Domestic Homicide Review

The London Borough of Lewisham

STANDING together

against domestic violence

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Anthony Wills

April 2013

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Domestic Homicide Review – WX

London Borough of Lewisham

Executive Summary

1. Outline of the incident

2. On 24th March 2012 at 11.44am WX was found dead at her home address in the London Borough of Lewisham. She had suffered stab wounds. Her son, YZ, had already been arrested at 10.05 am that same morning and detained under the Mental Health Act following a call by members of the public indicating that he had been threatening the public and was in a distressed state. YZ was charged with the murder of his mother.

3. YZ pleaded guilty to manslaughter with diminished responsibility in January 2013. He was sentenced to a hospital order under S.37 Mental Health Act 1908 with a restriction order attached.

4. The review process

5. These circumstances led to the commencement of this domestic homicide review (DHR) at the instigation of the Community Safety Partnership (CSP) in Lewisham. The initial meeting was held on 22 May 2012 to consider the circumstances leading up to WX's death.

6. The DHR was established under Section 9(3), Domestic Violence, Crime and Victims Act 2004. The purpose of these reviews is to:
   - 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
   - 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
   - Apply those lessons to service responses including changes to policies and procedures as appropriate
   - Prevent domestic homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

7. This review process does not take the place of the criminal or coroners courts nor does it take the form of a disciplinary process.

8. Terms of Reference

9. The full terms of reference are included in Appendix 1 in the overview report. The essence of this review is to establish how well the agencies worked both independently and together and to examine what lessons can be learnt for the future.

10. Methodology

11. The approach adopted was to seek Individual Management Reviews (IMRs) for all organisations and agencies that had contact with WX or YZ. A list of those agencies

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and the individuals involved is contained within the main report. 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.

12. Independence

13. The independent chair of the DHR is Anthony Wills, an ex-Borough Commander in the Metropolitan Police, and Chief Executive of Standing Together Against Domestic Violence an organisation dedicated to developing and delivering a coordinated response to domestic violence through multi-agency partnerships. He has no connection with the Borough of Lewisham or any of the agencies involved in this case.

14. Parallel Reviews

15. There were no reviews conducted contemporaneously that impacted upon this review.

16. **Contact with family and friends**

17. YZ has surviving relatives; an aunt and a sister referred to above. The sister of YZ has chosen to take no part in this review despite attempts to seek her involvement. It appears she has indicated her frustration with the care provided for both her brother and mother during the years of his illness. Now the case has been concluded further efforts were made by the Chair of the DHR panel both directly (letter) and indirectly (via police) to discuss this review with her but these have been unsuccessful. It was not possible to identify any friends who could have added value to this review.

18. The perpetrator has not been interviewed but enquiries continue with his Consultant Psychiatrist to see if this can be arranged. It was agreed by the panel that this should not be attempted until after the case was complete.

19. Summary of the case

20. Prior to 2007 YZ had incidents of mental ill health overseas and it is known he attempted to strangle his sister. He entered the criminal justice system in 1994, and was on a community order for offences of attempted robbery (which included assault on a child), possession of an offensive weapon, criminal damage and drugs.

21. YZ was known to substance misuse and mental health services. He had a long history of using illicit drugs and his psychotic episodes were assessed as drug induced. When YZ moved from substance misuse services in Brent weeks before the murder the transferral process to Lewisham was notably unsuccessful at a time when YZ was off his medication and evidently vulnerable.

22. In 2005 there were two reported incidents of domestic violence involving YZ and WX. WX declined to support police action on both occasions.

23. In a 14 year period WX had attended her GP with 12 suspected injuries.

24. In 2006 Probation helped YZ access supported housing, as his family relationships had broken down and he was homeless. Probation knew that there had been previous incidents of violence as YZ disclosed that he could not reside at home as the neighbours would call the police due to previous incidents. This information was

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not shared with his supported housing provider (Hestia) although the referral form did make mention of his mother not wishing to look after YZ because of his health issues. During his time at Hestia (despite his records being sparse), he volunteered within the setting of his accommodation. Although counselling was identified, this need was not addressed. Hestia did not consult with WX about YZ intentions to return to live with her, and he ended his tenancy in mid February 2012, when he moved to live with WX.

25. In January 2012 YZ unilaterally decided to stop taking his anti-psychotic medication and a 6 week trial off his medication was agreed by his doctor. There was a lack of his forensic history available in this assessment.

26. On 22nd March 2012 (two days before the murder), London Ambulance Service attended WX's address. YZ was aggressive and LAS recorded and shared their concerns about YZ at the hospital. This information was shared at staff handover but the detailed LAS alert form was not available and was not shared. The handover was verbal between triage and the staff nurse. WX was spoken to but she did not raise any concerns about her safety. She did disclose that she thought YZ was unwell and over the last 2 weeks he had got worse. At 20.15 YZ was discharged to his GP, no mental health referral was made, despite concerns.

27. In the meantime the LAS referral was received by Adult Social Care who made a referral for YZ to Speedwell Mental Health Service. His GP was contacted who confirmed he was on anti-psychotic medication but a diagnosis could not be confirmed as he was a new patient. The GP agreed to request a mental health assessment. Adult Social Care contacted WX who did not indicate any concerns (YZ was present at the time of the telephone call). WX was assessed as having capacity and as no concerns were raised the case was closed.

28. Key issues arising from the review

29. Broad themes identified throughout the review are summarised below.

30. Information sharing, record keeping and transfer summaries

31. This case has highlighted the common theme of how front line practice and system processes do not support information sharing and record keeping. Key issues were lost in case files and as new workers and agencies came into contact with YZ. Databases (particularly within health) did not support the ability of practitioners in reviewing or sourcing information to help them establish the issues that they needed to address in their care plans. Transfer summaries were rarely completed or given comprehensive review.

32. Awareness and understanding of the dynamics of DV and how it impacts on safeguarding responses

33. This case has highlighted a lack of understanding of the dynamic of domestic violence and particularly the connection and overlap with safeguarding adults at risk. All but one agency considered that the victim was experiencing domestic violence. The reality of domestic violence being an on-going factor was rarely recognised as a possibility. The need to consider safeguarding adult issues was also neglected. It is important for services to ensure domestic violence awareness is incorporated into their safeguarding responses and that professionals consider domestic violence in its broadest sense when working with adults at risk.

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34. *Mental Health*

35. YZ had a long history of mental health issues. Some agencies had information about the potential risk of harm he posed to his mother, (including his anxiety about returning to live with her), yet this was not explored by mental health services. The lack of enquiry for domestic violence within mental health impacted on their risk assessment process.

36. *Accommodation*

37. This was a significant and relevant factor in this case. YZ resided in supported accommodation, yet his support plan and move on arrangements did not include a risk assessment in relation to WX. This is despite information contained in the referral and also YZ's disclosures about anxieties of living with his mother again, and his decision to leave his supported housing to return to live with his mother.

38. *Substance Misuse*

39. YZ had ongoing contact with substance misuse agencies. Communication was ineffective and file transfer, record keeping and lack of enquiry about domestic violence are all aspects of practice that would benefit from development.

40. *Culture of questioning*

41. There were only two occasions (after police involvement in domestic call outs) that WX was ever considered as experiencing domestic violence. YZ had disclosed his own anxieties about returning to live with his mother and there were indicators of domestic violence in the referral made by Probation to Hestia, yet this was not explored. The lack of enquiry is especially evident by clinicians in all settings. Despite WX's frequent attendance at her GP for minor health concerns, the indicators of domestic violence were apparently never considered. Agencies must ensure that staff understand the dynamics of domestic violence and are trained in the best method of "asking the question". This is particularly important for clinicians, especially GPs who have ongoing contact with individuals and provide a safe and confidential opportunity to ask about domestic violence, and respond to disclosures. Staff need to understand the indicators of domestic violence, its impact on safeguarding responses and how this understanding alongside an enquiry should be incorporated into their clinical care and practice.

42. *Overlap of responses to safeguarding adults and domestic violence*

43. There is little understanding of domestic violence demonstrated in some agencies and there is limited evidence of how the response to safeguarding adults is recognised or considered in conjunction with the dynamic of domestic violence. These responses seem separated from each other despite their well-known connections. Safeguarding adults processes were not instigated in this case, possibly because the presence of domestic violence had not been identified. Given WX's age and the dynamic of the abuse, when domestic violence was identified (in 2005) the impact on her and any potential safeguarding adults concerns were not linked then or subsequently.

