Home Office

Interpersonal Abuse Unit
2 Marsham Street
London
SW1P 4DF

T: 020 7035 4848
www.gov.uk/homeoffice

Rob Vale
Head of Service
Trading Standards & Commercial Regulation
Public Protection Division
Civic Centre
Stockwell Close
Bromley
BR1 3UH

17 February 2021

Dear Rob,

Thank you for submitting the Domestic Homicide Review (DHR) report (Mary) for Bromley Community Safety Partnership to the Home Office. Due to the COVID-19 situation the Quality Assurance (QA) Panel was unable to meet as scheduled on 9th December therefore the report was assessed by a virtual process. For the virtual Panel, members provided their comments by email, the Home Office secretariat summarised the feedback and the Panel agreed the feedback.

The QA Panel felt that this was a well-written report that is thorough yet easy to read. The report is sensitive and sympathetic. The voice, concerns and perspectives of the family came through clearly and the issues they raised were thoroughly examined. It was also noted that AAFDA supported the family. The panel was representative of the issues raised, including mental health services and the specialist domestic abuse sector.

The chronology setting out the perpetrator's mental health and interactions with services was helpful; the report does well to explore risks to others of someone with mental ill health. The recommendations for the CCG and Oxleas in improving practice for people experiencing mental health issues were welcomed. In addition, the section looking at research around psychosis and violence, with analysis around carers as those at primary risk of violence for someone experiencing psychosis was commended.

The QA Panel felt that there are some aspects of the report which may benefit from further revision, but the Home Office is content that on completion of these changes, the DHR may be published.

Areas for final development:

- **Placing the victim at the centre of this report.** The report is detailed on the perpetrator and their interactions with mental health services and NHS in particular,

INVESTORS IN PEOPLE

and incidents and life events that point to the mental illness, relevant behaviours etc. There is a limited sense of the victim, who she was, who she interacted with in terms of services and in the community, whether she ever asked for help and whether there were any people or organisations to which she could have been signposted. This should be strengthened.

- **The age of the victim is not considered**. We are unclear of the victim's health position and what the impact of having a son with mental health issues was on her. Her age and the situation placed her in a vulnerable position. The ages are recorded, but there is no exploration of what that actually means for risk and vulnerability.

- **The role of alcohol and substance misuse as a coping mechanism and a separate condition** seems not to have been considered here and the relationship between that, prescribed drugs and risk factors. It would be useful to see a much more focussed examination of this aspect and any missed opportunities to understand the perpetrator's relationship with drugs, alcohol and his diagnosed conditions.

- **Risk assessments were limited to Mental Health.** The last assessment conducted before the perpetrator was allowed home maintained that there was no risk to himself, his family or members of the public. Further probing of that risk assessment would be welcome.

- **Information on what other agencies were involved with the family and what more could they have done.** There is a recommendation for health services dealing with the perpetrator to be more aware and cognisant of the needs and support the wider family might have – but there is no discussion of whether there were any disclosures by the victim to her own GP or the general availability to the victim of leaflets or advice.

- **Other issues:**
    - The Executive Summary has different fonts throughout
    - 5.4.6 Mentions a new name – Celia

Once completed the Home Office would be grateful if you could provide us with a digital copy of the revised final version of the report with all finalised attachments and appendices and the weblink to the site where the report will be published. Please ensure this letter is published alongside the report.

Please send the digital copy and weblink to DHREnquiries@homeoffice.gov.uk. This is for our own records for future analysis to go towards highlighting best practice and to inform public policy.

On behalf of the QA Panel, I would like to thank you, the report chair and author, and other colleagues for the considerable work that you have put into this review.

Yours sincerely,

Lynne Abrams
Chair of the Home Office DHR Quality Assurance Panel

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BROMLEY COMMUNITY SAFETY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

Overview Report into the death of Mary

August 2018

The Safer Bromley Partnership, in having regard to concerns raised by the family, have
informed the Home Office Quality Assurance Panel of the intention to only publish the
recommendations and action plan of this DHR due to compelling reasons relating to the welfare of any children or other persons directly concerned in the review.

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. Conclusions and Lessons to be Learnt

1.1 Conclusions

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

1.1.2 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.

1.1.3 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.

1.1.4 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.

1.1.5 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.

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

1.1.7 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.

1.1.8 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.

1.1.9 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.

1.1.10 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.

1.1.11 Simon's medication choices

1.1.12 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.

1.1.13 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

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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.

1.1.14 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.

1.1.15 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.

1.1.16 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.

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

1.1.18 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.

1.1.19 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.

1.1.20 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

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

1.2 Lessons to Be Learnt

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

1.2.2 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.

1.2.3 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.

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2. Recommendations

2.1 IMR Recommendations

2.1.1 **BLG MIND**

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

2.1.3 **Bromley Healthcare**

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

2.1.5 *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.*

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

2.1.7 **Oxleas NHS Foundation Trust**

2.1.8 *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.*

2.2 Domestic Homicide Review Recommendations

2.2.1 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.

2.2.2 **National recommendations**

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

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2.2.4 **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.

2.2.5 **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.

2.2.6 **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.

2.2.7 **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.**

2.2.8 **DHR Recommendations for Bromley Agencies**

2.2.9 **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.[1]

2.2.10 **Recommendation 2:** CCG and Oxleas to jointly facilitate a learning event for GPs that will refresh their practice and explore specific learning from the

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[1] 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.

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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.

2.2.11 **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.

2.2.12 **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.

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2.2.13 **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.

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

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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.

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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						

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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 PARTNERS HIP						

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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 followed through with previous prescriptions, GPs should discuss with patients and record why they did not attend recommended therapeutic sessions and/or the	CCG & OXLEAS						

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	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						

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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 PARTNERS HIP						

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