

Domestic Homicide Review

Alan/2011

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**Commissioned by:
Kent Community Safety Partnership
Medway Community Safety Partnership**

Executive Summary

1 The Review Process

- 1.1 This is the executive summary of a Domestic Homicide Review (DHR) commissioned by the Kent Community Safety Partnership. On 12th September 2011 a man was stabbed to death by his son in their home in Kent. The main purpose of a DHR is to establish lessons to be learned by examining the way that individuals and organisations work to safeguard victims of domestic abuse.
- 1.2 The review was conducted in accordance with the Domestic Violence, Crime and Victims Act 2004 and it's statutory guidance. Agreement for the DHR was made on 6th October 2011, however the Crown Prosecution Service requested that it did not commence until after the criminal proceedings had been completed. There was a further delay during the review as new information came to light requiring the final report to be amended and further consultation with the family.
- 1.3 The review was conducted by a multi-agency panel consisting of senior representatives of agencies from Kent and Medway who are involved in providing domestic abuse services. The review panel was independently chaired. The panel considered reports from the agencies involved with the family and a final report was written by the independent chair and approved by the panel that met on three occasions.
- 1.4 This review examined the services provided in the main to the offender and where relevant to family members. The focus of the review was on the offender as the mental health services had been involved with him since 1982 and possessed the most detailed history of this family and all the incidents of domestic abuse were linked to his mental ill health. The time period considered was 1st April 1982 until 12th September 2011.
- 1.5 Pseudonyms have been used to protect the identity of the family members.

2 Circumstances of the Homicide

- 2.1 Alan was seventy one years old when he died. He lived with his wife Clare (sixty eight years old) and their son Brian the offender in the family home in Kent. Brian had an older sister who lived elsewhere. The homicide took place at their home address where Brian fatally stabbed his father with a kitchen knife. Brian was forty eight years old at the time. Brian suffered from mental ill health since 1982 and was formally diagnosed with paranoid schizophrenia in 1991. About 1989-1990 Alan passed ownership of the house and his business to Brian because of financial difficulties: this issue of ownership later became a significant factor in their relationship breakdown.

- 2.2 Brian's relationship with his father had deteriorated over the years and there had been many incidents when Brian was violent towards Alan, several of these incidents involved a knife taken from the kitchen. These incidents usually coincided with periods when Brian refused to take his medication. Some of the incidents were reported to Kent Police.
- 2.3 In August 2011 Brian started to refuse his medication and despite an increased input from mental health professionals he continued to refuse to take it. As a result of concerns by his family and the mental health professionals involved in his care, a decision was made to assess Brian under the Mental Health Act (MHA) 1983 to see if he should be admitted to hospital. The assessment took place on 12th September 2011 and it concluded that he was not detainable. Around 22:30 hours the same day, Brian took a knife from the kitchen and fatally stabbed his father several times.
- 2.4 Brian was arrested by officers from Kent Police at the scene and was later charged with murder. On 1st June 2012 Brian pleaded guilty to manslaughter on the grounds of diminished responsibility and was sentenced to a hospital order which had a condition to restrict his discharge indefinitely.

3 Agency Involvement

- 3.1 The agencies involved in the review were:-
- Family GP
 - Kent County Council - Families and Social Care Directorate
 - Kent and Medway NHS and Social Care Partnership Trust (KMPT)
 - Kent Police
- 3.2 The agencies provided chronological accounts of their contact with the offender, the victim and their family prior to the homicide. These reports also contained an analysis of the service provided; this was achieved by comparing what happened and what was expected in accordance with existing policy and good practice within that agency and on a cross agency basis. Each agency also submitted recommendations for their own agency and where appropriate for multi-agency working based on the conclusions of their review.
- 3.3 The main agency involved with this family was KMPT who provide mental health services. The community mental health service consists of different teams that are made up of a combination of health professionals and social care staff who are seconded from Kent County Council.
- 3.4 Brian first received a service from KMPT in April 1982 when he was admitted to a psychiatric unit. Brian was admitted to the same unit a further fourteen times prior to the homicide. Brian's last period in hospital was between 12th April 2011 and 25th May 2011. On three occasions these admissions occurred as a consequence of Brian assaulting his father. During an incident in March 2011 Brian threatened to kill

Alan. Brian was a patient of the KMPT community mental health services throughout the period of this review and there were times when he was well enough to be discharged to the care of his GP.