44. *Equality and Diversity*

45. The nine protected characteristics as defined by the Equality Act of 2010 have all been considered within this review. (They are: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex,

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sexual orientation.) The panel did not feel that these issues had a material bearing on the circumstances of this case or the subsequent review except for mental health (as a disability) which is fully discussed within the report.

46. Conclusion

47. This review has highlighted the limited understanding and connection between the response to adults at risk and domestic violence. The issues of substance misuse and mental health have also not been recognised as part of a disastrous nexus with domestic violence. In this case there have been many opportunities to identify the risk to WX and these were not grasped. Had they been, the outcomes of this case could have been different.

48. When the issue of preventability is considered the failure to transfer the care effectively of YZ, the knowledge that he was not taking his medication, his use of services who did not explore his history and the failure to consider WX as vulnerable inevitably indicate that this death could have been prevented. As with so many cases a series of inconsistent and ineffective responses led to a fatal outcome. Had one of these gaps in service been approached differently the outcome could have been very different. It is to be hoped that the recommendations will make such an event in the future much less likely.

49. There was little investigation and enquiry behind the presenting issues by clinicians in both acute and mental health services. Timely and appropriate opportunities to investigate YZ's mental health were not actioned.

50. Given the gaps in process identified in this review, the following improvements to systems have been implemented:

    - Clinicians in CNWL have been reminded to communicate key changes to any patient's care "through the appropriate channels", including the team's senior consultant.
    - A new transfer policy has been instigated within CNWL and staff have also been reminded of the operating protocol relating to the duty of care during a referral and transfer process
    - KCH are considering training needs for individual members of staff and are seeking to review and promote the mental health co-working pathway which did exist at the time of YZs admission to hospital
    - CRI have "fully actioned" improvements to their referral, allocation and engagement processes and instituted daily referral meetings
    - Victim Support case recording system now records all attempts to make contact with victims regardless of whether this is successful.

51. It is agreed that the safeguarding response to both WX and YZ could have been improved. Apart from the police in 2005 (who made a referral to Victim Support) a consideration of WXs status as a potential and current victim of domestic violence was very rarely considered.

52. WX's wellbeing was insufficiently explored. When it was, she tended to minimise what was happening and did not seek support. Her history of minor injury was never considered and evidence of her ability to care for YZ was never comprehensively

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examined. The lack of awareness about the possible dynamic of domestic violence by all but one agency (the police) clearly indicates safeguarding adults at risk and domestic violence training is urgently required. This training must include a focus on mental health and domestic violence in its broadest sense (including family/parental violence).

53. The issue of YZs diagnosis has been considered by professionals at length. As there were different views of this it must be at least possible that a broader view of his potential diagnoses may have led to a more comprehensive approach. This may also have resulted in safeguarding adults at risk procedures being considered.

54. The lack of consideration of the dynamic of domestic violence impacted on the options available to support both WX and YZ. If the domestic violence had been identified this case could have been referred to the Multi Agency Risk Assessment Conference.

55. This case highlights the systemic problems of recognising the issue of domestic violence and the inter connection with safeguarding adults. The failings of agencies (all but the police) to consider WX as a victim of domestic violence, indicates that the implementation and understanding of the relationship between domestic violence and safeguarding adults are not implemented or understood.

56. Given the overlaps highlighted in this case between the agendas of protecting adults at risk and domestic violence, a Domestic Homicide Review Task and Finish Group is required to provide oversight to review and monitor progress of implementation of the recommendations of this review.

57. Recommendations

58. Some of the recommendations below will require actions beyond the London Borough of Lewisham. The overview report and the executive summary will be shared with The London Borough of Brent. The action plan that relates to these recommendations is shown at appendix 2.

59. Recommendation 1

60. For all agencies who do not conduct periodic reviews of their processes and policies they must conduct a review of all safeguarding adult and domestic violence processes and policies and explicitly consider the overlap of the dynamic of domestic violence in its broadest sense and the response to safeguarding adults at risk. (The review process should be overseen by the Lewisham Safeguarding Adults Board in addition to the Lewisham Community Safety Partnership.) All agencies will be required and expected to implement policies and procedures in this area and report on their progress. These processes and policies to be reviewed annually and reported back to both strategic boards.

61. Recommendation 2

62. To deliver training to ensure all practitioners have a good understanding of the dynamics of domestic violence and appropriate responses. This case must be used as part of the development of an enhanced training package for practitioners which addresses safeguarding issues and includes domestic violence and abuse in its broadest sense.

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63. *Recommendation 3*
64. The Lewisham Safeguarding Children's Board and the Safeguarding Adults Board training sub groups, to work together to review the partnership training programme delivered and commissioned by the London Borough of Lewisham on safeguarding and the links to domestic violence. This review to also examine the means by which this case can be included as a case study, in order to deliver an enhanced and relevant training package to the multi-agency workforce.

65. *Recommendation 4*
66. Adult Social Care and mental health services to review their information sharing processes to ensure effectiveness and the implementation of improved practice whereby agencies are aware of the policy and their staff trained to make use of the benefits of appropriate information sharing.

67. *Recommendation 5*
68. Lewisham Community Safety Partnership to agree and support a Domestic Homicide Review Task and Finish Group. This group to have oversight of the three domestic homicide reviews conducted in Lewisham and will be a sub group of the Performance and Delivery Group. The Domestic Homicide Review Task and Finish Group will review and monitor progress of implementation of the recommendations of this review (including the completion of agency internal recommendations). To report learning to both the LSCB and the SAB.

69. *Recommendation 6 (London Borough of Brent to also consider this recommendation)*
70. Ensure that within the commissioning framework for Supporting People contracts, domestic violence expertise is utilised to inform and advise the commissioning process.

71. *Recommendation 7 (London Borough of Brent to also consider this recommendation)*
72. Commissioners to visit, assess and review services using the Quality Assessment Framework as part of the Supporting People contract process.

73. *Recommendation 8*
74. Lewisham Clinical Commissioning Group and Public Health to consider piloting or commissioning a borough wide system to improve the response of primary care to patients who are experiencing domestic violence, such as Project IRIS.

75. *Recommendation 9*
76. This DHR to be shared with The London Borough of Brent Community Safety Partnership for consideration especially in relation to recommendations 6, 7 & 12.

77. *Recommendation 10*
78. Safeguarding Adults to conduct a case audit of referrals to establish the extent of adult cases with a domestic violence dynamic present and consider future practice and training needs.

79. *Recommendation 11 (for national consideration)*
80. Department of Health to recognise the issues of transferring patient notes and records from one practice to another and the dangers inherent in the current system.

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The system does not support clinicians in gaining knowledge of their patients, to be proactive in seeking out patient information or the provision of quality patient care.

81. Recommendation 12

82. Substance misuse services (in both Lewisham and Brent), in addition to their review and change of practice following this review, to audit their current practice and working arrangements to demonstrate systems involved in transfer of clients are operating effectively.

83. Recommendation 13

84. Lewisham Domestic Violence Services to conduct an audit of agency (excluding police) domestic violence referrals at standard and medium risk to ensure these cases have been correctly assessed and appropriate action commensurate with the available information and risk level has been taken.

85. Recommendation 14

86. Review the LAS safeguarding alert system to ensure all available information is presented to all medical practitioners involved in each case in a timely and useful format so that the information recorded on the alert is processed in real time to inform patient care and discharge planning.

87. Recommendation 15

88. Hestia to review their client intake assessment process to ensure that where accommodation issues with family members and/or intimate partners is identified as a concern, these are clearly highlighted and considered in the clients support plan and in any move on arrangements. Assessment processes should specifically consider consultation with relevant parties, which should be conducted in a safe and confidential manner to inform case management decisions.

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Domestic Homicide Review – WX

London Borough of Lewisham

OVERVIEW REPORT

89. **Introduction**

90. On 24th March 2012 at 11.44am WX was found dead at her home address in the London Borough of Lewisham. She had suffered stab wounds. Her son, YZ, had already been arrested at 10.05 am that same morning and detained under the Mental Health Act following a call by members of the public indicating that he had been threatening the public and was in a distressed state.

91. YZ was later charged with the murder of his mother. YZ pleaded guilty to manslaughter with diminished responsibility in January 2013. He was sentenced to a hospital order under S.37 Mental Health Act 1908 with a restriction order attached.

