FINAL VERSION FOR PUBLICATION

LEWISHAM COMMUNITY SAFETY PARTNERSHIP DOMESTIC HOMICIDE REVIEW

Overview Report into the death of Delphine

July 2015

Independent Chair and Author of Report: Althea Cribb

Associate Standing Together Against Domestic Violence

Date of Completion: November 2016

1. Executive Summary

1.1 Outline of the incident

1.1.1 Delphine was aged 81 at the time of her death. She was a widow with four children, who owned her own home in Lewisham and had lived there for many years. She was a Catholic who regularly attended church, and was very close to her family.

1.1.2 Delphine's son, Julien, was convicted of manslaughter for Delphine's homicide. He was aged 44, lived alone (near to Delphine) and had worked in a local store for 15 years. Julien had been under the care of South London and Maudsley NHS Foundation Trust (SLaM) for the previous five months. He was on agreed *Mental Health Act 1983 Section 17* leave (see explanation in 1.8.6) prior to discharge from a SLaM mental health adult inpatient unit, Clare Ward. The SLaM Investigation Report provided to this Review concluded that Julien had experienced "*an episode of adjustment disorder precipitated by difficulty in coping with stress at work (due to reduced staffing levels) in the context of a decreased tolerance of stress due to autism spectrum disorder.*"

1.1.3 On 8 July 2015 Julien attended Delphine's address. Delphine called the London Ambulance Service at 10.20am requesting help. Shortly after (10.30am) Delphine called Clare Ward expressing concerns over Julien's leave, but the phone cut off abruptly and staff were unable to reach Delphine.

1.1.4 An ambulance and Police attended the scene. Delphine was found having suffered severe head trauma and in cardiac arrest. Delphine's life was pronounced extinct at Kings College Hospital later that day.

1.1.5 Julien was arrested at the scene for grievous bodily harm against Delphine and, following her death, for murder.

1.1.6 Julien pleaded guilty to manslaughter on the basis of diminished responsibility in March 2016. He was sentenced to an indefinite hospital order on 7 April 2016. Specifically, the sentence made was a Hospital Order with a Restriction Order under *Sections 37 and 41 of the Mental Health Act 1983 (as amended 2007)* without time limit.

1.1.7 The DHR Panel expresses its sympathy to the family of Delphine and Julien for their loss.

1.2 Domestic Homicide Reviews

1.2.1 Domestic Homicide Reviews (DHRs) were established under *Section 9(3), Domestic Violence, Crime and Victims Act 2004*.

1.2.2 The Safer Lewisham Partnership, in accordance with the Revised Statutory Guidance for Domestic Homicide Reviews (March 2013), commissioned this Domestic Homicide Review. The purpose of these reviews is to:

(a) Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.

(b) Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.

(c) Apply those lessons to service responses including changes to policies and procedures as appropriate.

(d) Prevent domestic homicide and improve service responses for all domestic violence and abuse victims and their children through improved intra and inter-agency working.

1.2.3 This Review process does not take the place of the criminal or coroner's courts nor does it take the form of a disciplinary process.

1.2.4 The report was handed to the Safer Lewisham Partnership in September 2016.

1.3 Terms of Reference

1.3.1 The full Terms of Reference are included at Appendix 1. This Review aims to identify the learning from Delphine's and Julien's case, and for action to be taken in response to that learning: with a view to preventing homicide and ensuring that individuals and families are better supported.

1.4 Independence

1.4.1 The Chair of the Review was Althea Cribb, an associate DHR Chair with Standing Together Against Domestic Violence. Althea has received DHR training from Standing Together and has chaired and completed eight DHRs. Althea has over nine years of experience working in the domestic violence and abuse sector, currently as a consultant supporting local strategic partnerships on their strategy and response to domestic violence and abuse. Althea has no connection with the Safer Lewisham Partnership or the agencies involved in this Review.

1.4.2 Standing Together Against Domestic Violence is a UK charity bringing communities together to end domestic abuse. We aim to see every area in the UK adopt the Coordinated Community Response, in order to: keep survivors and their families safe, hold abusers to account and change damaging behaviours, and prevent and ultimately end domestic abuse. Standing Together has been

involved in the Domestic Homicide Review process from its inception, chairing over 50 reviews.

1.5 Parallel Reviews

1.5.1 Julien was under the care of the South London and Maudsley NHS Foundation Trust (SLaM) at the time of the homicide, and therefore a serious incident investigation had started at the time of the first DHR Panel meeting. The DHR Chair maintained regular contact with the SLaM investigation leads to ensure the two processes ran in parallel and minimised any confusion, in particular in relation to contact with the family and attempted contact with Julien.

1.5.2 The Chair reviewed the final Investigation Report (produced November 2016) prior to the completion of the Domestic Homicide Review.

1.6 Methodology

1.6.1 The approach adopted was to seek Individual Management Reviews (IMRs) for all organisations and agencies that had contact with Delphine and/or Julien.

1.6.2 Chronologies and IMRs were requested and received from:

(a) Bromley and Lewisham Mind

(b) Hexagon Housing

(c) Lewisham Medical Centre (General Practitioner for Delphine and Julien)

(d) London Ambulance Service

(e) London Borough of Lewisham Adult Social Care

(f) Metropolitan Police Service

(g) South London and Maudsley NHS Foundation Trust (SLaM)

(h) Burgess Autistic Trust

(i) University Hospital Lewisham (Lewisham and Greenwich NHS Trust)

1.6.3 Agency members not directly involved with the victim, perpetrator or any family members, undertook the IMRs.

1.6.4 The London Fire Brigade provided information for the Review and answered questions from the independent Chair. The information and answers are included in the Metropolitan Police Service section.

1.6.5 The Chair and DHR Panel agreed with SLaM that their serious incident investigation report would serve in place of an IMR, with the inclusion of the DHR Terms of Reference in that investigation.

1.6.6 The DHR Panel members and Chair were:

(a) Althea Cribb, Independent Chair (Associate, Standing Together Against Domestic Violence)

(b) Adeolu Solarin, London Borough of Lewisham Crime Reduction

(c) Aileen Buckton, London Borough of Lewisham Community Services

(d) Ben Taylor, Bromley and Lewisham Mind

(e) Brian Scouler, London Borough of Lewisham Adult Social Care

(f) Chris Melville, Hexagon Housing

(g) Christine Edgar / Justin Armstrong, Metropolitan Police Service Critical Incident Advisory Team

(h) Clare Capito, NHS England

(i) Edith Adejobi, South London and Maudsley NHS Foundation Trust

(j) Geeta Subramaniam-Mooney, London Borough of Lewisham Crime Reduction

(k) Julia Dwyer, Refuge (national domestic violence charity and local service provider)

(l) Kenneth Gregory, Lewisham Clinical Commissioning Group

(m) Lucy Stubbings, South London and Maudsley NHS Foundation Trust

(n) Richard Knowles / Kevin Hulls, Burgess Autistic Trust

(o) Dr Sarah Hawxwell, Lewisham Medical Centre

(p) Dr Teresa Sealy, University Hospital Lewisham (Lewisham and Greenwich NHS Trust)

1.6.7 Specific issues were identified through the Review relating to: Delphine's caring responsibilities for Julien; Julien's diagnosed Autistic Spectrum Condition; and Julien's mental health issues. As a result, Burgess Autistic Trust and Bromley and Lewisham Mind, in addition to being substantive members of the DHR Panel, were recognised respectively for their expertise on Autistic Spectrum Condition, and community family support for people with mental health issues.

1.6.8 To address the first issue, Carers Lewisham were consulted through a review of the draft Overview Report. They commented on the case and the findings of the Review, and these comments have been incorporated into the Overview Report.

1.6.9 The Chair wishes to thank everyone who contributed their time, patience and cooperation to this Review.

1.7 Contact with the family and friends

1.7.1 The Chair and DHR Panel acknowledged the important role Delphine and Julien's family could play in the Review.

1.7.2 The independent Chair wrote to the children of Delphine. One of Delphine's children, Fred, agreed to participate in the Review, and stated this was also on behalf of the other two of Delphine's children.

1.7.3 The Chair interviewed Fred. He commented on the Terms of Reference, and contributed his feedback to the Review on behalf of himself and his two sisters. The Chair maintained contact with Fred, and his AAFDA[1] Peer Mentor throughout the Review. Fred viewed and commented on an early draft of the Report, and viewed a later version. Fred reported being happy with the Review, and made some specific suggestions that have been added to the Overview Report.

1.7.4 The independent Chair also attempted to involve Julien in the Review. Letters were sent to the professionals in charge of Julien's care to inform them of the Review and request that they discuss this with Julien. The Chair also discussed Julien's involvement in the Review with his brother Fred, who agreed to discuss the Review with Julien during a visit. Julien did not participate in the Review.

1.8 Background information

Autistic Spectrum Condition

1.8.1 Julien received a diagnosis of Autistic Spectrum Condition[2] in 2010/11 following his contact with the SLaM Community Mental Health Team. Autistic Spectrum Condition (ASC) is explained by Burgess Autistic Trust in the following way:

"*a lifelong, developmental disorder affecting the way a person communicates and relates to people around them. … A diagnosis of ASC is characterised by a person having difficulties in three areas:*

- *Social interaction: the ability to relate and interact with others in a socially appropriate way*

[1] Advocacy After Fatal Domestic Abuse www.aafda.org.uk

[2] On the advice of the DHR Panel member from Burgess Autistic Trust, this term is used throughout this report, regardless of the terms used by agencies in contact with Julien.

- *Social communication: the ability to communicate verbally and/or non-verbally*
- *Social imagination/flexibility of thought: the ability to understand and predict other people's behaviour, to understand abstract ideas and to cope with unfamiliar situations.*

How ASC manifests itself varies enormously from person to person."[3]

Mental Health Processes and Terms

1.8.2 Capacity

The *Mental Capacity Act 2005* states: "*a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain. … It does not matter whether the impairment or disturbance is permanent or temporary.*"

The Act requires that capacity is thoroughly assessed and not based only on "*a person's age or appearance, or … a condition of his, or an aspect of his behaviour, which might lead others to make unjustified assumptions about his capacity.*"

1.8.3 *Mental Health Act 1983*

This Act concerns the "*reception, care and treatment of mentally disordered patients, the management of their property and other related matters.*"

1.8.4 *Mental Health Act 1983 Section 2*

This is the section of the Act used by professionals to detain an individual in hospital for assessment and treatment. It allows for an individual to be detained for up to 28 days and cannot be renewed.

1.8.5 *Mental Health Act 1983 Section 3*

This is the section of the Act that is used when a *Section 2* is going to expire but professionals consider that the individual requires ongoing treatment. It can last for up to six months, and can be renewed.

1.8.6 *Mental Health Act 1983 Section 17* (leave)

[3] http://www.burgessautistictrust.org.uk/about-asc/ [accessed 8 April 2016]

This section of the Act covers the granting of leave from an inpatient ward for those individuals who have been detained under a *Section 2* or *Section 3* (see above).

1.8.7 *Mental Health Act 1983 Section 135*

This is the section of the Act used by professionals to remove an individual to a place of safety in order for that individual to be assessed. The section lasts for up to 72 hours.

1.8.8 Approved Mental Health Professional (AMHP)

This role was created by the *Mental Health Act 1983*. An AMHP can be any professional with the required qualification to enable them to carry out assessments of individuals within the relevant sections of the Act (as outlined above).

1.8.9 *Mental Health Act 1983 Section 12*

A doctor who has been 'approved' under Section 12 of the Act has special expertise in the diagnosis and treatment of mental ill health and is approved to make assessments under Sections 2 and 3 of the Act (as outlined above).

1.8.10 Psychosis

Psychosis is a mental health problem that causes people to perceive or interpret things differently from those around them. This might involve hallucinations or delusions.[4]

1.8.11 SLaM Ladywell Hospital

Inpatient unit based at Lewisham Hospital.

1.8.12 SLaM Triage Ward

Inpatient admission unit; part of the Psychological Medicine Clinical Academic Group (department) Crisis Care Pathway. The wards provide brief assessment and treatment to patients, with longer-term treatment being provided in acute wards.

1.8.13 SLaM Acute Adult Inpatient Ward (Clare Ward)

Inpatient service for men and women aged 18-65, with acute psychiatric illnesses.

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[4] http://www.nhs.uk/conditions/Psychosis/Pages/Introduction.aspx [accessed 14 July 2016]

1.9 Summary of the case

1.9.1 Delphine was aged 81 at the time of her death. She was a widow with four children, and had lived in her property in Lewisham for many years. Her family told the Review that she was a Catholic who attended church regularly. She and the rest of the family had always cared for Julien, which was becoming increasingly difficult for Delphine as she aged.

1.9.2 Delphine had put a great deal of effort into finding support for Julien in complying with his physical health medication and taking care of himself. Delphine's family reported to the Review that she felt help was not forthcoming, and that the family were concerned for her due to her own physical health difficulties and her age.

1.9.3 Julien was aged 44 at the time of the homicide. He had worked for 15 years in a local, nationally known, chain store, and had lived alone in a Hexagon Housing property since May 2000. While he was able to live independently, the family continued to care for him – as they always had done – in relation to managing his money, and trying to help him to manage his physical health (specifically type-2 diabetes) and take his medication for his physical health.

1.9.4 Delphine had contact with her General Practice – Lewisham Medical Centre – and Lewisham Hospital with regard to her physical health. Julien had direct contact with: Lewisham Medical Centre; Metropolitan Police Service; London Fire Brigade; South London and Maudsley NHS Foundation Trust (SLaM); Burgess Autistic Trust; Hexagon Housing; London Ambulance Service. In addition to these, Delphine (and/or other family members) were in contact with the following in relation to seeking support for Julien: Lewisham Medical Centre; Bromley and Lewisham Mind; London Borough of Lewisham Adult Social Care.

1.9.5 The experiences of Julien and Delphine – and other family members – as outlined by agencies and the family to this Review were intertwined, and are therefore presented together.

General Practice (GP): Lewisham Medical Centre

1.9.6 All of Delphine's records with her GP were concerned with her physical health. Records of Delphine's concerns around Julien and his mental health were recorded within his records.

1.9.7 Julien had contact with the GP with regard to his physical health, and the medication required for this, including support in relation to his compliance to that medication. Lewisham Medical Centre had significant involvement with Delphine, Julien, and other family members with regard to Julien's mental health. This included home visits, and referrals to SLaM, in September and December

2010, May 2014, January and March 2015 (which ultimately led to Julien being taken to the Hospital under the *Mental Health Act 1983 Section 2*).

1.9.8 Following this, the GP recorded one further contact with Delphine, in which Julien's continued detention under the *Mental Health Act* was confirmed in June 2015.

South London and Maudsley NHS Foundation Trust (SLaM)

1.9.9 SLaM recorded three separate periods of contact with Julien, that also included contact with Delphine and other family members. These followed the referrals from Lewisham Medical Centre as outlined above.

1.9.10 There are minimal records available concerning the contact with Julien that started in October 2010 (Julien was then aged 39). Contact with Julien's brother was recorded in which he outlined the aspects of Julien's behaviour that the family found concerning: that Julien had recently been very unsettled in his flat, saying he saw ghosts and heard noises; he took all the light bulbs out and threw his work clothes away; he had started wetting the bed; he had been staying with their mother but she had diabetes and was 76; he had been outside his flat with just his underwear on. Julien's brother stated that this behaviour was in contrast with how Julien had been all his adult life.

1.9.11 The records suggest that Julien was seen in October 2010, and that following this Delphine complained to the GP about the response. The GP made a further referral and Julien was seen again. A discharge letter was sent to the GP. This was recorded on the Lewisham Medical Centre system, not on the SLaM system; the SLaM system does not record a further appointment, and recorded no contact with Julien after 30 December 2010, noting he was discharged in September 2011.

1.9.12 The letter from SLaM to the GP set out: that Julien would remain medication free and be discharged from SLaM to the GP; with the family to monitor Julien and look out for 'early warning signs' including Julien starting to "*make unusual statements about needing to 'clear out the flat' … seeing or hearing things such as ghosts … poor sleep … speech may become less readily understood … may start to behave in unusual ways, particularly seeking to clear possessions from his or other's homes, burning or cutting up possessions.*" A crisis plan was set out for the family to follow if they identified any of these signs, covering contact with the GP, Community Mental Health Team, and escalating to the Hospital Emergency Department or calling 999 if necessary.

1.9.13 The letter also stated: "*atypical transient psychotic or quasi-psychotic symptoms are known to occur in autism. These do not necessarily represent a psychotic*

prodome [a display of symptoms before an official diagnosis]. These states can often [be] managed conservatively but recurrent forms may need medication".

1.9.14 A GP referral in May 2014 was recorded. Julien was seen in July 2014 (due to waiting lists and the prioritisation of cases). The record noted concerns from Julien's brother, who attended the appointment with Julien (Delphine was also noted to be in attendance). Julien's brother was recorded as stating that Julien had stopped taking his physical health medication, and had been throwing his property away. The conclusion of the Community Psychiatric Nurse was that there were no symptoms of psychosis and Julien was discharged back to his GP. The record noted that Julien's family were encouraged to remain supportive and to prompt him when necessary "*as Julien felt they didn't understand his challenges and were not supportive"*.

1.9.15 Delphine contacted her Member of Parliament due to her frustrations that she felt Julien was not getting the support or care he needed. The Member of Parliament wrote to SLaM following their contact with Delphine. SLaM recorded that they had received the letter, and recorded that they wrote to Delphine to offer her a carer's assessment. SLaM records show that they did not receive a response from their letter to Delphine.

1.9.16 The next period of care started in February 2015, and was ongoing at the time of the homicide. A referral from the GP was recorded, and attempts were made to arrange a date for an appointment with Julien. This escalated in March 2015 when the GP made contact following their home visit, at which they found Julien lying in bed, not eating or drinking, urinating in the bed, a situation that had been ongoing for the previous five days; also that he had stopped taking his physical health medication (diabetes, high blood pressure, high cholesterol) some time previously. The Approved Mental Health Professional office conducted a visit and it was concluded that Julien would be detained under the *Mental Health Act 1983 Section 2* due to concerns over the impact on his physical health.

1.9.17 From 27 March 2015 to the date of the homicide, Julien was detained in Clare Ward, an adult mental health inpatient ward of SLaM (following a short stay in the Triage Ward). Initially, he was detained under Section 2 of the *Mental Health Act*; subsequently it was under Section 3. No care plan was made; a plan was noted to keep a record of Julien's behaviour and presentation, to attempt to understand his mental state. He was encouraged to eat, drink and take his medication every day. Julien was unable to explain why he had stopped doing these. The criterion for his discharge from the ward, as recorded at the start, was "*reduction in risk to physical health*". A risk assessment was done on 14 April 2015 that concluded Julien posed a 'low' risk to others, a 'moderate' risk of harm

to himself, and was at 'moderate' risk from others due to him being a "*vulnerable individual*". No further risk assessments were done.

1.9.18 During his time under SLaM's care Julien did not receive a definitive diagnosis. Nevertheless, staff noted their impressions of Julien which included:

(a) "*no evidence of ongoing psychosis*" (20 March 2015)

(b) admission "*due to psycho-social stressors & inability to cope in context of Aspergers.*" (25 March 2015)

(c) "*adjustment disorder in ASD [Autistic Spectrum Condition]; mixed anxiety & depressive disorder*" (31 March 2015)

(d) it seemed more likely to be a "*mood disturbance*" not a psychotic episode (8 April 2015)

(e) Julien "*is psychotic and needs to be treated*" (15 April 2015)

(f) Julien's "*mental state appears to be deteriorating but the reason remains unclear*" but there was no evidence of psychosis (23 April 2015)

1.9.19 Julien remained in his room for the majority of his stay in the ward. The Section 2 expired on 15 April 2015 and Julien firmly believed he would be leaving at that point, whatever his physical or mental health state. Once he was detained by the Section 3, Julien believed he would leave the ward when that expired (October 2015); he did not appear to understand that his discharge from the ward depended on his progress.

1.9.20 On 14 April 2015 it was noted that Julien appeared to need a highly structured routine, and this was put in place.

1.9.21 On 16 April 2015 Julien was seen by a member of the SLaM Autistic Spectrum Condition team and assessed as having an ASC. A referral was made for him to this team; the appointment was made and a letter sent shortly after the homicide, around three months later.

1.9.22 From April 2015 Julien started to consistently eat, drink and take his physical health medication. He also began to take escorted leave from the ward (*Mental Health Act 1983 Section 17* leave). This progressed to unescorted leave at the end of May 2015. Julien engaged with the Social Inclusion and Recovery Service

(SIRs)[5] and was accompanied on a visit to his home. A period of extended section 17 leave was agreed, starting in the week that the homicide took place.

1.9.23 Throughout this time, Delphine, and other members of the family, spoke to staff on the ward about Julien. They reported that they felt he was not as well as staff perceived him to be. Their statements were recorded.

1.9.24 The SIRs Occupational Therapist fed back to doctors on 11 June 2015 that Julien would need a "*quite a lot of support (transitional)*" in the form of a personal assistant for at least 12 weeks during his extended Section 17 leave from the ward, to prompt him in relation to personal hygiene and meals. In this same Ward Round, it was recorded that the consultant "*has concerns that we are not clear how far Julien currently is from baseline*" and a plan was recorded to delay the extended leave.

1.9.25 On the request of the Occupational Therapist from SIRs, who felt that Julien required a package of care to facilitate his leave from the inpatient ward, the SLaM Community Mental Health Team Care Coordinator met with Julien on 6 July 2015 to carry out a Screening, Assessment and Support Services assessment.

1.9.26 On 7 July 2015 SIRs informed the Care Coordinator that this additional care would not be needed once Julien was on extended leave from the ward. The reasons for this change were not recorded on the SLaM system.

1.9.27 There was agreement on Monday 6 July 2015 that Julien would go on extended section 17 leave "*once family are happy*" later that week. This was discussed with Julien, Delphine and Julien's sister on Tuesday 7 July 2015 during the ward round. Julien stated, "*he is ready to leave & won't throw anything out as he's 'got a stable mind now'.*" It was noted that Delphine was "*v[ery] pessimistic, which irritates [Julien], & says he will throw things out (& threw out her photoframe yesterday) & won't take his meds. Julien asked her to 'stop talking [negative]' several times, becoming inc[reasingly] annoyed.*" It was confirmed that the Occupational Therapist would visit him at home the following Monday (six days later; this was then changed to the 9 July 2015). Julien's sister stated they had a phone for Julien but had not given it to him as they were concerned he would throw it away. Delphine and Julien's sister were encouraged to contact the ward if they had any concerns during Julien's leave.

[5] Provides person-centred support with the aim of enabling people to explore their goals and ambitions, to become more independent, to stay well, and to feel part of their community.

1.9.28 On 8 July 2015 it was recorded that Julien had not been in the ward at the start of the shift the evening before (7 July 2015) having gone on unescorted leave to get his flat key from his family, to go to his flat and then return on the morning of 8 July 2015. Julien then returned to the ward "*abruptly*" at around 10pm stating he had been unable to get his key although staff were not clear what had happened.

1.9.29 Later that morning, Julien was recorded as having a low blood sugar level and was persuaded to drink and eat. Staff told him he would not be able to leave the ward until his blood sugar had been tested again to ensure it was high enough; and because "*he was still unsure where his keys were*".

1.9.30 After breakfast, "*Julien was risk assessed as per s[ection] 17 leave requirements & signed out of the ward stating that he was going to his sister's h[ou]se to sort out the keys to his flat & w[ou]ld return at 10.30am*". The ward then recorded a call from Delphine at 10.30am in which she expressed concern about the plan for Julien to go on extended leave and repeated the information recorded the day before about Julien destroying property at her home (it was noted that she was difficult to understand due to her accent). Staff "*reassured [Delphine that Julien] w[ou]ld be reviewed in ward round tomorrow before any decision was made about him going home, however the phone cut off abruptly.*" Staff attempted to call her back but there was no answer; the next contact was from the Police in relation to the ultimately fatal incident.

London Borough of Lewisham Adult Social Care

1.9.31 In April 2010 London Fire Brigade contacted Adult Social Care following the incident (reported to Police, see 1.9.42) in which Julien was burning his possessions in his garden and then inside his flat. The London Fire Brigade were advised to inform Police to refer Julien to the Mental Health Team if there were concerns for Julien. (NB: London Fire Brigade have no record of this contact.)

1.9.32 In October 2011 Julien's brother contacted Adult Social Care to register Julien under the Physical Disability Register scheme. This registration was completed on 18 October 2011 after liaison with Lewisham Medical Centre. Julien's brother stated, "*my family is very concerned that we have my brother registered just in case anything happens because the last time he had a 'psychotic episode' it turned our family upside down and until one has experienced this it's hard to explain how it impacts on the family.*" No further action was taken.

1.9.33 In June 2013 Lewisham Medical Centre, on behalf of Delphine, contacted Adult Social Care to request an assessment for Julien. Delphine was recorded as calling Julien every day to remind him to take his medication. Delphine was informed that, as Julien appeared to have capacity, unless he requested support

and consented to the referral, it could not progress. Delphine was advised, and agreed, to discuss the referral with Julien. No further contact was received.

Hexagon Housing

1.9.34 Julien was a 'General Needs' (i.e. no support needs identified) tenant with Hexagon Housing from May 2000.

1.9.35 In 2005 Julien fell behind in paying his rent, leading (after a lengthy process) to a Court Possession Order being obtained). Following this, Julien's rent arrears were cleared and no further action was taken.

1.9.36 Hexagon were notified by Police of the incident (see 1.9.42) in which Julien had been burning his possessions. A Hexagon officer contacted the Community Mental Health Team and established that Julien was not known to them. Julien was noted as being apologetic about the incident when staff attended to carry out repairs.

London Ambulance Service (LAS)

1.9.37 LAS attended Delphine's address on 17 March 2015 following a call from Delphine: this followed the contact with Lewisham Medical Centre over Julien's mental and physical health state. Ambulance staff documented that Julien was refusing food and drink, and was not taking his physical health medication. Julien was documented as having capacity, and staff recorded there were no safeguarding concerns.

1.9.38 LAS attended again on 19 March 2015 following a call from the GP. Mental health staff were also in attendance and ambulance staff transported Julien to Lewisham Hospital under the *Mental Health Act 1983 Section 135*.

University Hospital Lewisham

1.9.39 Delphine attended regular Hospital outpatient appointments from 1993 to 2013 in relation to her diabetes. This remained stable and so Delphine was discharged on 30 July 2013. She attended from 2010 to 2012, and twice in 2015, in relation to different physical health issues, including an inpatient stay in April 2010. Outpatient appointments were primarily with the Medicine for the Elderly Clinic.