- 3.5 The GP practice provided services to Alan, Clare and Brian and had contact with all of them for the period of this review. The staff at the GP surgery did not receive any allegations or information regarding domestic abuse from any member of the family and only had contact with Brian was he was not in a psychotic state. The GP had no contact with the police regarding Brian.
- 3.6 Kent Police first had contact with Brian when he went missing from the psychiatric unit in December 2002. They had further contact in May 2007 when he again went missing. Kent Police dealt with three reports of domestic abuse from Alan in 2007 and 2011. The incidents were allegations of assault and the last two involved Brian threatening his father with a knife. On each occasion Alan declined to support a prosecution of his son and the incidents were resolved by Brian being admitted to the psychiatric unit. The police decided not to treat Brian as a missing person when it was reported to them in June 2007 and in October 2007 they assisted KMPT to convey Brian to hospital.
- 3.7 The involvement of Kent County Council was limited to one entry on their safeguarding adult recording system. When the approved mental health professional carried out the assessment under the Mental Health Act 1983 on the day of the homicide they were acting on behalf of Kent County Council in its capacity as the Local Social Services Authority.

4 Family Involvement in the Review

- 4.1 On completion of the hearing at the crown court the victim's daughter was invited to contribute to the review and she provided additional information. On completion of the final report the daughter was given the opportunity to comment on the review's findings.

5 Key Issues

- 5.1 This review has confirmed that there is a link between domestic abuse and mental ill health.
- 5.2 Brian had a thirty year period of treatment by KMPT from 1982. His diagnosis in 1991 was paranoid schizophrenia. A well defined pattern of periods of compliance and co-operation would deteriorate into episodes of non-compliance and eventual break down of his mental state warranting his admission to the psychiatric unit.
- 5.3 In 1995 Brian was referred to the Forensic Psychiatric Team for assessment as there were concerns about the incident involving Brian threatening his father with a knife. Taking into account the increased violence, continued use of sharp instruments, as

well as the vulnerability of his family, there may have been benefit in having a further assessment by the Forensic Team in 2007 and 2011.

- 5.4 The pattern of aggression and paranoia towards his father was also a constant feature prior to his admissions. There was only one occasion recorded where he physically attacked another individual other than his father. Brian appeared unable to live alone yet whilst living with his parents there were obvious tensions. Although there were regular contacts with Brian and his family by KMPT the family dynamics were never explored in any depth. It was suggested on four occasions in 2007 and 2011, that the family should have family therapy as it was becoming more evident with each admission that the tensions at home were a contributory factor in Brian's wellbeing. Family therapy or similar work was never arranged. The lack of follow through regarding actions from meetings and the provision of management oversight on several occasions in 2007 and 2011 was substandard.
- 5.5 Adult protection was only considered once by KMPT staff although there were several occasions when an alert should have been considered, especially as the parents got older. This was a family that consisted of a man suffering from significant mental ill health being cared for by two parents who at the time of the homicide were aged seventy one years and sixty eight years old and therefore both of them could have been classed as vulnerable, in addition Alan had been the victim of abuse by Brian. There were allegations by Brian about his parents and incidents involving Brian that should have been considered as adult protection.
- 5.6 There was no recognition by the health professionals involved with this family that this was domestic abuse and that they had a responsibility to both the victim and the offender who was their patient.
- 5.7 There is an underestimation of the difficulties in caring for someone with a severe mental illness. In this case there was heavy reliance on the parents to seek support for Brian if they needed to, particularly once the assessment for formal detention had failed. Yet his father, the most affected family member when Brian's mental health was deteriorating in September 2011 was the only relative not consulted on whether that was acceptable or not. A Carers Assessment was completed with Brian's mother in 2011 by a care manager assistant who then referred Clare for further support locally from the mental health charity MIND.
- 5.8 Information sharing by the health service was limited to the mental health teams and the family GP, which in the main was by sending copies of discharge summaries. On the one occasion that Brian went missing from hospital information was shared with the police in order to aid his safe return. There is no written evidence that information was shared on the grounds of domestic abuse or any other vulnerability of either Brian or his parents by KMPT. There were no other agencies that the police could have shared information with as no other agency were or should have been involved.
- 5.9 During the time that Brian had contact with KMPT the system of recording information had changed from paper files to electronic files supported by paper files and then in

2011 all files were to be held electronically. In addition, prior to 2011 community teams and inpatient teams held separate files and not all of the information was available to all members of KMPT. When the new system was implemented some of the historic information, including risk assessments and patient history was not automatically migrated to the new system and care co-ordinators were required to complete up to date risk assessments and care plans using the historic information. Not all of the relevant information was included in the new record for Brian. The creation of a chronology at an early stage which was reviewed and updated each time there was an admission or other significant event could have overcome the difficulties that staff face when dealing with a patient who has a long and complex history and would have assisted in the easier identification of patterns of past behaviour and treatment regimes.

