Domestic Homicide Review: Executive Summary

London Borough of Newham

‘AB’

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2016

Executive Summary

1. Introduction

1.1. Details of the incident

1.1.1. This review concerns the death of AB, a sixty-seven-year-old man, killed at home by his twenty-seven-year-old son, BB, at their home in Newham. BB was a mental health patient being managed in the community. It is believed that the attack on AB took place after BB had stopped taking anti-psychotic medication, unbeknown to his family and healthcare professionals.

1.1.2. The homicide investigation established that BB killed his father with an axe, whilst they were alone together at home. BB pleaded guilty to manslaughter on the grounds of diminished responsibility, and was sentenced to a hospital order.

1.1.3. There had been no previous incidents of domestic abuse within the family and no known risks presented by BB.

1.2. Domestic Homicide Review

1.2.1. These events led to the commencement of this Domestic Homicide Review (DHR) at the instigation of the London Borough of Newham Community Safety Partnership (CSP). The initial meeting was held on 2 August 2013, and there have been two subsequent meetings of the DHR panel to consider the circumstances of this death.

1.2.2. The DHR was established under Section 9(3), Domestic Violence, Crime and Victims Act 2004.

1.3. Terms of reference

1.3.1. All agencies that had contact with the family were asked to complete Individual Management Reviews (IMRs). They were asked to review all contact between 1 January 2009 and 13 June 2013.

1.3.2. Home Office guidance is that the review should be completed within six months of the decision to establish a review. This process was greatly delayed due to the perpetrator not being fit for interview. The chair feels the decision to delay the review is justified as the perpetrator provided information that was not available to any parties of the review. He had stopped taking his medication before the incident and had hidden the fact from others.

1.3.3. The following agencies took part in the review:

a. Aanchal Women's Aid
b. East London Foundation Trust (ELFT)
c. London Borough of Newham Domestic and Sexual Violence Commissioner
d. London Borough of Newham Safeguarding Adults
e. London Probation Trust, Newham
f. Metropolitan Police Service
g. Newham Action Against Domestic Violence (NAADV)
h. Newham Clinical Commissioning Group (NCCG)
i. Standing Together Against Domestic Violence (Independent Chair and minutes).

1.3.4. The independent Chair of the DHR is Mark Yexley, a former Detective Chief Inspector in the Metropolitan Police Service and a lay chair for NHS Health Education Services in London, Kent, Surrey and Sussex. Mark represents Standing Together Against Domestic Violence, an organisation dedicated to developing and delivering a coordinated response to domestic violence through multi-agency partnerships.

1.4. Family

1.4.1. To assist this review, the chair made contact with the family; they were represented by the victim's wife and his eldest son. The family provided constructive insight into the relationships with statutory services and community groups.

1.5. Parallel Reviews

1.5.1. A parallel review has been conducted into this case by the ELFT, and it was signed off by the trust board on 26 September 2013. The review findings were shared with the victim's family, NHS England and the chair of this DHR.

1.6. Summary of the case

1.6.1. The victim was born in Sri Lanka in 1946. He was married with two sons. AB moved to the UK as a political refugee; his wife and children joined him in 1990. The victim lived with his wife and sons at the home up until the time of his death. The family were practicing Catholics and worshipped at the local church. AB owned a restaurant as the family business. Both BB and his elder brother CB lived at home with their parents.

1.6.2. The youngest son, BB, left home to study at university. Whilst at university BB was admitted to hospital with mental health problems. BB had three months of hospital treatment and he was then discharged into the care of his family. The responsibility for BB's medical needs was passed onto ELFT. BB was referred to the Newham Early Intervention in Psychosis Team in June 2009 with a diagnosis of paranoid schizophrenia. BB was considered to be well-engaged and took oral medication.

1.6.3. In January 2011, BB reported that he had attended regular exorcism sessions at his church. He said that the sessions helped him and he reduced his oral medication at that time. There were a number of times when BB wanted to reduce his medication. BB continued to receive medical treatment and psychological support, attending a number of support sessions and classes. In March 2013 BB was reported to show little evidence of psychotic symptoms.

1.6.4. On 31 May 2013, BB contacted ELFT and asked for his medication to be increased, stating that his father thought he might be relapsing. He stated he would increase some of his medication himself. It was around this time that BB's family feared that he was not taking his medication and his behaviour was deteriorating; he was agitated although not violent. BB missed his ELFT group meeting on 4 June 2013. BB's extended family suggested that he visit a pastor in South London for exorcism.