1.9.40 On 10 December 2014 Delphine attended the Emergency Department with a facial injury: she had been sleeping while sitting in a chair, had fallen forward and hit her left eye on a table. Delphine was given pain relief and discharged to her GP.

1.9.41 Julien attended the hospital once – for a physical health issue that was treated – prior to being brought to the Emergency Department by Ambulance and Mental

Health staff on 19 March 2015. Julien had a physical examination and was discharged to SLaM.

Metropolitan Police Service (including London Fire Brigade)

1.9.42 In April 2010 Police were called to Julien's address twice: first in the evening as he was burning CDs and vinyl records in the back garden close to the block of flats (he was warned to stop, and he did); and later that night as he was burning items in his kitchen. On the latter attendance Julien was recorded as saying "*I need to get rid of everything*"; he was arrested.

1.9.43 While at the police station following this arrest, the Forensic Medical Examiner (FME, providing medical service for the Police) and the Mental Health Liaison Nurse saw Julien with regard to any possible mental health issues. They recorded that Julien had "*diabetes, depression and Asperger's*" with no other actions or notes recorded. Julien stated that he was not on any medication, and was not having treatment for mental health issues. The Police took no further action as there was no intention by Julien to endanger life, and Hexagon Housing did not support a police investigation.

Burgess Autistic Trust

1.9.44 The first contact with this agency was from Julien's brother, asking for information about services in June 2014. He then completed the referral form on Julien's behalf, and an initial meeting took place with Julien and Delphine in August 2014. Delphine was listed as Julien's carer. The Practitioner noted that Julien had no friends and had a tendency to hoard. They also noted a disagreement between Julien and Delphine about the Autistic Spectrum Condition diagnosis, and about the amount of time he spent at her house on his days off from work. An action plan was completed and a follow up letter sent the same day.

1.9.45 Julien and Delphine attended a Lunch Club in October 2014, at which Delphine requested further information. The Outreach Practitioner sent a calendar of events, and information about applying for Personal Independence Payments, on the same day. This was the last direct contact the Trust had with Julien or Delphine.

1.9.46 Julien's brother contacted the Trust again in April 2015 with regards to supporting Julien; information was sent.

Bromley and Lewisham Mind

1.9.47 Mind had no direct contact with Julien; all of their contact was with his brother, who contacted the service in July 2014. The Service emailed Fred with the

referral form; Fred responded via email and telephone call pointing out that the form had not been attached.

1.9.48 Fred telephoned the Service and stated that it would be better for the referral form to be sent to Delphine, for Julien's GP to complete. The Service recorded posting the form the following day. Information about the service was also included. This was the last contact with the family.

Information from the family of Delphine and Julien

1.9.49 The independent Chair met with Fred: Delphine's son and Julien's brother. He informed the Chair that he was speaking to the Review on behalf of his two sisters.

1.9.50 Fred explained that Julien had worked in a local, nationally known chain store for 15 years, had a stable background, lived alone and had no criminal record or history of violence. He described all the family as very close.

1.9.51 The Chair asked Fred about the support the family felt they had in relation to supporting Julien. Fred outlined that he felt that the family could have been better supported both prior to Julien being sectioned, and while he was on Clare Ward.

1.9.52 Julien had had what the family called a "*psychotic episode*" five years previously, which triggered the assessment and diagnosis with Autistic Spectrum Condition, which Fred described as Julien having "*struggled with*" all his life. However, Julien did not accept the diagnosis, nor did he fully understand it – Fred explained this as being due to it coming so late in his life.

1.9.53 Fred described the "*psychotic episode*" in 2010/11 as having been prompted by their mother, Delphine, going into hospital at the same time as the death of a friend with whom Julien would attend rare vinyl record fairs. At the time this was Julien's only friend.

1.9.54 Fred reported that this friend had at one point used Julien's address as his own and as a result Julien received letters regarding this person's debts, including letters from bailiffs. Once the family were aware of the letters, they engaged a solicitor to ensure that this situation was dealt with. For them, it was a clear example of Julien's vulnerability.

1.9.55 Julien had been diagnosed with type-2 diabetes and was required to take medicine every day. He initially struggled with this as he had medication to take at different times of the day, and therefore he did not take it. (Fred explained that Julien would be reluctant to take medication at work, for example, and that this may have been explained by his Autistic Spectrum Condition in that he would have found communication with his manager or colleagues about medication

difficult if not impossible.) The GP reorganised Julien's medication so that he took it all in one go each day, and this helped him.

1.9.56 Prior to being sectioned in March 2015, Fred described how Julien had stopped taking his diabetes medication, and that the family were very concerned for him, as they knew the potential physical and psychological impact this would have. The family were alarmed at how Julien's mental health deteriorated and how this was exhibited: i.e. not eating, drinking, or getting out of bed to wash or urinate.

1.9.57 Fred explained that he, his sister and mother were the main people supporting Julien. Fred's sister was responsible for Julien's finances: she had arranged for all of his bills to be paid by Direct Debit, and gave Julien an allowance for his own spending. Fred stated that prior to this, Julien could not manage his money: he would spend it all on rare vinyl records, and leave all post (including bills) unopened on his sofa. It was not until he was threatened with eviction that the family realised what was happening, and that was when their sister took over Julien's money and paid off his debt to Hexagon Housing. Julien had been evicted from a flat on a previous occasion for non-payment of rent.

1.9.58 Fred also explained that it was difficult for the three of them to support Julien to the extent that he needed it: Delphine due to her age and own health difficulties; Fred and his sister due to their own families, jobs and lives.

1.9.59 As a result, Fred tried to get Julien involved with Burgess Autistic Trust, and Julien did attend with Delphine, but did not want to go back. They also tried to get support through Bromley and Lewisham Mind Peer Support but this "*did not go anywhere*".

1.9.60 While Julien was in Clare Ward, the family felt that they weren't sufficiently informed of the treatment and support that Julien was getting there. They were unaware of what medication he was taking, what therapy he was getting, what exploration was being done with him to understand why he was not taking his diabetes medication, to ensure that he started taking it and did not stop again.

1.9.61 When Julien started to be on unsupervised day release, they were even more concerned as they felt he should be under the care of Clare Ward – as he had been sectioned – and therefore not allowed to go out completely alone (although they did understand that leaving the ward was part of his rehabilitation).

1.9.62 While on unsupervised day release, Julien attended his work and chatted to colleagues: the family felt embarrassed by this because they had been trying to explain to Julien's work that he was in hospital, and had been supplying sick notes to this effect.

1.9.63 Delphine and Julien's sister visited Clare Ward the day before the incident to explain their concerns about Julien being unsupervised when leaving the Ward. Fred stated that the family were never informed of when Julien was leaving the Ward:

"*they didn't tell us that they let him out. They gave him no money, no food, no drink, they just let him out for the whole day. … At the end of the day, you're either in a secure unit or you're not, and if you take a person out, there has to be some continuity of that security, and supervision, and none was there for my brother.*"

1.9.64 The family felt very strongly that Julien should not be allowed to return to Delphine's home as that was where his problems had started:

"*The last place he should be coming back is here; we had officers come here to literally remove him from this place, so the last place he should be coming is back here, to say don't come here as if he's going to respond to that, it's stupid really.*"

1.9.65 The family did not define themselves as 'carers'. Fred was clear that there was no more Delphine could have done, and that she needed more support.

1.9.66 Fred stated the following in relation to the registration of Julien on the disability register following his Autistic Spectrum Condition diagnosis:

"*That meant that he was officially registered as a mentally vulnerable man living on his own in need of support and help from Lewisham Council which under the Autism Act 2009 they are legally responsible to help him.*"

1.9.67 Fred was very clear that he thought that the registration would lead to support for Julien and the family in their care of Julien. Fred also felt that the information about his brother should have been shared with other agencies so that they knew his situation – for example, Hexagon Housing.

1.9.68 The family were also frustrated by the fact that professionals, for example the GP, would not discuss Julien with them when they were trying to seek help for him.

1.10 Issues raised by the Review

Introduction

1.10.1 Delphine was tragically killed by her son, Julien. Delphine was an elderly person with multiple physical health issues as a result of her age. She, and her other children, had always cared for Julien due to the impact on his day-to-day life of Autistic Spectrum Condition. Delphine often took this caring role on alone. Delphine continued to want to be involved in Julien's care, and to do what she

felt was best for him; but this was becoming increasingly difficult and she could not be seen as an appropriate carer for Julien. Delphine tried many different ways to get support, including contacting her Member of Parliament, but ultimately felt unsupported.

Preventability

1.10.2 Julien had not been violent to family members prior to the homicide. At the start of his inpatient stay, he had been assessed by SLaM as posing a low risk of harm to others and when asked stated that he had no thoughts of harming others (20 March 2015). He was not deemed to be a risk to his family when he was taking leave from Clare Ward. The family consistently stated that their main concerns were that Julien would have a relapse, and not comply with his medication. Julien's brother, Fred, told the Review that Julien had no history of violence; but that there were times that Delphine and the family were fearful of what Julien was capable of, given the unpredictability of his mental health.

1.10.3 Julien had destroyed Delphine's property on a number of occasions and this is evidence of domestic abuse within the Government definition (2013). This behaviour was not named as such by any agency in contact with the family, nor by the family of Delphine and Julien.

1.10.4 Agencies were also in a position to recognise the vulnerability of Delphine due to her age and her own physical health issues, particularly in the context of her ongoing caring responsibilities for Julien, who was also vulnerable. This should have been addressed with Delphine, and could have been by a number of agencies on different occasions. Practitioners could – and at points should – have made referrals to carers support services, a specialist domestic abuse service, to adult social care and/or to safeguarding vulnerable adults.

1.10.5 Delphine was an elderly person with multiple physical health issues as a result of her age; she continued to care for Julien as she had done for all his life and was unsupported by agencies in doing this.

1.10.6 There were two routes, which, if taken, had the possibility of developing opportunities for the homicide to have been predicted and/or prevented. But it is not possible to say, definitively, that either could have prevented the homicide.

1.10.7 One route was through identification of Delphine as a possible victim of domestic abuse and/or as a vulnerable adult in need of safeguarding. Either (or both) of these pathways could have been taken, and led to appropriate risk identification, referral, and multi-agency working to safeguard Delphine and/or reduce the risk Julien may have posed. This could have followed Delphine's disclosure that Julien had damaged her property. These actions fall within the definition of domestic abuse but did not generate any additional concern by the agencies

Delphine disclosed to. A view of Delphine as a whole person – her age, her physical health, the demands placed on her by caring for Julien – could have led to her identification as a vulnerable adult.

1.10.8 The other was through the thorough, comprehensive and holistic treatment of Julien's mental health condition. He had no care plan; one should have been completed and monitored. This would have taken account of his Autistic Spectrum Condition and family situation, and given adequate weight to the views of the family alongside the views of professionals. It would have included recognition of the fact that Julien himself could be a vulnerable adult due to his Autistic Spectrum Condition, physical health issues and mental health. The family questioned at the time, and continue to do so, whether Julien was fully well enough to be granted extended section 17 leave (just before the homicide took place).

Understanding of and response to people with an Autistic Spectrum Condition

1.10.9 SLaM, Lewisham Medical Centre, London Borough of Lewisham Adult Social Care and Burgess Autistic Trust were aware of Julien's Autistic Spectrum Condition. The Housing Officer from Hexagon Housing had made a note that they felt – based on their interactions with Julien – that he had "*learning difficulties*".

1.10.10 SLaM noted a lack of staff understanding of ASC and how it impacted on Julien's presentation during 2015, and that staff had not sought the advice or support of those with relevant expertise. Had a care plan been developed and implemented, expert advice would have formed part of that.

1.10.11 The recommendations made and actions taken by SLaM have addressed this, and this will be monitored through their update reports to the Safer Lewisham Partnership following the completion of this Domestic Homicide Review.

1.10.12 The fact that the London Borough of Lewisham and the Lewisham Clinical Commissioning Group have jointly commissioned Burgess Autistic Trust to deliver a specialist service in the borough shows that there is recognition locally of the need for a specialist response. The DHR Panel demonstrated a high level of awareness of the service.

1.10.13 A recommendation (1) is made for the Safeguarding Adults Board to increase awareness of Autistic Spectrum Condition amongst professionals in the borough.

Recognition of and response to disclosures of domestic abuse

1.10.14 Every agency that provided information to the Review outlined that they were unaware of any domestic abuse and had not received any disclosures. Concerns

were focused on Julien's self-care and the risk to himself from his non-compliance with physical health medication and when he stopped eating or drinking.

1.10.15 In fact, the GP and SLaM did receive disclosures from Delphine of behaviour by Julien that would fit within the Government definition of domestic abuse (2013).

1.10.16 Damage to property – or threats of such – are recognised forms of domestic abuse[6]. While Delphine's primary concern – as recorded by staff – was that this was an indicator of a relapse for Julien, staff were in a position to identify this as domestic abuse. Further questioning of Delphine of how she felt about Julien coming to the house, for example whether she felt in fear, could have revealed more (Delphine's family told the Review that, while Delphine was unlikely to have accepted the label 'domestic abuse', she was frightened of what Julien was capable of, as his mental health issues made his behaviour unpredictable). Even without this questioning, Delphine's disclosure should have led to risk identification and referral to a specialist service[7], as well as actions to ensure that the identification of this potentially abusive behaviour influenced decisions around the care provided to Julien. Delphine should have been given every opportunity to be seen alone to ensure that she was safe and comfortable to make any disclosures and to answer any questions.

1.10.17 Older women are at risk of experiencing domestic abuse[8] from partners, ex-partners, family members, non-related carers and others. More awareness and understanding is required, locally and nationally[9]: a national recommendation (2) is made for the Home Office to utilise DHRs findings to develop more understanding of the risk factors relating to familial abuse; a local recommendation (3) is made for the Safer Lewisham Partnership to work with the commissioned service to improve local awareness of the dynamics and responses required.

1.10.18 A recommendation (4) is made for SLaM to conduct a review of its response to domestic abuse, in light of the learning from this Review, to ensure that the policy and procedure are carried through to practice. A further recommendation

[6] 'Controlling or Coercive Behaviour in an Intimate or Family Relationship: Statutory Guidance Framework' Home Office, December 2015, p17

[7] Lewisham commission a specialist Familial Abuse Worker, currently delivered by Refuge

[8] McGarry, J. (2011) 'The impact of domestic abuse for older women: a review of the literature' *Health and Social Care in the Community* 19 (1), 3-14

[9] Women's Aid (2007) *Older Women and Domestic Violence: An Overview* Women's Aid, London

(5) is made for a meeting to be held between the four boroughs covered by SLaM's services to identify any common learning from DHRs or other sources.

1.10.19 A recommendation (6) is made for all DHR Panel members and Safer Lewisham Partnership members to develop and implement domestic abuse policies and procedures, supported by training. These new policies, and those already in place, should ensure that the issue of domestic abuse from one family member to another is addressed, incorporating the learning from this Review.

Recognition of vulnerability

1.10.20 Delphine was vulnerable due to her age, physical health issues and her caring responsibilities for Julien. Julien was vulnerable due to his physical health issues, Autistic Spectrum Condition and undiagnosed mental health issues. Neither was recognised as such. This led to Delphine in particular feeling unsupported by agencies, with the focus being on Julien's mental health and what services needed to do to respond to that. While Delphine supported these efforts, and wanted to be part of the care for Julien, agencies should have been more proactive in identifying and responding to her needs, including recognising her vulnerability.

1.10.21 This was relevant to SLaM, Lewisham Medical Centre, Burgess Autistic Trust, Adult Social Care and Lewisham Hospital, all of whom had opportunities to proactively engage with Delphine about her own needs, and make a referral to the Safeguarding Vulnerable Adults service based on all of the factors that were ongoing for her. They also had opportunities to refer Julien as a vulnerable adult, in addition to the London Fire Brigade, who, if they attended a similar incident now, would refer to Adult Social Care.

1.10.22 A recommendation (7) is made for the Safeguarding Adults Board to share the learning from this Review with all members to highlight that consideration should always be given to the potential vulnerability of those with caring responsibilities, with particular reference to where age, health and caring are combined.

Recognition of those with caring responsibilities and response to family concerns / requests for support

1.10.23 Delphine was very supportive of Julien, and tried repeatedly to get help for him. At times, this support was not forthcoming when it should have been, most obviously in relation to offering a carer's assessment, and support, directly for Delphine herself. She was not seen as a whole person, taking into account her age, physical health, the physical and emotional demands of caring for Julien, and she was not asked about her own needs and wishes (or her rights in relation to the carer's assessment). For the definition of a 'carer' see Appendix 3.

1.10.24 The Lewisham Medical Centre, SLaM, Adult Social Care and Burgess Autistic Trust had opportunities to talk to Delphine – and other family members – about her caring responsibilities for Julien, which were not taken.

1.10.25 Delphine and other family members should have been offered support for their role in caring for Julien. This could have been in the form of carers assessments, or a referral to Adult Social Care for a carer's assessment to be completed. Alternatively, referrals could have been made to support in the community, for example, from Carers Lewisham. It is possible that the family were not aware of the support available, or carers assessments, and therefore not asked for them; they did not see themselves as carers, as they were looking after Julien in the ways they always had done.

1.10.26 The way in which caring responsibilities are discussed is critical to ensuring individuals and families get the right kind of support. Training for professionals on supporting people with caring responsibilities should ensure that conversations are open, non-judgemental and allow for the range of different kinds of support an individual or family may need, including the possibility that they do not wish to continue to care for someone. A recommendation (8) is made to ensure that this learning is acted upon.

Meaningful involvement of families in the care of individuals

1.10.27 The DHR Panel agreed that SLaM staff gave insufficient weight to the views of Julien's family in relation to Julien's behaviour at the time that he was starting the extended section 17 leave. The family fed this back to SLaM from the family as part of their investigation, and SLaM have taken action to address this in future. A recommendation (9) is made for progress on these actions to be reported on to the Safer Lewisham Partnership.

1.10.28 The final SLaM Internal Investigation Report highlights that Delphine and Julien's family were involved in the investigation: they contributed terms of reference, met with the investigation team and reviewed drafts of the Report. Their comments focused on the lack of communication with the family and adequate explanations of processes including the section 17 leave granted to Julien. SLaM have offered ongoing engagement with the Trust for the family.

1.10.29 This issue led to the DHR Panel having a wider discussion on how all agencies connect with family members who may be involved with a service due to one member of the family receiving support/intervention. The DHR Panel agreed that it is essential that practitioners work with families in a collaborative way, not simply asking them to support the actions of the service; and that involvement of family should continue for the duration of that agency's involvement.

1.10.30 The DHR Panel agreed that this issue should be a fundamental part of any professional's training, and this has been included in recommendation 7.

Recording of information / information sharing and contact between agencies

1.10.31 SLaM's recording around Julien's involvement with the service in 2010/11 is incomplete and it is not possible to identify exactly what happened. In March 2015 there appeared to be a lack of discussion or action around the fact that this was the third time in five years that Julien had come to their attention for apparently psychotic symptoms. During the first contact (2010) it was noted that while that episode did not require treatment, should the symptoms recur, treatment should be considered. There is no documentation to suggest that staff checked back through previous records. The inconsistent recording in relation to Julien's compliance with medication, food and drink has also been noted.

1.10.32 Lewisham Medical Centre noted in DHR Panel discussions that feedback from SLaM to GPs following patients becoming mental health inpatients was minimal and that this needed to improve. Specifically, that dialogue around patients who are in hospital for some time is sometimes lacking; this becomes particularly important when patients are on leave from the ward, as they can access GP services at those times and the GP is seeing them without full information on their condition, treatment or care plan. GPs also often continue to see family members, and the GP likewise can be trying to support them without fully understanding the situation. A recommendation (10) is made.

1.10.33 The Care Act sets out that all local partnerships have a duty to provide information to professionals and the public on services available to them, and that this information should be readily accessible. A recommendation (11) has been made to address this.

Continuing issues from previous Domestic Homicide Reviews (DHRs)

1.10.34 Many issues from this DHR were recognised in two previous Lewisham DHRs (cases of PF and EC). These include: lack of recognition of domestic abuse; involvement of families in care planning; and using information from families to support risk assessment in relation to mental health.

1.10.35 A recommendation (12) is made for the actions taken in response to those DHRs to be reviewed in light of the learning from this case and further actions to be identified where required.

1.10.36 It was highlighted at the DHR Panel that, given that this is the sixth DHR for the Safer Lewisham Partnership, it is surprising that the same issues are recurring in

relation to awareness of domestic abuse, appropriate responses to the issue, and knowledge about specialist services.

1.10.37 Leadership is a foundation of an effective partnership and agency response to the issue of domestic abuse; and agencies must take responsibility for their own responses, while working in partnership as part of a whole system approach. This is set out clearly in research and information on the Coordinated Community Response to domestic abuse[10].

1.10.38 A recommendation (13) is made for the Safer Lewisham Partnership and Adult Safeguarding Board to work together to ensure effective, consistent and ongoing leadership in responses to vulnerability and risk is provided by all organisations in the borough, including commitment from those agencies to address their own responses and communicate this to the Boards, and to work collaboratively.

1.10.39 A recommendation (14) is made for the Home Office to address more widely the learning in relation to homicides perpetrated by people with previously identified mental health issues. The family reported to the Review that they felt that there "*are too many*" of these and that "*more needs to be done*" to understand why some people with mental health issues become violent, and what services are doing to work with them, and prevent tragedies, like this one, happening again.

1.11 Recommendations

The recommendations below to be acted on through the development of an action plan, with progress reported on to the Safer Lewisham Partnership within six months of the Review being approved by the Partnership. DHR Panel agencies to report on the progress of IMR recommendations to the Safer Lewisham Partnership within the same timeframe.

1.11.1 Recommendation 1 (ref 1.10.13)

Safeguarding Adults Board to consult with Autistic Spectrum Condition (ASC) experts in the borough and with people living with ASC, to support the development of briefings for all professionals in Lewisham on:

- Identifying people living with ASC
- Understanding how routine assessments may need to be delivered differently with a person living with ASC
- Challenging assumptions and stereotypes about people living with ASC

[10] http://www.standingtogether.org.uk/about-us; http://www.ccrm.org.uk

Subsequently for audits to be carried out within services (and the results shared with the Safeguarding Adults Board) to identify the impact of the briefings.

1.11.2 Recommendation 2 (ref 1.10.17)

Home Office to utilise Domestic Homicide Review findings to develop – and share nationally – a greater understanding of the nature and risk factors relating to familial abuse, and any trends to be aware of.

1.11.3 Recommendation 3 (ref 1.10.17)

Safer Lewisham Partnership to work with the locally commissioned specialist service for victims of familial abuse to better understand the dynamics of these cases, and the best practice responses to them. To share this learning widely within Lewisham.

1.11.4 Recommendation 4 (ref 1.10.18)

SLaM to review its response to domestic abuse, in light of the learning from this Review, covering (but not limited to): staff awareness and availability of training; the effectiveness and impact of policies and procedures; the identification of victims and perpetrators, risk identification and referral, and safe and appropriate ongoing work with those individuals including multi-agency working, and for a mechanism to be put in place for ongoing monitoring of the response.

1.11.5 Recommendation 5 (ref 1.10.18)

A discussion to be held between violence against women and girls and Clinical Commissioning Group representatives from Lewisham, Croydon, Southwark and Lambeth, with the SLaM DA lead and internal review leads to address common themes across DHRs in the four boroughs.

1.11.6 Recommendation 6 (ref 1.10.19)

Safer Lewisham Partnership to set out its minimum standard for what all domestic abuse policies and procedures must contain, and for all Partnership member agencies to:

- ensure that their policies and procedures meet this minimum standard
- implement the policy and procedure with training for staff
- carry out a case audit six months after implementation to ensure that the policy and procedure has carried through to practice
- feed back the outcome of the audit to the Safer Lewisham Partnership

1.11.7 Recommendation 7 (ref 1.10.22)

Lewisham Safeguarding Adults Board to share the learning from this Review with all its members, to highlight that consideration should always be given to the potential vulnerability of those with caring responsibilities, with particular reference to old age and health.

1.11.8 Recommendation 8 (ref 1.10.26)

Safer Lewisham Partnership and Lewisham Adult Safeguarding Board to review, and amend where necessary, multi-agency policy and training to address the learning from this Review concerning support offered for families with caring responsibilities, including:

- Separate living arrangements should not prevent practitioners from seeing people as carers.
- Practitioners must be alert to individual's caring responsibilities, and enquire wherever possible, and carer's assessments should always be offered.
- Conversations with those who have caring responsibilities should not be limited to offering carer's assessments, and must be open, non-judgemental and avoid labelling someone as 'a carer': to allow individuals and families to express their needs and wishes, and be directed to appropriate support.
- Seek and incorporate the views and needs of family members in assessments and plans where possible and appropriate to do so.
- Ensure that, in addition to carer's assessments being completed, referrals are always made to the relevant local specialist service.

1.11.9 Recommendation 9 (ref 1.10.27)

SLaM to report to the Safer Lewisham Partnership on the ways in which family concerns are acted upon during inpatient stays, and in particular in relation to risk assessment, planning for discharge and Section 17 leave.

1.11.10 Recommendation 10 (ref 1.10.32)

SLaM to review the systems in place in adult mental health inpatient wards for maintaining dialogue with inpatients' GPs while they are on the ward. To feed back to the Safer Lewisham Partnership and to work with the CCG and NHS England as appropriate for taking any action needed to improve communication with GPs in Lewisham.

1.11.11 Recommendation 11 (ref 1.10.33)

To ensure awareness about what services are available, the whole systems model of care through the Health and Social Care Integration Board should

consider this report as part of its responsibilities to develop advice and information pathways along with workforce development across all professionals.

1.11.12 Recommendation 12 (ref 1.10.35)

Safer Lewisham Partnership to review actions taken in response to Domestic Homicide Reviews for PF and EC, in light of the learning from this case, and review/refresh/set new actions where required. To include addressing mental health and drug and alcohol services' recognition of, and response to, adult men accessing those services who may pose a risk to their mothers/parents.

1.11.13 Recommendation 13 (ref 1.10.38)

The Safer Lewisham Partnership and Adult Safeguarding Board to work together to ensure effective, consistent and committed leadership for responses to vulnerability and risk is provided by all organisations in the borough, including commitment from those agencies to address their own responses and communicate this to the Boards, and to work collaboratively.

1.11.14 Recommendation 14 (ref 1.10.39)

NHS England and the Home Office to utilise the learning gained from Domestic Homicide Reviews (and other Mental Health Reviews) to develop a greater understanding of the issues surrounding domestic homicides committed by individuals with diagnosed mental health conditions, to develop understanding around why some individuals with mental health conditions become violent towards family members/intimate (ex)partners; and to share the learning nationally.

