Norfolk County Community Safety Partnership

DOMESTIC VIOLENCE HOMICIDE REVIEW

EXECUTIVE SUMMARY

REPORT INTO THE DEATH OF:

Mrs M age 34 years

on 13 June 2012

Report produced by:

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1 The Review Process:

1.1 This summary outlines the process undertaken by the Norfolk Community Safety Partnership domestic homicide review pane in reviewing the death of Mrs M.

1.2 The perpetrator was her husband Mr N. He was charged with her murder, but was found guilty of guilty of manslaughter due to loss of control on 14 December 2011 and sentenced to 11 ½ years imprisonment with a 4 year reduction for pleading guilty to manslaughter.

1.3 The process began with a meeting called by the Chair of the Norfolk Community Safety Partnership on 21 June 2012 where the decision was taken that the circumstances of the case met the requirements to undertake a Domestic Homicide Review. The Home Office were notified of this decision on the 10 July 2012. The Review was concluded on 23 April 2013. The process was not able to be completed in the 6 months required by the statutory guidance due to the timing and conclusion of criminal proceedings.

1.4 Agencies taking part in this case Review are:

- Norfolk Constabulary - chronology concerning the incident
- Norwich City Council Housing Department - chronology
- NHS Norfolk & Waveney Commissioning Support Unit for GP Practice - chronology & Independent Management Review
- Norfolk and Norwich Hospital Trust - chronology
- Norfolk & Suffolk Foundation Trust – chronology & Independent Management Review
- Norfolk Probation Trust – assistance with documents post conviction.
- Trust Alcohol & Drug Service - information
- Leeway Women's Aid – IDVA & Refuge Services – Panel member

- Family and friends have also contributed to this Review

1.5 11 agencies were contacted to check for involvement with the parties concerned with this Review. 6 agencies returned a nil contact. 2 Health sector agencies – GP practices and Mental Health submitted Independent Management Reviews due to the extent of their involvement with the victim, and 3 agencies chronologies only due to the brevity of their involvement.

1.6 There was no previous Police involvement with the couple involved in this Review prior to the violent incident which led to the victim's death.

Purpose and Terms of reference of the review:

1.7 The purpose of the review is to:

- Establish the facts that led to the death of Mrs M on 11 June 2012 and whether there are any lessons to be learned from the case about the way in which local professionals and agencies worked together to safeguard Mrs M.

- Identify what those lessons are, how they will be acted upon and what is expected to change as a result.

- Establish whether the agencies or inter agency responses were appropriate leading up to and at the time of the incident on 11 June 2012.

- Establish whether agencies have appropriate policies and procedures to respond to domestic abuse and to recommend any changes as a result of the review process.

- To seek to establish whether the events of 11 June 2012 could have been predicted or prevented.

- This Domestic Homicide Review is not an inquiry into how the victim died or who is culpable. That is a matter for coroners and criminal courts.

Terms of Reference:

1. To review the events and associated actions that occurred up to the date of the death of Mrs M on 13 June 2012 and approximately the previous 2 years when the relationship with the alleged perpetrator began.

2. To review the quality and scope of action/s and services provided by the agencies defined in Section 9 of the Act which had involvement with Mrs M, her dependants, and Mr N (partner at the time of her death) and other individuals e.g. friends or extended family, as identified within the agencies' records, Individual Management Reviews (IMR) or other information sources as deemed appropriate by the Independent Chair of the DHR.

3. Agencies with knowledge of the victim in her early years when she was known as by her maiden name, or the alleged perpetrator Mr N, are asked to provide a brief synopsis of their involvement.

4. To examine the knowledge and training of staff involved in relation to the identification of indicators of domestic abuse and appropriate risk assessment i.e. the DASH risk assessment checklist, and knowledge and use of appropriate specialist domestic abuse services.

5. Examine the effectiveness of single and inter-agency communication and information sharing, both verbal and written.

6. To assess the extent to which agencies relevant policies and procedures were followed, and whether these are up to date and fit for purpose in assisting staff to practice effectively where domestic abuse is present.

7. To involve the family and extended family of Mrs M and Mr N (partner at the time of her death). The overview report writer will be responsible for meeting with the family to invite their contribution to the DHR.

2 Key Issues Arising from the Review:

2.1 The key issues in this Review centre around the victim's mental ill-health, the years it took to finally achieve a diagnosis for her behaviour and mood swings, and the lack of understanding concerning the vulnerable positions and risk she could be placed in due to her mental health condition.