1.6.5. On 9 June 2013, BB attended a service with a pastor in South London where he received exorcism. CB stated that BB was told that he had two demons in him, one was removed and another remained. CB states his brother had never mentioned 'demons' before the exorcism.

1.6.6. On 11 June 2013, BB attended his ELFT group, appeared well and calm during his meeting. The next day BB's psychologist received a strange text message from him. This was reported to BB's care coordinator. The care coordinator spoke to BB who apologised for his text message and said that he had developed an 'addictive personality' with the psychologist. BB confirmed that he was taking his medication, and was not relapsing. BB agreed to meet with his care coordinator on the 19 June 2013, his care was due for discussion at a team meeting on 14 June 2013.

1.6.7. On 13 June 2013, BB phoned his brother and told him that he had killed their father using an axe. CB went home and found his father in a pool of blood. Police and emergency medical services were called to the home. After all efforts had been made to revive AB, he was pronounced dead. He died from

axe wounds to the head and neck. BB was assessed by a forensic psychiatrist and admitted to a forensic medium secure unit. He was considered too ill to be interviewed. On 12 March 2014, BB appeared at the Central Criminal Court. He pleaded guilty to the manslaughter of his father on the grounds of diminished responsibility. He was sentenced to a hospital order under Section 37 Mental Health Act 1983.

1.7. **Health based contact**

1.7.1. The DHR process has not revealed any contact between AB and any support or criminal justice agency. There are no records of any reported incidents or concern of a domestic or criminal nature. The main points of contact were between this family and health services. There was nothing arising from AB's health records that raised any concerns for the review panel. He was seen as acting in a supportive role to his son and attended his Care Programme Approach (CPA) meetings at ELFT. AB never raised any concerns of any physical risk presented by BB.

1.7.2. BB's first known psychotic episode took place in 2008 whilst he was studying for his finals at university. He started having paranoid feelings and slammed his finger in a door. He was given a diagnosis of paranoid schizophrenia and made subject of a hospital order. BB's care was transferred to ELFT in 2009. He was prescribed appropriate medication and had regular depot injection of antipsychotic drugs.

1.7.3. During 2009 BB reported some psychotic symptoms, when he received 'messages' from unknown persons or God that would cause him to shake involuntarily. These symptoms continued during 2010 but did not raise a risk of harm to others. His medication was reviewed on a regular basis, he had a good relationship with his care coordinator.

1.7.4. In January 2011 BB reported that he was undergoing monthly exorcism rituals at his Catholic church and he found this beneficial. He felt normal after exorcism and he did not feel like that after taking medication. In a Care Programme Approach (CPA) meeting in March 2011, BB discussed his exorcisms with the consultant psychiatrist. He said that he had sessions at the local church until the evil spirits left him. The psychiatrist suggested that the priest should attend the next meeting with BB's father. The priest states that he was never invited to meetings by the family or ELFT.

1.7.5. In July 2011, BB had a medical review with his psychiatrist and his father was present. BB stated that he had occasional episodes of his legs shaking when he received messages. He did not report hearing voices and there were no other psychotic symptoms.

1.7.6. During 2012 BB raised concerns about the medication he was taking. BB was anxious about an abscess at his injection site and wanted to take oral medication. His father continued to support BB in taking his medication. In April he wanted to reduce his medication and had stopped taking one drug. He was asked to take all of his drugs. He was reviewed regularly.

1.7.7. BB continued to request that his drugs were reduced. In August 2012, BB requested a further medical review of his medication. He represented that he had been relatively stable for two years, he was not depressed and was not having psychotic episodes. As BB wanted to reduce his medication and his father supported the request, the psychiatrist agreed to reduce dosage of antipsychotic drugs with the stipulation that BB be monitored and supported by his care coordinator. BB was considered to have capacity to make decisions and told that he would require maintenance medication indefinitely.

1.7.8. In January 2013, BB was supported by ELFT to attend courses to improve his confidence. He reported that he was gambling on line to gain excitement. It was planned that BB would be discharged from his mental health team over the following year. He continued to participate in courses. BB was invited by his psychologist to involve his family in relapse prevention plans but he declined. His final psychology session was in March 2013. His meetings continued with his care coordinator and BB reported improved mood and no negative or suicidal thoughts.