2. DHR Safer Lewisham Partnership, Delphine

Overview Report

Introduction

2.1 Outline of the incident

2.1.1 Delphine was aged 81 at the time of her death. She was a widow with four children, who owned her own home in Lewisham and had lived there for many years. She was a Catholic who regularly attended church, and was very close to her family. Her family described her as a loving, caring person who "*kept herself to herself*"; they continue to struggle with what happened, and to understand why Julien acted in the way that he did, as for them it was "*not in his nature*".

2.1.2 Delphine's son, Julien, was convicted of manslaughter for Delphine's homicide. He was aged 44, lived alone (near to Delphine) and had worked in a local, nationally known, chain store for 15 years. Julien had been under the care of South London and Maudsley NHS Foundation Trust (SLaM) for the previous five months. He was on agreed *Mental Health Act 1983 Section 17* leave (see explanation in 1.8.6) prior to discharge from a SLaM mental health adult inpatient unit, Clare Ward. The SLaM Investigation Report provided to this Review concluded that Julien had experienced "*an episode of adjustment disorder precipitated by difficulty in coping with stress at work (due to reduced staffing levels) in the context of a decreased tolerance of stress due to autism spectrum disorder*".

2.1.3 On 8 July 2015 Julien attended Delphine's address. Delphine called the London Ambulance Service at 10.20am requesting help. Shortly after (10.30am) Delphine called Clare Ward expressing concerns over Julien's leave, but the phone cut off abruptly and staff were unable to reach Delphine.

2.1.4 An ambulance and Police attended the scene. Delphine was found having suffered severe head trauma and in cardiac arrest. Delphine's life was pronounced extinct at Kings College Hospital later that day.

2.1.5 Julien was arrested at the scene for grievous bodily harm against Delphine and, following her death, for murder.

2.1.6 Julien pleaded guilty to manslaughter on the basis of diminished responsibility in March 2016. He was sentenced to an indefinite hospital order on 7 April 2016.

Specifically, the sentence made was a Hospital Order with a Restriction Order under *Sections 37 and 41 of the Mental Health Act 1983 (as amended 2007)* without time limit.

2.1.7 The DHR Panel expresses its sympathy to the family of Delphine and Julien for their loss.

2.2 Domestic Homicide Reviews

2.2.1 Domestic Homicide Reviews (DHRs) were established under *Section 9(3), Domestic Violence, Crime and Victims Act 2004*.

2.2.2 The Safer Lewisham Partnership, in accordance with the Revised Statutory Guidance for Domestic Homicide Reviews (March 2013), commissioned this Domestic Homicide Review.

2.2.3 The Metropolitan Police Service notified the Safer Lewisham Partnership that the case should be considered as a DHR. The Safer Lewisham Partnership made a decision to conduct a DHR, and having agreed to undertake a review, the Home Office was notified of the decision on 27 July 2015 (within statutory guidance timescales).

2.2.4 The purpose of these reviews is to:

(a) Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.

(b) Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.

(c) Apply those lessons to service responses including changes to policies and procedures as appropriate.

(d) Prevent domestic homicide and improve service responses for all domestic violence and abuse victims and their children through improved intra and inter-agency working.

2.2.5 This Review process does not take the place of the criminal or coroner's courts nor does it take the form of a disciplinary process.

2.2.6 The first meeting of the DHR Panel was held on 8 September 2015. There were subsequent meetings on 16 December 2015, 17 March, 3 May, 22 June and 8 August 2016. The report was handed to the Safer Lewisham Partnership in September 2016. Delays were experienced in completing the Review due to the need to await the finalised investigation report from SLaM (final version

produced November 2016), and to ensure the family had sufficient time to review and comment on the Overview Report.

2.3 Terms of Reference

2.3.1 The full Terms of Reference are included at Appendix 1. This Review aims to identify the learning from Delphine's and Julien's case, and for action to be taken in response to that learning: with a view to preventing homicide and ensuring that individuals and families are better supported.

2.3.2 The DHR Panel comprised agencies from Lewisham, as the victim and perpetrator lived in the Borough. Agencies were contacted as soon as possible after the DHR was established to inform them of the Review, their participation and the need to secure their records.

2.3.3 At the first meeting, the DHR Panel shared brief information about agency contact with the individuals involved, and as a result, established that the time period to be reviewed would be from 1 January 2010 up to the homicide; this was agreed as appropriate for capturing the significant events for Delphine and Julien. Agencies were asked to summarise any contact they had had with Delphine or Julien prior to 1 January 2010.

2.3.4 At the first DHR Panel meeting, the Chair and Panel discussed those issues that were particularly pertinent to this Review, which at that stage were seen to be: Autistic Spectrum Condition; mental (ill) health and families with caring responsibilities. As a result, Burgess Autistic Trust and Bromley and Lewisham Mind, in addition to being substantive members of the DHR Panel, were also recognised for their expertise on these issues.

2.3.5 Carers Lewisham were consulted through a review of the draft Overview Report. They commented on the case and the findings of the Review, and these comments have been incorporated into the Overview Report.

2.4 Independence

2.4.1 The Chair of the Review was Althea Cribb, an associate DHR Chair with Standing Together Against Domestic Violence. Althea has received DHR training from Standing Together and has chaired and completed eight DHRs. Althea has over nine years of experience working in the domestic violence and abuse sector, currently as a consultant supporting local strategic partnerships on their strategy and response to domestic violence and abuse. Althea has no connection with the Safer Lewisham Partnership or the agencies involved in this Review.

2.4.2 Standing Together Against Domestic Violence is a UK charity bringing communities together to end domestic abuse. We aim to see every area in the UK adopt the Coordinated Community Response, in order to: keep survivors and their families safe, hold abusers to account and change damaging behaviours, and prevent and ultimately end domestic abuse. Standing Together has been involved in the Domestic Homicide Review process from its inception, chairing over 50 reviews, including 41% of all London DHRs from 1 January 2013 to May 2016.

2.5 Parallel Reviews

2.5.1 Julien was under the care of the South London and Maudsley NHS Foundation Trust (SLaM) at the time of the homicide, and therefore a serious incident investigation had started at the time of the first DHR Panel meeting. The DHR Chair maintained regular contact with the SLaM investigation leads to ensure the two processes ran in parallel and minimised any confusion, in particular in relation to contact with the family and attempted contact with Julien.

2.5.2 The Chair reviewed the final Investigation Report prior to the completion of the Domestic Homicide Review. The Investigation Report demonstrated significant involvement with and contributions from Dephine and Julien's family, with their views having been fully taken on board.

2.6 Methodology

2.6.1 The approach adopted was to seek Individual Management Reviews (IMRs) for all organisations and agencies that had contact with Delphine and/or Julien. Whether they had contact was established at the first meeting and through letters and telephone calls to those not in attendance.

2.6.2 It was also considered helpful to involve those agencies that could have had a bearing on the circumstances of this case, even if they had not been previously aware of the individuals involved. This included Refuge as a local specialist domestic violence organisation.

2.6.3 Chronologies and IMRs were requested and received from:

(a) Bromley and Lewisham Mind

(b) Hexagon Housing

(c) Lewisham Medical Centre (General Practitioner for Delphine and Julien)

(d) London Ambulance Service

(e) London Borough of Lewisham Adult Social Care

(f) Metropolitan Police Service

(g) South London and Maudsley NHS Foundation Trust (SLaM)

(h) Burgess Autistic Trust

(i) University Hospital Lewisham (Lewisham and Greenwich NHS Trust)

2.6.4 Agency members not directly involved with the victim, perpetrator or any family members, undertook the IMRs.

2.6.5 Given their very limited involvement, the Review agreed that the Metropolitan Police Service would supply a chronology and a letter outlining their involvement.

2.6.6 The London Fire Brigade provided information for the Review and answered questions from the independent Chair, the information and answers are included in the Metropolitan Police Service section.

2.6.7 The Chair and DHR Panel agreed with SLaM that their serious incident investigation report would serve in place of an IMR, with the inclusion of the DHR Terms of Reference in that investigation. The SLaM investigation report focused on the period of Julien's care from March 2015 to the homicide; questions were asked in DHR Panel meetings about the prior periods of care.

2.6.8 Victim Support reviewed their files and notified the DHR Panel that they had no involvement with Delphine or Julien and therefore had no information for an IMR.

2.6.9 Most IMRs received were comprehensive and identified appropriate learning with recommendations for immediate action. Where this was not the case, the Chair requested further information and analysis, and in all cases this was provided.

2.6.10 The DHR Panel members and Chair were:

(a) Althea Cribb, Independent Chair (Associate, Standing Together Against Domestic Violence)

(b) Adeolu Solarin, London Borough of Lewisham Crime Reduction

(c) Aileen Buckton, London Borough of Lewisham Community Services

(d) Ben Taylor, Bromley and Lewisham Mind

(e) Brian Scouler, London Borough of Lewisham Adult Social Care

(f) Chris Melville, Hexagon Housing

(g) Christine Edgar / Justin Armstrong, Metropolitan Police Service Critical Incident Advisory Team

(h) Clare Capito, NHS England

(i) Edith Adejobi, South London and Maudsley NHS Foundation Trust

(j) Geeta Subramaniam-Mooney, London Borough of Lewisham Crime Reduction

(k) Julia Dwyer, Refuge (national domestic violence charity and local service provider)

(l) Kenneth Gregory, Lewisham Clinical Commissioning Group

(m) Lucy Stubbings, South London and Maudsley NHS Foundation Trust

(n) Richard Knowles / Kevin Hulls, Burgess Autistic Trust

(o) Dr Sarah Hawxwell, Lewisham Medical Centre

(p) Dr Teresa Sealy, University Hospital Lewisham (Lewisham and Greenwich NHS Trust)

2.6.11 Agencies were represented at the appropriate level and demonstrated a good level of understanding of the dynamics of domestic abuse, their own agency's role and the role of the partnership in Lewisham.

2.6.12 The Chair wishes to thank everyone who contributed their time, patience and cooperation to this Review.

2.7 Contact with the family and friends

2.7.1 The Chair and DHR Panel acknowledged the important role Delphine and Julien's family could play in the Review.

2.7.2 The independent Chair wrote to the children of Delphine (who are the siblings of Julien) to invite them to be part of the Review. These were hand delivered by the Police Family Liaison Officer, and they discussed the Review with them at that time. All letters contained the appropriate Home Office DHR leaflet and information about support the family could access, for example through Victim Support Homicide Support Service and Advocacy After Fatal Domestic Abuse (AAFDA).

2.7.3 All letters made clear that the family's participation in the Review was voluntary, and that they could contribute in different ways: for example through a face-to-face meeting with the Chair, through a telephone conversation, or through a written statement. The letter emphasised that their contributions could take place at a time and place of their choosing, and that their involvement in the Review would not be rushed.

2.7.4 Fred contacted the independent Chair directly, and a meeting was held in which Fred commented on the Terms of Reference, and contributed his feedback to the Review on behalf of himself and his two sisters.

2.7.5 The Chair maintained contact with Fred, and his AAFDA[11] Peer Mentor throughout the Review. Fred viewed and commented on an early draft of the Report. This was done with the independent Chair, and the AAFDA Peer Mentor, so that Fred would have the opportunity to feedback his thoughts as he read the Overview Report.

2.7.6 A later version of the Overview Report was sent to the AAFDA Peer Mentor, who met with Fred to go through the Report together. Fred's feedback was given to the independent Chair. Fred was reported to be happy with the Review, and made some specific suggestions that have been incorporated into the Overview Report. The independent Chair also spoke with Fred on the telephone to discuss these changes.

2.7.7 Fred contributed alternative names for the Review, in discussion with the independent Chair.

2.7.8 The independent Chair also attempted to involve Julien in the Review. Letters were sent to the professionals in charge of Julien's care to inform them of the Review and request that they discuss this with Julien. The Chair also discussed Julien's involvement in the Review with his brother Fred, who agreed to discuss the Review with Julien during a visit. Julien did not participate in the Review.

[11] Advocacy After Fatal Domestic Abuse www.aafda.org.uk

3. The Facts

3.1 Outline / The death of Delphine

3.1.1 Delphine was aged 81 at the time of her death. Her son, Julien – aged 44 – had been under the care of South London and Maudsley NHS Foundation Trust (SLaM) since March 2015. He was on agreed *Mental Health Act 1983 Section 17* leave (see explanation in paragraph 3.4.6) prior to discharge from a SLaM mental health adult inpatient unit, Clare Ward. The SLaM Investigation Report provided to this Review concluded that Julien had experienced "*an episode of adjustment disorder precipitated by difficulty in coping with stress at work (due to reduced staffing levels) in the context of a decreased tolerance of stress due to autism spectrum disorder.*"

3.1.2 On 7 July 2015 Delphine was at home when Julien attended wishing to stay there while on leave from Clare Ward; he was due to collect his keys from Delphine and go to his own flat. Julien's brother reported to Clare Ward later that day that when Julien had gone to Delphine's house over the previous few days, he had "*taken 2 CDs which he took down to the garden and smashed up violently … given his [history] … this bizarre behaviour unsettled the family*". Delphine did not allow Julien to stay and he returned to Clare Ward at 10pm. It is not known what happened with Julien's keys.

3.1.3 On 8 July 2015 Julien returned to the address and again tried to gain entry. Delphine called 999 at 10.20am requesting help. Shortly after (10.30am) Delphine called Clare Ward expressing concerns over Julien's leave, but the phone cut off abruptly and staff were unable to reach Delphine.

3.1.4 An ambulance was dispatched at 10.28am and arrived at the house ten minutes later. Police also attended the scene. Delphine was found having suffered severe head trauma and in cardiac arrest. Delphine's life was pronounced extinct at Kings College Hospital at 12pm the same day.

3.1.5 Julien was initially arrested at the scene for grievous bodily harm on Delphine. He was subsequently arrested for murder following her death.

3.1.6 Julien pleaded guilty to manslaughter on the basis of diminished responsibility in March 2016. He was sentenced to an indefinite hospital order on 7 April 2016. Specifically, the sentence made was a 'Hospital Order with a Restriction Order under *Sections 37 and 41 of the Mental Health Act 1983 (as amended 2007)* without time limit'.

3.2 Information about Delphine and Julien

3.2.1 Delphine was aged 81 at the time of her death. She was a widow with four children, and had lived in her property in Lewisham for many years. Her family told the Review that she was a Catholic who attended church regularly.

3.2.2 Her family described her as a loving, caring person who "*kept herself to herself*". She and the rest of the family had always cared for Julien, which was becoming increasingly difficult for Delphine as she aged and was an increasing source of worry for her and her other children.

3.2.3 The family continue to struggle with what happened, and to understand why Julien acted in the way that he did as it was "*not in his nature*".

3.2.4 Delphine had put a great deal of effort into finding support for Julien in complying with his physical health medication and taking care of himself; she had always tried to support him. She spoke to her GP (Lewisham Medical Centre), Adult Social Care, Burgess Autistic Trust and SLaM. Feeling unsupported, Delphine contacted her Member of Parliament for help (December 2014, see 3.6.20). Her family reported to the Review that she felt help was not forthcoming, and that the family were concerned for her due to her own physical health difficulties and her age. Delphine did not seek help for herself: her focus was always on help for Julien. While she should have remained involved in his care, Delphine should not have been seen as an appropriate carer for him.

3.2.5 Julien was aged 44 at the time of the homicide. He had worked for 15 years in a local major store, and had lived alone in a Hexagon Housing property since May 2000. While he was able to live independently, the family continued to care for him – as they always had done – in relation to managing his money, and trying to help him to manage his physical health (specifically type-2 diabetes) and take his medication for his physical health.

3.3 Information about Autistic Spectrum Condition (ASC)

3.3.1 Julien received a diagnosis of Autistic Spectrum Condition[12] in 2010/11 following his contact with the SLaM Community Mental Health Team. Autistic Spectrum Condition (ASC) is explained by Burgess Autistic Trust in the following way:

"*a lifelong, developmental disorder affecting the way a person communicates and relates to people around them. A person with an ASC can have difficulty with social interaction and can find it hard to form friendships and understand emotions. ASC is often referred to as a 'hidden disability' because of the lack of*

[12] On the advice of the DHR Panel member from Burgess Autistic Trust, this term is used throughout this report, regardless of the terms used by agencies in contact with Julien.

outward physical signs. A diagnosis of ASC is characterised by a person having difficulties in three areas (these are sometimes called the 'triad of impairments'):

- *Social interaction: the ability to relate and interact with others in a socially appropriate way*
- *Social communication: the ability to communicate verbally and/or non-verbally*
- *Social imagination/flexibility of thought: the ability to understand and predict other people's behaviour, to understand abstract ideas and to cope with unfamiliar situations.*

How ASC manifests itself varies enormously from person to person. Some people may have very limited language skills. Others may have extremely good verbal skills, although these often hide a difficulty in understanding the social use of language."[13]

3.3.2 It is noted that the records gathered for this Review suggest that Julien did not accept this diagnosis but that his family, and the professionals in contact with him, did.

3.4 Information about mental health processes

3.4.1 Much of the family's contact with agencies concerned Julien's mental health. The relevant terms and processes are explained here to assist the understanding of the facts set out in the sections below.

3.4.2 Capacity

The *Mental Capacity Act 2005* states: "*a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain. … It does not matter whether the impairment or disturbance is permanent or temporary.*"

The Act requires that capacity is thoroughly assessed and not based only on "*a person's age or appearance, or … a condition of his, or an aspect of his behaviour, which might lead others to make unjustified assumptions about his capacity.*"

3.4.3 *Mental Health Act 1983*

[13] http://www.burgessautistictrust.org.uk/about-asc/ [accessed 8 April 2016]

This Act concerns the "*reception, care and treatment of mentally disordered patients, the management of their property and other related matters.*"

3.4.4 *Mental Health Act 1983 Section 2*

This is the section of the Act used by professionals to detain an individual in hospital for assessment and treatment. It allows for an individual to be detained for up to 28 days and cannot be renewed; a section 3 can be used if further detention is required. Individuals have the right to appeal against a *Section 2* detention within the first 14 days of that detention.

3.4.5 *Mental Health Act 1983 Section 3*

This is the section of the Act that is used when a *Section 2* is going to expire but professionals consider that the individual requires ongoing treatment. It can last for up to six months, and can be renewed. Individuals have the right to appeal the detention once during the first six months. An individual detained under *Section 3* can be treated against their will for up to three months, at which point it must be reviewed and ongoing treatment without consent must be approved.

3.4.6 *Mental Health Act 1983 Section 17* (leave)

This section of the Act covers the granting of leave from an inpatient ward for those individuals who have been detained under Section 2 or Section 3 (see above). This leave must be granted by the relevant professional and documented, and can be subject to any conditions deemed necessary by that professional, for example, to be accompanied by a member of staff. The leave can be for any length of time as decided by the professional.

3.4.7 *Mental Health Act 1983 Section 135*

This is the section of the Act used by professionals to remove an individual to a place of safety in order for that individual to be assessed. It allows for Police to enter that person's home (with or without an Approved Mental Health Professional, depending on the part of the section used), even if they do not consent to this, and take them to e.g. a hospital or police station for an assessment. The section lasts for up to 72 hours.

3.4.8 Approved Mental Health Professional (AMHP)

This role was created by the *Mental Health Act 1983*. An AMHP can be any professional with the required qualification to enable them to carry out assessments of individuals within the relevant sections of the Act (as outlined above).

3.4.9 *Mental Health Act 1983 Section 12*

A doctor who has been 'approved' under Section 12 of the Act has special expertise in the diagnosis and treatment of mental ill health and is approved to make assessments under Sections 2 and 3 of the Act (as outlined above).

3.4.10 Psychosis

The NHS website[14] states: Psychosis is a mental health problem that causes people to perceive or interpret things differently from those around them. This might involve hallucinations or delusions. The two main symptoms of psychosis are:

- Hallucinations – where a person hears, sees and, in some cases, feels, smells or tastes things that aren't there; a common hallucination is hearing voices.
- Delusions – where a person believes things that, when examined rationally, are obviously untrue – for example, thinking their next door neighbour is planning to kill them.

The combination of hallucinations and delusional thinking can often severely disrupt perception, thinking, emotion, and behaviour. Experiencing the symptoms of psychosis is often referred to as having a 'psychotic episode'.

Psychosis isn't a condition in itself – it's triggered by other conditions.
It's sometimes possible to identify the cause of psychosis as a specific mental health condition, such as:

- Schizophrenia – a condition that causes a range of psychological symptoms, including hallucinations and delusions.
- Bipolar disorder – a mental health condition that affects mood; a person with bipolar disorder can have episodes of depression (lows) and mania (highs).
- Severe depression – some people with depression also have symptoms of psychosis when they're very depressed.

Psychosis can also be triggered by traumatic experiences, stress, or physical conditions, such as Parkinson's disease, a brain tumour, or as a result of drug misuse or alcohol misuse.

3.4.11 SLaM Ladywell Hospital

Inpatient unit based at Lewisham Hospital.

[14] http://www.nhs.uk/conditions/Psychosis/Pages/Introduction.aspx [accessed 14 July 2016]

3.4.12 SLaM Triage Ward

Inpatient admission unit; part of the Psychological Medicine Clinical Academic Group (department) Crisis Care Pathway. The wards provide brief assessment and treatment to patients, with longer-term treatment being provided in acute wards.

3.4.13 SLaM Acute Adult Inpatient Ward (Clare Ward)

Inpatient service for men and women aged 18-65, with acute psychiatric illnesses.

The experiences of Julien and Delphine – and other family members – as outlined by agencies and the family to this Review were intertwined, and are therefore presented together.

3.5 Delphine's and Julien's General Practice (GP): Lewisham Medical Centre

3.5.1 Both Delphine and Julien were registered at this General Practice.

3.5.2 Within the Terms of Reference timeframe, Delphine attended the Practice twice and the Practice was in contact with Lewisham Hospital on four occasions, all related to Delphine's physical health issues.

3.5.3 On 11 September 2010 (a Saturday) Delphine contacted the Out of Hours GP reporting concerns about Julien's behaviour, and requesting a home visit. The Out of Hours doctor recorded that Julien had "*over the past few weeks … behaved irrationally – walking outside without his shoes on – wearing inappropriate clothes to work – putting all objects he can find in the bin*". It was noted that Julien was throwing things away from Delphine's home as well as his own. The doctor spoke with Delphine who was noted to be "*very elderly*". The outcome of the visit was that Delphine was advised to see her usual doctor on the Monday (13 September 2010). Julien was prescribed a sleeping tablet and a report was sent to the main GP from the Out of Hours GP.

3.5.4 Delphine's and Julien's usual GP spoke with Julien on 13 September 2010; he stated he could not remember any abnormal behaviour from the 11 September 2010 when Delphine called the Out of Hours service. Julien was referred to the SLaM Community Mental Health Team.

3.5.5 On 27 September 2010 the GP spoke with Julien who reported that he was sleeping better, his behaviour was recorded as having improved and he stated that he wanted to return to work.

3.5.6 On 11 October 2010 the GP noted speaking with Delphine prior to an appointment with Julien. Delphine was recorded as stating that Julien was able

to sleep with a sedative; and that when she had returned from a hospital appointment, Julien had cut up all of her records. The GP then saw Julien, who was unable to recall these actions. The GP recorded that there were no depressive symptoms and no obvious psychotic symptoms.

3.5.7 The GP record noted information received from SLaM about an appointment for Julien with the Community Mental Health Team on 27 October 2010. The record stated Julien did not think he had a mental health problem that needed the support of the Mental Health Team. Julien felt he should not have been referred to the Team and did not want any follow up. The GP recorded that Julien had been discharged to the GP. (NB: See SLaM section 3.6, there is no record of the appointment of discharge.)

3.5.8 Delphine attended the GP on 8 November 2010, and was recorded as being dissatisfied with the Mental Health Team decision outlined in the previous paragraph. A letter was sent from the GP to the Mental Health Team with regard to considering collateral information (see SLaM 3.6.6).

3.5.9 The GP system recorded a letter from the SLaM Community Mental Health Team Consultant Psychiatrist on 2 December 2010. In discharging Julien back to the GP, it noted the following:

"*Diagnosis: transient reactive psychosis, now fully resolved; precipitated by stressors of his mother's admission to hospital and the absence of two colleagues at work leaving him on his own; although there is no formal diagnosis Julien appears to suffer from an autistic spectrum disorder … atypical transient psychotic or quasi-psychotic symptoms are known to occur in autism. These do not necessarily represent a psychotic prodrome*[15]*. These states can often be managed conservatively but recurrent forms may need … antipsychotic medication*".

3.5.10 A plan was set out in the letter: that Julien would remain medication free and be discharged from SLaM to the GP; with the family to monitor Julien and look out for 'early warning signs' including Julien starting to "*make unusual statements about needing to 'clear out the flat' … seeing or hearing things such as ghosts … poor sleep … speech may become less readily understood … may start to behave in unusual ways, particularly seeking to clear possessions from his or other's homes, burning or cutting up possessions*". A crisis plan was set out for the family to follow if they identified any of these signs, covering contact with the

[15] An early symptom indicating the onset of a disease or illness

GP, Community Mental Health Team, and escalating to the Hospital Emergency Department or calling 999 if necessary.

3.5.11 The GP system recorded information from SLaM about a "*planned*" home visit by the Community Mental Health Team on 17 February 2011 (there is no record of this on the SLaM system). The record itself contained the information from the letter received on 2 December 2010. No further records were made.

3.5.12 From June to December 2013 the GP had contact with the diabetic clinic at Lewisham Hospital with regard to Julien's type-2 diabetes.

3.5.13 On 6 May 2014 Delphine, and Julien's brother Fred, attended the GP, as they were concerned about Julien's medication and his wellbeing. A home visit was arranged by the GP.

3.5.14 This home visit took place on 13 May 2014. The GP recorded that they discussed issues concerning Julien's mental health and physical health. Julien was noted as being reluctant to have medical input for diabetes, as he "*feels it is under control, keen to come off medication completely*". Julien was recorded as having agreed to attend the GP surgery for LIMOS assessment and blood tests. A discussion regarding a referral to the "*psych team*" was recorded (see SLaM 3.6.12 onwards). LIMOS is a specialist service in Lewisham that supports people with their compliance with medication. Julien attended for this assessment and a recommendation was made to the GP for a dosette box to be provided to support Julien in taking all his medication in one go each day.