2.2 Mrs M was a young woman who had experienced long term depression since her adolescence including 4 suicide attempts 2 of which were in her teenage years. She experienced mood swings; sometimes being very high, when she could be creative and prone to impulsive actions and decision making, and if upset or provoked, capable of aggressive outbursts. At other times she could be very low, suicidal and self destructive.

She had low self esteem and could be negatively affected by criticism and yet she could put on a veneer of confidence and could be the life and soul of a party. Mrs M could also be strong and resilient in the face of adversity and yet her mental ill-health made her vulnerable and unpredictable at times.

2.3 Mrs M frequently saw her GP for symptoms of depression. She used alcohol and recreational drugs on occasions which exacerbated her mood swings and depression, and her substance misuse may have impeded professional perceptions of her mental health needs rather than seeing the substance misuse as a consequence of her depression and anxiety. At one stage after a suicide attempt in 2007 she was referred to the Mental Health Crisis Team and to the Drug and Alcohol Service, however the mental health assessment was not accepted due to her drug use and Mrs M did not keep the appointments offered at the Drug and Alcohol Service. There was no indication that Mrs M understood that the Drug and Alcohol appointment was a prerequisite for accessing mental health support. There were no queries about Mrs M's children's safety or welfare raised by healthcare professionals at the time of this suicide attempt or when a disclosure indicated a possible risk, and no safeguarding referral made.

2.4 Mrs M briefly had a mental health link worker on one occasion, but with the help of a family member she funded regular private sessions with a clinical psychologist which she found helpful, but when she lost her job after an impromptu holiday she could no longer afford to attend. The psychologist wrote to her GP asking if NHS psychological support could be obtained, but no further action was noted concerning this request.

2.5 Mrs M found personal relationships difficult, particularly sustaining relationships with men. She had children from two relationships one of which lasted approximately 4 years. After a few other relationships one of which nearly came to marriage, Mrs M met Mr N in the Autumn of 2010. They had been acquainted since 2007. In the summer of 2010 she had a breakdown and suddenly decided to leave the country. The discovery that she had gone was a shock to her family and arrangements had to be made to deal with her belongings and the children's fathers gained custody. This type of impulsive act of flight was indicative of Mrs M's coping strategy when things became too much for her. However, her stay abroad did not last long, but when she returned she had nowhere to live and was estranged from her family for a while. Mr N offered her somewhere to stay and their friendship developed into an intimate relationship. Mr N paid for her to have counselling sessions around this time.

2.6 In December 2010 they split up; both citing different reasons. A year later they resumed their relationship and agreed to marry which they did in March 2012. Mrs M's family and friends were pleased that she seemed to have found someone who cared and supported her. Mr N had his own business and Mrs M gave up her job to take on a role in the business. Mrs M found the adjustment to marriage difficult after living in her own home. She would meet up with friends and complain that she felt stifled and suffocated. Mr N would phone her often when she was out and she felt he did not want her to see her friend. Mr N maintained that he was trying to distance her from sources of alcohol as her GP had told her to avoid it and to avoid illicit drugs.

2.7 In May 2012 Mrs M saw her GP accompanied by her husband to seek a referral to a Psychiatrist. She was no longer on anti-depressants and had not been taking alcohol or drugs. A referral was made, but the GP warned that it may not be possible. This may have been due to the stepped approach for accessing Mental Health services and a consultation with a Psychiatrist. Via contact with another health professional Mrs M obtained a private consultation with a Consultant Psychiatrist on 23 May 2012 which her husband funded. The objective was to obtain a diagnosis for her mental ill-health. Mrs M was diagnosed with Personality Disorder Cluster B with some level of depression. With Mrs M's consent the Psychiatrist telephoned on the 24 May and told Mr N of the diagnosis. He does not recall

any discussion taking place around support or coping strategies for him. On 25 May a letter containing a management plan for Mrs M was sent by routine post to her GP. However, Mrs M had changed her GP the day before to a surgery where she now lived with her husband. The Psychiatrist's letter arrived at her previous surgery on 31 May and was then sent to the Primary Care Trust to be forwarded to her new GP, as were her GP clinical notes.

2.8 On 6 June 2012 Mrs M saw her new GP with her husband. She was feeling suicidal and having sad and dark thoughts. There is no indication that the GP notes or the Psychiatrist's letter had arrived at the surgery at this time. Mrs M informed the GP of the visit to the Psychiatrist and said she had 'the label' of Personality Disorder which she was not happy about. Mrs M was prescribed medication for anxiety and a routine referral was made to the Community Mental Health Team. No support appears to have been offered to Mr N, although a further appointment was booked for the following week, and he had access to the GP if needed.