1.7.9. Around April 2013, a friend of BB died. His mother remembers that he was worried and sad about the loss of his friend. He appeared to be getting more anxious. As BB's family became more concerned for his welfare they were referred by an uncle to a 'pastor' or healer who operated from a church in South London. He was prayed for by the healer and during these sessions BB would faint and fall to the ground.

1.7.10. Towards the end of April 2013 Adult Social Care wrote to BB requesting proof of expenditure on courses arranged by ELFT. At this point BB started to miss appointments at ELFT.

1.7.11. On 8 May 2013, BB was joined by his father for his CPA meeting with ELFT. He was considered to be doing relatively well with “little evidence of positive psychotic symptoms”. He was given a care plan with instructions to his GP for prescribing and a further CPA review in six months. BB was seen at a further meeting on 21 May and was reported as being calm and stable on his programme.

1.7.12. On 31 May 2013, BB telephoned his care coordinator requesting to increase his antipsychotic medication. He stated that his father believed he may be relapsing. It was explained to BB that he would need to be reviewed by a doctor. BB said that he would increase his dosage and contact the doctor if symptoms remained. BB failed to attend his group session on 4 June 2013.

1.7.13. On 9 June 2013, the family took BB to the healer in South London. BB had been informed by the healer that he had two demons inside him. His brother recognised that BB was having a schizophrenic episode. His mother felt that BB’s condition deteriorated over the four days that followed.

1.7.14. BB did attend his group activity the next Tuesday, 11 June 2013. He was seen to be calm and engaged in conversation.

1.7.15. On 12 June 2013, BB’s psychologist received a text message from BB’s mobile phone. The message asked the psychologist not to talk to him again and expressed regret at giving her a present. This was reported to the care coordinator. The care coordinator telephoned BB. He discussed the text message. BB said that he had developed an addictive relationship with the psychologist and apologised for sending the text. BB was asked if he was relapsing, and he said he was not. He said that he had not increased his medication and would contact the care coordinator if he showed symptoms or felt unwell. Due to the contact that was made by BB with his therapist, the therapist felt it necessary to raise his risk from green to amber and his case was scheduled to be discussed at a team meeting on 14 June 2013. An amber level of risk indicated that concern had been raised, but not to a critical level. An appointment was made for BB to attend the EIS office the following week on 19 June 2013.

1.7.16. On 13 June 2013 BB killed his father during a psychotic episode.

1.7.17. When BB was interviewed by the chair of the DHR he stated that he had taken the decision to reduce his dosage by fifty per cent three weeks before he killed

his father. He said that he did not realise he was relapsing, as his illness manifested differently. He said that he felt supported by ELFT staff.

2. Analysis

2.1. The following analysis examines the lives of the victim of this homicide and the perpetrator.

2.2. AB had never reported any incidents of threats or violence towards himself and his family were not aware of any. He had not reported any undue stress or other concerns. It is apparent that AB was concerned for the health and welfare of BB, and took an active part in meetings with ELFT.

2.3. From the information available to ELFT, it could not have been anticipated that BB was presenting a significant risk to his family.

2.4. There were also changes in BB's behaviour at home and it is not clear from the victim's family that they had an established line of communication to express concerns with ELFT. BB states that his relapse plan was known to his father. The family never considered themselves to be at risk of harm.

2.5. The fact that the exorcisms were not reported to the mental health team is of concern. It is appreciated that the family may have wanted to keep this private. In 2011, the initial report was made to ELFT of the involvement in exorcisms. The priest did not attend the meeting, after the family were asked to invite him, and there is no record of the issue of exorcisms being discussed again in any meeting thereafter. Enquires with the priest have established that he was never invited to the ELFT meetings. ELFT maintain that there is a distinct separation between the notification of exorcisms in 2011 and the undisclosed exorcisms in 2013. BB has revealed that he was still referring to exorcism prayer books issued to him after he attended the 2013 exorcisms. It is considered that there were many opportunities to discuss what other spiritual 'healing' was being offered to BB. This could have established an open dialogue with the family.

2.6. In relation to BB's gambling, there appears to have been no communication between the healthcare professionals and social care. Financial stresses caused by gambling can be a causal factor in domestic violence. BB reported that he had lost £3000 in gambling and there appears to be no assessment of his ability to pay this. He was paid a sum of over £1800 in February 2013 for courses which he never attended. This is particularly pertinent given that ELFT had made the initial application to social care for the funding. On the facts

provided, a man who reported concerns with gambling was provided with money from public funds that was unaccounted for. This could have caused stress to the individual and his family relationships, however none of the surviving family members report this as a cause for concern.