3.5.15 Delphine telephoned the GP on 27 January 2015 expressing concerns about Julien's Autistic Spectrum Condition and that he was refusing treatment for his diabetes. Delphine was recorded as stating she had contacted her Member of Parliament as "*nothing had been done*". The GP asked Delphine to bring Julien to the surgery for assessment. A referral to the SLaM Community Mental Health Team was completed on 5 February 2015 (see SLaM 3.6.22).

3.5.16 Julien attended the surgery on 18 February 2015, accompanied by Delphine. The GP recorded that Julien had not been taking his diabetes medication for six months. Julien was recorded as saying he felt better without the medication, and that it was his idea to stop them. He denied having hallucinations, or using drugs/alcohol or smoking. Blood test results showed reasonable control of Julien's blood sugar. Julien declined the offer of pharmacist support to improve adherence to the medication.

3.5.17 A home visit was requested by Delphine and made on 16 March 2015 to Julien at Delphine's home, with Delphine and Julien's sister present. The GP recorded that Julien was refusing to get out of bed, that there was a strong smell of urine, Julien was unwashed, was not eating or drinking, and was using rambling and

vague language. The GP recorded a concern that the behaviours were caused by a mental health problem. The GP called the SLaM Community Mental Health Team to request that Julien be seen that day.

3.5.18 Delphine contacted the Out of Hours service on 17 March 2015 reporting that Julien was still in bed, hallucinating, losing weight, and wetting the bed. A notification was made to the GP by the Out of Hours service.

3.5.19 The GP recorded that they had called the Community Mental Health Team again, twice, to request that Julien be seen that day. The GP recorded that the call was "*unsatisfactory*" and they had asked to speak to a consultant, who was busy. The GP advised Delphine to call an ambulance to take Julien to the Emergency Department. When the GP called Delphine again, an ambulance had not been called. The GP offered to call one for them and Delphine refused: the GP recorded that it "*sounds like*" Julien was reluctant to go to hospital and the family were trying to persuade him. Delphine called the surgery at 5.25pm to inform them that an ambulance had been called.

3.5.20 The next day – 18 March 2015 – the GP surgery Receptionist telephoned Delphine, who reported that Julien had refused to go in the ambulance to hospital the day before, and was still refusing to eat or drink. The GP called the Community Mental Health Team again to request that Julien be seen that day.

3.5.21 On 19 March 2015 the GP telephoned Delphine, who informed them that Julien was still at home but was "*due to be sectioned today*". The GP recorded that the Community Mental Health Team were present and Julien was taken in an ambulance to Lewisham Hospital.[16]

3.5.22 The GP surgery received an inpatient admission to ward form in relation to Julien from SLaM on 24 March 2015.

3.5.23 The GP telephoned Delphine on 30 June 2015, who stated that Julien was still in hospital. The GP issued sickness certificates for Julien's work.

3.5.24 The next record for the GP is an inpatient discharge notification from SLaM in relation to Julien; this was received on 14 July 2015, a week after the homicide.

3.5.25 On 17 July 2015 the GP surgery received a copy of the appointment letter to Julien from the SLaM Autistic Spectrum Condition assessment team.

3.6 South London and Maudsley NHS Foundation Trust (SLaM)

[16] See SLaM section paragraphs 3.6.30 – 32 for the detailed outline of what occurred on that day.

3.6.1 SLaM's first period of contact with Julien started on 15 October 2010 with a referral from Julien's GP to SLaM, which was received by the Assessment and Brief Treatment (ABT) Team.

3.6.2 On 21 October 2010 Delphine telephoned the ABT Team to rearrange the appointment that had been arranged for Julien, and the appointment was then booked for 27 October 2010 (see Lewisham Medical Centre 3.5.7). A letter of confirmation was sent.

3.6.3 The next record was on 23 November 2010 when a member of the Team had a telephone conversation with Julien's brother, Fred. Fred stated that there was a "*catalogue*" of concerns, which he said he would email to the Team. Fred believed Julien to be "*at the higher end of the autistic spectrum*" and had "*always had difficulties interacting, with empathy and communication*" but now his behaviour had "*gone off the chart… something has happened which has made him snap*". Fred referred to Julien having – up to then – an impeccable work record with a major local store. Julien had burned all his vinyl records, which had been his obsession since he was young.

3.6.4 Fred said that his brother was very much a loner, with "*no friends at all*". He had recently been very unsettled in his flat, saying he saw ghosts and heard noises. He took all the light bulbs out and threw his work clothes away. He had also started wetting the bed. He had been staying with their mother but she had diabetes and was 76. He had been outside his flat with just his underwear on. Fred stated that this behaviour was in contrast with how Julien had been all his adult life. The Team member asked what the family's theory was about why Julien's mental state had changed so much. Fred answered that they wondered if he had taken out a loan from loan sharks who then threatened to take his records away when he missed payments. There was no evidence for this – it was more that they were trying to find a reason for the sudden change (see 3.15.6).

3.6.5 The Team member informed Fred that they "*would see his brother again next week*" and acknowledged that they "*should have approached the matter differently*" and that Fred could call at any time with questions or concerns. They recorded that it seemed likely there had been some event that had so disturbed Julien's routine that an episode of possibly psychotic disturbance had been triggered.

3.6.6 On 24 November 2010 there was a record of a re-referral from Lewisham Medical Centre, and an urgent Assessment and Brief Treatment Review was booked for 26 November 2010. A letter was sent to Julien first class but they could not reach him or Fred via the telephone that day.

3.6.7 On 26 November 2010 the ABT Team member who had spoken with Fred on 23 November 2010 texted him as they had not received the email Fred had promised. Fred telephoned and stated that the family were very keen for Julien to be seen as soon as possible as they were "*worried he would get into further trouble*".

3.6.8 On the same day a relative (name not recorded) telephoned to cancel Julien's appointment. The letter had only arrived that morning, which was not enough time to arrange for Julien to attend. Another appointment was arranged for 2 December 2010 and a letter sent (see LMC 3.5.9)

3.6.9 On 3 December 2010 Delphine was spoken with on the telephone and she was recorded as having understood that the next appointment would be on 9 December 2010. The Team informed her that they would conduct a duty visit but were unable to confirm the time until the 6 December 2010.

3.6.10 On 30 December 2010 Julien was telephoned on Delphine's number. Julien was recorded as saying he had forgotten about the appointment that day. He stated he would not be able to return to his own address today, and requested that the appointment be rearranged for January. The notes record that Julien's family were aware to contact the Team if Julien's mental health deteriorated, that the Emergency Department was available out of hours, and that 999 could be called in an emergency.

3.6.11 The next record was on 29 September 2011, stating that Julien had not kept his appointment with the doctor; it was not clear which appointment was being referred to. The recorded plan was "*as there has been no further contact with ATS*[17]*, he should be discharged to GP*".

3.6.12 A referral was recorded for Julien on 20 May 2014 but it does not state whom it was from or what Team it was received into (it was from the GP, see 3.5.14).

3.6.13 At the referrals meeting on 6 June 2014 a plan was noted for the Administrator to contact the GP to gain Julien's family's contact details, and to pass the file to the Duty Team[18] for liaison with the family and booking an appointment.

3.6.14 This action was taken on 16 June 2014, when the Community Mental Health Team contacted Julien's GP for the family's contact details. The Practice informed the Team that they did not have any information regarding contact

[17] The Review and SLaM were unable to establish what this acronym refers to; it is assumed to mean the mental health service that had previously been in contact with Julien.

[18] Comprises duty workers who cover for the Care Co-ordinator at the Community Mental Health team when the care co-ordinator is absent

details. The SLaM system was checked and the contact details found; these were passed to the Duty Team.

3.6.15 A voicemail message was left on the landline number found on the system on 18 June 2014. A mobile number for Fred was found on the system and was called; it was not available without an option to leave a voicemail.

3.6.16 A further telephone call was made to Fred on 20 June 2014, in which the following was noted: the family were requesting a review for recent mental health deterioration of Julien; that he was diagnosed with Autistic Spectrum Condition and they were feeling unsupported; he had poor compliance with medication for type-2 diabetes; he was disposing of furniture and clothing; was lacking motivation and had poor personal hygiene; there was no food in his home; he attended work regularly; he lived independently but visited his mother (Delphine) regularly; their sister managed Julien's finances.

3.6.17 An appointment was made for 9 July 2014 and the family agreed to accompany Julien. The appointment letter was sent to Julien's home address, and copied to his GP (Lewisham Medical Centre have no record of this).

3.6.18 On 9 July 2014 Julien attended this appointment with a Community Psychiatric Nurse (CPN) Duty Assessor[19], accompanied by Delphine and his brother Fred. The following was recorded:

(a) "*Fred claimed that Julien was having a mental breakdown. He reported that Julien was throwing his clothing and property out of his flat. He added that his brother had not been consistently taking his physical health medication.*"

(b) The CPN Duty Assessor noted or discussed with Julien his: appearance ("*casual … but appropriately dressed*"); appetite ("*good*"); speech ("*normal … articulate … coherent*"); sleep ("*no problems*") and drug/alcohol use (none). In addition, the following notes were made: "*he presented as bright in mood and was very interactive. … [H]e denied auditory and visual hallucinations. And denies having any thought interference. He denies feeling low or having any thoughts of wanting to harm self.*"

(c) Julien was noted as stating he lived on his own and had decided to "*de-clutter*" and get rid of unwanted property; he was quoted as saying it was like "*a child getting rid of his old toys*". This was intentional and his own decision. It was noted that Julien's brother Fred disagreed with Julien's

[19] CPN Duty Assessors cover for the Care Co-ordinator at the Community Mental Health Team when the Care Co-ordinator is absent

interpretation of events, seeing it instead as "*indicators of a relapse*" (there was no record of enquiry over what this meant).

(d) Julien stated that he struggled with his medication; it made him want to urinate often. The CPN Duty Assessor recorded that Julien's understanding of his physical health condition was good: "*but felt that the inconvenience brought on by the medication was not worth it. [H]e also felt that the medication was such that would only be taken when there was a crisis.*"

(e) The CPN Duty Assessor recorded having given Julien "*psycho-education*"[20] on the importance and benefits of his medication and controlling his sugar level; and that the person prescribing should be the only one to increase/decrease the dose.

(f) The CPN noted that Fred informed them that despite changes to when Julien took the medication (through provision of a dossette box by the GP), his compliance had always been an issue. Julien then stated that he would rather take the medication at lunchtime, and this agreed plan was noted.

(g) Julien's family were encouraged to remain supportive and to prompt him when necessary "*as Julien felt they didn't understand his challenges and were not supportive.*"

(h) There was also a discussion about Julien "*attending a support group linked with the learning disability service – Asperger's*". (This Review assumes that this note refers to Julien attending an Autistic Spectrum Condition support group.)

3.6.19 The notes recorded the following conclusion: "*Julien does not present with any symptoms of psychosis. He currently holds a full time job which is very busy and sometimes stressful in nature. He experiences some side effects of the medication … which impacts on his non-concordance. He also appears to have slight difficulty in processing information readily which in my opinion is congruent with Asperger's syndrome. However, Julien shows understanding of his physical health condition and is ready to consult with the prescriber prior to making decisions in relation to medication change.*" Julien was referred back to his GP, and this letter was sent on 11 July 2014 (Lewisham Medical Centre have no record of this).

[20] The education provided about someone's mental health condition to them and their families to support them in managing their condition.

3.6.20 The SLaM system recorded a contact with regard to Delphine and Julien on 23 December 2014. Delphine had contacted her Member of Parliament for help as she felt Julien needed support that he was not getting. The SLaM system recorded that a letter was sent to Delphine with regard to carers needs.

3.6.21 A note on the system on 19 January 2015 recorded that there was no response to the letter sent to Delphine on 23 December 2014. Delphine's Member of Parliament was written to saying that no further action would be taken. A note was made that if Delphine made further contact then a carer's assessment would be considered.

3.6.22 The SLaM Community Mental Health Team discussed a GP referral for Julien on 13 February 2015 (see Lewisham Medical Centre 3.5.15); a plan was recorded to offer a home visit for Julien to see a doctor and a Community Psychiatric Nurse.

3.6.23 Julien's brother Fred was telephoned on 5 March 2015 to offer a home visit on 13 March 2015. The telephone was not accepting calls and a plan was recorded for another attempt to be made.

3.6.24 This was done the next day, 6 March 2015. Fred stated that the date proposed for the home visit was not convenient as Julien would be at work, and advised that the best day would be a Wednesday as that was Julien's day off. The Community Mental Health Team agreed to find a Wednesday and get back to Fred.

3.6.25 The next record on the SLaM system is a telephone call from Lewisham Medical Centre on 17 March 2015 in which the GP reported Julien's mental health deterioration and requested that the Assessment and Liaison (Lewisham) Neighbourhood 2 Community Mental Health Team see Julien that day for a *Mental Health Act* assessment that the GP felt would be "*appropriate*".

3.6.26 The GP was recorded as giving a full statement about Julien's physical and mental health situation: that he was in bed and not self-caring; that he was refusing to be examined or treated. The GP reported that Julien was "*withdrawn and vague and is a poor historian*" and that in the GP's opinion, Julien did not have capacity to consent to or refuse treatment. The GP was advised to contact the Mental Health Assessment Team directly, however the GP informed them that as Julien had previously had contact with the Community Mental Health Team, this route was more appropriate.

3.6.27 The record noted that the GP was informed that following the previous referral for Julien (February 2015), a home visit had been arranged but "*the client's brother had declined the appointment as the time was not suitable*". A plan was

made for the situation to be discussed with the call taker's Duty Manager and the GP would be contacted again.

3.6.28 The Team member then called Delphine, who gave a description of the situation similar to the GP's. Delphine reported that she would be willing to call an ambulance and if one were to arrive that Julien could be persuaded to attend hospital.

3.6.29 The Team called Delphine again the next day (18 March 2015). She informed them that she had called an ambulance on 17 March 2015 and that Julien had refused to be taken to hospital, and that the ambulance staff could take no action without Julien's consent. She reported that the situation remained the same.

3.6.30 The Consultant Psychiatrist at the Assessment and Liaison (Lewisham) Neighbourhood 2 Community Mental Health Team visited Julien at Delphine's house the same day (18 March 2015). They spoke first with Delphine and Julien's sister, who were recorded as saying that they had noticed no change to Julien's mental state until five days previously; that Julien had not been taking his medication for around two months. Five days ago he had come to Delphine's house from work saying, "*it was busy and he felt tired*". He had not been out of bed, eaten or drank anything since. Julien was seen and presented as "*conscious and alert*" and was able to hold a conversation with the doctor for 20-30 minutes, and did not become angry when a possible admission against his will was discussed. Julien was recorded as describing a "*fixed, unshakeable belief*" in what he was doing as a way to "*recover*". Someone had "*told him to do this*" but he couldn't state whom. The doctor informed Julien that they, and other professionals, strongly felt that he was endangering his health through this course of action. Julien remained firm in his belief but could not explain why he felt that way but that he would know when it was the "*right time*" to start eating and drinking again. The doctor recorded their conclusion that Julien did not have capacity to make decisions around his physical health.

3.6.31 The doctor discussed the situation with the Approved Mental Health Professional (AMHP) office (see 3.4.8 for explanation). The record stated that there were "*not clear grounds*" to use the *Mental Capacity Act*, and that "*delusional ideas on a background of Asperger's appear to be causing the evolving physical health problem*". The record stated that the *Mental Health Act* was the more appropriate approach. A plan was recorded to detain Julien under the *Mental Health Act*. It was noted that a full picture of Julien's physical health was difficult to establish while he refused to be examined.

3.6.32 This plan was carried out on 19 March 2015: Julien was detained under the *Mental Health Act section 2* and brought to the Emergency Department of Lewisham Hospital, followed by admission to the Triage Ward of Ladywell

Hospital. In addition to the history that had already been recorded of Julien's physical state and condition, the following was recorded:

(a) "*Julien reported having 'a nervous breakdown' at work & said he had been off sick for about 2 w[ee]ks. He said he felt unable to cope with the pressure he was under.*"

(b) "*[H]is mother says that he does not normally behave like this.*"

(c) "*Julien shrank away from the food & drink that we offered him. He appeared to be frightened of touching it.*"

(d) "*Both assessing d[octo]rs suspect that he is suffering from a psychotic episode but Julien is v[ery] guarded in the info[rmation] he will reveal.*"

(e) "*[Julien] was cooperative with the [admission] process but adamant that he [would] no longer take his prescribed meds as he has taken them for many y[ea]rs now & that was enough. He mentioned that his GP had told him it was ok not to take his meds anymore.*"

3.6.33 Julien stayed in the Triage Ward from 20 to 27 March 2015, at which point he was transferred to the adult inpatient ward, Clare Ward. Records were made in the Triage Ward of Julien's compliance with medication, eating and drinking and general behaviour. These noted that Julien did not take the prescribed medication, ate and drank very little and only when persuaded to do so, and was unable to explain what had happened that had led to his admission. On his first day on the Triage Ward (20 March 2015), Julien was recorded as having no thoughts of harming others or himself, and stating that his relationship with his family was good. That record concluded that there was "*no evidence of ongoing psychosis*" and that Julien's mental health was "*stable*". Julien was recorded as saying he felt improved since arriving at hospital.

3.6.34 A plan was recorded on Triage Ward to observe Julien and encourage his compliance with medication (for his physical health: diabetes, high blood pressure, high cholesterol) and to review at the ward round. The criteria for him to be judged fit for discharge were: "*reduction in risk to physical health*"; this was predicted to take place in seven days.

3.6.35 The ward round review on 25 March 2015 recorded feedback from the nursing staff on the triage ward that Julien was "*isolating himself but eating. Has been taking his med[ication]s.*" Julien was spoken with and recorded as saying he was "*fine*"; that he had been very busy at work and had collapsed, that things had returned to normal but he was feeling "*depressed*". The impression recorded by the consultant was that the admission was "*due to psycho-social stressors & inability to cope in context of Asperger's.*" A plan for Julien to have escorted

leave with his family, and for him to be discharged from the ward at the start of the following week was recorded.

3.6.36 From 20 March 2015 to the date of the homicide, records of 'general observations' were made in the SLaM system by the staff on the Triage Ward and then Clare Ward (Julien was transferred there on 27 March 2015). These records noted Julien's appearance, behaviour, eating and drinking, blood pressure and blood sugar level. Julien was consistently offered his medication and food and drinks. Of the 239 entries:

(a) 110 recorded he took his medication; 27 recorded that he did not; 102 did not record this information

(b) 145 stated that he had something to eat and/or drink; 33 recorded that he did not; and 61 did not record this information

3.6.37 Julien was transferred to Clare Ward on 27 March 2015. He was recorded as calm, amenable and well-kempt. In addition, the following was noted: "*He had some clothes he was holding in his hands & asked where he c[ou]ld put them, he was advised to keep them in his r[oo]m & he c[ou]ld wash them later. He went away only to return about 10 min[utes] later asking for a bin so he c[ou]ld throw the clothes away. He was encouraged to keep them or give them to his mum but he refused & he put them in the bin.*"

3.6.38 From 19 March 2015 to 6 May 2015 Julien's compliance with medication and willingness to eat and drink varied from day to day (and sometimes within the day). After 6 May 2015 he became consistent in taking his medication as well as eating and drinking.

3.6.39 From 30 March to 15 April 2015 Julien was held on Clare Ward under Section 2 of the *Mental Health Act 1983*. This expired at 23:59 on 15 April 2015. A clinical decision was made on 14 April 2015 to convert it to a Section 3.

3.6.40 Julien was consistently recorded as believing that he would be leaving the ward on the date the Section 2 expired. He continued to refuse medication, and to eat and drink minimally. He gave different explanations for this including that he had had enough medication, that he no longer had diabetes, that he needed to eat/drink very little to manage his weight and diabetes, and that doctors had told him not to take medication. At times, he couldn't give an explanation, and at other times took the medication, meal or drink.

3.6.41 He often gave confused answers to questions, and had repetitive conversations about his work and the stress it had caused him leading him to be admitted. He was described as agitated, anxious, occasionally hostile and finding it stressful to interact with staff, other patients and his family. Julien was recorded as declining

to take the escorted leave off the ward that he was entitled to. Throughout his time in Clare Ward (i.e. from 27 March 2015 to the date of the homicide), Julien was generally described as "*resting*" in his room, or "*isolating himself*" by staying there. He was sometimes recorded as sitting on the bed staring at the floor, or rocking back and forth, lying on the floor or standing/sitting immediately behind the door.

3.6.42 A "*differential diagnosis*"[21] was recorded on 31 March 2015: "*adjustment disorder in ASD [Autistic Spectrum Condition]; mixed anxiety & depressive disorder*".

3.6.43 On 3 April 2015 Julien's sisters visited and stated: that they felt Julien was getting worse (not eating or drinking and in his behaviour); that he was depressed and "*things have been getting worse*" since a friend died a few years previous and Julien was now "*quite isolated*"; that Julien was fixated on the date he thought he would be leaving (15 April 2015) and that he therefore felt he didn't need to do anything until then, as he could eat/drink/shave after that; that Julien thought he would be going home to Delphine's house but that they were keen for him to go to his home due to Delphine's age and health and so that Julien could live independently. Staff reassured Julien's sisters that he would not be discharged if he were not well and that there was a different section of the *Mental Health Act 1983* under which Julien could be assessed and kept in the hospital (i.e. Section 3).

3.6.44 From 7 April 2015 Julien started to say that he was feeling better; and continued to believe that he would be leaving the ward on 15 April 2015, as stated in the Section 2 document, and at one point was recorded as saying he had booked a taxi to take him home. Despite this he refused to take escorted leave, variously stating that it was because he had been told patients weren't allowed outside, that he had visitors that day, or that he had no shoes (but refused help to get shoes).

3.6.45 Delphine attended the ward round on 8 April 2015 and it was noted that she said that Julien had "*never really understood what diabetes is*". She also reported that when Julien was a child he had a psychologist and went to a school for children with special educational needs. He did not receive a diagnosis, and was "*promised to be followed-up but this didn't happen*". He went to college but when Delphine went away on holiday he stopped going and refused to go back. Delphine was recorded as talking about the previous episode in 2010, which occurred when Delphine went into hospital and Julien was concerned she would

[21] The process of assessing the probability of one disease versus that of other diseases that could account for a patient's illness

not come out again – as his father had died in hospital – and at the same time "*his only friend died*". Delphine described Julien's presentation as "*up & down*" since May 2014: throwing things away and destroying them; inappropriate behaviour and talking less.

3.6.46 The consultant was recorded as informing Delphine that they were monitoring Julien in order "*to understand him better in order to decide the correct course of treatment*" and that it seemed more likely to be a "*mood disturbance*" and not a psychotic episode. A *Mental Health Act 1983 Section 3* assessment was discussed as a possibility if Julien needed to stay on the ward for longer.

3.6.47 A case discussion on 14 April 2015 recorded that the main concern in relation to Julien was his eating and drinking, and that a comprehensive assessment was required to understand him better and plan for discharge. It was noted that Julien appeared to need a highly structured routine. A plan was recorded to request involvement and assessments from Social Inclusion and Recovery Service[22] (SIRs) and Autistic Spectrum Disorder Teams; and a timetable for Julien's activities on the ward to be developed.

3.6.48 A professional from the Approved Mental Health Practitioner (AMHP) team and a Section 12 doctor (see explanations in paragraphs 3.4.8 & 9) saw Julien on 15 April 2015. The Section 12 doctor was recorded as stating they believed Julien "*is psychotic and needs to be treated*" and that the form for the Section 3 would be signed once they had discussed Julien's treatment plan with the Responsible Clinician (i.e. the person in charge of Julien's care). Despite being a voluntary patient at this time due to the Section 2 expiring, Julien agreed to stay until he had seen a doctor.

3.6.49 Julien was anxious and upset not to be discharged on 15 April 2015 and remained fixed in his belief that this should have happened, as the papers gave this date.

3.6.50 On 16 April 2015 Julien was seen by a member of staff (unspecified) to assess him against the Autism-Spectrum Quotient[23]. Julien was noted as having scored 32 out of 50, and that 80% of those diagnosed with Autistic Spectrum Condition score this or above. This information was noted as planning to be passed to the Clinical Psychologist dealing with Julien's Autistic Spectrum Condition

[22] Provides person-centred support with the aim of enabling people to explore their goals and ambitions, to become more independent, to stay well, and to feel part of their community.

[23] A screening tool to establish an individual's score on a spectrum of autistic traits, developed by the Autism Research Centre: http://www.autismresearchcentre.com/project_7_asquotient

assessment. The appointment letter from the Autistic Spectrum Disorder Team was sent to Julien on 9 July 2015 for an appointment on 6 August 2015.

3.6.51 The section 3 was agreed on 17 April 2015 due to ongoing serious concerns over Julien's health and wellbeing, and the assessment that he would likely be non-compliant with support in the community from the Community Mental Health Team. The ward staff were noted as having a "*clear plan to est[ablish] a prog[ramme] of behavioural treatment including nursing care, O[ccupational] T[herapy] input, psychological therapy & the use of visual aids*".

3.6.52 From this point onwards Julien was detained in the hospital under Section 3 of the *Mental Health Act*. For the first part of this, Julien's behaviour, eating and drinking and non-compliance with medication remained the same. For a period of four weeks he was consistently noted to have been lying on the floor during the day and night, and at other times to have been standing or sitting immediately behind his bedroom door. Julien continued to decline offers of escorted leave out of the ward.

3.6.53 On 23 April 2015 it was noted that his "*mental state appears to be deteriorating but the reason remains unclear*" but that there was no evidence of psychosis, and the plan was continued as previous: structured activities and encouraging eating, drinking and taking medication.

3.6.54 On 27 April 2015 it was recorded that Julien "*[t]ore staff nurse's shirt at the w[ee]kend when panicking about having BM [blood glucose monitoring] done*". Julien was asked on this day about his friend who had died but Julien was unable to remember who this was. A plan was recorded of referring Julien to the "*autism psychologist*".

3.6.55 Julien was recorded as having "agreed for the first time to take his physical health med[ication]s" on 30 April 2015 (the records show 22 instances of him taking medication prior to this, and 43 instances in which it was not recorded). On 7 May 2015 he was recorded as having an improved mental state, to be eating and drinking and consistently taking medication. From this date Julien is frequently described as "*bright*" in mood and not needing to be reminded to come out of his room for meals. He was unable to explain why he hadn't been taking his medication before.

3.6.56 On 12 May 2015 it was recorded that Julien "*went outside for the first time*". On 19 May 2015 it was recorded that "*Julien took his first escorted leave from the ward*". He wanted to take his escorted leave at the same time each morning and when staff tried to suggest this wasn't possible it was noted Julien was "*quite concrete in his thinking & routines, staff find it difficult in getting him to be slightly flexible in certain things*".