92. These circumstances led to the commencement of this domestic homicide review (DHR) at the instigation of the Community Safety Partnership (CSP) in Lewisham. The initial meeting was held on 22 May 2012 to consider the circumstances leading up to this death.

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

94. The purpose of these reviews is to:
    - 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
    - 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
    - Apply those lessons to service responses including changes to policies and procedures as appropriate
    - Prevent domestic homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

95. This review process does not take the place of the criminal or coroners courts nor does it take the form of a disciplinary process.

96. **Terms of Reference**

97. The full terms of reference are included at Appendix 1. The essence of this review is to establish how well the agencies worked both independently and together and to examine what lessons can be learnt for the future.

98. **Independence**

99. The independent chair of the DHR is Anthony Wills, an ex-Borough Commander in the Metropolitan Police, and Chief Executive of Standing Together Against Domestic

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Violence an organisation dedicate to developing and delivering a coordinated response to domestic violence through multi-agency partnerships. He has no connection with the Borough of Lewisham or any of the agencies involved in this case.

100. Parallel Reviews

101. There were no reviews conducted contemporaneously that impacted upon this review.

102. Methodology

103. The approach adopted was to seek Individual Management Reviews (IMRs) for all organisations and agencies that had contact with WX or YZ. 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.

104. Contact with family and friends has been attempted and is discussed further below (paragraph 179 - 181).

105. Once the IMRs had been provided, panel members were invited to review them all individually and debate the contents at subsequent panel meetings. This became an iterative process where further questions and issues were then explored. This report is the product of that process.

106. Composition of the DHR panel

- South London and Maudsley (SLaM)
- Central North West London Mental Health Trust
- Metropolitan Police (Lewisham Borough and Specialist Crime Review Group)
- London Borough of Lewisham Adult Social Care and Community Safety
- A GP representative from NHS South East London
- Lewisham Healthcare NHS Trust
- London Probation Trust
- Crime Reduction Initiative (substance misuse)
- Kings College Hospital
- Victim Support Lewisham.

107. The Facts

108. YZ was 43 (born 5th June 1968) at the time of the murder and was known to a large number of agencies prior to the death. The chronology details the contacts in very great detail. The following is an outline of YZs contact with those agencies and the relevant issues. Where available, details of WXs contact with agencies are also mentioned, but this was limited as this report will demonstrate.

109. The terms of reference specifically seek information about YZ from 1st January 2007 but to assist this DHR some earlier information is included.

110. Information relating to YZ prior to 2007

111. In 1983 YZ moved with his mother, father and sister to Spain. It is whilst there that he is recorded as using drugs whilst at school and in 1986 his first mental health

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episode was recorded. This was diagnosed as cannabis induced paranoid psychosis. He then received further treatment in Italy which included two periods in Italian mental health hospitals.

112. In 1986, when in Italy, he is also reported as having attempted to strangle his sister. He was admitted to hospital for this matter. Following this stay in Italy he travelled back to Spain (with his father) who he lived with whilst he was in Spain.

113. Following the family's return from Spain, YZ continued to suffer from mental health issues and was also convicted of a variety of criminal offences. Between 1994 and 2006 there are 7 convictions and 3 cautions for offences ranging from attempted robbery (which included an assault on a child), offensive weapon, criminal damage and drugs. The last series of offences in 2006 led to a community order and supervision order with a residence requirement which is discussed below.

114. Central and North West London NHS Foundation Trust (CNWL)

115. In 2007 YZ came into contact with CNWL both for mental health issues and drug addiction. Brent Mental Health repeatedly found that he was not suffering from a mental health disorder and that his psychotic episodes and breakdowns were drug induced. He was prescribed anti-psychotic medication. In June 2010 he was referred for Cognitive Behavioural Therapy and a Needs Led Assessment. This was his final contact with the mental health team at CNWL, although no record of what happened to this referral or of any discharge can be found. This was at a time of considerable re-organisation within CNWL.

116. YZ also saw Addiction Services regularly from 2007. With some lapses between this time and 2011 he was managing his drug use through prescribed drug-substitute medication.

117. In 2011 he began to have difficulties with housing (see below) and became less consistent in attending appointments. He also reported using cannabis. On 10th January 2012 at a meeting with a specialty doctor, he stated he had stopped using his prescribed medication and had used cocaine and heroin but had stopped doing so during the last week. This was confirmed by a drug test. He did not want to take his anti-psychotic medication and a 6 week trial where he remained off-medication was agreed with the doctor.

118. It is accepted in the CNWL IMR that there was a lack of knowledge about YZs full forensic history, particularly with the key worker involved in his case.

119. The off-medication trial was based on the fact that he had not been taking his medication for the previous 8 weeks. His mother was not part of this trial. It appears that YZ reassured the doctor and agreed to inform his mother and his GP should any symptoms of mental illness emerge. There was no evidence in the case record of his mother being directly consulted about this or being aware of this arrangement, although YZ reported that his mother was aware that he had stopped his medication and she would be supervising him. The specialty doctor has said that greater knowledge of his forensic history may have caused her to explore further and influence her decision about this trial.

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120. This decision, whilst recorded on electronic records, was not communicated further to the team, either to individual supervisors or in team meetings. The key worker, who saw YZ subsequently on 16th January, had not read the entry from the 10th January.

121. YZ then had four further meetings with Addiction Services. His mental state gave no cause for concern. He stated he was moving to Lewisham to stay with his mother and the referral process to the drug services in Lewisham was commenced. On 8th March 2012 the referral was made by fax to Lewisham CRI but confirmation of receipt was only received after the death (on 26th March). YZ was clear that he could not afford to travel back to Brent for prescriptions as this was too expensive. He was supplied with the details of CRI Lewisham and advised to contact them. CNWL left telephone messages at CRI to confirm receipt of the referrals but there is no record of these being returned.

122. London Probation Trust

123. Probation first came into contact with YZ in late 2006 following his conviction for offences in Manchester. These crimes were committed at a time when he was homeless and considered to have lost the support of his family and had no other support network. His sentence at this time included a Community Order for 2 years with a condition of residence. Initially he was staying in Approved Premises in Manchester but he was quickly found a place in Brent where he resided until 20th January 2009.

124. The pre-sentence report that was produced for his conviction in Manchester and many other documents offer considerable information about YZ. The following is a brief resume of the information available at that time:
    - YZ had resided in Westminster until evicted for rent arrears when he made his way to Manchester
    - He was well known to the Abbey Road Community Mental Health Team at this time
    - He was known to have a long history of drug abuse
    - The psychiatrist who examined YZ when in Manchester, discusses violence in YZs home when he was young, possible sexual abuse by a teacher, substance misuse and use of sex workers
    - Other correspondence around his earlier time in Westminster also confirms YZs "compulsive use of prostitutes"
    - This doctor also concludes that YZs diagnosis is "most likely substance induced psychosis" but there was previous history (in Spain) of a diagnosis of paranoid schizophrenia. Mention had been made of a personality disorder but not pursued
    - This same doctor also recommended a drug rehabilitation requirement as well as his mental health being monitored
    - The actual sentence was supervision with a residence requirement
    - Throughout the Community Order YZ regularly returned to illicit substances
    - It was known his mother's neighbours were likely to call the police if he returned to her address "due to previous violence".

125. Whilst on his Community Order YZ stayed for over two years in the Approved Premises. This length of stay is highly unusual and whilst there he seems to have

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always complied with curfews and general rules. He was consistently prescribed anti-psychotic medication and the doctors examining him did not feel he was “mentally unstable enough for further intervention”. He also had no contact with the police. During this time YZ also successfully completed a law degree.

126. He received lengthy support from Brent drug services, first with Addaction then the Junction Project.

127. It is reported that he was determined to return to Westminster, where he had a long history, or to be near his mother in Lewisham. There is clear reference to the issues with his mother being problematic. She was happy to meet up with him but did not want him to stay with her. Both WX and YZ were concerned about neighbours becoming involved if WX was felt to be in need of protection from YZ. The Probation IMR, states that it was “never seemingly grasped that his mother is at risk of serious harm from him (YZ)”. The Multi-Agency Risk Assessment Conference (MARAC) process started in 2006 in Brent but WX was not risk assessed, hence no referral to the MARAC was ever made.

128. Probation expended very considerable effort into rehousing YZ as his Community Order drew to a close. YZs resistance to being housed in Brent was a consistent problem but, with the help of Probation he was finally found supported housing with Hestia in Brent.