- 5.10 Kent Police officers who attended the allegations of assault by Brian on his father in 2007 and 2011 recognised the incidents as domestic abuse and recorded them accordingly. They carried out domestic abuse risk assessments, and provided safety advice to Alan. The police did liaise with the mental health services. The police recognised the risk that Brian posed when they requested a professionals meeting if Brian was to be discharged after he was admitted in March 2011. This meeting was never arranged. The police were unaware that Brian was living back at home at the time of the homicide.
- 5.11 At the beginning of August 2011 Brian refused his injection and he continued to refuse the injection each week when his care co-ordinator visited.
- 5.12 On Friday 9th September 2011 a decision was made to assess Brian under the MHA. This assessment was not carried out as Brian had left the house and there was no attempt to carry out the assessment over the weekend.
- 5.13 In the afternoon of Monday 12th September 2011, a different team carried out the assessment of Brian. The team decided that there were insufficient grounds to detain Brian; they concluded that he was not psychotic. He was not demonstrating any aggressiveness to either of his parents and it was agreed that he did not pose any risk of suicide, self harm or significant risk to others. The team did agree that his condition could deteriorate and he could become a risk to others. Brian continued to refuse his injections. The appreciation of past risk to inform present risk and manage it accordingly was not evident in this assessment. There were several breaches of the MHA Code of Practice in the preparation and conduct of the assessment.
- 5.14 The team concluded that Brian needed to be closely monitored by his care co-ordinator and that an urgent review by the consultant psychiatrist should be arranged. Brian's father was not consulted as he was at work. Brian's mother was advised to contact the police or the duty team of KMPT if there was a problem. The police were not informed.

- 5.15 There was no safeguarding measure in place to protect the family or indeed an increasingly vulnerable patient. Brian had now been without medication for six weeks. If staff had fully understood his history and the risks he posed they may not have so readily accepted an informal agreement with him.
- 5.16 There was never a meeting between KMPT, the GP and the police to understand the incidents and to develop a risk reduction plan for Brian's parents, in particular Alan. Brian's case was discussed at the KMPT Recovery Team Clinical Risk Management Forum and the only concern identified was possible exploitation of Brian regarding the ownership of the house. All of the details of the history were not shared with the forum as the paper file was not used and the staff relied on the electronic record.

6 Conclusions

- 6.1 The panel did conclude that it was likely there would have been further incidents of domestic abuse and probably involving a sharp instrument; the factors that they identified to support that conclusion were:-
- There were at least seven incidents recorded involving a sharp instrument.
 - The first time a sharp instrument was recorded as being used was 1991.
 - The nature of Brian's enduring serious mental ill health.
 - Brian's frequent refusal to take medication which stabilised his behaviour.
 - The increasing vulnerability of Brian's parents.
 - The tensions caused by the issue of ownership of the house.
 - The pattern of non-compliance followed by violence.
- 6.2 The panel has concluded based on all of the information presented to them that KMPT could have done more to reduce the risk that Brian presented, especially to his father. There were times when the mental health services worked effectively with Brian and his behaviour was quickly modified. There was more that could have been done in terms of risk identification, putting strategies into place to manage that risk, as well as some of their responses to specific events. KMPT operated often in isolation when there would have been benefits for Brian and his family, as well as the staff involved, if they had worked more closely with the police. The main issues the panel identified that require improvement are:-
- Identification of the assaults and threats as domestic abuse.
 - Recognition that there were allegations of adult abuse.
 - Exploration of the family dynamics by arranging family therapy or other form of engagement.
 - Establishing the truthfulness of comments made by patients regarding family members/carers to enable accurate information recording and appropriate responses, for example the allegation of Brian's father abusing alcohol.
 - Working with the police in managing Brian in the community by informing them that Brian's behaviour was worsening and the family may call if he threatened or assaulted them.

- Standard of record keeping.
- Failure to transfer relevant historic information from paper files onto the new electronic system.
- Identification of the patterns of non-compliance by Brian followed by violence.
- Improvement of communication between teams.
- Unrealistic expectation of Brian's parents to manage his behaviour, especially as their own vulnerability increased.
- Increased involvement of families when they are caring for a member who is mentally ill.
- Improved risk assessments and contingency planning including the role of Clinical Risk Management Forums.
- Following through agreed actions and standards of supervision.
- Improvement in preparation when carrying out MHA Assessments, for example reading the whole record and having a team meeting prior to attendance and agree an approach.
- A lack of urgency by not pursuing the MHA Assessment over the weekend of 10th and 11th September 2011 and not informing the community consultant psychiatrist and the care co-ordinator of the outcome of the assessment held on 12th September 2011.
- Deployment of staff that know the patient and their history when carrying out MHA assessments.