3.6.57 Julien was engaged with SIRs from 17 April 2015. The SIRs Occupational Therapist met with Julien on the ward every few days to discuss his return to work (or other activities) following discharge, and what his needs might be at that time. Julien wasn't clear on whether he wanted to return to work (and if so on reduced hours) or to leave his job completely. He was provided with support from the service's vocational specialist. The service later engaged with Julien's employer on his behalf. On 15 May 2015 they noted that Julien stated when he was discharged he would go and live with Delphine for a time.

3.6.58 On 26 May 2015 Delphine reported to staff that she felt that Julien was not well yet: that he appeared "*superficially well but some of the things he says isn't quite right. She is worried that he will return to her h[ou]se to live if he is discharged*". Burgess Autistic Trust was discussed as somewhere for Julien to go following discharge, and Julien agreed to this. Delphine was recorded as saying Julien "*didn't want to attend before & he probably won't go back despite saying he will*".

3.6.59 On 27 May 2015 Julien used his unescorted leave for the first time, and continued to be recorded as using it most days from this point forward. Julien was recorded as feeling that now he was complying he should be discharged and was concerned that the papers stated he would be there until October; it was explained that he could be discharged sooner. On 28 May 2015 a discussion was recorded of "*diagnosis of adjustment disorder, anxiety / depressive component which has resolved without med[ication]s*".

3.6.60 On 2 June 2015 the SIRs Occupational Therapist went with Julien to his home. This was an opportunity to assess his independence which was positive. It was noted, "*Julien does not wish to engage with the Burgess Trust as he feels that a diagnosis of Asperger's is not applicable to him. He feels his family sometimes "put words" into his mouth. Julien gave me a key which he had found on a bus last w[ee]k & has asked that I hand it into the bus garage, which I will do*". This key turned out to belong to Julien, and was retrieved by the Occupational Therapist; it was a back door key that he never used and therefore didn't recognise. Julien was recorded as being concerned that someone had been in his flat or that someone else had been staying there as he didn't recognise everything and some things had been moved. He was reassured that it was his family taking care of the flat in his absence.

3.6.61 The SIRs Occupational Therapist fed back to doctors on 11 June 2015 that Julien would need a "*quite a lot of support (transitional)*" in the form of a personal assistant for at least 12 weeks once he was on extended Section 18 leave from the ward, to prompt him in relation to personal hygiene and meals. In this same Ward Round it was recorded that the consultant "*has concerns that we are not*

clear how far Julien currently is from baseline" and a plan was made to delay the extended leave.

3.6.62 On 20 June 2015 Julien was recorded as not understanding why he should take leave from the ward, when he would "*rather just be discharged*" and then he could stay at home. On 22 June 2015 the visit home was suggested as the reason for him "*deteriorating slightly*". From this point onwards the records generally noted that Julien was "*bright*" and "*positive*" and interacting well with staff.

3.6.63 On 25 June 2015 the SIRs Occupational Therapist met with Julien's sister who was recorded as expressing concern that Julien "*had leave from the wards yesterday but was not supported. He had no £ or food & she mentioned that he has diabetes & is v[ery] vulnerable. He visited his mother at home but no prior arrangements were made so it was lucky she was in as Julien had walked from the ward*".

3.6.64 On 30 June 2015 the family asked SIRs for support after Julien's discharge as they were finding it difficult to support him.

3.6.65 On the request of the Occupational Therapist from SIRs, who felt that Julien required a package of care to facilitate his discharge from the inpatient ward, the SLaM Community Mental Health Team Care Coordinator met with Julien on 6 July 2015 to carry out a Screening, Assessment and Support Services assessment.

3.6.66 On 7 July 2015 SIRs informed the Care Coordinator that this additional care would not be needed once Julien was on extended leave from the ward. The reasons for this change were not recorded on the SLaM system.

3.6.67 There was agreement on Monday 6 July 2015 that Julien would go on extended section 17 leave "*once family are happy*" later that week. This was discussed with Julien, Delphine and Julien's sister on Tuesday 7 July 2015 during the ward round. Julien stated, "*he is ready to leave & won't throw anything out as he's 'got a stable mind now'.*" It was noted that Delphine was "*v[ery] pessimistic, which irritates [Julien], & says he will throw things out (& threw out her photoframe yesterday) & won't take his meds. Julien asked her to 'stop talking [negative]' several times, becoming inc[reasingly] annoyed.*" It was confirmed that the Occupational Therapist would visit him at home the following Monday (this was then changed to 9 July 2015). Julien's sister stated they had a phone for Julien but had not given it to him as they were concerned he would throw it away. Delphine and Julien's sister were encouraged to contact the ward if they had any concerns during Julien's leave.

3.6.68 Julien was keen to leave, however there was a delay in getting a dosette box for his medication and he was told he would be able to go on extended section 17 leave in two days (Thursday 9 July 2015) when that arrived; and that he would return after two weeks for a review. Julien was encouraged to stay on the ward until the dossette box was ready. The record notes that the member of staff:

"*strongly emphasised to him that the delay was not at all related to his family but was something that the ward team was taking responsibility for & that we apologised to him for the delay in getting his dosette box. I felt it was important to convey this info to him as Julien had previously expressed concern that his family were delaying his discharge. Due to his neurodevelopmental disorder Julien seems to have some difficulty understanding certain types of info[rmation], therefore we made an effort to convey this to him as clearly as poss[ible]. Julien ack[nowledged] this info[rmation] & I believe took it on board.*"

3.6.69 An additional record on this date (7 July 2015) notes that Delphine and Julien's sister had attended the ward to collect the keys to Julien's home in order to get a spare set made (the keys were being held by the nursing staff). Delphine stated that she understood Julien would be going home on Thursday 9 July 2015.

3.6.70 Later this day (7 July 2015) it was recorded:

"*Julien has been sent home on leave tonight. Julien has been told that he is being sent home on leave, that he needs to come in tomorrow AM for his meds & that he must take his meds regularly. [Julien's brother] was contacted & [he] asked if we had been made aware by [Delphine] that Julien had gone to her h[ou]se, gone upstairs & taken 2 CDs which he took down to the garden & smashed up violently. Given his [history] of destroying a huge CD collection, this bizarre behaviour unsettled the family.*"

3.6.71 On 8 July 2015 it was recorded that Julien had not been on the ward at the start of the shift the evening before (7 July 2015) having gone on unescorted leave to get his flat key from his family, to go to his flat and was scheduled to return on the morning of 8 July 2015. Julien then returned to the ward "*abruptly*" at around 10pm stating he had been unable to get his key although staff were not clear what had happened.

3.6.72 That morning Julien was recorded as having a low blood sugar level and was persuaded to drink and eat. Staff told him he would not be able to leave the ward until his blood sugar had been tested again to ensure it was high enough; and because "*he was still unsure where his keys were*".

3.6.73 After breakfast "*Julien was risk assessed as per s[ection] 17 leave requirements & signed out of the ward stating that he was going to his sister's h[ou]se to sort out the keys to his flat & w[ou]ld return at 10.30am.*" The ward then recorded a

call from Delphine at 10.30am in which she expressed concern about the plan for Julien to go on extended leave and repeated the information recorded the day before about Julien destroying property at her home (it was noted that she was difficult to understand due to her accent). Staff "*reassured [Delphine that Julien] w[ou]ld be reviewed in ward round tomorrow before any decision was made about him going home, however the phone cut off abruptly*". Staff attempted to call her back but there was no answer; the next contact was from the Police in relation to the ultimately fatal incident.

3.7 London Borough of Lewisham Adult Social Care

3.7.1 Adult Social Care had records of some limited involvement with the family in July 1997. The first was a 'General Concern' contact received by the Lewisham Hospital Social Work Team in relation to Delphine's husband. There was no information other than a brief note saying he needed help and "*might be at risk of abuse*", and a note that no further action was taken.

3.7.2 The second was ten days later in the same month, in which the Social Care Team received an 'Adult Protection Alert' for Delphine from an 'unknown relative'. Other than stating that no further action was taken, no information is available.

3.7.3 Both of these were migrated records from Adult Social Care's previous system; both records show the contacts were overseen by a senior Social Worker or Manager and decisions of no further action were taken. The absence of further information means that no paper file was set up for these two contacts – as these would have been scanned and migrated to the new system.

3.7.4 On 30 April 2010 the London Fire Brigade contacted the Adult Social Care Advice and Information Team (SCAIT) following the incident in which Julien had been setting fires in his garden and flat (see 3.12.2). The SCAIT advised the Fire Brigade that Adult Social Care would not get involved but that the Police should make a referral to the Mental Health Team if they were concerned about Julien's behaviour. The Fire Brigade officer agreed to follow up with the Police on this. No further action was taken by Adult Social Care. The London Fire Brigade checked their records and could find no record of this contact, or follow up action.

3.7.5 On 14 October 2011 a request was received by SCAIT from Julien's brother, for Julien to be registered under the Physical Disability Register scheme. This registration was completed on 18 October 2011 after liaison with Julien's General Practice. Julien's brother stated, "*my family is very concerned that we have my brother registered just in case anything happens because the last time he had a 'psychotic episode' it turned our family upside down and until one has experienced this it's hard to explain how it impacts on the family.*" No further action was taken.

3.7.6 On 16 June 2013 Delphine's General Practitioner contacted SCAIT requesting an assessment for Julien, as Delphine was concerned he was non-compliant with his medication. Delphine was recorded as calling Julien every day to remind him to take his medication, and also assisted him with budgeting and shopping. She described Julien as able to self-care to some degree.

3.7.7 Delphine was informed that, as Julien appeared to have capacity, unless he requested support and consented to the referral, it could not progress. Delphine was advised, and agreed, to discuss the referral with Julien. No further contact was received by SCAIT.

3.8 Hexagon Housing

3.8.1 Julien began a 'General Needs' tenancy with Hexagon Housing on 22 May 2000. This type of tenancy meant that no support needs had been requested. This followed a standard route of Julien being nominated for housing, as a single male with no additional needs, by the London Borough of Lewisham.

3.8.2 In 2005 Julien fell behind in paying his rent, and Hexagon followed their standard process in relation to rent arrears. This culminated on 10 October 2005 with a Court Possession Order being obtained. This was suspended and would not be acted upon provided Julien kept to a repayment plan, which he did.

3.8.3 On 6 June 2006 Julien's rent arrears were cleared in full and therefore no further action was taken.

3.8.4 On 10 February 2010 Julien was sent a letter asking him to ensure that communal areas were kept free of obstruction. The request was complied with.

3.8.5 On 26 April 2010 Hexagon received a report from the Police to notify them of the incidents on 23 and 24 April 2010 of Julien making fires in his garden and flat. The Hexagon record stated that the Police did not consider Julien's actions to be arson, and that the Police doctor did not believe there to be mental health issues.

3.8.6 A Hexagon officer contacted the local Community Mental Health Team (SLaM) on 29 April 2010 to find out if they knew Julien. The officer noted on the file that they felt Julien might have "*learning difficulties*"; this was their opinion based on interaction with Julien.

3.8.7 Following this notification, Hexagon officers made a number of attempts to contact Julien. On 17 May 2010 Hexagon wrote to Julien's named contact – his sister – to ask if she could assist with getting in contact with Julien. Julien responded on 19 May 2010 to allow access for inspection and repairs. He was noted as being apologetic about the fire incident.

3.8.8 A general letter was sent to all residents on 3 November 2011 with regard to the condition of the shared garden. Julien responded to the letter to confirm that the residents were working together to sort out the garden. This was the last direct contact with Julien.

3.9 London Ambulance Service (LAS)

3.9.1 LAS received a 999 call from Delphine at 5.14pm on 17 March 2015. Delphine reported that Julien was in her home and was not eating, felt weak and had been unwell for four days. It was documented that Julien's General Practitioner had advised Delphine to call an ambulance. The call was recorded as "*diabetic problems: not eating, feeling weak*" and triaged as a non-life threatening event.

3.9.2 An ambulance was dispatched at 8.47pm that day, and arrived at the address at 8.53pm. On arrival ambulance staff saw Julien who was in bed and fully alert. It was documented that he was not compliant with his medication and had refused to take any for four days. Julien was also refusing to eat or drink, and was recorded as stating that he would eat and drink when he wanted to.

3.9.3 All clinical observations were within 'normal parameters' with the exception of Julien's blood glucose level, which was low. The ambulance staff documented that Julien had capacity, and was aware that not eating or drinking would result in his condition worsening. It was documented that there were no safeguarding concerns.

3.9.4 Julien refused any assistance and he was left in the care of his family.

3.9.5 Ambulance staff contacted the out of hours doctor, who advised that they were going to contact Julien's General Practice to rearrange a visit that should have been made that day.

3.9.6 Two days later, on 19 March 2015, Julien's General Practitioner called 999 to request an ambulance to Delphine's address. This was recorded as a planned call in relation to a Section 135 order (see explanation in paragraph 3.4.7). The call was received at 1.07pm; an ambulance was dispatched at 1.19pm and arrived at 1.26pm. Julien was lying in bed fully alert when staff arrived.

3.9.7 It was documented that Julien was under Section 135 and was to be transferred to University Hospital Lewisham for assessment, before being admitted to Ladywell Mental Health Unit (SLaM). Staff recorded that Julien had a five-day history of not eating or drinking and had been lying in bed urinating. It was further documented that Julien had Autistic Spectrum Condition and had a similar episode in 2011.

3.9.8 Julien was examined and all clinical observations were within normal parameters except for raised blood pressure and low blood glucose level. Julien appeared calm, and denied hearing voices or having hallucinations.

3.9.9 Julien was transferred to the ambulance, which left the address at 1.49pm. It arrived at the Hospital at 1.58pm and his care was transferred to Hospital staff.

3.10 University Hospital Lewisham (Delphine)

3.10.1 Delphine attended regular Hospital outpatient appointments from 1993 to 2013 in relation to her diabetes. This remained stable and so Delphine was discharged on 30 July 2013.

3.10.2 From April 2010 to July 2012 Delphine attended the Hospital on nine occasions in relation to physical health issues, which were treated and following which Delphine was discharged to her General Practice. This included an inpatient stay of 12 days in April 2010; the remaining attendances were for outpatient appointments, primarily at the Medicine for the Elderly Clinic.

3.10.3 On 10 December 2014 Delphine attended the Emergency Department with a facial injury: she had been sleeping while sitting in a chair, had fallen forward and hit her left eye on a table. Delphine was given pain relief and discharged to her GP.

3.10.4 In March and May 2015 Delphine attended the Hospital on three occasions for physical health issues, which were treated and following which Delphine was discharged to her GP.

3.11 University Hospital Lewisham (Julien)

3.11.1 Julien attended the Emergency Department on 14 November 2011 having collapsed at work due to gastroenteritis; he was treated and discharged.

3.11.2 On 19 March 2015 Julien was brought to the Emergency Department by the London Ambulance Service for medical clearance, as planned under the Section 135. Julien had a physical examination the results for which were all normal. He was then discharged to Ladywell Hospital (SLaM).

3.12 Metropolitan Police Service (including London Fire Brigade)

3.12.1 On 1 September 2009 Police were called by a member of the public who claimed they had been the victim of fraud by Julien. They claimed to have placed a wanted advert in a magazine seeking a vinyl record, following which they had paid Julien for the record but it had not been sent. The Police concluded that there was insufficient evidence of a crime, and it was recorded as a civil dispute. No action was taken.

3.12.2 At 8.19pm on 23 April 2010 the London Fire Brigade and Police were called to Julien's address. Julien was burning CDs and vinyl records in the back garden close to the block of flats, and the smoke was causing a nuisance to the residents. The Fire Brigade put out the fire and Julien was warned to stop.

3.12.3 At 10.20pm the Fire Brigade and Police were called again; on this occasion Julien was burning items in his kitchen. Julien was recorded as having said to the Police "*I need to get rid of everything*". Julien was arrested for arson and Delphine acted as the 'Appropriate Adult'[24]. Police assessed that there was no intention to endanger life and Julien's actions did not amount to arson; in addition the owners of the property (Hexagon Housing) did not support a police investigation, as the damage was minimal. As a result no further action was taken.

3.12.4 The Forensic Medical Examiner (FME, provides medical service for Police services) and the Mental Health Liaison Nurse saw Julien with regard to any possible mental health issues. They recorded that Julien had "*diabetes, depression and Asperger's*" with no other actions or notes recorded. Julien stated that he was not on any medication, and was not having treatment for mental health issues.

3.13 Burgess Autistic Trust

3.13.1 Julien's brother Fred called Burgess Autistic Trust on 3 June 2014 and followed it up with an email, in which he asked about services for Julien. The Information, Support and Advice service sent a Service Information Leaflet and a self-referral form to Fred.

3.13.2 The Information, Support and Advice Service received the completed self-referral form (completed by Fred on behalf of Julien) on 9 July 2014. The form provided a brief personal history, contact details, any medication, and the areas of support Julien might be interested in. The referral form came with a copy of a letter from a Doctor from the local SLaM Mental Health Team, dated 17 January 2010, referring to Julien experiencing a transient psychotic episode. The letter noted no evidence of recurrence, and recorded a recent diagnosis of Autistic Spectrum Condition. The letter advised that Julien should not be left to work on his own for long periods, as this creates stress and may exacerbate his illness. The referral also contained a copy of a letter from London Borough of Lewisham Adult Social

[24] An Appropriate Adult is responsible for safeguarding the rights and welfare of a child or an adult deemed to be 'mentally vulnerable' who has been detained by Police, or is being interviewed voluntarily under caution. Created by the *Police and Criminal Evidence Act 1984*.

Care Access and Information Team noting that Julien was on their database as having Autistic Spectrum Condition, with a reference number.

3.13.3 Julien was invited to an Initial Review Meeting. On 6 August 2014 the Information, Support and Advice Service attempted to call Delphine as she and Julien had not attended this appointment. The Service spoke to Fred and the appointment was rearranged.

3.13.4 The Initial Review Meeting took place on 13 August 2014. (The form was dated 6 August 2014, however the follow up letter (see below) suggests that it in fact took place on 13 August 2014.) The Outreach Service recorded Delphine as Julien's carer, along with details of Julien's medical, living, education/employment situations and experience, the support he received and/or needed, his interests, aims, and personal presentation. An action plan was completed. The Service noted that Julien had no friends and had a tendency to hoard. They also noted a disagreement between Julien and Delphine about the Autistic Spectrum Condition diagnosis, and about the amount of time he spent at her house on his days off from work.

3.13.5 The Outreach Service offered assistance with completing an application for Personal Independence Payments. Julien was added to the waiting list for the 'Understanding Diagnosis' workshop, which he agreed to attend.

3.13.6 A follow up letter was sent the same day. It outlined the support offered by the Trust that may be of interest to Julien and confirmed the actions that had been agreed at the meeting.

3.13.7 Julien and Delphine attended a Lunch Club on 10 October 2014, at which Delphine requested further information. The Outreach Service sent a calendar of events, and information about applying for Personal Independence Payments, on the same day. This was the last direct contact the Trust had with Julien or Delphine.

3.13.8 Fred contacted the Information, Support and Advice Service on 9 April 2015 seeking support for Julien. He stated that Julien was currently sectioned in the psychiatric hospital and Fred was looking for support for him once he was discharged. The Service explained the Trust's Independent Lifestyles and Supported Living options that could support Julien. The Service followed this phone call with an email to Fred on the same day, attaching details of the options outlined on the phone and providing the contact details for that service.

3.13.9 This was the last contact with the family of Julien and Delphine.

3.14 Bromley and Lewisham Mind

3.14.1 Mind had no direct contact with Julien; all of their contact was with his brother, Fred. Fred first contacted the service on 17 July 2014, stating that a local SLaM Mental Health Team had given him details of the Mind Peer Support Service. The email was sent directly to a member of staff who had left, and the email was forwarded to the correct person shortly after.

3.14.2 The Service emailed Fred on 29 July 2014 with the referral form; Fred responded via email and telephone call pointing out that the form had not been attached.

3.14.3 On 31 July 2014 Fred telephoned the Service and stated that it would be better for the referral form to be sent to Delphine, for Julien's GP to complete.

3.14.4 The Service posted the form the following day, 1 August 2014. Information about the service was also included. This was the last contact with the family.

3.15 Information from the family of Delphine and Julien

3.15.1 The independent Chair met with Fred – Delphine's son and Julien's brother. Fred informed the Chair that he was speaking to the Review on behalf of his two sisters.

3.15.2 Fred explained that Julien had worked in a local major store for 15 years, had a stable background, lived alone and had no criminal record or history of violence.

3.15.3 The Chair asked Fred about the support the family felt they had in relation to supporting Julien. Fred outlined that he felt that the family could have been better supported both prior to Julien being sectioned, and while he was on Clare Ward.

3.15.4 Julien had had what the family called a "*psychotic episode*" five years previously, which triggered the assessment and diagnosis with Autistic Spectrum Condition, which Fred described as Julien having "*struggled with*" all his life. However, Julien did not accept the diagnosis, nor did he fully understand it – Fred explained this as being due to it coming so late in his life.

3.15.5 Fred described the "*psychotic episode*" in 2010/11 as having been prompted by their mother, Delphine, going into hospital at the same time as the death of a friend with whom Julien would attend rare vinyl record fairs. Other than this friend, Julien was a "*loner*".

3.15.6 Fred reported that this friend had at one point used Julien's address as his own and as a result Julien received letters regarding this person's debts, including letters from bailiffs. Once the family were aware of the letters they engaged a solicitor to ensure that this situation was dealt with. For them it was a clear example of Julien's vulnerability.

3.15.7 Julien had been diagnosed with type-2 diabetes and was required to take medicine every day. He initially struggled with this as he had medication to take at different times of the day, and therefore he did not take it. (Fred explained that Julien would be reluctant to take medication at work, for example, and that this may have been explained by his Autistic Spectrum Condition in that he would have found communication with his manager or colleagues about medication difficult, if not impossible.) The GP reorganised Julien's medication so that he took it all in one go each day, and this helped him.

3.15.8 Prior to being sectioned in March 2015, Fred described how Julien had stopped taking his diabetes medication, and that the family were very concerned for him, as they knew the potential physical and psychological impact this would have. The family were alarmed at how Julien's mental health deteriorated and how this was exhibited: i.e. not eating, drinking, or getting out of bed to wash or urinate.

3.15.9 Fred explained that he, his sister and mother were the main people supporting Julien. Fred's sister was responsible for Julien's finances: she had arranged for all of his bills to be paid by Direct Debit, and gave Julien an allowance for his own spending. Fred stated that prior to this, Julien could not manage his money: he would spend it all on rare vinyl records, and leave all post (including bills) unopened on his sofa. It was not until he was threatened with eviction that the family realised what was happening, and that was when their sister took over Julien's money and paid off his debt to Hexagon Housing. Julien had been evicted from a flat on a previous occasion for non-payment of rent.

3.15.10 Fred also explained that it was difficult for the three of them to support Julien to the extent that he needed it: Delphine due to her age and own health difficulties; Fred and his sister due to their own families, jobs and lives.

3.15.11 As a result, Fred tried to get Julien involved with Burgess Autistic Trust, and Julien did attend with Delphine, but did not want to go back. They also tried to get support through Bromley and Lewisham Mind Peer Support but this "*did not go anywhere*".

3.15.12 While Julien was in Clare Ward, the family felt that they weren't sufficiently informed of the treatment and support that Julien was getting there. They were unaware of what medication he was taking, what therapy he was getting, what exploration was being done with him to understand why he was not taking his diabetes medication, to ensure that he started taking it and did not stop again.

3.15.13 When Julien started to be on unsupervised day release, they were even more concerned as they felt he should be under the care of Clare Ward – as he had been sectioned – and therefore not allowed to go out completely alone (although they did understand that leaving the ward was part of his rehabilitation).

3.15.14 While on unsupervised day release, Julien attended his work and chatted to colleagues: the family felt embarrassed by this, because they had been trying to explain to Julien's work that he was in hospital, and had been supplying sick notes to this effect.

3.15.15 Delphine and Julien's sister visited Clare Ward the day before the incident to explain their concerns about Julien being unsupervised when leaving the Ward. Fred stated that the family were never informed of when Julien was leaving the Ward:

"*they didn't tell us that they let him out. They gave him no money, no food, no drink, they just let him out for the whole day. … At the end of the day, you're either in a secure unit or your not, and if you take a person out, there has to be some continuity of that security, and supervision, and none was there for my brother.*"

3.15.16 The family felt very strongly that Julien should not be allowed to return to Delphine's home as that was where his problems had started:

"*The last place he should be coming back is here; we had officers come here to literally remove him from this place, so the last place he should be coming is back here, to say don't come here as if he's going to respond to that, it's stupid really.*"

3.15.17 The family did not define themselves as 'carers'. Fred was clear that there was no more Delphine could have done, and that she needed more support.

3.15.18 Fred stated the following in relation to the registration of Julien on the disability register following his Autistic Spectrum Condition diagnosis:

"*That meant that he was officially registered as a mentally vulnerable man living on his own in need of support and help from Lewisham Council which under the Autism Act 2009 they are legally responsible to help him.*"

3.15.19 Fred was very clear that he thought that the registration would lead to support for Julien and the family in their care of Julien. Fred also felt that the information about his brother should have been shared with other agencies so that they knew his situation – for example Hexagon Housing.

3.15.20 The family were also frustrated by the fact that professionals, for example the GP, would not discuss Julien with them when they were trying to seek help for him.

3.15.21 Fred read the Overview Report and fed back his thoughts in response to it. Where possible these have been included in the body of the Report.

3.15.22 In addition Fred raised a specific point about their family's engagement with the Police following the homicide. Fred felt that there had been little communication to the family from Police in relation to sentimental belongings that had been removed from Delphine's home during the investigation. Fred stated that he – and his sisters – did not know why certain items were being removed, what role they were expected to play in the investigation, and when they were going to get them back. The family did not receive a list of the items taken.

3.15.23 This point was put to the Police, who provided the following information:

3.15.24 "*[A]t the scene of a serious incident a dedicated forensic crime scene manager will complete an assessment, and decide what items should be seized for potential evidential purposes. These are then logged by an exhibits officer and stored within MPS premises. Depending on the evidential value ([for example] blood staining, DNA examination) items will not be restored to the family as they may be required to be stored to deal with any further legal proceedings such as an appeal against conviction.*"

3.15.25 The Police also outlined that there are specific guidelines for Family Liaison Officers with regard to property taken as part of an investigation, and a Home Office pack is provided to families where appropriate that also includes information about forensic evidence.

3.16 Information from Julien

3.16.1 Julien did not participate in the Review. (Please see paragraph 2.7.8 for details of the attempts that were made).