129. Hestia Housing and Support

130. YZ moved into Hestia’s service in Harrow Road on 19th January 2009. Hestia is funded by Supporting People and their role is to provide a safe and supportive environment where the individual can develop the “emotional and practical skills needed to manage their lives and to use support networks in the community”.

131. Hestia had access to considerable information relating to YZ, such as the original Manchester pre-sentence report, the London Probation Housing Referral Form (completed by Probation) and they also conducted an interview with him. This identified the following risks:
- Suicide/self-harm
- Violence/aggression
- Illicit drug use.

132. The housing referral form completed by Probation, identified YZ as being a medium risk of offending and harm. Significantly the referral form stated that YZ had previously resided with his elderly mother but she can no longer house him as “they have broken up and she cannot cope with his health issues”[1]. Probation records also indicated that he wished to move to South London and live with his mother, but this was not possible as YZ stated that the neighbours would call the police due to previous violent behaviour towards WX.

[1] Following several opportunities, this information was provided by Hestia subsequent to the IMR process, as part of the final drafting of the overview report.

133. As part of his residency at Hestia, he was not subject to any licence and there were no restrictions on him regarding who he could have contact with and where he could travel.

134. From August 2011 until the time of the death, the contact between YZ and workers from Hestia was sporadic at best. The chronology (which describes information held on their internal electronic system) mainly records no contact or YZ not being seen. Information from 2009 until mid-2011is very sparse but YZ had volunteered within Hestia regularly whilst based there. The IMR also mentions that YZ would benefit from counselling but this does not seem to have been advanced.

135. Hestia had no contact with WX during YZs time with them. Hestia knew that he had anxiety about moving in with his mother. There is no note of their response to his mother's address becoming his place of residence. This issue was not explored with YZ or WX.

136. Their IMR does discuss the difficulty of finding YZ accommodation within Brent; partly due to lack of suitable property and also due to YZs anxiety about the time he would have to wait for re-housing.

137. Hestia did know he may have been using illicit drugs. Hestia also comment that the hostel had other residents who may have been using illegal drugs giving YZ easy access to them. Hestia state that their records did not include any specific evidence of his drug use, but consider this possible given his behaviour and potential access to drugs from other residents.

138. YZs time in the hostel ended around mid-February 2012 when YZ left a letter stating that he was withdrawing his tenancy (this may have been due to YZ claiming benefits in Brent whilst living in Lewisham). It is unclear when Hestia knew that YZ had moved to Lewisham but the first mention of him spending time at his mother's home was in mid January 2012. In February 2012 he wrote to Hestia to relinquish his tenancy which was confirmed in March 2012. Hestia did not address his previous anxieties about moving in with this mother, nor did they consider the concerns which were originally highlighted in the referral form to Hestia about his mother not being able to cope with his health issues.

139. CRI New Direction

140. CRI New Direction received a referral from the Junction Project on 8th March 2012. The Junction Project was provided with the hours that YZ could access the service which would then have led to assessment and the start of the process to initiate the transfer of the prescribing regime to CRI. At this time CRI did have an appointments system where it had previously relied upon the open access approach. The referral should have been allocated within 24 hours with the case being overseen by a doctor and a risk assessment completed. The Junction Project was provided with contact details for CRI as was YZ (by Junction).

141. YZ made no contact with CRI and they did not take action to follow up the referral. The CNWL IMR makes it clear that "until the referral is accepted by CRI Lewisham, CNWL is still effectively managing their patient". Neither CNWL nor CRI contacted YZ after 8th March 2012.

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142. London Ambulance Service (LAS) NHS Trust

143. There are two incidents referred to in the IMR from the LAS. The first is on 22nd March 2012 when YZ apparently suffered a seizure and was found by the LAS on the pavement near his home address. He was conveyed to hospital where a handover of care was given to hospital staff.

144. During this event the ambulance crew noted that "YZ became very aggressive towards WX". Although not described in this IMR they in fact completed a Form LA280 (Vulnerable Adult in Need/at Risk report form). This was passed to Kings College Hospital (KCH) and is helpfully described in their IMR and includes the following points:
    - Patient is homeless and temporarily staying with mother
    - Whilst attending to patient he became very angry with bystanders watching him
    - On arrival of his mother on scene he became angry and aggressive towards her
    - On route to A&E patient had several volatile outbursts directed at his mother
    - Patient would then relent and appear worried at his outburst
    - Mother told crew she was very frightened of her son and that he has the potential to physically hurt her
    - Patient no longer has CPN (Community Psychiatric Nurse) and is being non-compliant with his anti-psychotic medication.

145. The second call reported by them is at 12.09pm on 24th March 2012 when they were called to WXs house and saw through the window that WXs injuries "were incompatible with life." They did not enter the premises to avoid contaminating the crime scene.

146. Kings College Hospital

147. KCH had previously treated YZ for an infected sebaceous cyst on 2nd January 2012. They had drained and treated this and discharged him with a follow up to be undertaken by his GP. His medication at that time was described as being amlodipine, used to counteract hypertension, and perindopril, also used in connection with hypertension. There was no examination of his social history at this time.

148. On 22nd March 2012 YZ was brought to KCH by the LAS (see above). The triage nurse was briefed by the LAS who were advised to complete the form referred to above. There were notes about his medical condition including the following comment: "*pt (patient) not coping with his mental health, ?compliance with meds."*

149. The triage nurse handed YZ over to a staff nurse but the latter could not remember the information the triage nurse supplied. The triage nurse, recollects speaking to the staff nurse about her concerns for the "welfare of the patient and his mother".

150. The form completed by the LAS was not available to the staff nurse as it was filed in reception and later amalgamated with the completed "CAS" card. The nurse recorded that YZ acknowledged that he was bi-polar and had not been taking his medication, and that he is not coping. The concerns about the seizure seemed to recede as he recovered.

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151. WX was also spoken to by the same nurse and she raised no concerns about her well-being or safety. She did say that YZ had not been taking his medication and had been mentally unwell for 10 years and had become worse over the last two weeks.

152. During a further handover at about 8 pm that day WX explained she was worried that YZ would leave without medical review when he left the cubicle for a cigarette. He did return and WX then left, despite being asked to stay.

153. Finally at 8.15 pm the department doctor saw YZ and noted a significant intake of alcohol (6 pints, normally 10) and that he appeared to be suffering from:
    - Hypertension
    - Bipolar
    - Pseudoseizure

154. He was noted as taking amlodipine and “afebrile, appears well, occasional episodes of unprovoked laughter”. It was then agreed, following discussions with the registrar, to discharge YZ “with GP follow-up or to return if any problems”.

155. It must also be noted that YZ had been racially abusive during his time at the hospital. Despite safeguarding training having been delivered within the KCH Trust the Doctor did not examine, in any depth, the issue of YZs psychosis.

156. YZ was discharged in his electronic patient records (EPR) at 9.38 pm although seen on CCTV (during the later homicide investigation) to have left the hospital well before this. Further examination of the discharge process shows that YZ was discharged earlier and left normally. The EPR was simply completed later.

157. No referral was made to the mental health facilities within KCH via the Psychiatric Liaison Officer.

158. Adult Social Care (ASC)

159. The LAS referral reached the Emergency Duty Social Work Service on the same day as YZ was in KCH (22nd March 2012). They were aware that some of the concerns were about YZs mental health and WXs personal safety. A written referral was made to the Speedwell Mental Health Service (managed by the South London and Maudsley Hospital Trust (SlaM)) and attempts were also made to contact them by phone but with no response. This worker believed that as YZ was in KCH they would identify any mental health concerns and respond accordingly.

160. The Adult Social Care and Information Team (SCAIT) took up the enquiries the next day (23rd March) and initially searched on their records. YZ was known by the Northover Mental Health Team in 1998, WX was shown as changing her marital status to widowed in 2002 and YZs father was shown as deceased in 2002 and whose recorded condition was frailty. It appears that WX was on this system due to her role as carer to her husband.

161. SCAIT contacted KCH who advised that YZ had been admitted and then discharged the same day. Further enquiries showed that YZ was not known to the Speedwell team. Consideration was then given to WXs need for safeguarding. A more senior

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worker phoned the GP shown on the referral form to ascertain the extent of any mental health issues. The GP was able to say that YZ had been prescribed anti-psychotic drugs (Olanzapine) but could not confirm a diagnosis as YZ was a new patient and there was only limited information available. The GP agreed to request a mental health assessment (as did the social worker) and provided WXs contact details.