2.7. BB's mother and brother were concerned about the deterioration in his health in the weeks before the homicide. BB had capacity to make decisions on his health and his father supported him in the role as carer. It is not clear that BB or AB shared any information with family members. BB felt that the stigma associated with mental health would have stopped his father discussing matters. BB's mother and brother were not aware of how to raise concerns. Although BB had refused to involve his wider family in his relapse prevention plan, consideration needs to be given to the duty of care to those sharing a house with a patient, balanced against the patient's rights to privacy. However, in this case it should be considered that the mental health trust did not have information to show the family were at risk.

2.8 Lessons Learned from this Review:

2.8.1 Information sharing

a) Information sharing is an essential element in the prevention and management of domestic violence. There was a lack of inter-agency information sharing.

b) There appears to be no communication between Adult Social Care and ELFT over the expenditure of funds by BB and his gambling.

c) In relation to the information shared with carers, it is not apparent that a 'carers' pack' or ELFT information leaflet had been provided to the carer. The surviving family were not aware of this.

d) There appears to be good information sharing between ELFT and the family GP.

2.8.2 Risk Assessment

a. Throughout this process ELFT made regular assessments on the risks, based on their own face-to-face dealings with BB. There is no record of ELFT staff visiting BB at home and assessing him in that environment.

b. On the day before the homicide the assessment of BB's condition was based on telephone contact. If ELFT had liaised with the family at this point they would have been in a better position to assess risk to all parties. It was clear that BB did not wish

to include his family in his relapse prevention plan. However, based on the facts available to the ELFT, and the family's own dealings with BB it was not reasonable to anticipate that he presented a risk to others that would have required a breach in confidentiality.

2.8.3 Understanding of the existence of domestic violence

a) No agency involved in this DHR process was aware of any domestic violence being present between BB and AB before the homicide. This incident falls within the definition of domestic violence, but there is no suggestion that there was ever any domestic abuse within the family. These are extremely tragic circumstances and it needs to be considered that any other person, including a healthcare professional or member of the public, could have been a victim of BB, given the circumstances and his psychotic state.

2.8.4 Mental Health

a) The issue of mental health is at the centre of this DHR. BB was found to be suffering from a psychotic episode shortly after the attack on his father and was likely to have been in that state at the time of the attack. BB was of the opinion that family would not discuss mental health, due to the associated stigma.

2.8.5 A culture of questioning

a) The family felt that, as BB was being cared for in a community setting, it would have been helpful if he could have been seen in his home environment by healthcare professionals. This may have allowed better communication between ELFT and the family.

b) A factor in this case is the involvement in exorcisms. The matter was originally raised in 2011 referring to sessions taking place at the local church. It appears that this matter was never looked into again after that initial contact. There were some conflicted views within the family on the effect of the exorcisms and better lines of communication could have supported the family to report their concerns to ELFT. In this case BB's family wanted desperately to help their son. It may have helped the situation if the use of an exorcist had been discussed with ELFT, however ultimately the family were not aware that BB had stopped taking his medication.

2.8.6 Policies and processes

a) It appears that existing policies and processes are in place within agencies to support the identification and prevention of domestic violence.

b) There are no reported breaches of policies or processes in relation to the direct medical care of BB. It is important to note that AB was considered to be acting in the role of carer for his son. ELFT is committed to the principles of the best practice 'Triangle of Care' model. The carers strategy for ELFT from 2013-2016 indicates that care coordinators should contact carers on a monthly basis and obtain a carer's input. There should also be information packs provided for the patient and carers on treatment and how to deal with emergencies.

c) ELFT comment that the family did not contact the trust with concerns they had with BB's behaviour, whilst the family state they had no written guidance or directions to support this contact. BB maintains that his father was aware of his relapse prevention plan.