4. Analysis

4.1 Domestic Abuse/Violence Definition

4.1.1 The government definition of domestic violence and abuse (2013) is:

"*Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse: psychological; physical; sexual; financial; and emotional.*

Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim."

4.1.2 Julien had destroyed Delphine's property on a number of occasions and this is evidence of domestic abuse within the above definition. This behaviour was not named as such by any agency in contact with the family, nor by the family of Delphine and Julien.

4.1.3 The family consistently stated that their main concerns were that Julien would have a relapse in relation to his mental health, and not comply with his medication; nevertheless they were also concerned over his behaviour when he destroyed property and were fearful of what he could be capable of as his mental health made him unpredictable. Agency practitioners were in a position to name the behaviour as potentially abusive and to act accordingly in terms of risk identification and referral.

4.1.4 This Review showed the extent to which Delphine needed help in caring for Julien; and the lengths she went to in seeking support. Delphine did not name herself as Julien's 'carer'. Some agencies engaged with her as his carer, in the support she was able to provide to Julien around his mental health, but she was not offered support for herself. While Delphine should have remained involved in Julien's care, she should not have been seen as an appropriate carer for him.

4.1.5 Agencies should have recognised Delphine's needs, and her vulnerability due to her age and her own physical health issues, in the context of her ongoing caring responsibilities for Julien, who was also vulnerable. This should have been

addressed with Delphine, and could have been by a number of agencies on different occasions. Practitioners could – and should – have made referrals to carers support services, a specialist domestic abuse service, to adult social care and/or to safeguarding vulnerable adults.

4.1.6 Delphine repeatedly sought help, but ultimately felt unsupported.

4.2 Lewisham Medical Centre (LMC)

4.2.1 Lewisham Medical Centre held the unique position of having the care of, and regular contact with, both Delphine and Julien. It is of note that the records for Delphine were solely focused on her physical health; at no time in Delphine's medical records was there a mention of her caring role for Julien. Contact with Delphine about Julien was recorded in Julien's medical records.

4.2.2 The Lewisham Medical Centre (LMC) IMR recognises that contact with Delphine focused on her physical health care needs and not on her as a carer for Julien, with little evidence of discussions with her on how she was coping, or her mental wellbeing. There is evidence that on one occasion the GP printed off a leaflet for Carer's UK for her to seek further help; but more discussion with Delphine could have been helpful (see discussion in 5.2.4); and a direct referral made for Delphine rather than leaving it up to her to take action. The IMR notes that the GP may have made an incorrect assumption that because Julien was not living with Delphine, and was working and living independently, that Delphine was not a carer.

4.2.3 The IMR also highlighted that Delphine was not asked about domestic abuse at any point, and that this could have opened an opportunity for Delphine to talk about her relationship with Julien and any needs or concerns she may have had.

4.2.4 The GP's actions in relation to Julien's mental health were proactive and positive. Referrals were made to the mental health service each time he (or the family) presented with these issues. In March 2015 the GP was persistent in getting the mental health service to attend Julien and assess him, making four phone calls in three days. This included prompt follow up to the report from the Out of Hours doctor on 17 March 2015. (LMC have outlined to the Review their robust system for ensuring that all out of hours reports are acted upon as quickly as possible).

4.2.5 The family have highlighted to the Review the positive involvement of the GP with Julien around his mental health at that time.

4.2.6 The IMR makes the following recommendations:

4.2.7 "*Domestic violence and Adult Safeguarding training as commissioned by Lewisham CCG to be mandatory for all staff. Additionally the Lewisham IRIS*

team will be invited to deliver in-house specialist domestic violence training sessions and support the practice team to become better equipped to respond to concerns and disclosures of Domestic Violence/Abuse (DVA) from all patients including perpetrators.

(a) *The practice team will develop and enhance their safeguarding responses to both children and vulnerable adults and benefit from a streamlined and simple referral pathway for their patients to a named advocate educator, reducing time required from GPs and practices to respond to disclosures and related issues. This training will consist of 3 sessions. These are:*

(b) *Session 1: Clinical staff; 2 hours of training, delivered by the advocate educator and clinical lead. The training focuses identifying DVA, on the health impacts and the referral pathway for support.*

(c) *Session 2: 6 - 8 weeks later to Clinical staff; 2 hours of training, delivered by the advocate educator. A follow up to how session 1 has been implemented in practices and any issues relating to this. The session also focuses on risk indicators, working with perpetrators of abuse.*

(d) *Session 3: 1 hour delivered to reception staff involving awareness raising of DVA and responding to a disclosure appropriately.*

4.2.8 *Domestic violence to be routinely asked about in consultations, particularly if there are vulnerability factors. This expectation will be communicated in practice meetings and periodically confirmed through audit of consultations. The IRIS[25] training will help to raise awareness of the importance of this. [Training has been arranged; audit of 'domestic violence/abuse' code on patient record system to be carried out, in addition to audits of consultations, use of IRIS HARK template and IVDA referrals before and repeated 1 month after the training to see if improvement, and periodically thereafter..]*

4.2.9 *Caring responsibilities to be routinely asked about in consultations, to identify carers and provide opportunity for carers to talk about any difficulties or support they might need. This expectation will be communicated in practice meetings and periodically confirmed through audit of consultations. This requirement is also covered in the practices Identification of Carers policy. [Training to be sought from Carers Lewisham; audit of 'carer' code on the LMC patient record system to be carried out.]*

[25] A general practice-based domestic violence and abuse (DVA) training support and referral programme that has been evaluated in a randomised controlled trial. Core areas of the programme are training and education, clinical enquiry, care pathways and an enhanced referral pathway to specialist domestic violence services. www.irisdomesticviolence.org.uk

4.2.10 *Carers should routinely be offered referral to social services for a carer's assessment via scait@lewisham.gov.uk.*

4.2.11 *The practice has set up a bypass line, to enable communication between other healthcare professionals and GP, and avoid the delays that can occur if the caller has to go through reception at busy times.*"

4.3 South London and Maudsley NHS Foundation Trust (SLaM)

4.3.1 SLaM had three separate periods of contact with Julien: 2010/11, 2014 and 2015.

4.3.2 From the GP referral received on 15 October 2010 the recording of SLaM's contact with Julien and his family does not support a thorough analysis: for example there is no record of the Assessment and Brief Treatment Team's first meeting and assessment with Julien, which is assumed to have occurred on 27 October 2010 (based on the GP record, see 3.5.7) and no record of the discharge that the GP was notified of (2 December 2010, see 3.5.9). On 23 November 2010 during a telephone conversation with Julien's brother Fred there is a note that they "*should have approached the matter differently*" but there is no indication given as to what was wrong about the initial approach or how this would change in future contact.

4.3.3 Delphine's son Fred informed the Review that in the appointment on 27 October 2010, a Care Worker saw Delphine and Julien separately, not a Consultant Psychiatrist, as had been requested by themselves and the GP. Julien told the Care Worker that he was fine and needed no help; Delphine felt that her concerns had been "*dismissed*" [Fred's words]. This was a distressing and frustrating experience for Delphine. She complained to Lewisham Medical Centre, who re-referred Julien and he was subsequently seen again (see 3.5.8).

4.3.4 A further meeting took place, the result of which was the letter to the GP dated 2 December 2010 from the Consultant Psychiatrist at the Community Mental Health Team (see 3.5.9); neither the appointment nor the letter were recorded on the SLaM system.

4.3.5 As far as the subsequent records indicate, Julien was not met with again after this, due to an inability to arrange a suitable time for a home visit and then due to Julien apparently forgetting an appointment in December 2010. The family were advised of what to do in an emergency, which is good practice. There were no further records until September 2011 (nine months later) in which it was recorded that Julien would be discharged to his GP "*as there has been no further contact*".

4.3.6 If these records are an accurate reflection of the contact with Julien then he was not provided with a high level of service; if not then they reflect very poor

recording by the practitioners involved. The family's difficulties in arranging an appointment were reasonable and should not have been a reason for contact ceasing. The way in which Julien was discharged – following no apparent contact for nine months – means that there was no update to the plan detailed in the letter to the GP on 2 December 2010 to support Julien or his family.

4.3.7 The next period of contact started on 20 May 2014 with another referral for Julien. Although it does not state from whom the referral came, the GP records indicate it was from them (see 3.5.14). This referral was processed on 6 June, and the family were contacted on 20 June 2014 due to difficulties in gaining contact details: the delay was caused by the Team attempting to get these contact details from the GP, rather than checking their own system first.

4.3.8 There was no reference in the records to the previous episode in which Julien had been in contact with the Mental Health Team (2010/11). An assessment was conducted with Julien, with his brother's views also noted along with any disagreement between the two. At one point the assessment was contradictory: recording that Julien's understanding of his physical health condition was good, but also recording that Julien felt he only needed to take his medication "*when there was a crisis*" which suggests that he did not fully understand why he needed the medication. This is unfortunate as it was partly on the basis of the assessor's conclusion that Julien did understand his physical health condition that he was discharged back to his GP (in addition to there being no evidence of symptoms of psychosis).

4.3.9 During this contact there was no apparent consideration of the needs of Julien's family in their role as carers for Julien. A carer's assessment could have been considered or other referral e.g. to Carers Lewisham, or at the very least an exploration of the support networks in place for the family and what their needs were. The practitioner noted that they had advised the family to be more supportive of Julien, as Julien had stated he felt that his family did not understand his situation and were not supportive (see 3.6.18.g). This apparent 'unsupportiveness' could have been challenged by the practitioner – particularly in light of the fact that Fred attended the appointment with Julien – in addition to ensuring that Julien's family were given a voice of their own as to their situation and needs.

4.3.10 The only time that SLaM responded to Delphine explicitly as a carer of Julien was when Delphine's Member of Parliament contacted them (as a result of Delphine's complaint). A letter was sent but there was no response from Delphine and she was therefore discharged. Nevertheless Delphine continuing to feel unsupported: it is possible she did not receive the letter, or did not feel it applied to her. The approach of writing a letter was not the most proactive or

personal one that could have been taken; but Julien was not at that time within the care of the Trust this was understandable.

4.3.11 There were many other opportunities, throughout Julien's inpatient stay in 2015, for SLaM staff to engage with Delphine directly in relation to her support needs. Delphine was treated directly as Julien's carer, particularly around the support that she and the family could offer Julien during his planned extended section 17 leave. Despite this, staff consistently failed to offer Delphine a carer's assessment and/or a referral to Carers Lewisham.

4.3.12 The final period of contact with Julien started in February 2015 with a referral from the GP. The appointment offered was not convenient as Julien would be at work, and the Community Mental Health Team agreed to find an appropriate time; there is no record of this being done. Julien's GP contacted SLaM on 17 March 2015 due to Julien's deterioration, and the GP was informed that a home visit had been arranged but "*the client's brother had declined the appointment*". This is not a true reflection of the contact with Julien's brother: he did not decline the appointment but requested it be rearranged, which was not done.

4.3.13 SLaM acted quickly to assess Julien's needs following the GP's intervention on 17 March 2015. Julien was appropriately detained under *Mental Health Act Section 2* based on significant concerns over the impact his mental health was having on his physical health.

4.3.14 During his time under SLaM's care Julien did not receive a definitive diagnosis of his condition, and this has been judged by the SLaM investigation as understandable given the difficulties staff had in assessing his thoughts and mood. Nevertheless, staff gave their impressions of Julien which included:

(a) "*no evidence of ongoing psychosis*" (20 March 2015)

(b) admission "*due to psycho-social stressors & inability to cope in context of Aspergers.*" (25 March 2015)

(c) "*adjustment disorder in ASD [Autistic Spectrum Condition]; mixed anxiety & depressive disorder*" (31 March 2015)

(d) it seemed more likely to be a "*mood disturbance*" not a psychotic episode (8 April 2015)

(e) Julien "*is psychotic and needs to be treated*" (15 April 2015)

(f) Julien's "*mental state appears to be deteriorating but the reason remains unclear*" but there was no evidence of psychosis (23 April 2015)

4.3.15 No care plan was made. Staff planned to monitor Julien, encourage him to take his medication, to eat and drink, and to take leave from the ward. No other plan

was made until 14 April 2015 when it was decided to develop a structured timetable for Julien to support him in his recovery.

4.3.16 This demonstrated that staff recognised the fact that Julien needed structure and routine. This understanding was not always present, and a month later (19 May 2015) it was recorded that "*staff find it difficult in getting him to be slightly flexible in certain things*".

4.3.17 The professionals working with Julien sought no expertise in relation to his Autistic Spectrum Condition. This should have been done at the earliest opportunity during assessment on Clare Ward. Julien was referred to SLaM's Lewisham Autistic Spectrum Condition and ADHD Service on 14 April 2015, and he had an initial assessment on 16 April 2015. Due to waiting lists, Julien was not offered an appointment by the service until 6 August 2015 – the letter with this appointment was sent the day after the homicide. There was a record of a referral being made to the "*autism psychologist*" on 27 April 2015 but this did not appear to have been actioned (see 3.6.54).

4.3.18 The service provides diagnostic assessments for Autistic Spectrum Condition, as well as a specialist psychology service that provides psychological treatment for adults with a Condition who have additional mental health problems. Had this service been brought in earlier in the assessment and care planning with Julien it could have lead to a greater understanding of the interplay between his Autistic Spectrum Condition, his physical health issues and his mental health and led to a potentially improved response.

4.3.19 The records throughout Julien's time in hospital were inconsistent: given that the only initial plan was to encourage Julien to take his medication and to eat and drink, it is surprising that, of the 239 entries made by ward staff relating to 'general observations' of Julien, 102 did not record whether he took his medication and 61 did not record whether he had something to eat and/or drink.

4.3.20 This is particularly of note when staff recorded that Julien had taken his medication for the first time on 30 April 2015, and observe that from this point forward he consistently took his medication. The records in fact show that, of the 89 records prior to this, in 22 Julien was recorded as having taken his medication, and in 43 it was not recorded whether he did or not. Subsequent to 30 April 2015, there were a further 59 entries in which Julien's medication compliance was not recorded. (NB: this information was most likely captured on the medication chart; but should also have been entered on to the main system.) This point has been fed back within SLaM to the internal review of ePJS (Electronic Patient Journey System).

4.3.21 This is a significant number of records with information missing, and potentially undermined SLaM's ability to fully assess Julien's behaviour and progress; and suggests that the interpretation on 30 April 2015 that Julien was taking his physical health medication 'for the first time' may not have been correct. In addition different staff interpreted Julien's behaviour differently. Throughout his inpatient stay, Julien spent nearly all his time in his room. This was variously recorded as Julien "*isolating himself*" or Julien spending time "*resting*" in his room.

4.3.22 Julien was consistently noted as not fully understanding his situation: when he was given dates on which *Mental Health Act 1983* Sections (2 and 3) would expire he remained fixed on those being the dates on which he would be discharged, regardless of his compliance with medication or other requirements (see for example paragraphs 3.6.40 and 3.6.59). Staff attempted to explain the different section assessments and outcomes to him but the records suggest that he never fully took these explanations on board.

4.3.23 Julien often appeared confused, having fixed and repetitive conversations with staff and giving confusing and at times contradictory answers to questions about his history (for example the death of his friend) and his life (for example his living arrangements).

4.3.24 The records and the progress of Julien towards extended Section 17 leave and discharge from the ward suggest that staff were highly optimistic about Julien's ability to cope and manage with minimal SLaM intervention during extended leave and following discharge. There was no recording of what staff considered could be risk factors for Julien to deteriorate; and significantly there was no recording of discussion of the fact that this was a recurring situation for Julien, the first occasion being 2010/11. On discharge at that time, the Psychiatrist noted that if issues recurred then medication could be required (ref 3.5.9) and this did not appear to have been addressed in 2015. The SLaM investigation found that Julien had told the Occupational Therapist that he did not need a care package or further support, because he had lived independently for many years. This contradicted the family's information that they had been supporting Julien and caring for him for a long time; this did not appear to have been explored.

4.3.25 Julien's family were unconvinced of Julien's readiness to go home and in their feedback to the Review stated that they felt that their concerns were not adequately responded to. For example, the family told staff that Julien had thrown away a number of mobile phones they had bought for him; yet part of the

plan was for them to get him a phone on which the Social Inclusion and Recovery Service (SIRs)[26] staff would attempt to contact him.

4.3.26 Another example is that the family were concerned that Julien was being allowed on unescorted leave from the ward with no money, food, drink or supervision as to where he was going. In one instance this led to him going to his work and chatting to staff, which made the family feel uncomfortable, as they had provided medical certificates to the effect that Julien was in hospital. The family were clear that Julien was vulnerable when out of the ward alone, and they would have been proactive in supporting him if they had known when he was taking this leave. They informed the Review that they never fully understood the nature of the Section 17 leave; that staff had not explained what it meant, or how Julien would continue to be cared for. Combined with the feeling of their concerns over Julien's behaviour not being listened to, this has left the family since the homicide feeling angry and frustrated. SLaM accepted in their investigation that staff had not adequately communicated with the family; the actions in relation to this are set out below (5.2.5.b). In addition, the SLaM investigation showed that staff did not want Julien to return to Delphine's home, and that staff could have taken more action to avoid this.

4.3.27 Julien was noted as being "*concrete in his thinking and routines*" and that it was difficult to try to get him to be flexible, as a result of which a structured timetable was developed for Julien to support him during his time on the ward. This was not carried through to extended Section 17 leave planning or discharge planning, and there did not appear to be recognition of, or discussion around, the impact on Julien of the end to this structure and routine once he left the ward. This was despite the concerns of one consultant being recorded, on 11 June 2015, that it was not clear "*how far Julien currently is from baseline*".

4.3.28 The SIRs Occupational Therapist showed a dedicated and patient approach with Julien and appeared to develop a good relationship with Julien. They initially recommended that Julien required a high level of support in his transition to being in the community again (11 June 2015) through provision of a Care Coordinator.

4.3.29 The planned Care Coordinator involvement was not proceeded with. In an email exchange between the Care Coordinator and the SIRs Occupational Therapist on 7 July 2015 it was recorded that SIRs no longer felt Julien needed the Care Coordinator despite the fact that it was "*difficult to predict how Julien will manage*

[26] Provides person-centred support with the aim of enabling people to explore their goals and ambitions, to become more independent, to stay well, and to feel part of their community.

once he is back home". The reasons for the scaling back of support to Julien were not recorded.

4.3.30 A plan was in place to monitor Julien once he was on extended Section 17 leave from the Ward; this was focused on his ability to self-care, to eat and drink and take his physical health medication. There appeared to be a lack of exploration around his mental health: there was a lack of (recorded) discussion or understanding from staff of what had caused Julien's mental health deterioration or what the risks were that could lead to a relapse.

4.3.31 On 6 July 2015 Delphine informed staff that Julien had destroyed her property during a visit to her home the day before. This was not viewed as evidence of potential domestic abuse, and no action was taken in relation to this new information about Julien's behaviour outside of hospital. Staff documented tensions between Julien and Delphine on 6 July 2015 but no action was taken and this did not influence any risk assessment around Julien's leave from the ward. Delphine was not offered a carer's assessment at any point during Julien's inpatient stay and there is no record of discussion between staff and Delphine over her needs.

4.3.32 The SLaM investigation report – provided to this Review in place of an IMR – concluded that Julien had experienced "*an episode of adjustment disorder precipitated by difficulty in coping with stress at work (due to reduced staffing levels) in the context of a decreased tolerance of stress due to autism spectrum disorder.*" He was considered well enough for extended Section 17 leave, on the basis that SIRs would be visiting him, and he would return to Clare Ward for review.

4.3.33 The SLaM investigation report outlined the following areas of notable practice:

(a) "*Even though Julien's presentation was complex and his diagnosis unclear, Clare Ward appreciated the complexities of his neurodevelopmental disorder. The ward made a plan to collect a large mental state sample over a significant period of time in order to intervene appropriately, and resisted intervening pharmacologically when they were unsure what they were treating. The ward assessed the pros and cons of treatment versus non-treatment.*"

(b) *The Occupational Therapist's involvement in Julien's care was exceptional. They went to Julien's house with him on one occasion, communicated well with his family and seemed to know Julien more than any other staff member. They had also put a plan in place to support Julien in the community following his upcoming discharge from the ward. However the family did not feel that the Occupational Therapist fully understood the*

impact of Julien's Asperger's syndrome on his understanding of situations and it is the opinon of the investigation team that if Julien had had a care plan it would have made expectations clearer.

(c) *The family commended the assessment made by the court liaison mental health assessor following the incident.*"

4.3.34 This Review suggests that in the first finding, while it was notable that staff were prepared to "*collect a large mental state sample*" over time, that in practice this appeared to prioritise Julien's compliance with medication, eating and drinking: other aspects of his behaviour or mental state, such as the fact he rarely left his room while on the ward, or that he clearly had difficulties with communication received little attention or response.

4.3.35 The SLaM investigation report outlined the following care service and delivery problems:

(a) "*No care plan or associated documentation was completed for Julien.*

(b) *Areas identified as a risk in the full risk assessment of 14 April 2015 were not care planned or explicitly acted on by the ward team. A risk management plan was not written to address the areas raised in the risk assessment. The risk assessment of 14 April 2015 was not updated following significant events.*

(c) *There is no documented mental state assessment and risk was not explicitly considered by nursing staff prior to the patient going on leave on the morning of 8 July 2015.*

(d) *The family felt that the concerns they expressed at the ward round of 7 July 2015 were not taken on board.*

(e) *The family did not receive a carer's assessment.*

(f) *There were poor communications from Clare Ward with the Julien's family.*

(g) *Although a referral had been made to the relevant service, local Autistic Spectrum Condition-related expertise was not utilised.*"

4.3.36 This Review endorses these findings, which are being acted on by SLaM in addition to those outlined in this Review.

4.3.37 SLaM – through their own internal process – have identified recommendations and actions to address all of these findings.

"*Psychosis Clinical Academic Group [CAG; department] – Acute Pathway:*

(a) *Psychosis CAG senior management to develop a process to review the length of stay when diagnosis is unclear through the local bed management system.*

(b) *Clare Ward leadership team to conduct a full review of its internal ePJs documentation auditing processes.*

(c) *Clare Ward Manager and Consultant will ensure there are robust governance systems in place to address any missing documentation to assure them that all patients have care plans and risk assessments that address the plans made in the Multi-Disciplinary Team ward rounds. Ward Rounds on Clare Ward to ensure that care plan have been completed and reviewed. This includes leave care plans.*

(d) *Clare Ward to review policy and working practice on the ward regarding the conducting of risk assessments prior to patients taking Section 17 leave. This is to be audited after six months.*

(e) *Clare Ward to review the supervision processes on the ward and ensure that review of named nurse clients is included in the process and supervision notes.*

Psychological Medicine Clinical Academic Group [department] – Triage:

(f) *The Triage Ward Managers and Consultant to ensure there are systems in place to address any missing documentation to assure them that all patients have care plans and risk assessments that address the plans made in the MDT ward rounds.*

(g) *Clare Ward leadership Team to develop information leaflets for patient's families.*

Trust-wide:

(h) *Professional Leads for each Clinical Academic Group [department] will enlist the help of experts in Autistic Spectrum Condition (ASC) to be considered when a patient with ASC is admitted to hospital. Pathways for obtaining this expertise to be clarified.*"

4.3.38 In addition, the learning from the internal investigation will be shared across the Trust. This Review welcomes these actions.

4.4 London Borough of Lewisham Adult Social Care

4.4.1 The first two contacts of Adult Social Care with the family were in 1997. Unfortunately due to a new system now being in place it was not possible for the

IMR author or the DHR Panel to fully analyse the contacts or the outcomes of no further action.

4.4.2 Following the contact with the Fire Service on 30 April 2010 no further action was taken, and this was viewed by the IMR author as appropriate, as no concerns had been identified sufficient for a referral to be made, and advice was given.

4.4.3 The DHR Panel discussed the contact of Adult Social Care with Fred, Julien's brother, when he registered Julien on the Physical Disability Register scheme (October 2011). The service confirmed that Local Authorities are no longer required to keep a Register.

4.4.4 Fred had fed back that, when this registration took place, the family saw this as a significant event that should have led to an offer of support for Julien and the family. This did not match the understanding of Adult Social Care, for whom the Register was an administration process that would not have been expected to lead to assessment or an offer of support. More effort should have been made to understand and manage Fred's expectations; and regardless of the administrative nature of the process, signposting for support should have been provided.

4.4.5 The DHR Panel agreed that the information provided by Fred on the phone during this registration process (i.e. the reference to Julien's "*psychotic episode*") could have triggered the provision of information about referrals to Adult Social Care or about appropriate support services for Julien and the family.

4.4.6 A carer's assessment should have been considered for Delphine when she was in contact with the service in June 2013. While a referral could not be progressed for Julien without his consent, there should have been recognition that Delphine herself might also have needed help, particularly given her age at that time (79).

4.4.7 Adult Social Care confirmed that, were a similar contact to be made now, then information would be provided about Burgess Autistic Trust and a carer's assessment would be offered. The lack of social care involvement – through referrals for Delphine and/or Julien – in this case is notable. Referrals could have been made by Lewisham Medical Centre or SLaM, which could also have opened opportunities for multi-agency working and support for them both.

4.5 Hexagon Housing

4.5.1 Julien had a 'General Needs' tenancy with Hexagon Housing, which meant that no additional needs had been identified for him and therefore no expectation of Hexagon to offer support. Any additional needs would have had to have been identified by the London Borough of Lewisham during the housing process, and this information passed to Hexagon at the start of the tenancy. Alternatively,

Hexagon could have become aware through another agency, or Julien's family, informing them; or if issues had been identified through their interactions with Julien around his tenancy. As none of this happened, Hexagon were completely unaware of Julien's mental health and other needs.

4.5.2 Hexagon confirmed that during the lengthy process of dealing with Julien's rent arrears, that any vulnerabilities would have been recognised; that the process got to the point of going to court suggests that no vulnerabilities were identified for Julien. Given that they have such a role in supporting people in maintaining tenancies – and taking eviction action where necessary – it would be helpful for staff to have an awareness of issues such as Autistic Spectrum Condition and how it can impact on a person's day to day living and ability to maintain a tenancy. This is addressed as a wider learning point in 5.2.1.

4.5.3 In response to the arson, Hexagon acted appropriately in not pursuing a Police charge as this was the first such event and there were no additional concerns in relation to Julien's tenancy. The Community Mental Health Team were contacted to check whether Julien was in contact with them (which he was not at that time), which is the Hexagon procedure when such concerns are raised. Hexagon also has a pathway through to Adult Social Care if vulnerability or other concerns are identified, which they were not in this case.