2.9 Around mid afternoon on 11 June 2012 Police and the Ambulance Service attended Mrs M's and Mr N's home address. Mr N was arrested for causing grievous bodily harm to Mrs M. She had been strangled and then hit in the face and head with a hammer following an argument. Mr N made a detailed admission during interview concerning the incident in which he described Mrs M becoming verbally abusive and throwing cups of tea over him. Mr N said he was also very stressed over some work he was doing and had 'lost it'. The argument had concerned the movement and handling of objects belonging to Mr N prior to Mrs M starting to decorate. Mrs M was still alive at the scene when the Police and Ambulance arrived. She was taken to the local hospital from where she was transferred to the regional hospital at Addenbrooke's Hospital in Cambridge. She died 2 days later on 13 June 2012. Mr N was charged with her murder and remanded in custody. On 14 December 2012 he was found guilty of manslaughter due to loss of control. He was sentenced on 25 January 2013 to 11 ½ years imprisonment, reduced by 4 years for pleading guilty to manslaughter.

3 Conclusions:

3.1 A primary purpose of the Domestic Homicide Review in addition to identifying actions taken and lessons to be learnt is to determine whether the homicide was predictable and preventable.

3.2 Given the information available to the professionals at the time, it is unlikely that the incident that led to Mrs M's death could have been predicted. However the Panel identified the need for increased awareness around the potential risks to people with mental illness of suffering or perpetrating domestic abuse. This Review cannot say with any confidence that such a level of awareness exists at this time within the Health agencies with whom Mrs M came into contact. The author hopes this Review will engender a change in that awareness.

3.3 Mrs M's marriage to Mr N was of approximately 8 months duration, although they had been in a relationship before marriage. During this time apart from Health appointments they were unknown to any agency and there was no obvious cause for concern. Their relationship did not present any fears among family and friends of a nature which made any of them think about contacting an agency or seeking advice on her behalf. There appear to be a number of factors causing stress to Mr N including financial and business worries, not just Mrs M's mental ill health, however this does not excuse his actions. Many people face similar stresses without taking their partner's life. One cannot assess in hindsight whether, if Mr N had received support from an agency to help him manage his frustration with caring for his wife following her diagnosis, the outcome would have been any different. The only

way of guaranteeing a different outcome would have been if they were not together. It is therefore not possible to say that her death at his hands was preventable by the actions of agencies based on the information available to them. This does not mean that there are not lessons to be learnt however.

Lessons to be Learnt:

3.4 The author has sympathy with the view expressed by the victim's mother that mental health (or mental ill-health) is central to this case. This Review highlights the need for wider awareness and understanding of the risk and prevalence of domestic abuse faced by those with mental ill-health, particularly women with conditions such as chronic depression, anxiety disorders, and Personality Disorder.

3.5 As Alwin et al[1] point out given that 10% of people have problems which could meet the criteria for Personality Disorder and rates among psychiatric out patients are in excess of 80%, a multi-agency, multi-disciplinary approach is needed to support this population, and they identify staff in a wide range of agencies that require some level of training to understand Personality Disorder ranging from basic awareness to specialist training. Agencies including Health, Social Care, Education, criminal justice agencies and the voluntary sector need this knowledge combined with awareness of domestic abuse and its high prevalence within this cohort. Domestic abuse support agencies routinely work in a multi-agency manner. Specialist Health services such as Mental Health would achieve enhanced services for their patients by following this lead.

3.6 The Norfolk and Suffolk Foundation Trust Domestic Abuse and Service Users Policy is dated 2013. As agencies in this case were not aware of domestic abuse or the potential for domestic abuse no one would have consulted this policy. Again this highlights the importance of training, to raise awareness and give staff the skills to identify domestic abuse and know how to work with specialist agencies collaboratively to support victims.

3.7 **Safeguarding:** Although practice will have changed since the early years of Health involvement with Mrs M, it is worth reminding Mental Health and GP practices of their duty to consider the welfare of children when they are assessing the needs of parents. Children are invariably affected by their parent's mental ill-health, and even if they are not put at risk by their parent's illness, in some cases they may become young carers and be entitled to support in their own right.

3.8 **Inter-Agency Communication:** Throughout the years of Health involvement with Mrs M there does not appear to have been a multi-disciplinary meeting at which a management plan was discussed. Very little information is recorded within GP notes making the transfer of vital information concerning a patient's care difficult. This lack of information also limits the assurance that inter-agency working was taking place.

3.9 There is a need for greater speed and efficiency in transferring clinical notes, management plans, and patient information securely between GPs, Health professionals seeing patients in a private capacity, and other sectors of Health to ensure continuity of care and patient safety. The receipt of important notes and correspondence should always be recorded to provide an audit trail and to ensure there has been safe delivery.