162. The SCAIT worker then contacted WX by phone who outlined YZs mental history and drug use and "did not indicate that he presented an imminent danger to herself". YZ then took over the phone conversation and discussed his housing situation and a future visit to his GP. He was apparently amicable during this call and the end of the conversation was controlled with him concluding the call abruptly if politely by saying "thank you".

163. This review process has established that phoning in such cases is expected and is usual practice for the SCAIT. The team deals with all initial enquiries for adults regarding referrals to adult social care. The team is made up of skilled and experienced senior advice and information officers, who work alongside qualified social workers and occupational therapists. The SCAIT team checked and collected information relating to YZ, and it was a senior advice and information officers who made the phone call to WX. This officer discussed the case with her manager and no further action was agreed on the basis that WX appeared to have mental capacity and did not articulate any danger from her son or lack of safety.

164. The case was then closed with a referral from SCAIT and GP to the mental health team although the murder occurred before this led to further action.

165. The senior advice and information officers are unqualified social care staff but are trained in the advice and information giving role, and part of the person specification for the post holders is that they must have knowledge and experience of working in adult social care. All staff have had learning sessions in relation to recognising adult safeguarding concerns.

166. General Practice – South East and North West London

167. WX was registered at the Forest Hill GP practice throughout this period and she did not have any diagnosed chronic disease. It is noted in the IMR that she attended more frequently than might be expected for minor injuries. These are not fully explained in the notes although one scalp injury was blamed on a fall "while climbing up to get a spider". There a total of 12 of these injuries over a 14 year period but they did not lead to more intrusive questioning about the cause of the injuries.

168. YZ only transferred to the GP practice at Forest Hill in February 2012 and his file is described as *"voluminous".* It appears to contain records of the medical interventions referred to above. It also mentions, on a number of occasions, the relationship with his mother, periods of separation, comments about YZ pushing his mother and the fact that she did not want contact with him because of his use of drugs.

169. YZ also suffered from Hepatitis C (this is mentioned in other IMRs) but was not often able to access treatment because of his "hypertension and mental health problems".

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170. **Metropolitan Police Service (MPS)**

171. Apart from the convictions referred to above the MPS do have other records of their involvement with YZ and WX. On 8th August 2005 neighbours had heard WX "screaming in her flat" and when police arrived YZ was alleged to have shouted at her and assaulted her (by poking her in the eye). WX declined to make a statement or support any police action. YZ was arrested and bailed but the Crown Prosecution Service advised that no further action should be taken.

172. On 11th September 2005 neighbours again called the police. WX had declined entry to YZ because of his previous behaviour and she began to pass his property to him through a window but YZ then apparently smashed a window. YZ was again arrested, WX declined to assist the police and no further action was taken following a review by a local detective inspector.

173. It is notable that YZ was recognised as requiring an "appropriate adult" on both occasions when he was arrested. YZ had denied having any disability when first taken into custody. The Police National Computer shows that YZ has a flag for mental health so on each occasion the adult social care duty team were called to provide an appropriate adult (and this happened each time). Lewisham Social Services have a commissioned service to provide appropriate adults but it is unclear if this service was available in 2005. The feedback process from the appropriate adult service to other agencies that may have an interest in specific individuals is unclear.

174. In April 2007 WX called the police stating she was being tormented by people who were poking her. The police attended and she said the call was a hoax and did not want police action. She appeared safe and well. No further action was taken.

175. The final contact with police prior to the incident was on 22nd December 2011 when YZ reported WX missing as she had gone shopping and had not returned. She did so two hours later and once the police confirmed her wellbeing the case was closed.

176. **Victim Support**

177. This agency had two referrals from the Metropolitan Police for WX in relation to the above incidents. One was in 2005 where the report indicated she had been assaulted by her son. Contact with WX was not made until 25 days[2] later when WX declined support and the case was closed.

178. The second referral was on 16th September 2005 for criminal damage. As the relationship to the suspect was not noted no contact was made with WX and the case was closed. No linkage to the previous referral was made.

179. Contact with family or friends

180. YZ has surviving relatives; an aunt and a sister referred to above. She has chosen to take no part in this review despite attempts to seek her involvement. It appears she has indicated her frustration with the care provided for both her brother and mother

[2] Victim Support have confirmed that their case management system now records all attempts made to contact victims referred to them

during the years of his illness. Now the case has been concluded further efforts were made by the Chair of the DHR panel both directly (letter) and indirectly (via police) to discuss this review with her but these have been unsuccessful. It was not possible to identify any friends who could have added value to this review.

181. The perpetrator has not been interviewed but enquiries continue with his Consultant Psychiatrist to see if this can be arranged. It was agreed by the panel that this should not be attempted until after the case was complete.

182. Analysis

183. YZ was a troubled child who used drugs increasingly, which possibly contributed to some of his mental health problems. As he got older there was a history of treatment for mental health issues, mainly consisting of medication, drug misuse and periods of adherence to drug treatments followed by subsequent lapses. He had much contact with agencies whose role it is to support individuals with these issues and it is clear from the details above that great effort was made to help him survive independently if no cure was ultimately possible.

184. What is shown within the IMRs and through discussions within the DHR panel is that practice has moved on and many of the issues that arose would be responded to in a much changed way (e.g. Probation). It is also evident that practice must continue to develop and the following discusses both areas; to ascertain what should have been different and what can change in the future. Whilst there is much of significance in his earlier life, and contact with the agencies, it may be suitable to look more thoroughly at the recent events where contemporary practice needs review and development more obviously possible.

185. It is also true that during the two years prior to the death, YZ had not been in contact with the police and appears to have behaved well until the days very close to that death. Aside from reporting WX missing in November 2011, YZ had not been in contact with the police since 2006. He had of course stopped taking his medication in the weeks prior to the fatal incident.

186. YZs attendance at hospital after the seizure on 22nd March was approximately one day before the killing of his mother. The response of the LAS in completing the correct safeguarding form was good practice and in accordance with safeguarding procedures. The process for the available information to be utilised was unimpressive. There was a failure to share information that was available within the hospital system and a parallel failure to fully explore the mental health issues by KCH. These mental health issues could have been recognised even without the LAS information as his behaviour (unprovoked laughter, racist behaviour, YZs disclosures about threatening his mother) was sufficiently unusual to warrant further investigation. The KCH IMR uses the term “acute psychiatric symptoms”. The additional gap, where no referral to the psychiatric liaison nurse was made, exacerbated this situation. There was also the disclosure by YZ of what seems to be a considerable reliance on alcohol that is not addressed in any way.

187. YZ was discharged without further treatment or medication. The approach to adult safeguarding within KCH was apparently not systematic or well developed.

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188. ASC responded quickly to the referral and made enquiries of the GP. There was also an expectation that KCH, whilst YZ was in their care, would have been responsive to YZs needs. The question has been asked by the panel whether the phone call to WX was appropriate in the circumstances but WX did not give cause for concerns over her safety although she had clearly been worried the previous day. The fact that things had improved appears to have been taken as a sign that no urgency was necessary and a standard referral to the mental health team was acceptable. The abrupt termination of the call by YZ, although not aggressive may also have been a small indicator of concerns that could have led to further action.

189. Another theme of this review is the question of support given to WX in very difficult circumstances. ASCs response was an occasion to consider what more could be done but without the full spread of information that was secreted throughout YZs notes within a variety of agencies their response seems acceptable.

190. Another potentially missed opportunity was the attendance by YZ at KCH for the treatment of his cyst some weeks before the death. YZ admitted to being on medication for drugs connected with his mental health but this did not lead to further investigation by the emergency department staff. Discussions amongst the panel indicated that whilst staff in such situations were very busy it would be helpful to explore the history of individuals to arrive at a more complete picture.

191. On 8th March 2012 there was an attempt to transfer YZs drug care regime from CNWL to CRI Lewisham. Both agencies acknowledge that this was done ineffectively. CNWL did not complete this process and, despite two further messages left on the phone at CRI, they were still, in theory in charge of YZs welfare. CRI had just begun a new process of referral acceptance which should have led to an appointment being offered to YZ very quickly. This did not happen and he never received support from CRI.

192. This was at a time when YZ was undergoing a self-selected trial of being off his medication and it must be assumed that his need was at its greatest. CNWL did not manage this process well or take a second opinion on the initial decision or subsequently review that decision. There also appears to be no follow up with YZ although there was an expectation that YZ would tell his mother if there were any problems. Again this places a heavy responsibility on the mother who had consistently demonstrated her concerns about YZs mental health and drug usage.