6.3 It is not the role of the panel of this review to conclude whether Brian should have been detained on 12th September 2011. On the day of the homicide the team carrying out the assessment did not appear to consider the escalation of risk of harm and were too optimistic that Brian would comply. The importance of the principle that previous behaviour being an indicator of future behaviour was not applied sufficiently and this may have been a consequence of them not reading all of the long history with the patterns of behaviour and responses to treatment.

6.4 The panel also concluded that Kent Police acted in accordance with existing guidance when they dealt with the incidents involving Brian, recognising them as domestic abuse and responding accordingly. They did try to work with the mental health services when they identified the risk that Brian posed if released from hospital, however the mental health services did not arrange a meeting when Brian was released in May 2011 despite the police having requested a meeting.

6.5 The panel concluded that the GP surgery involved in treating Brian did not have a major role in the care of Brian, as in the main they only saw him when he was compliant and attending for his medication or regarding a physical ailment. Throughout this review there have been numerous occasions when the rule of optimism has been evident and it appears that no one in KMPT seriously considered the potential risk that Brian posed, in particular to his father.

6.6 This review has highlighted issues of good and poor practice that have been identified previously in other reviews of domestic abuse prior to the inception of DHRs as well as serious case reviews of child and adult protection cases. Rather than turn those items of poor practice into recommendations which are reminders to staff to apply current procedures and act in accordance with good practice, the issues are listed below and agencies should encourage all staff that may come into contact with families involved in domestic abuse to read this report. In addition, all agencies in Kent and Medway should ensure that the findings of this review are incorporated into their existing and any new training in the response to domestic abuse. These matters should also be considered when any policy, guidance or process is being reviewed. The main issues are:

- The benefit of the creation and maintenance of a chronology which is reviewed at six monthly intervals and always considered before the decision to close a case is made, or when making significant decisions such as the discharge of a patient from a psychiatric unit and when care is being transferred between teams.
- When members of staff take over complex and/or longstanding cases they should take time to read the whole file to ensure a good understanding of the case and identify patterns.
- The importance of considering past behaviour as an indicator of future behaviour and the benefit of reading files prior to undertaking assessments, in particular when staff do not know the individual.
- Referrals to Multi Agency Risk Assessment Conferences should be considered using professional judgement for complex cases such as those involving mental ill health and coupled with abuse that has endured for a long time and violence is escalating.
- To liaise with other agencies that are providing services to an individual to ensure treatment is complimentary.
- To consider the family as a whole especially when others within the family are vulnerable.
- To have current domestic abuse policies.
- To have an awareness of chronic co-dependent relationships (the 'cannot live together but cannot live apart' relationships).
- All staff who may come into contact with those affected by domestic abuse to have undergone basic domestic abuse awareness training.
- The importance of sharing information in all domestic abuse and adult safeguarding cases.

6.7 The panel considered whether there were any issues regarding ethnic, cultural, linguistic and religious identity of the victim, their family and the offender regarding the service they received and the panel concluded that there were no such issues. The report has highlighted the issues of vulnerability for both Brian and his parents.

7 Recommendations

7.1 As a consequence of this case, KMPT and Kent County Council are carrying out a review of the role of the approved mental health professional. The purpose of the review is to identify the learning from this case and to consider how MHA Assessments are carried out in Kent and Medway with the intention of developing improved practice. In addition KMPT have developed an action plan as a result which includes:-

- Requirement to complete chronologies when patients transfer between teams.
- Increased involvement of families when MHA assessments take place.
- Urgent reviews of patients with longstanding issues when they begin to default on their medication which is crucial to their wellbeing.
- Safeguarding and domestic abuse to always be considered when actual violence has occurred or there is evidence or potential for other form of abuse.
- All actions within a treatment plan to have an identified lead and timescale for completion.
- All frontline staff and managers to access training on domestic abuse.
- A review of the availability of family therapy for families with high expressed emotions.
- KMPT have raised the issue of governance of independent Section 12 doctors with NHS England.

7.2 The DHR review panel made the following recommendations:-

- There should be an identified clear communication protocol outside of the Kent Police custody environment for police to refer and be able to seek advice regarding mental health issues in the community.
- Consideration of the creation of a multi-agency information sharing and assessment process to identify and manage people with mental health issues that present a potential safety risk to the public. (Individuals outside of existing protocols such as MARAC, Multi Agency Public Protection Arrangements etc).
- The issue of GPs providing reports as opposed to IMRs conducted by an independent GP requires consideration by the Kent and Medway Community Safety Partnership.
- The MHA Assessment process could be improved.
- KMPT should review their process of providing information to a DHR when they have already completed an internal review to ensure all relevant information is submitted to the DHR.