4.5.4 During DHR Panel discussions it was noted that all Registered Social Landlords in Lewisham are in the process of updating and implementing Violence Against Women and Girls policies and procedures. This was a finding and recommendation from a previous DHR in Lewisham (case of Kazia). An additional action from that DHR was for Hexagon Housing to ensure the organisation was engaged in the Multi-Agency Risk Assessment Conference (MARAC)[27]; during a DHR Panel meeting this was discussed and action was taken immediately to ensure that this was taking place.

4.6 London Ambulance Service (LAS)

4.6.1 The call made on 17 March 2016 was triaged as a non-life threatening event and therefore the ambulance was not dispatched as a priority. Operational pressures on the service also impacted on the delayed dispatch as life-threatening contacts were responded to first.

[27] Multi-agency, monthly, meetings for the purpose of sharing information and collaborative safety planning for the highest risk victims.

4.6.2 The contact with the Out of Hours doctor was in line with usual procedure for handing over care following attendance.

4.6.3 The IMR author concluded that the LAS response on the two dates that ambulances were called were according to procedure and appropriate. Julien was at that time under the care of his GP, and the LAS staff shared information with them appropriately.

4.7 University Hospital Lewisham

4.7.1 The Hospital had a significant amount of contact with Delphine in relation to physical health issues, which were largely due to her age. At no time did Delphine disclose any concerns or issues around home or family relationships. Enquiry could have been made around her needs and living arrangements at any point during her contact, given the pressures placed on her by her age and physical health conditions. This could have led to support (signposting or referral) in relation to any needs Delphine may have had, or consideration (in light on all these issues in addition to her caring responsibilities) for a safeguarding adults referral.

4.7.2 When Delphine attended the Emergency Department on 10 December 2014 it was concluded – and the IMR author agreed – that her injury was consistent with the explanation given, and therefore this did not raise any concerns. While the injury itself was accidental, exploration could have taken place around Delphine's living arrangements, and whether she was safe in her home, for example in relation to falls, and whether she was managing in light of her age and physical health needs. Further enquiry could also have led to discussions (and signposting or referral) with Delphine over her needs in relation to caring for Delphine.

4.7.3 The Hospital have made the following recommendation in their IMR to address this learning: "*highlight as part of trust safeguarding training that healthcare professionals should ask older patients if they have caring responsibilities for others as standard practice, and offer a carer's assessment if relevant*".

4.7.4 Julien's only substantial contact with the hospital was when he was brought by ambulance on 19 March 2015. The Hospital records match the information provided by the London Ambulance Service, and he was processed appropriately and handed over to SLaM.

4.7.5 The IMR outlines the processes and procedures in place at the Hospital for the identification of domestic abuse and response to disclosures and concerns.

4.8 Metropolitan Police Service

4.8.1 The Police response to the incident on 23 April 2010 in which Julien was burning his property was appropriate and proportionate given that he was not aiming to harm anyone, and that Hexagon Housing would not support a prosecution. While Julien was under arrest the Forensic Medical Examiner and Mental Health Liaison Nurse saw Julien, and did not record any concerns or actions in relation to his mental health. This inevitably relied on Julien's presentation at that time, and his self-disclosure, neither of which raised any concerns.

4.9 Burgess Autistic Trust

4.9.1 London Borough of Lewisham and Lewisham Clinical Commissioning Group jointly commissioned this service specifically for people with Autistic Spectrum Condition in recognition of the gap in local services. While people with the Condition were recognised as in need of a specific service, they rarely met the threshold or eligibility criteria for Adult Social Care or Mental Health involvement, and care plans from those services were not always the appropriate response.

4.9.2 The Trust provided information to the family on request, and met with Julien to assess his needs and offer their services. These are accessed on a voluntary basis, and when Julien declined the service no further action was taken, in line with procedure. No additional concerns were identified during their contact with Julien and the family.

4.9.3 Julien was recorded as disagreeing with his family about whether he had Autistic Spectrum Condition, however the Trust find this to be common amongst its service users and therefore this was not of concern.

4.9.4 It would have been appropriate for the Trust to discuss with Delphine if she had any support needs in relation to her caring for Julien, and to provide information, signposting or referral in relation to this. In particular given the conflict which the Service observed between Delphine and Julien: while a common occurrence in the families the Trust works with, given Delphine's age concerns could have been raised.

4.10 Bromley and Lewisham Mind

4.10.1 Mind Peer Support Service had no direct contact with Julien, and the IMR author was unable to establish whether it was Julien requesting the service or the family.

4.10.2 Fred fed back to the independent Chair that after contacting the Peer Support Service they "*heard nothing back*". From the Mind records, information and a referral form were sent as requested. It is not Mind policy to follow up on information sent; this is in part due to the volume being too high and also that people access the service voluntarily.

4.10.3 The information and referral form were posted to Delphine's house as requested, for this to be passed to the GP to be completed. The GP has no record of seeing this referral form. We cannot know whether the information and form didn't arrive, or the family decided not to pursue it.

4.11 Diversity

4.11.1 *Gender*

Being female is a risk factor for being targeted by a perpetrator of domestic abuse. Delphine experienced behaviours from Julien that are within the definition of domestic abuse, albeit there was no evidence of Julien exerting coercive control. The increased risk women face in relation to domestic abuse could have been recognised by SLaM and Delphine's GP on the occasions when Delphine disclosed that Julien had visited her home and destroyed her property and that she was concerned about this. This is addressed below in the discussion on domestic abuse recognition (5.2.2).

4.11.2 *Age*

Delphine's age was noted on a number of occasions during DHR Panel discussions, and was seen by the family as a significant factor in her inability to continue to care for Julien in the way she had done previously. This did not appear to be recognised by her GP, SLaM or Adult Social Care when they were discussing with Delphine her caring responsibilities for Julien. This is addressed below in the discussion on vulnerability (5.2.3) and carers (5.2.4).

4.11.3 *Disability*

Julien's family saw him as having a disability in relation to his Autistic Spectrum Condition. In Julien's contact with Burgess Trust and SLaM there was evidence that he disagreed with his family about the diagnosis, to the extent that he did not believe he had the Condition and needed no support around it. Awareness of Autistic Spectrum Condition is discussed below (5.2.1).

Julien could also have been considered to have had a disability in relation to his ongoing mental health issues, albeit they were undiagnosed. In particular, the fact that these issues were recurring: first seen in 2010/11, then a gradual deterioration from May 2014 up to the rapid changes in March 2015. The interplay of Julien's various issues is discussed below (5.2.3).

4.11.4 *Race / Nationality*

Julien was recorded as 'Mauritian' and 'Black' by SLaM however there were no other records to suggest that this impacted on his needs or care. On the day of the homicide, SLaM noted that when Delphine telephoned she was difficult to

understand due to her accent; this was the first and only occasion any agency made reference to Delphine having an accent or being difficult to understand.

Delphine's son told the Review that English was Delphine's second language, and there were times when he and his sisters felt this led to her not communicating clearly with services, hence they would often follow up Delphine's contact with an email or phone call to make sure it was clear. He stated that Delphine's communication could be challenging if she were distressed or upset.

With the exception outlined here, no agency mentioned any difficultly in communicating with Delphine.

4.11.5 *Religion and belief; sexual orientation; gender reassignment; marriage / civil partnership; pregnancy and maternity*

No information was presented within the Review to indicate these were issues.

5. Conclusions and Recommendations

5.1 Preventability

5.1.1 Delphine was tragically killed by her son, Julien. Delphine was an elderly person with multiple physical health issues as a result of her age. She, and her other children, had always cared for Julien due to the impact on his day-to-day life of Autistic Spectrum Condition. Delphine often took on this caring role alone. Delphine continued to want to be involved in Julien's care, and to do what she felt was best for him; but this was becoming increasingly difficult and she should not have been seen as an appropriate carer for Julien. Delphine tried many different ways to get support, including contacting her Member of Parliament but ultimately she felt unsupported.

5.1.2 Julien had not been violent to family members prior to the homicide. At the start of his inpatient stay he had been assessed by SLaM as posing a low risk of harm to others and when asked stated that he had no thoughts of harming others (20 March 2015). He was not deemed to be a risk to his family when he was taking leave from Clare Ward. Julien's brother Fred told the Review that Julien had no history of violence; but that there were times that Delphine and the family were fearful of what Julien was capable of, given the unpredictability of this mental health.

5.1.3 There were two routes, which, if taken, had the possibility of developing opportunities for the homicide to have been predicted and/or prevented. But it is not possible to say, definitively, that either could have prevented the homicide.

5.1.4 One route was through practitioners fully *seeing* Delphine, her whole situation, needs and the risks she faced. Delphine could have been identified as a possible victim of domestic abuse and/or as a vulnerable adult in need of safeguarding – either or both of these pathways could have been followed and could have led to Delphine being safeguarded from harm. Additionally this could have come from agencies carrying out their duty in offering Delphine a carer's assessment and referring her to Carers Lewisham.

5.1.5 These pathways could have led to appropriate risk identification, referral, and multi-agency working to safeguard Delphine and/or reduce the risk Julien may have posed. In relation to domestic abuse, this could have followed Delphine's disclosure that Julien had damaged her property. These actions fall within the definition of domestic abuse but did not generate any additional concern by the agencies she disclosed to. A view of Delphine as a whole person – her age, her

physical health, the demands placed on her by caring for Julien – could have led to her identification as a vulnerable adult.

5.1.6 The other was through the thorough, comprehensive and holistic treatment of Julien's mental health condition, taking account of his Autistic Spectrum Condition and the family situation, and giving adequate weight to the views of the family alongside the views of professionals. This could have been achieved if staff had completed a care plan, which they did not. A care plan should have been done, and included recognition that Julien himself could be a vulnerable adult due to his Autistic Spectrum Condition, physical health issues and mental health; and could have led to an assessment that, prior to the homicide, he was not well enough to be granted extended section 17 leave.

1. Identification and referral for Delphine as a victim of domestic abuse or vulnerable adult in need of safeguarding

5.1.7 There were opportunities to identify Delphine as a potential victim of domestic abuse, to carry out an *ACPO-CAADA Domestic Abuse, Stalking and Honour Based Violence Risk Identification Checklist*[28] (DASH 2009) and refer her to a domestic abuse specialist service (see 5.2.2). London Borough of Lewisham commissions a dedicated service for victims of familial violence. The Familial Abuse Worker (currently delivered by Refuge) supports victims of familial abuse in Lewisham and works closely with family members and the victim. The familial abuse scheme supports family members, older people and males and females over the age of 16, including children.

5.1.8 The Review notes that many agencies and services in Lewisham, in addition to specialist domestic abuse providers, have received domestic abuse training and can use the DASH and follow appropriate care pathways and referrals. The independent Chair answered the 27 questions of the DASH Checklist (see Appendix 2) with the information provided to the Review from agencies and the family: based on this, we can speculate that Delphine may have been assessed as 'standard risk'[29]. The Review did not uncover any evidence of a pattern of

[28] http://www.dashriskchecklist.co.uk Further information provided here is taken from the DASH 2009 Checklist and this website

[29] Three levels of risk are used. Standard: Current evidence does not indicate likelihood of causing serious harm. Medium: There are identifiable indicators of risk of serious harm. The offender has the potential to cause serious harm but is unlikely to do so unless there is a change in circumstances, for example, failure to take medication, loss of accommodation, relationship breakdown, drug or alcohol misuse. High: There are identifiable indicators of risk of serious harm. The potential event could happen at any time and the impact would be serious. In some cases risk is identified by checking the total number of 'yes' answers provided to the 27 questions against a locally agreed threshold. In all cases, and regardless of the number of ticks, the practitioner uses their professional judgement to identify the risk level based on the information given by the victim.

coercive control from Julien towards Delphine; but this of course is without the benefit of the professional judgement of the experienced practitioner who could have completed this with Delphine at the time.

5.1.9 Identification of Delphine as a potential victim of domestic abuse, followed by risk identification and referral, could have provided an opportunity for that service to work with Delphine – and other family members – to establish a full understanding of the situation and for them to be emotionally and practically supported.

5.1.10 Multi-agency working should then have followed, between the specialist service and the referring agency, and others, to appropriately safeguard Delphine from any risk posed to her by Julien.

5.1.11 This support, multi-agency working and risk management could also have flowed from a referral to the safeguarding vulnerable adults service and/or a carer's assessment which, given Delphine's age, physical health issues and caring responsibilities could have been considered by SLaM, Lewisham Medical Centre, Burgess Autistic Trust and Adult Social Care when she made contact with regard to Julien.

5.1.12 Unfortunately we cannot say whether Delphine would have accepted the label of 'domestic abuse' in relation to Julien's behaviour (her family suggest that she may not have), or a referral to a specialist service: but she should have been given the opportunity. If she had, we cannot say what risk level a DASH Risk Checklist would have identified at that time. Potential issues around using the DASH in situations of familial domestic abuse (as opposed to intimate partner abuse) are discussed below (5.2.2).

5.1.13 Likewise she may not have seen herself as a 'vulnerable adult' or as a 'carer' but this pathway should have been considered for the support it could have offered her. Whether or not the labels were applied, or whether they were accepted by Delphine, should not have been a barrier for Delphine accessing support.

2. Thorough and holistic understanding and care planning for Julien

5.1.14 The SLaM investigation report states that Julien did not have a Care Plan, and that staff did not involve the appropriate Autistic Spectrum Condition experts in Julien's care. A Care Plan should have been done.

5.1.15 Only one risk assessment was done with Julien, which was at the start of his care; this was not updated. Most significantly, no updating of the risk assessment was done on 7 or 8 July 2015, particularly when Julien returned to the ward unexpectedly on the night of 7 July 2015, and left again on 8 July 2015. It should

be noted that staff considered Julien to be 'low risk' at this time, hence the decision to grant him extended section 17 leave.

5.1.16 The DHR Panel agreed that Clare Ward staff gave insufficient attention and weight to Julien's family's concerns over his behaviour and overall mental health.

5.1.17 SLaM staff were satisfied that Julien's presentation on admission had resolved itself (based on his compliance with the medication for his physical health, and his consistent eating and drinking).

5.1.18 Delphine's and other family members' concerns that Julien was not as 'well' as he appeared, including reports of concerning behaviours while he was on leave (that to the family were signs of his deterioration, as they were similar to previous occasions) were documented. Nevertheless, ward doctors and staff felt that Julien had improved his self-care and could look after himself without a care package. The extended leave was seen as a "*test*" of whether Julien could take care of himself without that care package. Given the length of time Julien had been on the ward; the potential impact of the removal of a structured routine; and the lack of a clear diagnosis or understanding of what had brought about the initial deterioration, this appears to reflect a high level of optimism around his ability to manage in the community.

5.1.19 Burgess Autistic Trust informed the DHR Panel that an adverse reaction to change – characterised by high levels of anxiety and stress – is common with people who have an Autistic Spectrum Condition. This was not recognised by the staff responsible for Julien's care in the extended Section 17 leave planning, despite their identification earlier that Julien responded well to structure and routine. Thorough care planning and subsequent extended Section 17 leave planning should have taken account of Julien's need for structure and routine, and the significant change about to take place with the extended period of leave.

5.1.20 Had SLaM staff completed a Care Plan, and through this sought advice and joint working – from the start of Julien's inpatient stay – to fully understand and respond to the interplay of Julien's Autistic Spectrum Condition and his mental ill health, and fully taken on board the views of Delphine and other family members in relation to Julien's state, then this could have impacted on risk assessments and discharge planning in such a way that the homicide may have been prevented, as the signs of possible deterioration (e.g. his destruction of CDs) could have been spotted and the extended Section 17 leave delayed. But it is not possible to state with certainty that it could have prevented the homicide, as the change in his behaviour (towards violence) was so significant.

5.2 Issues raised by the Review

5.2.1 *Understanding of and response to people with an Autistic Spectrum Condition*

(a) SLaM, Lewisham Medical Centre, Adult Social Care and Burgess Autistic Trust were aware of Julien's Autistic Spectrum Condition. The Housing Officer from Hexagon Housing had made a note that they felt – based on their interactions with Julien – that he had "*learning difficulties*".

(b) SLaM noted a lack of staff understanding of ASC and how it impacted on Julien's presentation during 2015, and that staff had not sought the advice or support of those with relevant expertise.

(c) This lack of understanding appeared to lead to optimism around Julien's ability to cope in the community, and a lack of analysis of the extent to which the structure provided to Julien in hospital had supported his recovery – and what impact the absence of this would have during extended Section 17 leave and following discharge.

(d) Reviewing the SLaM records of Julien's inpatient stay from March 2015 up to the homicide, it is difficult to see that Julien fully understood what was happening and what was being explained to him. This did not appear to impact on plans for Julien's extended Section 17 leave. The use of expertise on Autistic Spectrum Condition in the management of this case could have alerted staff to this situation and ensured they responded appropriately.

(e) The recommendations made and actions taken by SLaM have addressed this, and this will be monitored through their update reports to the Safer Lewisham Partnership following the completion of this Domestic Homicide Review.

(f) The fact that the London Borough of Lewisham and the Lewisham Clinical Commissioning Group have jointly commissioned Burgess Autistic Trust to deliver a specialist service in the borough shows that there is recognition locally of the need for a specialist response. The DHR Panel demonstrated a high level of awareness of the service.

(g) A recommendation (1) is made for the Safeguarding Adults Board to increase awareness of Autistic Spectrum Condition amongst professionals in the borough.

5.2.2 *Recognition of and response to disclosures of domestic abuse*

(a) Every agency that provided information to the Review outlined that they were unaware of any domestic abuse and had not received any disclosures. Concerns were focused on Julien's self-care and the risk to himself from his non-compliance with physical health medication and when he stopped eating or drinking.

(b) In fact, the GP and SLaM did receive disclosures from Delphine of behaviour by Julien that would fit within the definition of domestic abuse (see above 4.1.1):

(i) In December 2010 Delphine told her GP that Julien had destroyed some of her records while she had been in hospital.

(ii) On the risk assessment completed by SLaM at the beginning of Julien's inpatient stay, the answer on history of domestic violence was 'don't know'; this was not followed up. Towards the end of Julien's inpatient stay with SLaM, Delphine disclosed to staff that Julien had visited her at home and destroyed some of her property – some CDs on one occasion, and a picture frame on another. The records suggest that this was not seen as concerning behaviour: either as an indication of Julien's mental state (given that it mirrored earlier behaviours that had been cause for concern and mental health service involvement) or as an indicator of risk towards Delphine herself.

(c) Damage to property – or threats of such – are recognised forms of domestic abuse, for example as highlighted in the Home Office Statutory Guidance Framework on coercive and controlling behaviours[30]. While Delphine's primary concern – as recorded by staff – was that this was an indicator of a relapse for Julien, staff were in a position to identify this as domestic abuse (particularly in light of the increased risk identified for women, see 4.11.1). Further questioning of Delphine of how she felt about Julien coming to the house, for example whether she felt in fear, could have revealed more (Delphine's family told the Review that, while Delphine was unlikely to have accepted the label 'domestic abuse', she was frightened of what Julien was capable of, as his mental health issues made his behaviour unpredictable). Even without this questioning, Delphine's disclosure should have led to risk identification (for example through the DASH, see 5.1.5) and referral to a specialist service, as well as action to ensure that the identification of this potentially abusive behaviour influenced decisions around the care provided to Julien. Delphine should have been given every opportunity to be seen alone to ensure that she was safe and comfortable to make any disclosures and to answer any questions.

[30] 'Controlling or Coercive Behaviour in an Intimate or Family Relationship: Statutory Guidance Framework' Home Office, December 2015, p17

(d) Older women are at risk of experiencing domestic abuse[31] from partners, ex-partners, family members, non-related carers and others. Men can also be at risk; and this crosses age ranges and life stages, with increasing cases of young people (aged under-18) abusing their parents becoming known.

(e) Of the Domestic Homicide Reviews in Lewisham, three (including this one) have been cases of adult sons who have killed their mothers, including mental health issues and/or drug and alcohol misuse on the part of the sons. The Office for National Statistics Statistical Bulletin on Homicide (11 February 2016) shows that 23% of female domestic homicide victims were killed by a family member; and 97% of all female domestic homicide victims were killed by a male.

(f) Most research focuses on abuse of older people from partners/ex-partners or non-related carers, how to identify and respond to such abuse. Less is known about situations in which adult (or younger) children abuse their parents, and how risk can be identified and managed given the complexities the parent-child relationship adds to any abuse being perpetrated; in particular as both Delphine and Julien could be have been seen as vulnerable in this situation. Standard responses to domestic abuse, while appropriate to a point, may not identify the full situation and a risk identification process such as the DASH may only help so far, given that they were not necessarily developed with familial abuse in mind. More awareness and understanding is required, locally and nationally[32]: a national recommendation (2) is made for the Home Office to utilise DHRs findings to develop more understanding of the risk factors relating to familial abuse; a local recommendation (3) is made for the Safer Lewisham Partnership to work with the commissioned specialist service to improve local awareness of the dynamics and responses required, including awareness of the commissioned service.

(g) SLaM, the Metropolitan Police Service and Lewisham Hospital informed the Review that they have in place a domestic abuse policy and procedure, and this is welcomed. The DHR Panel heard that Hexagon Housing – along with all other Registered Social Landlords in Lewisham – are developing a violence against women and girls policy. These policies should be reviewed

[31] McGarry, J. (2011) 'The impact of domestic abuse for older women: a review of the literature' *Health and Social Care in the Community* 19 (1), 3-14

[32] Women's Aid (2007) *Older Women and Domestic Violence: An Overview* Women's Aid, London

to ensure there is recognition of possible domestic abuse within families, and that destruction of property is shown as a potential indicator of domestic abuse.

(h) A recommendation (4) is made for SLaM to conduct a review of its response to domestic abuse, in light of the learning from this Review, to ensure that the policy and procedure are carried through to practice. A further recommendation (5) is made for a meeting to be held between the four boroughs covered by SLaM's services to identify any common learning from DHRs or other sources.

(i) The remaining DHR Panel member agencies should develop and implement domestic abuse policies and procedures, supported by training, to ensure that all staff are able to identify and respond appropriately and safely to domestic abuse – whether it is disclosed or not. As in the previous paragraph, these policies and procedures should include domestic abuse within families and all indicators of possible domestic abuse including destruction of property.

(j) As highlighted in the NICE Guidelines[33], these policies, procedures and training should be distinct from – but link to – safeguarding policies, procedures and training.

(k) A recommendation (6) is therefore made.

5.2.3 *Recognition of vulnerability*

(a) Delphine was vulnerable due to her age, physical health issues and her caring responsibilities for Julien. Julien was vulnerable due to his physical health issues, Autistic Spectrum Condition and undiagnosed mental health issues. Neither was recognised as such. (See above 4.11.2 and 4.11.3.) This led to Delphine in particular feeling unsupported by agencies, with the focus being on Julien's mental health and what services needed to do to respond to that. While Delphine supported these efforts, and wanted to be part of the care for Julien, agencies should have been more proactive in identifying and responding to her needs, including recognising her potential vulnerability.

(b) This was relevant to SLaM, Lewisham Medical Centre, Burgess Autistic Trust, London Borough of Lewisham Adult Social Care and Lewisham Hospital, all of whom had opportunities to proactively engage with Delphine

[33] https://www.nice.org.uk/guidance/ph50

about her own needs, and make a referral to the Safeguarding Vulnerable Adults service based on all of the factors that were ongoing for her. Multi-agency working could then also have taken place between the relevant agencies to ensure that Delphine was adequately supported.

(c) SLaM and Lewisham Medical Centre could also have referred Julien to Adult Social Care due to his vulnerability, as could the London Fire Brigade, Metropolitan Police Service or Hexagon Housing following the fire incident in 2010. All agencies now have policies and processes in place to ensure this happens.

(d) A recommendation (7) is made for the Safeguarding Adults Board to share the learning from this Review with all members to highlight that consideration should always be given to the potential vulnerability of those with caring responsibilities, with particular reference to age and health.

(e) The need to label an individual as 'a victim of domestic abuse', 'a carer' or 'a vulnerable adult' should not be a barrier to ensuring they are offered any service that could support them – pathways exist for each of these routes, and they all could have been considered and followed. A barrier for Delphine could have been her experience of self-sufficiency, and her feeling that she and Julien were not getting the help they needed – therefore further effort was likely to be required to facilitate her access to those services, to show her that support was available for her.

5.2.4 *Recognition of those with caring responsibilities and response to family concerns / requests for support*

(a) Delphine was very supportive of Julien, and tried repeatedly to get help for him. This support was not forthcoming when it should have been, most obviously in relation to offering a carer's assessment, and support, directly for Delphine herself. She was not seen as a whole person, taking into account her age, physical health, the physical and emotional demands of caring for Julien, and she was not asked about her own needs and wishes (or her rights in relation to the carer's assessment). For the definition of a 'carer' see Appendix 3.

(b) Lewisham Medical Centre, SLaM, London Borough of Lewisham Adult Social Care and Burgess Autistic Trust had opportunities to talk to Delphine – and other family members – about her caring responsibilities for Julien, which were not taken.

(c) Delphine and other family members should have been offered support for their role in caring for Julien. This could have been in the form of a carer's assessment, or a referral to Adult Social Care for a carer's assessment to

be completed. Alternatively referrals could have been made to support in the community for example from Carers Lewisham. It is possible that the family were not aware of the support available, or carers assessments, and therefore not asked for them; the family reported that they did not see themselves as carers, as they were looking after Julien in the ways they always had done. Nevertheless, Delphine's son, Fred, said that Delphine would have been happy to be referred to Carers Lewisham: she knew she and Julien needed help, and would have welcomed it.

(d) Carers Lewisham outlined the service that someone in Delphine's position could have access to, if referrals are made and accepted: "*[from October 2016] we will be offering all carers in Lewisham a Carers Star assessment … to enable us and them to identify and manage their support needs holistically so that together we can help prevent or delay their need for intensive support and (where possible and desired) enable them to continue caring whilst leading independent lives.*"

(e) That Julien did not live with Delphine was one possible reason why Delphine was not seen as a carer, but this was an incorrect interpretation of the situation. Agencies should have discussed with Delphine the extent to which she was caring for Julien and taken action accordingly, rather than relying on assumptions. That they didn't, meant that Delphine (and the family) often felt, and were, unsupported in caring for Julien and the impact it had on her.

(f) The DHR Panel agreed that discussions with family members about their caring responsibilities should not be limited to offering a carer's assessment. While this is an important part of offering support, recognition must be given to the fact that many people do not define themselves as 'carers' – or may not want to, depending on how they understand that term. The DHR Panel recognised that often what the family were seeking was for someone else to care for Julien, in order to take the pressure from Delphine, given her age and health issues.