193. Whilst YZ was in the Hestia hostel his time there seems to be notable for his volunteering and lack of engagement with the support processes. This latter issue is a consistent issue within their chronology and the IMR, and does not seem to have led to an increase in concern or activity on the part of Hestia. This is a support facility for those at medium or low risk of offending and little support actually seems to have reached YZ. The issue of YZ being likely to benefit from counselling, for example, does not seem to have been progressed.

194. The information included in the original referral from Probation to Hestia included relevant information about previous issues of YZ living with his mother. This should have informed the support plan and the assessment process, particularly when he indicated he wished to withdraw his tenancy and return to live with his mother.

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195. Given the information already known to Hestia as part of the original referral, as well as the concerns noted about his mood swings and YZ's own anxiety about moving in with his mother, the lack of enquiry and assessment was significant. The lack of enquiry would suggest that information sharing, file review and record keeping processes is not systematic. This would also highlight the lack of awareness of safeguarding adult processes that should have been considered.

196. Hestia did not consider or attempt to seek WX's views and the impact of YZ returning to live with her seems not to have been addressed. The questions whether it was acceptable to her for YZ to move in and whether it was safe remained unasked.

197. The diagnosis for YZ has been a constant theme of debate amongst the panel although few members are sufficiently well qualified to make a judgement on the complex state of YZs mental health. CNWL do not feel "it can rule out the possibility that YZ does suffer from a mental illness, such as schizophrenia". This therefore indicates that a more holistic approach to YZs mental health may have introduced different responses, medication and activities that could have led to different outcomes.

198. The IMR from Probation is very thorough but relates to a period in the past (concluding in 2009) after which substantial changes have been made to systems and processes, covering the issues of concern raised within the IMR. It remains helpful to consider what was discovered to add weight to the recommendations emanating from this review. Despite a useful psychiatric report the PSR did not recommend what would have been possibly a more suitable sentence for YZ that would have included his mental health being monitored. Additionally the clues that YZ provided about his mother, use of prostitutes and drug problems could have all been further considered as a means of providing a more complete picture that could have led to more effective outcomes.

199. Probation also make the point that YZs continued lapses could have been more helpfully defined as a full relapse leading to other action, rather than a series of one–off events.

200. Good supervision and quality processes rather than a target driven approach are also highlighted as gaps then but where improvements have now been made. It is also noted that the files on YZ had much useful and pertinent information that could have added to a more complete view of his needs and problems. The psychiatric report from the doctor in Stockport is a good example. Probation are also better informed now about personality disorders following work in conjunction with the Department of Health.

201. As ever GPs are a constant thread running through the lives of people who have mental health and drug issues. They also, as in this case, have the care of relatives as an added responsibility. It does appear as though the unexplained injuries for WX should have prompted further action. There does not seem to be an awareness of the potential for domestic abuse which could have led to further action.

202. YZ did admit to pushing his mother but this did not lead to consideration of safeguarding issues for WX. The question is asked whether the geographic and at

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times emotional distance between WX and YZ for much of the last decade, led to a failure to recognise the potential for the GPs response to be coordinated and supportive to both.

203. The history of YZ was rarely fully considered, partly through absence of investigation but also because of geographic distance, complexity of the case and agency capacity. Decisions were therefore made without the full knowledge of what was known about his forensic history.

204. Within CNWL their computerised records system, JADE, will be used to enhance the identification of patients history and this will be audited to establish effectiveness. The need to understand a patient's history by keyworkers is also accepted and CNWL are delivering an induction programme and training programme to address this.

205. Training is an obvious consideration and had this been a more consistent process in the agencies involved in this case the outcomes may have been different. DV and safeguarding issues were evidently not prioritised throughout all of the partner agencies.

206. Housing was a constant difficulty in YZs life. He was homeless on occasions and his return to his mother's flat was accepted rather than progressed as a suitable change in his accommodation needs. There were examples of him being given extensive support in this area, demonstrating an understanding of his needs. His length of tenure in Approved Premises and his move into supported housing was a clear example of good and highly supportive practice, by Probation.

207. Finally the issue of a local partnership supporting the development of more effective responses to domestic abuse must be considered. It has been difficult to see the impact of such a partnership on the development of awareness, practice and systems. The MARAC has become well embedded in the Lewisham borough (since its inception in February 2009) but WX was not referred to this. Many agencies mention that there is a growing understanding of its value in this kind of case but WX was never risk assessed according to the IMRs. This may underline the need to reconsider how the partnership could have driven change and overseen agency accountability.

208. **Equality and diversity**

209. The nine protected characteristics as defined by the Equality Act of 2010 have all been considered within this review. (They are: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation.) The panel did not feel that these issues had a material bearing on the circumstances of this case or the subsequent review except for mental health (as a disability) which is fully discussed within the report.

210. Conclusion (and preventability)

211. It is clear that YZs condition worsened after beginning his period of being off-medication which was his choice, but overseen by a qualified doctor. The previous years, despite some lapses, had not seen significant concerns about his behaviour

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when his use of prescribed drugs was relatively stable. At this same time an attempt to transfer his care from one substance misuse service to another was made but this failed and in a way which, when connected with his off-medication stance, can be considered disastrous.

212. An opportunity to investigate his mental health, when significant concerns were raised by the LAS, was not progressed following his admission to KCH.

213. Preventability

214. It must be construed that had the process of care for YZ at this time been more effective in terms of him coming off medication, his transfer to a new drugs service and whilst in KCH the fatal outcome of this case could have been avoided. Had any one of these three issues been addressed differently the circumstances of this case could have been different. Additionally the fact that WXs vulnerability was not sufficiently recognised is also worthy of consideration when assessing how change must be delivered in the future.

215. When the issue of preventability is considered more clearly the issues in the preceding paragraph inevitably indicate that this death could have been prevented. As with so many cases a series of inconsistent and ineffective responses led to a fatal outcome. Had one of these gaps in service been approached differently the outcome could have been very different. It is to be hoped that the recommendations will make such an event in the future much less likely.

216. This obviously raises a number of questions, but action has been taken to improve processes and practice immediately following this death. Clinicians in CNWL have been reminded to communicate key changes to any patient's care "through the appropriate channels", including the team's senior consultant. A new transfer policy has been instigated within CNWL and staff have also been reminded of the operating protocol relating to the duty of care during a referral and transfer process.

217. KCH are considering training needs for individual members of staff and are seeking to review and promote the mental health co-working pathway which did exist at the time of YZs admission to hospital.

218. CRI have "fully actioned" improvements to their referral, allocation and engagement processes and instituted daily referral meetings.

219. Whilst these improvements to processes are welcome, there are issues which should be addressed more broadly and generally to reduce the likelihood of this type of incident taking place in the future.

220. The safeguarding response to both WX and YZ could have been improved. Apart from the police in 2005 (who made a referral to Victim Support) a consideration of WXs status as a potential and current victim of domestic violence was very rarely considered. This is particularly evident in the discussions YZ had with Hestia about returning to live with his mother and the lack of enquiries to establish the appropriateness of this arrangement.

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221. Following this case further training on domestic violence has been delivered to the adult social care advice and information team so that staff understand the dynamic of domestic violence in all cases and the implications for practice.

222. WX, it appears, was rarely spoken to about her wellbeing but when she was she tended to gradually minimise the events and not seek support. Her history of minor injury was never considered and evidence of her ability to care for YZ was never comprehensively explored.

223. YZs case was complex but opportunities were missed to change the circumstances of his life. More effort could have been made to improve his independence whilst in supported housing or use his full history to make more informed choices. Had agencies been able to understand or see the expert diagnosis (the report by a psychiatrist when a pre-sentence report was being prepared for example) different approaches could have taken place. These factors all indicate that more effort should be expended to consider the wellbeing of adults within, or connected to, the adult safeguarding system.

224. The issue of YZs diagnosis has been considered by professionals at length. As there were different views of this it must be at least possible that a broader view of his potential conditions may have led to a more comprehensive approach.

225. These issues above point to a variety of needs. Safeguarding training for all agencies, including a focus on mental health and domestic abuse, would enhance the response to similar individual cases in the future.

