units (PVP's) and mental health services, should introduce a formal process to ensure that when a sectioned patient is released from hospital after police involvement, the Police are notified of the impending release, to ensure that risks are properly assessed and managed.