3.10 **Case Management:** There are a number of episodes of care when Mrs M was referred to other agencies, including to the Mental Health Trust, twice as a child and twice as an adult, one which was just before her death, and there are examples of a lack of information being shared with her GP i.e. from drug and alcohol services. This limits the GPs knowledge of

[1] ibid

outcomes. This may be mitigated in future by the launch in February 2013 of the Access and Assessment Team which will manage and collate all referral information. At the time of this Review it is not apparent that there is a framework to take into account an individual's presentation when deciding in which order a client's needs should be addressed and this can affect effective case management. Although only diagnosed formally with personality disorder just before her death, Mrs M had a long history of mental ill-health and substance misuse which would have benefited from a more coordinated approach. Patients with personality disorders and substance misuse problems can be challenging to manage and support, this makes inter-agency collaboration all the more important as failure to communicate can contribute to drop out and patients can be lost from services[2]. This appears to have happened to Mrs M in the past with her failure to attend appointments and periods of not accessing Health services. Best practice within the Care Programme Approach is for one identified worker to be the 'Care Co-ordinator'[3]. The gap identified between primary care notes and those available within a patient's hospital notes should be addressed with the implementation of patient electronic records.

3.11 **Referral to a Consultant Psychiatrist:** Mrs M was advised to see a Psychiatrist by another Consultant Psychiatrist in another branch of the Mental Health Services; she followed this advice by requesting a referral from her GP. This was done by the GP with the request that they be advised if this was not possible. No rationale was given as to why it would not be possible. The GP advised this may have to be a private appointment. The current pathway does not usually enable a direct referral to a Psychiatrist. It is a stepped approach with access to services assessed on need prior to onward internal referral. As a result it is unclear as to whether the GPs referral, sent to a specific Consultant, was seen by the Consultant or sent to a different part of the organisation for assessment of need. By arranging her own appointment and seeing the Consultant Psychiatrist privately Mrs M was taking responsibility for progressing her own care and to achieve this she asked the Psychiatrist to share the diagnosis with her GP. However, a member of the public may well not fully appreciate that by going down the private route they are outside the NHS system to such a degree, and aware of the changes to the management of care and ability for direct access to NHS services this brings.

3.12 The stepped approach pathway to access an assessment by a Psychiatrist appears to limit a GP's ability to navigate their way to obtaining an assessment from a Psychiatrist for their patient as the access point has to follow a given course. This may have influenced the GP's advice to Mrs M that she may have to go down the private route to see a Psychiatrist as there would have been no guarantee that the GP referral would have resulted in such an appointment. There does not appear to be an interface between professionals within the Mental Health service which could facilitate a more direct referral system. For example if the Consultant Psychiatrist who recommended that Mrs M saw a Psychiatrist could have liaised with the GP to add their opinion and recommendation to a referral, with a suitably flexible pathway a route to psychiatric assessment could be enhanced. Similarly, if a process existed for direct referral from Consultant to Consultant Mrs M could have been referred by the Consultant Psychiatrist who made the recommendation direct to another Psychiatrist thus keeping her within the NHS system. From February 2013 a facility for GPs to access urgent advice from a Consultant came into being and GPs will have been made aware of this. This is most welcome. However, Mrs M's referral may not have been seen as urgent by her GP or a Consultant.

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[2] Banerjee S, Clancy C, Crome I (eds) (2002) *Co-existing Problems of Mental Disorder and Substance Misuse (dual diagnosis) An Information Manual*. The Royal College of Psychiatrists' Research Unit

[3] ibid

3.13 The national agenda for Mental Health is supporting the need to ensure that there is the ability for a GP acting as a primary care commissioner on behalf of her or his patient, to make a referral to a Psychiatrist requesting they provide support to patients which does not require them to be managed on a whole pathway of care, but which offers specific and time limited intervention to review their care or diagnosis when this is most appropriate. It is most welcome that from February 2013 GPs will be able to access direct telephone advice from Psychiatrists for urgent cases. It would be most helpful if this type of access was to progress to include a responsive process which allows GPs to confer and request access to this level of support for all their patients where it is deemed necessary.

Recommendations:

3.14 These recommendations arise from the Independent Management Reviews submitted to the Review and from the Review author.

3.15 **National Recommendation:**

3.16 **1.** That the National Institute for Clinical Excellence (NICE) review their Clinical Guidelines to include the following:

a) That with the consent of a person diagnosed with a mental illness their family or carer should be provided with information about local support groups at the time of diagnosis or as soon as practicable following diagnosis along with information for further help and advice.