226. Information sharing, as an expectation, is essential, whether this be within agencies or across them. Accompanying this process must be an understanding of the issues involved which should result in a risk assessment process that, in this case, could have identified the needs of both WX and YZ. This then leads to the possibility of more cases being referred to the MARAC where a multi-agency problem solving approach can help achieve safer outcomes. YZs apparent reliance on alcohol also could have been an issue addressed within the substance misuse services or possibly as a problem solving approach within a MARAC referral.

227. These processes existed at the time of WXs death and this indicates that implementation and understanding of those processes may be in question.

228. The ASC IMR refers to the need for operational practices to be considered within the Adult Safeguarding Board and the Safer Lewisham Partnership. Considering the scope of issues raised within this DHR it may be challenging for the latter body to give full weight and oversight to these issues and the recommendations. Many local areas have specific domestic violence partnerships overseen by a strategic group which seek to deliver better responses in the areas discussed within this DHR. They also have the capacity and expertise to consider these issues and any recommendations arising from this report and this may be necessary in Lewisham.

229. Internal agency recommendations

230. Some of the agencies involved in this DHR process had identified changes to their internal processes and approaches. For completeness these are shown below.

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231. **CRI – New Directions**
232. All of the actions identified have been completed as set out below:
    - Concise internal pathways re-established to ensure rapid and flexible response to all referrals received and appropriate onward referral as required
    - Daily referral and allocations meeting, chaired by Team Leader or Services Manager, to ensure all referrals are allocated and responded to within 24hrs of receipt of referral
    - Daily referral meeting attended by service doctor to ensure senior clinical oversight of all referrals
    - Robust engagement and re-engagement pathways and process followed to assertively maximise engagement of all referrals.

233. Central and North West London Trust
234. CNWL recommendations are supported by a separate action plan. (Recommendation 5 below discusses how internal recommendations will also be the subject of review).
    - The Trust to identify a solution on JADE by which to flag up or inform staff if a client has an identified forensic history
    - Service to ensure that systems are in place that gives assurance that the data input to JADE is accurate and up to date. A system of audit should be developed to give assurance to the service that the clinical data contained within JADE is robust.
    - The role of the keyworker necessitates an in depth knowledge of a patient's critical information, forensic history and the associated risks arising out of this. Local induction and training should be reviewed to ensure a full understanding of the critical information of which they should be aware is emphasised.
    - Clinicians to be reminded of the need to communicate and discuss key changes to a patient's care through the appropriate channels. This should include informing the team's Consultant of any significant medication changes carried out by junior members of staff.
    - Staff to be reminded of the need to review and have a thorough knowledge of recent events and contacts in the patient file.

235. The team to be reminded of the operating protocol relating to responsibility of care during a referral and transfer process, and the need to ensure robust follow up so that the transfer occurs within the set timeframe. The panel are aware this has been reinforced trust wide through the development of a new transfer policy.

236. **Kings College Hospital**
237. In the light of the findings of this report the clinical supervisor should review the facts with the JCF using the NPSA decision making tool.
238. Review and promote mental health co-working pathway.
239. Use this case as a training tool (case study) to highlight learning points.

240. **London Probation Trust**
241. The IMR recommendations relate to how changes have been implemented within the Trust on a more general level so they are not included in this section of the review.

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242. **DHR recommendations**

243. The following recommendations are based on what should happen now, beyond what has taken place. It is to the credit of the agencies involved that they have taken action to remedy the problems discovered during this process. However if the likelihood of further incidents of this type are to be avoided additional activity is necessary.

244. Some of the recommendations below will require actions beyond the London Borough of Lewisham. This report will therefore be shared with The London Borough of Brent. The action plan is shown at appendix 2.

245. Recommendation 1

246. For all agencies who do not conduct periodic reviews of their processes and policies they must conduct a review of all safeguarding adult and domestic violence processes and policies and explicitly consider the overlap of the dynamic of domestic violence in its broadest sense and the response to safeguarding adults at risk. (The review process should be overseen by the Lewisham Safeguarding Adults Board in addition to the Lewisham Community Safety Partnership.) All agencies will be required and expected to implement policies and procedures in this area and report on their progress. These processes and policies to be reviewed annually and reported back to both strategic boards.

247. Recommendation 2

248. To deliver training to ensure all practitioners have a good understanding of the dynamics of domestic violence and appropriate responses. This case must be used as part of the development of an enhanced training package for practitioners which addresses safeguarding issues and includes domestic violence and abuse in its broadest sense.

249. Recommendation 3

250. The Lewisham Safeguarding Children's Board and the Safeguarding Adults Board training sub groups, to work together to review the partnership training programme delivered and commissioned by the London Borough of Lewisham on safeguarding and the links to domestic violence. This review to also examine the means by which this case can be included as a case study, in order to deliver an enhanced and relevant training package to the multi-agency workforce.

251. Recommendation 4

252. Adult Social Care and mental health services to review their information sharing processes to ensure effectiveness and the implementation of improved practice whereby agencies are aware of the policy and their staff trained to make use of the benefits of appropriate information sharing.

253. Recommendation 5

254. Lewisham Community Safety Partnership to agree and support a Domestic Homicide Review Task and Finish Group. This group to have oversight of the three domestic homicide reviews conducted in Lewisham and will be a sub group of the Performance and Delivery Group. The Domestic Homicide Review Task and Finish Group will review and monitor progress of implementation of the recommendations

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of this review (including the completion of agency internal recommendations). To report learning to both the LSCB and the SAB.

255. ***Recommendation 6*** *(London Borough of Brent to also consider this recommendation)*

256. Ensure that within the commissioning framework for Supporting People contracts, domestic violence expertise is utilised to inform and advise the commissioning process.

257. ***Recommendation 7*** *(London Borough of Brent to also consider this recommendation)*

258. Commissioners to visit, assess and review services using the Quality Assessment Framework as part of the Supporting People contract process.

259. Recommendation 8

260. Lewisham Clinical Commissioning Group and Public Health to consider piloting or commissioning a borough wide system to improve the response of primary care to patients who are experiencing domestic violence, such as Project IRIS.

261. Recommendation 9

262. This DHR to be shared with The London Borough of Brent Community Safety Partnership for consideration especially in relation to recommendations 6, 7 & 12.

263. Recommendation 10

264. Safeguarding Adults to conduct a case audit of referrals to establish the extent of adult cases with a domestic violence dynamic present and consider future practice and training needs.

265. Recommendation 11 *(for national consideration)*

266. Department of Health to recognise the issues of transferring patient notes and records from one practice to another and the dangers inherent in the current system. The system does not support clinicians in gaining knowledge of their patients, to be proactive in seeking out patient information or the provision of quality patient care.

267. Recommendation 12

268. Substance misuse services (in both Lewisham and Brent), in addition to their review and change of practice following this review, to audit their current practice and working arrangements to demonstrate systems involved in transfer of clients are operating effectively.

269. Recommendation 13

270. Lewisham Domestic Violence Services to conduct an audit of agency (excluding police) domestic violence referrals at standard and medium risk to ensure these cases have been correctly assessed and appropriate action commensurate with the available information and risk level has been taken.

271. Recommendation 14

272. Review the LAS safeguarding alert system to ensure all available information is presented to all medical practitioners involved in each case in a timely and useful format so that the information recorded on the alert is processed in real time to inform patient care and discharge planning.

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273. Recommendation 15

274. Hestia to review their client intake assessment process to ensure that where accommodation issues with family members and/or intimate partners is identified as a concern, these are clearly highlighted and considered in the clients support plan and in any move on arrangements. Assessment processes should specifically consider consultation with relevant parties, which should be conducted in a safe and confidential manner to inform case management decisions.

Glossary of acronyms	
LAS	London Ambulance Service
MPS	Metropolitan Police Service
DHR	Domestic Homicide Review
CSP	Community Safety Partnership
IMR	Individual Management Review
SLaM	South London and Maudsley NHS Foundation Trust
CNWL	Central North West London NHS Foundation Trust
KCH	King's College Hospital
EPR	Electronic Patients Record
SCAIT	Adult Social Care and Information Team
LPT	London Probation Trust
CSC	Children's Social Care (Children's Social Services)
ASC	Adult Social Care
GP	General Practitioner
NHS	National Health Service
DV	Domestic violence

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Appendix 1

Domestic Homicide Review Terms of Reference for WX

This Domestic Homicide Review is being completed to consider agency involvement with WX, and WX's son, YZ, following the murder of WX on 24th March 2012. The Domestic Homicide Review is being conducted in accordance with Section 9(3) of the Domestic Violence Crime and Victims Act 2004.