(g) Carers Lewisham contributed the following in relation to this: "*We know that many people dislike the term 'carer' and will avoid the label. This is often because it gives the impression of a changing power balance within a relationship or it evokes a dependency and/or responsibility, which the carer may not wish to, or feel able to, accept. It also subtly removes a little of the element of choice and can make a choice – to be in relationship – seem more like a burden. It is vital therefore that agencies are mindful of this and seek to avoid labelling. … it is also vital that agencies are clear what help and support could be offered to carers*".

(h) Carers Lewisham suggested that a solution could be "*to promote being a carer as a positive concept and to proactively encourage referrals to Carers Lewisham. We know from our work, however, that there is still a lot of ignorance and misunderstanding amongst agencies (GPs in particular) about carers, caring and Carers Lewisham.*"

(i) This highlights that the way in which caring responsibilities are identified and discussed is critical to ensuring individuals and families get the right kind of support. Training for professionals on supporting people with caring responsibilities should ensure that conversations are open, non-judgemental and allow for the range of different kinds of support an individual or family may need, including the possibility that they do not wish to continue to care for someone.

(j) A recommendation (8) is made to ensure that this learning is acted upon.

5.2.5 *Meaningful involvement of families in the care of individuals*

(a) SLaM treated Delphine and other members of Julien's family as 'carers', albeit without explicitly stating this and offering the appropriate assessment and referral. With the family's consent, they were relied upon to help prepare for Julien's extended section 17 leave. Nevertheless, as the family have fed back to this Review (and to the SLaM investigation), they felt that they did not fully understand the plan for this extended leave, or how Julien's care would continue.

(b) The DHR Panel agreed there was poor communication with SLaM staff and Julien's family. This was also fed back to SLaM by the family as part of the SLaM internal investigation, and accepted. The SLaM Board approved the new Family and Carer Strategy in September 2015. The following actions have been taken:

(i) Family and Carers Handbook reprinted and distributed to all teams. Central stock is kept.

(ii) SLaM held its annual Family and Carers Listening Event. Further borough-based events will take place.

(iii) A programme for those carers who are keen to develop their own skills has been rolled out and is part of the Recovery College prospectus.

(iv) Minutes of the Family and Carers Group meetings are on the Get Involved website. The Family and Carers Strategy is on the SLaM website. There are a number of carer forums in each of the departments (CAGs).

(v) Family and carers are part of the fortnightly SLaM induction programme.

(vi) A Carers Leads Network was launched and has a dedicated intranet site. There will be four meetings a year. Attendance at Network Meetings will be CPD accredited.

(c) Further ongoing activities include:

(i) Activities to identify and support young carers.

(ii) Including more carer themes on the SLaM website, for example knowing your rights.

(iii) Continuing to raise awareness of families and carers.

(iv) Gathering feedback from families about their experiences and using this feedback in further developing staff training.

(v) Work with all departments on their training for staff on responding to carers.

(vi) Produce a Think Family Approach Manual for staff.

(d) A recommendation (9) is made for progress on these actions, and what SLaM have learned about family contact, to be reported on to the Safer Lewisham Partnership. This will be very important in ensuring that the family of Delphine and Julien are reassured that changes are being made.

(e) This issue led to the DHR Panel having a wider discussion on how all agencies connect with family members who may be involved with a service due to one member of the family receiving support/intervention. The DHR Panel agreed that it is essential that practitioners work with families in a collaborative way, not simply asking them to support the actions of the service; and that involvement of family should continue for the duration of that agency's involvement.

(f) The DHR Panel agreed that this issue should be a fundamental part of any approach to service provision where families are involved, and this has been included in recommendation 7.

5.2.6 *Recording of information / information sharing and contact between agencies*

(a) There were issues with the recording of information about Julien and Delphine by Lewisham Medical Centre and SLaM.

(b) With regard to SLaM, the recording around Julien's involvement with the service in 2010/11 is incomplete and it is not possible to identify exactly

what happened. In March 2015 there appeared to be a lack of discussion or action around the fact that this was the third time in five years that Julien had come to their attention for apparently psychotic symptoms. During the first contact (2010) it was noted that while that episode did not require treatment, should the symptoms recur treatment should be considered. There is no documentation to suggest that staff checked back through previous records. The inconsistent recording in relation to Julien's compliance with medication, food and drink has also been noted.

(c) Lewisham Medical Centre and SLaM agreed that communication between the two could have been improved: for LMC to be more proactive in contacting SLaM about Julien's inpatient stay, and for SLaM to communicate with LMC when Julien's extended section 17 leave was being planned. A recommendation (10) is made.

(d) Information flow between Lewisham Medical Centre and SLaM has recently improved in relation to referrals made by the GPs: these are now emailed, and checks are made to ensure that referrals have been delivered and more feedback is being received at that point. This development is welcome.

(e) The DHR Panel discussed the responsibility of agencies to pass information to others involved in an individual's care. The Clinical Commissioning Group confirmed that health professionals are expected to complete referral forms when a patient is transferred from one service to another; while these may differ due to patient circumstances, there is a standardised expectation of what information these should contain and the timescales for sending them.

(f) The Care Act sets out that all local partnerships have a duty to provide information to professionals and the public on services available to them, and that this information should be readily accessible. A recommendation (11) has been made.

(g) The family made the point that there were agencies who were engaged with Julien at different points who were unaware of his Autistic Spectrum Condition and his mental health issues. For example, Hexagon Housing, and the Police. In this case it is difficult to see how these agencies – or others who may have become involved – could have learnt of Julien's situation, unless they were specifically contacted by for example Lewisham Medical Centre, SLaM, or a member of the family.

(h) The wider point is the need for agencies to work together to address an individual's – and a family's – needs; as outlined above, had a referral been made to Adult Social Care, this could have opened opportunities for multi-agency working and information sharing.

5.2.7 *Continuing issues from previous Domestic Homicide Reviews (DHRs)*

(a) Many issues from this DHR were recognised in two previous Lewisham DHRs (cases of PF and EC). These include: lack of recognition of domestic abuse; involvement of families in care planning; and using information from families to support risk assessment in relation to mental health.

(b) A recommendation (12) is made for the actions taken in response to those DHRs to be reviewed in light of the learning from this case and further actions to be identified where required.

(c) It was highlighted at the DHR Panel that, given that this is the sixth DHR for the Safer Lewisham Partnership, it is surprising that the same issues are recurring in relation to awareness of domestic abuse, appropriate responses to the issue, and knowledge about specialist services.

(d) Leadership is a foundation of an effective partnership and agency response to the issue of domestic abuse; and agencies must take responsibility for their own responses, while working in partnership as part of a whole system approach. This is set out clearly in research and information on the Coordinated Community Response to domestic abuse[34].

(e) A recommendation (13) is made for the Safer Lewisham Partnership and Adult Safeguarding Board to work together to ensure effective, consistent and ongoing leadership on responses to vulnerability and risk is provided by all organisations in the borough, including commitment from those agencies to address their own responses and communicate this to the Boards, and to work collaboratively.

(f) A recommendation (14) is made for the Home Office to address more widely the learning in relation to domestic homicides perpetrated by people with previously identified mental health issues. The family reported to the Review that they felt that there "*are too many*" of these and that "*more needs to be done*" to understand why some people with mental health issues become violent, and what services are doing to work with them, and prevent tragedies, like this one, happening again.

5.3 Recommendations

The recommendations below to be acted on through the development of an action plan, with progress reported on to the Safer Lewisham Partnership within six months of the Review being approved by the Partnership. DHR Panel

[34] http://www.standingtogether.org.uk/about-us; http://www.ccrm.org.uk

agencies to report on the progress of IMR recommendations to the Safer Lewisham Partnership within the same timeframe.

5.3.1 Recommendation 1 (ref 5.2.1.g)

Safeguarding Adults Board to consult with Autistic Spectrum Condition experts in the borough and with people living with Autistic Spectrum Condition, to support the development of briefings for all professionals in Lewisham on:

- Identifying people living with Autistic Spectrum Condition
- Understanding how routine assessments may need to be delivered differently with a person living with Autistic Spectrum Condition
- Challenging assumptions and stereotypes about people living with Autistic Spectrum Condition

Subsequently for audits to be carried out within services to identify the impact of the briefings, and the results shared with the Safeguarding Adults Board.

5.3.2 Recommendation 2 (ref 5.2.2.f)

Home Office to utilise Domestic Homicide Review findings to develop – and share nationally – a greater understanding of the nature and risk factors relating to familial abuse, and any trends to be aware of.

5.3.3 Recommendation 3 (ref 5.2.2.f)

Safer Lewisham Partnership to work with the locally commissioned specialist service for victims of familial abuse to better understand the dynamics of these cases, and the best practice responses to them. To share this learning widely within Lewisham.

5.3.4 Recommendation 4 (ref 5.2.2.h)

SLaM to review its response to domestic abuse, in light of the learning from this Review, covering (but not limited to): staff awareness and availability of training; the effectiveness and impact of policies and procedures; the identification of victims and perpetrators, risk identification and referral, and safe and appropriate ongoing work with those individuals including multi-agency working, and for a mechanism to be put in place for ongoing monitoring of the response.

5.3.5 Recommendation 5 (ref 5.2.2.h)

A discussion to be held between Local Authority Violence Against Women and Girls Leads, Clinical Commissioning Group representatives from Lewisham, Croydon, Sothwark and Lambeth with the SLaM domestic abuse lead and

internal review leads to address common themes across DHRs in the four boroughs.

5.3.6 Recommendation 6 (ref 5.2.2.k)

Safer Lewisham Partnership to set out its minimum standard for what all domestic abuse policies and procedures must contain, and for all Partnership member agencies to:

- ensure that their policies and procedures meet this minimum standard
- implement the policy and procedure with training for staff
- carry out a case audit six months after implementation to ensure that the policy and procedure has carried through to practice
- feed back the outcome of the audit to the Safer Lewisham Partnership

5.3.7 Recommendation 7 (ref 5.2.3.d)

Lewisham Safeguarding Adults Board to share the learning from this Review with all its members, to highlight that consideration should always be given to the potential vulnerability of those with caring responsibilities, with particular reference to old age and health.

5.3.8 Recommendation 8 (ref 5.2.4.j)

The Safer Lewisham Partnership and Lewisham Adult Safeguarding Board to review, and amend where necessary, policy and training to address the learning from this Review concerning support offered for families with caring responsibilities, including:

- Separate living arrangements should not prevent practitioners from seeing people as carers.
- Practitioners must be alert to individual's caring responsibilities, and enquire wherever possible, and carer's assessments should always be offered.
- Conversations with those who have caring responsibilities should not be limited to offering carer's assessments, and must be open, non-judgemental and avoid labelling someone as 'a carer': to allow individuals and families to express their needs and wishes, and be directed to appropriate support.
- Seek and incorporate the views and needs of family members in assessments and plans where possible and appropriate to do so.
- Ensure that, in addition to carer's assessments being completed, referrals are always made to the relevant local specialist service.

5.3.9 Recommendation 9 (ref 5.2.5.d)

SLaM to report to the Safer Lewisham Partnership on the ways in which they have responded to the lesson learned about family concerns being acted upon during inpatient stays, and in particular in relation to risk assessment, planning for discharge and Section 17 leave.

5.3.10 Recommendation 10 (ref 5.2.6.c)

SLaM to review the systems in place in adult mental health inpatient wards for maintaining dialogue with inpatients' GPs while they are on the ward. To feed back to the Safer Lewisham Partnership and to work with the CCG and NHS England as appropriate for taking any action needed to improve communication with GPs in Lewisham.

5.3.11 Recommendation 11 (ref 5.2.6.f)

To ensure awareness about what services are available, the whole systems model of care through the Health and Social Care Integration Board should consider this report as part of its responsibilities to develop advice and information pathways along with workforce development across all professionals.

5.3.12 Recommendation 12 (ref 5.2.7.b)

Safer Lewisham Partnership to review actions taken in response to Domestic Homicide Reviews for PF and EC, in light of the learning from this case, and review/refresh/set new actions where required. To include addressing mental health and drug and alcohol services' recognition of, and response to, adult men accessing those services who may pose a risk to their mothers/parents.

5.3.13 Recommendation 13 (ref 5.2.7.e)

The Safer Lewisham Partnership and Adult Safeguarding Board to work together to ensure effective, consistent and committed leadership for responses to vulnerability and risk is provided by all organisations in the borough, including commitment from those agencies to address their own responses and communicate this to the Boards, and to work collaboratively.

5.3.14 Recommendation 14 (ref 5.2.7.f)

NHS England and the Home Office to utilise the learning gained from Domestic Homicide Reviews (and other Mental Health Reviews) to develop a greater understanding of the issues surrounding domestic homicides committed by individuals with diagnosed mental health conditions, to develop understanding around why some individuals with mental health conditions become violent towards family members/intimate (ex)partners; and to share the learning nationally.

Appendix 1: Domestic Homicide Review Terms of Reference

This Domestic Homicide Review is being completed to consider agency involvement with Delphine and Julien, following Delphine's death on 8 July 2015. The Domestic Homicide Review is being conducted in accordance with Section 9(3) of the Domestic Violence Crime and Victims Act 2004.

Purpose

1. Domestic Homicide Reviews (DHR) place a statutory responsibility on organisations to share information. Information shared for the purpose of the DHR will remain confidential to the panel, until the panel agree what information should be shared in the final report when published.

2. To review the involvement of each individual agency, statutory and non-statutory, with Delphine and Julien during the relevant period of time: 1 January 2010 to the date of the homicide.

3. To summarise agency involvement prior to 1 January 2010.

4. To establish whether there are lessons to be learned from the case about the way in which local professionals and agencies work together to identify and respond to disclosures of domestic abuse.

5. To identify clearly what those lessons are, how they will be acted upon and what is expected to change as a result and as a consequence.

6. To improve inter-agency working and better safeguard adults experiencing domestic abuse and not to seek to apportion blame to individuals or agencies.

7. To commission a suitably experienced and independent person to:
   a) chair the Domestic Homicide Review Panel;
   b) co-ordinate the review process;
   c) quality assure the approach and challenge agencies where necessary; and
   d) produce the Overview Report and Executive Summary by critically analysing each agency involvement in the context of the established terms of reference.

8. To conduct the process as swiftly as possible, to comply with any disclosure requirements, panel deadlines and timely responses to queries.

9. On completion present the full report to the Safer Lewisham Partnership.

Membership

10. It is critical to the effectiveness of the meeting and the DHR that the correct management representatives attend the panel meetings. Your agency representative must have knowledge of the matter, the influence to obtain material efficiently and can comment on the analysis of evidence and recommendations that emerge.

11. The following agencies are to be on the Panel:
    a) Lewisham Medical Centre (General Practitioner for Delphine and Julien)
    b) Lewisham Clinical Commissioning Group
    c) Refuge
    d) London Borough of Lewisham Adult Social Care
    e) NHS England
    f) Hexagon Housing
    g) London Borough of Lewisham Crime Reduction and Supporting People
    h) South London and Maudsley NHS Foundation Trust (SLaM)
    i) University Hospital Lewisham
    j) Metropolitan Police Service, Lewisham
    k) Metropolitan Police Service (Critical Incident Advisory Team)

12. Although Probation (National Probation Service and/or Community Rehabilitation Company) are statutorily required to be part of DHRs, in this case they had no involvement and have therefore been excused.

13. Chronologies and Individual Management Reviews (IMRs) will be completed by:
    a) Lewisham Medical Centre (General Practitioner for Delphine and Julien)
    b) Lewisham Clinical Commissioning Group
    c) London Borough of Lewisham Adult Social Care
    d) Hexagon Housing
    e) South London and Maudsley NHS Foundation Trust (SLaM)
    f) University Hospital Lewisham
    g) Metropolitan Police Service

14. Victim Support will be contacted to establish whether they had contact, and a chronology and IMR requested if they did.

15. A local voluntary / community organisation specialising in mental health will be identified and invited to the Panel, to understand what support may have been available; and to check whether they had contact.

16. A serious incident investigation is in progress by SLaM; the DHR Chair will make contact with the investigation chair to ensure the two processes can run in parallel, and efforts will be made to avoid any duplication.

Collating evidence

17. Each agency to search all their records outside the identified time periods to ensure no relevant information was omitted, and secure all relevant records.

18. Each agency must provide a chronology of their involvement with Delphine and Julien during the relevant time period.

19. Each agency is to prepare an Individual Management Review (IMR), which:
    a) sets out the facts of their involvement with Delphine and/or Julien;
    b) critically analyses the service they provided in line with the specific terms of reference;
    c) identifies any recommendations for practice or policy in relation to their agency, and
    d) considers issues of agency activity in other boroughs and reviews the impact in this specific case.

20. Agencies that have had no contact should attempt to develop an understanding of why this is the case and how procedures could be changed within the partnership which could have brought Delphine or Julien into contact with their agency.

21. In addition to the chronologies and IMRs, the Chair will review two previous DHRs conducted in Lewisham in which the circumstances of victim and perpetrator were similar.

Analysis of findings

22. In order to critically analyse the incident and the agencies' responses to the family, this Review should specifically consider the following six points:
    a) Analyse the communication, procedures and discussions, which took place between agencies.
    b) Analyse the co-operation between different agencies involved with the victim, alleged perpetrator, and wider family.
    c) Analyse the opportunity for agencies to identify and assess domestic abuse and/or mental health risk.
    d) Analyse agency responses to any identification of domestic abuse and/or mental health issues.
    e) Analyse organisations access to specialist domestic abuse and/or mental health agencies.
    f) Analyse the training available to the agencies involved on domestic abuse and/or mental health issues.

Liaison with the victim's and alleged perpetrator's family

23. We aim to sensitively involve the family of the victim in the Review, identifying the most appropriate method and route of contact bearing in mind the fact that they are also the family of the alleged perpetrator. Initially this contact will be via the Police Family Liaison Officer, recognising that the family are already in contact with this service, but also being aware that the family may wish to be in direct contact with the Chair (i.e. not via the Police or other agency), or be in contact with the Chair via another support agency.

24. We aim to sensitively involve the alleged perpetrator, who may be able to add value to this process.

25. The Chair will lead on family engagement with the support of relevant Panel members, including coordination of family liaison to reduce the emotional hurt caused to the family by being contacted by a number of agencies and having to repeat information.

Development of an action plan

26. Individual agencies will take responsibility to establish clear action plans for agency implementation as a consequence of any recommendations in their IMRs. The Overview Report will set out the requirements in relation to reporting on action plan progress to the Safer Lewisham Partnership: for agencies to report to the Partnership on their action plans within six months of the Review being completed.

27. Safer Lewisham Partnership to establish a multi-agency action plan as a consequence of the recommendations arising out of the Overview Report, for submission to the Home Office along with the Overview Report and Executive Summary.

Media handling

28. Any enquiries from the media and family should be forwarded to the Chair who will liaise with the Safer Lewisham Partnership. Panel members are asked not to comment if requested. The Chair will make no comment apart from stating that a Review is underway and will report in due course.

29. The Safer Lewisham Partnership is responsible for the final publication of the report and for all feedback to staff, family members and the media.

Confidentiality

30. All information discussed is strictly confidential and must not be disclosed to third parties without the agreement of the responsible agency's representative. That is, no material that states or discusses activity relating to specific agencies can be disclosed without the prior consent of those agencies.

31. All agency representatives are personally responsible for the safe keeping of all documentation that they possess in relation to this DHR and for the secure retention and disposal of that information in a confidential manner.

32. It is recommended that all members of the Review Panel set up a secure email system, e.g. registering for criminal justice secure mail, nhs.net, gsi.gov.uk, pnn or GCSX. Confidential information must not be sent through any other email system. Documents can be password protected.

Disclosure

33. Disclosure of facts or sensitive information may be a concern for some agencies. We manage the Review safely and appropriately so that problems do not arise and by not delaying the Review process we achieve outcomes in a timely fashion, which can help to safeguard others.

Appendix 2: Domestic Abuse, Stalking and Harassment and Honour Based Violence (DASH, 2009) Risk Identification Checklist

Current Situation The context and detail of what is happening is very important. The questions highlighted in bold are high risk factors. Tick the relevant box and **add <u>comment</u>** where necessary to expand.	YES ☑	NO ☑
1. Has the current incident resulted in injury? (please state what and whether this is the first injury)		☑
2. Are you very frightened? Comment:	☑	
3. What are you afraid of? Is it further injury or violence? (Please give an indication of what you think (name of abuser(s)….. might do and to whom) Kill: Self ☐ Children ☐ Other (please specify) ☐ Further injury and violence: Self ☐ Children ☐ Other (please specify) ☐ Other (please clarify): Self ☑ Children ☐ Other (please specify) ☐	☑	
4. Do you feel isolated from family/ friends i.e. does (name of abuser(s)…..) try to stop you from seeing friends/family/Dr or others?		☑
5. Are you feeling depressed or having suicidal thoughts?		☑
6. Have you separated or tried to separate from (name of abuser(s)….) within the past year?	☑?	
7. Is there conflict over child contact? (please state what)		☑
8. Does (…..) constantly text, call, contact, follow, stalk or harass you? (Please expand to identify what and whether you believe that this is done deliberately to intimidate you? Consider the context and behaviour of what is being done)		☑
CHILDREN/DEPENDENTS (If no children/dependants, please go to the next section)	YES	NO
9. Are you currently pregnant or have you recently had a baby (in the past 18 months)?		☑
10. Are there any children, step-children that aren't (…..) in the household? Or are there other dependants in the household (i.e. older relative)?		☑
11. Has (…..) ever hurt the children/dependants?		☑
12. Has (…..) ever threatened to hurt or kill the children/dependants?		☑
DOMESTIC VIOLENCE HISTORY	YES	NO
13. Is the abuse happening more often?	☑?	
14. Is the abuse getting worse?	☑?	
15. Does (…….) try to control everything you do and/or are they excessively jealous? (In terms of relationships, who you see, being 'policed at home', telling you what to wear for example. Consider honour based violence and stalking and specify the behaviour)		☑
16. Has (…..) ever used weapons or objects to hurt you?		☑

17. Has (…..) ever threatened to kill you or someone else and you believed them?		☑
18. Has (…..) ever attempted to strangle/choke/suffocate/drown you?		☑
19. Does (….) do or say things of a sexual nature that makes you feel bad or that physically hurt you or someone else? (Please specify who and what)		☑
20. Is there any other person that has threatened you or that you are afraid of? (If yes, consider extended family if honour based violence. Please specify who)		☑
21. Do you know if (…..) has hurt anyone else ? (children/siblings/elderly relative/stranger, for example. Consider HBV. Please specify who and what) Children ☐ Another family member ☐ Someone from a previous relationship ☐ Other (please specify) ☐		☑
22. Has (…..) ever mistreated an animal or the family pet?		☑
ABUSER(S)	YES	NO
23. Are there any financial issues? For example, are you dependent on (…..) for money/have they recently lost their job/other financial issues?		☑?
24. Has (…..) had problems in the past year with drugs (prescription or other), alcohol or mental health leading to problems in leading a normal life? (Please specify what) Drugs ☐ Alcohol ☐ Mental Health ☑	☑	
25. Has (…..) ever threatened or attempted suicide?		☑
26. Has (…..) ever breached bail/an injunction and/or any agreement for when they can see you and/or the children? (Please specify what) Bail conditions ☐ Non Molestation/Occupation Order ☐ Child Contact arrangements ☐ Forced Marriage Protection Order ☐ Other ☐		☑
27. Do you know if (……..) has ever been in trouble with the police or has a criminal history? (If yes, please specify) DV ☐ Sexual violence ☐ Other violence ☐ Other ☐		☑
Other relevant information (from victim or officer) which may alter risk levels. Describe: (consider for example victim's vulnerability - disability, mental health, alcohol/substance misuse and/or the abuser's occupation/interests-does this give unique access to weapons i.e. ex-military, police, pest control)		
Is there anything else you would like to add to this?		

Answer	Number
Definite 'yes'	3
Possible 'yes' (i.e. not enough information but it was a possibility)	1
Possible 'no' (i.e. not enough information but unlikely)	3
Definite 'no'	20

Appendix 3: Definition of 'Carers'

Carers Lewisham provided the following information to the DHR.

A carer is defined as someone who spends a proportion of their life providing unpaid support and care to a friend or family member who – due to illness, age, disability, mental health or addiction – cannot cope without their support. It includes parents caring for a child with disabilities or a young person caring for a parent. Each carer's experience is unique to their own circumstances and the causes of taking on caring responsibilities can be varied and multiple, including: serious physical illness; long-term physical disability; long-term neurological conditions; mental health problems; dementia; addiction; learning difficulties.

Just as the reasons why someone becomes a carer vary greatly, the variety of tasks that a carer fulfils is diverse. They can include the following duties:

- Practical household tasks such as cooking, cleaning, washing up, ironing, paying bills and financial management.
- Personal care such as bathing, dressing, lifting, administering medication and collecting prescriptions.
- Emotional support such as listening, offering advice and friendship.

Although the distinction is often made between a full-time or part-time carer, there is not a minimum time requirement or age restriction that qualifies someone as being more or less of a carer.

According to the 2011 Census, the increase in unpaid carers in England and Wales has outstripped population growth between 2001 and 2011. Growing evidence points to the adverse impact on health, future employment and education opportunities as well as the social and leisure activities of those providing unpaid care.

The same Census shows there were 22,521 people self-identifying as carers in Lewisham, performing a crucial role in families and the wider community by providing support, care and help to those who otherwise would struggle to manage alone. This is an increase of 14% since the 2001 Census. Data-quality issues and difficulties with information-sharing means many people who identify themselves as a carer may be

unknown (in that specific role) to statutory agencies in Lewisham. Actual carer figures are therefore likely to be much higher than current figures and young carer numbers are increasing.

The Care Act (2014) simplifies and consolidates existing legislation, and strengthens rights for carers putting them on an equal legal footing to those they care for. New entitlements for carers are coupled with new Local Authority duties to promote wellbeing, prevent needs for statutory care and support, and establish and maintain services that provide information and advice relating to care and support for adults and carers. In particular, all carers are entitled to a statutory carer's assessment and local authorities must be proactive where a carer may have any level of needs for support.

Appendix 4: Action Plan

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
What is the over-arching recommendation?	*Should this recommendation be enacted at a local or regional level (N.B national learning will be identified by the Home Office Quality Assurance Group, however the review panel can suggest recommendations for the national level)*	*How exactly is the relevant agency going to make this recommend ation happen?* *What actions need to occur?*	*Which agency is responsible for monitoring progress of the actions and ensuring enactment of the recommendati on?*	*Have there been key steps that have allowed the recommendation to be enacted?*	*When should this recommendation be completed by?*	*When is the recommendation and actually completed?* *What does the outcome look like?*