(b) NICE guidelines[4] do not currently recommend a timescale within which primary care should be informed of a patient's discharge to their care. This Review would recommend that when a diagnosis of formal mental illness is provided to the patient for the first time information should be sent to the referrer or the person's GP using an escalation process to notify them of a significant finding or diagnosis within 24 hours to ensure that they are made aware at the first opportunity so as to be able to support the patient and family or carer.

National Level and County Level Recommendation:

3.17 **2.** Training for Health and Social Care professionals including Mental Health, Midwives, Social Workers, Drug and Alcohol Services, GPs and other primary care staff should include training about Personality Disorders and other mental health illnesses combined with the prevalence and risk of domestic abuse faced by patients with these disorders. This should include awareness of the possibility of a patient's volatile behaviour due to their illness placing them and others at increased risk of harm. This includes the welfare of any dependent children in line with NICE Clinical Guidance 78 January 2009. The training should include the identification of domestic abuse, risk assessment, and services available to support victims and should be mandatory. Issues around Dual Diagnosis should be included since substance misuse can also be prevalent in this cohort which can present an additional risk factor.

County Level:

3.18 **3.** All agencies should ensure that healthcare staff are aware of the need to consider the implications for children or other dependents of a person presenting with, or disclosing high risk behaviours, and take action to safeguard them against harm and/or to ensure that children have support in their own right. To this end agencies should conduct an audit of

[4] NICE Clinical Guidelines 78 Borderline Personality Disorder: Treatment and management. Issued January 2009

staff training and safeguarding knowledge to ensure that all staff carrying out an assessment or support role have up to date training and are confident in acting on and applying safeguarding procedures. This could be addressed in the personal development or appraisal process of staff.

3.19 **4.** All Health agencies should review their information sharing policies and practices to ensure that they have identified the referrer and/or case manager, and that accurate, full, and timely information is available to ensure that effective triaging and the ongoing holistic care of the client/patient can be achieved.

3.20 **5.** Timescales for the transfer of clinical notes between GP practices should be reduced to enable efficient, effective and safe continuity of care for patients.

3.21 **6.** Where a client has contact with a number of services a case manager or Care Co-ordinator should be identified whose role it is to review all information and follow up concerns and gaps in care. A pathway for the treatment of clients with Dual Diagnosis should include the criteria for the order in which a client is seen for drug and alcohol assessment and treatment, and mental health assessment and intervention. Decisions made should be documented and include the rationale for decisions reached. It should be clearly indicated where case management responsibility is held for every client.

3.22 **7.** It is most welcome that from February 2013 GPs will be able to access direct telephone advice from Psychiatrists for urgent cases. It is recommended that GP commissioners commission a service which gives them the option of bypassing the set pathway of care, and to opt for appropriate access to support or diagnosis for any patient the GP feels needs to see a Psychiatrist to ensure their patients safety, wellbeing and best management of their care.

3.23 **8.** To back up staff training the Norfolk and Suffolk Foundation Trust should review its Domestic Abuse and Service Users Policy 2013 to ensure that it includes guidance to staff regarding the risk and prevalence of domestic abuse where Personality Disorder and other mental disorders are affecting clients/patients, and that this equips them with information relating to specialist agencies or practitioners with expertise in these dual areas. Collaborative working should be actively encouraged.

3.24 **9.** Any professional seeing a patient who has been given a mental health diagnosis should be aware of the following best practice:

(a) NICE guidelines[5] recommend that with the consent of the person diagnosed their family or carer should be provided with information about local support groups. As a result of this Review it is recommended that this is provided at the time of diagnosis or as soon as practicable following diagnosis along with information for further help and advice.

(b) NICE guidelines[6] do not recommend a timescale within which primary care should be informed of a patient's discharge to their care. This Review would recommend that when a diagnosis of formal mental illness is provided to the patient for the first time information should be sent to the referrer or the person's GP using an escalation process to notify them of a significant finding or diagnosis within 24 hours to ensure that they are made aware at the first opportunity so as to be able to support the patient and family or carer.

(c) Arrangements to follow up the client are made and shared with them before leaving the consultation.

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[5] NICE Clinical Guidelines 78 Borderline Personality Disorder: Treatment and management. Issued January 2009
[6] ibid

Professionals should be cognisant of the fact that a mental health diagnosis may be a life changing event for the client who will require a speedy support package of care to mitigate the impact on their wellbeing and that of their family. This is particularly important for a mental health diagnosis where a patient may already be unwell.