2.8.7 Family contact

a) The contribution of the family is a valuable part of this review. AB was described by his family as a very caring man who would go out of his way to help anyone. He was always there to support BB and would attend medical appointments with him.

b) They said that they had noticed that for about two weeks before the incident BB was not himself; however, BB was never known to be violent when they suspected he was not taking medication. The family wanted to do something to help BB but did not want him admitted to hospital, because they knew this would distress BB.

c) The use of an exorcist was proposed by an uncle. BB was seen by a pastor, of a denomination other than Roman Catholic, who told BB that he had two demons inside him; he behaved differently after the exorcism. The family recounted a time when BB was angry and shouting and showed a 'demon like' face. They knew this was a schizophrenic episode but got caught up by the thoughts of exorcism.

d) BB got on well with all of the healthcare professionals and was very involved with group activities. AB would attend appointments with his son. However, BB's mother and brother did not have any emergency contact numbers to report any urgent concerns about his mental health.

e) The family felt that there should have been more regulation of BB's medication and that he should have been visited at home. They also felt that they should have known the side effects of BB not taking his medication.

f) They concluded by saying that both BB and AB were loving and caring people and the family felt this was an unfortunate accident.

g) The parish priest had known the family well and AB had been involved with the church. He had only spoken to BB on a few occasions. He said that he remembered seeing BB praying quietly in the church about a week before his father's death. He said that there had been no exorcisms practiced at his church in relation to BB. He had only heard of the exorcisms after he had been told of AB's death. It should be noted that this account is at odds with ELFT records, and BB's account, where exorcisms at the Catholic church are mentioned.

3. Conclusions and Recommendations

3.1. The issue of preventability

3.1.1. This case has allowed examination of current statutory systems and processes in relation to risk assessment, management and domestic violence. Although agencies have generally followed policies in relation to their internal working relationships, communication between some agencies and the family could have been better.

3.1.2. A key concern for the surviving family is that they did not have a point of contact with mental health services, where they could share their concern. There was no awareness within the family of carers' information packs being provided and this was not mentioned in the mental health trust review.

3.1.3. Whilst there are issues on inter-agency and family communication they are not felt to be of sufficient gravity to indicate that AB's death could have been prevented. It is apparent that BB had drastically reduced his medication and he felt that others may not have been aware of this. From his family's point of view, they had concerns that making a referral to hospital could have caused distress to BB. It is not known whether this incident could have been prevented. However, this case demonstrates the importance of establishing the triangle of care between healthcare providers, patients and carers.

3.1.4. There were no signs or indicators of domestic violence before this incident and consideration needs to be given to the fact that any other person could have been victim to attack from BB whilst he was in a psychotic state.

3.1.5. For these reasons it is important to test the performance of the agencies working individually and together to satisfy the partnership that practice has improved. The recommendations are designed to achieve this outcome and fall largely into the following areas:

a. Partnership effectiveness

b. Policies and processes

c. Training – dynamics and practice.

3.1.6. The information examined by the panel has not shown that this death was preventable. The family consider the event a tragic accident. This case has highlighted the fact that the potential for violence exists in the most loving and caring families, when there are the particular risks linked to the psychotic episode of a family member. The surviving family demonstrates their care through regular weekly visits to BB in the secure mental health facility. This case does not reveal a failure to deal with long standing reported issues of domestic violence, it demonstrates the need to maintain a dynamic view of potential risks to all members of a family and the community, when managing mental health.

3.2. General Recommendations

3.2.1. The recommendations below are, in the main, for the partnership as a whole but many organisations have internal recommendations that mirror these. It is suggested that the single agency action plans should be subject of review via the CSP action plan hence the first recommendation.

3.2.2. Recommendation 1: That all agencies report progress on their internal action plans to the relevant task and finish group of Newham CSP.

3.2.3. Recommendation 2: That the partnership conducts a review of its effectiveness to establish its strengths and weaknesses. This review, which should be completed by a task and finish sub-group of the Newham CSP, to include an examination of:

a. The effectiveness of support to carers supporting people with mental health concerns

b. The consideration of faith based abuse and the challenges presented when managing domestic violence and mental health.

3.2.4. Recommendation 3: That the training strategy be reviewed, to ensure the following:

a. To allow frontline practitioners to understand the dynamics of domestic violence and good practice

b. To support an increase in questioning about domestic violence and potential risk

c. To support an increase in awareness around the role of carers and links to the risk assessment process.

3.2.5. Recommendation 4: That ELFT examine its processes for information sharing with carers and families and effectively involve them in risk assessment. This should include provision of carers' packs and clear written guidelines for carers on the availability of a crisis line. Consideration should also be given to the potential risks to the wider family and community.

3.2.6. Recommendation 5: That there should be early joint consultation between Community Safety Partnerships and NHS England to discuss primacy for investigation between DHR and Mental Health Homicide Investigation.