The Review will work to the following Terms of Reference:

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 is shared in the final report when published.

2) To explore the potential learning from this murder and not to seek to apportion blame to individuals or agencies.

3) To review the involvement of each individual agency, statutory and non-statutory, with *WX* and *YZ* during the relevant period of time: 1st January 2007 – 24th March 2012.

4) To summarise agency involvement prior to 24th March 2012.

5) The contributing agencies to be as follows:
   a) South London and Maudsley (SLaM)
   b) Central North West London Mental Health Trust
   c) Metropolitan Police
   d) Lewisham Adult Social Care
   e) GPs
   f) Lewisham Healthcare NHS Trust
   g) London Probation Trust
   h) Crime Reduction Initiative (substance misuse)
   i) Kings College Hospital
   j) Victim Support Lewisham

6) For each contributing agency to provide a chronology of their involvement with the victim, WX and alleged perpetrator, YZ during the relevant time period.

7) For each contributing agency to search all their records outside the identified time periods to ensure no relevant information was omitted, and secure all relevant records.

   a) For each contributing agency to provide an Individual Management Review: identifying the facts of their involvement with *WX* and/or *YZ*, critically analysing the service they provided in line with the specific terms of reference; identifying any recommendations for practice or policy in relation to their agency.

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b) To consider issues of activity in other boroughs and review impact in this specific case.

8) In order to critically analyse the incident and the agencies' responses to the family, this review should specifically consider the following five points:
   1. Analyse the communication, procedures and discussions, which took place between agencies.
   2. Analyse the co-operation between different agencies involved with the victim, alleged perpetrator, and wider family.
   3. Analyse the opportunity for agencies to identify and assess domestic abuse risk.
   4. Analyse agency responses to any identification of domestic abuse issues.
   5. Analyse organisations access to specialist domestic abuse agencies.
   6. Analyse the training available to the agencies involved on domestic abuse issues.

   And therefore:
   i) 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.
   ii) 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.
   iii) To improve inter-agency working and better safeguard adults experiencing domestic abuse.

9) 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 *WX* or *YZ* in contact with their agency.

10) To sensitively involve the family of *WX* in the review, if it is appropriate to do so in the context of ongoing criminal proceedings. Also to explore the possibility of contact with any of the alleged perpetrator's family who may be able to add value to this process.

11) To coordinate with any other review process concerned with the child/ren of the victim and/or perpetrator.

12) To commission a suitably experienced and independent person to chair the Domestic Homicide Review Panel, co-ordinating the process, quality assuring the approach and challenging agencies where necessary; and to subsequently produce the Overview Report critically analysing the agency involvement in the context of the established terms of reference.

13) To establish a clear action plan for individual agency implementation as a consequence of any recommendations.

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14) To establish a multi-agency action plan as a consequence of any issues arising out of the Overview Report.

15) To provide an executive summary.

16) To conduct the process as swiftly as possible, to comply with any disclosure requirements, and on completion, present the full report to the Safer Lewisham Partnership, with subsequent learning disseminated to the Domestic Violence Forum and the local MARAC, where appropriate.

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Appendix 2

Panel Members and agencies represented

Agency	Panel Member
Children's Social Care	Ian Smith
Health - GP	Dr. Nicola Payne
Healthcare NHS Trust	Dr. Teresa Sealy
Local authority – Community services	Aileen Buckton
Local authority – Crime reduction	Geeta Subramaniam-Mooney
Local authority – DV lead	Ade Solarin
Local authority – Joint commissioning	Dee Carlin
Metropolitan Police	Natalie Cowland
	Phil Fitzgerald
Probation – LB Brent	Joe Hopewood
Standing Together Against Domestic Violence	Anthony Wills (Chair)
SLaM	Wanda Palmer

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Appendix 3 DHR - WX

Action Plan

All recommendations will be overseen by the Lewisham Community Safety Partnership, and will be delivered by a task and finish sub-group of that partnership

Recommendation	Action to take	Lead	Key milestones achieved in enacting recommendation	Target Date	Date of completion and outcome
Theme 1 – Local partnership					
Lewisham Community Safety Partnership to agree and support a Domestic Homicide Review Task and Finish Group. This group to have oversight of the three domestic homicide reviews conducted in Lewisham and will be a sub group of the Performance and Delivery Group. The Domestic Homicide Review Task and Finish Group will review and monitor progress of implementation of the recommendations of this review (including the completion of agency internal recommendations). To report learning to both the LSCB and the SAB.	Hold regular T&F meetings with updates from all agencies and provide reports to the Safer Lewisham Partnership	Crime Reduction Service	1st Task and Finish meeting held 4th June 2013. Meetings to be held quarterly.	Ongoing - quarterly	

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Recommendation	Action to take	Lead	Key milestones achieved in enacting recommendation	Target Date	Date of completion and outcome
Theme 2 – Processes/systems /audits					
For all agencies who do not conduct periodic reviews of their processes and policies they must conduct a review of all safeguarding adult and domestic violence processes and policies and explicitly consider the overlap of the dynamic of domestic violence in its broadest sense and the response to safeguarding adults at risk. (The review process should be overseen by the Lewisham Safeguarding Adults Board in addition to the Lewisham Community Safety Partnership.) All agencies will be required and expected to implement policies and procedures in this area and report on their progress. These processes and policies to be reviewed annually and reported back to both strategic boards.		ASC – Joan Hutton			
Adult Social Care and mental health services to review their information sharing processes		ASC – Joan Hutton			

Recommendation	Action to take	Lead	Key milestones achieved in enacting recommendation	Target Date	Date of completion and outcome
to ensure effectiveness and the implementation of improved practice whereby agencies are aware of the policy and their staff trained to make use of the benefits of appropriate information sharing.		SLaM – Dee Carlin			
Substance misuse services (in both Lewisham and Brent), in addition to their review and change of practice following this review, to audit their current practice and working arrangements to demonstrate systems involved in transfer of clients are operating effectively. **(Also for Brent)**	Addictions Service (Brent) Implement the Addictions line management supervision to include the review of all cases with forensic history All staff to be trained in local procedures for Admission, Transfer and Discharge and a training record signed by each member. Local procedure for Admission, Transfer and Discharge to be	Addictions Service (Brent) Addictions Service (Brent) Addictions Service (Brent)	Service line audit to be completed for 2012/2013 Addictions HQ to provide service line audit for 2011/2012 Local procedure completed.	30th October 2012 30th October 2012 30th November 2012 31st January 2013	30th October 2012 November 2012

Recommendation	Action to take	Lead	Key milestones achieved in enacting recommendation	Target Date	Date of completion and outcome
	reviewed to include learning from this incident. CRI Actions Daily referral and allocations meeting, chaired by Team Leader or Services Manager, to ensure all referrals are allocated and responded to within 24hrs of receipt of referral Daily referral meeting attended by service Dr to ensure senior clinical oversight of all referrals	CRI – Fiona Kirkman CRI – Fiona Kirkman			October 2012 October 2012
Lewisham Domestic Violence Services to conduct an audit of agency (excluding police) domestic violence referrals at standard and medium risk to ensure these cases have been correctly assessed and	Dip sampling to be done. Victim Support to identify what period to be sampled.	Victim Support Lewisham			

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Recommendation	Action to take	Lead	Key milestones achieved in enacting recommendation	Target Date	Date of completion and outcome
appropriate action commensurate with the available information and risk level has been taken.					
Review the LAS safeguarding alert system to ensure all available information is presented to medical practitioners involved in each case in a timely and useful format so that the information recorded on the alert is processed in real time to inform patient care and discharge planning.		London Ambulance Service Kings Hospital			
Hestia to review their client intake assessment process to ensure that where accommodation issues with family members and/or intimate partners are identified as a concern, these are clearly highlighted and considered in the clients support plan and in any move on arrangements. Assessment processes should specifically consider consultation with relevant parties, which should be		Hestia – Carla Julien			

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Recommendation	Action to take	Lead	Key milestones achieved in enacting recommendation	Target Date	Date of completion and outcome
conducted in a safe and confidential manner to inform case management decisions.					
Theme 3 – Training					
The Lewisham Safeguarding Children's Board and the Safeguarding Adults Board training sub groups, to work together to review the partnership training programme delivered and commissioned by the London Borough of Lewisham on safeguarding and the links to domestic violence. This review to also examine the means by which this case can be included as a case study, in order to deliver an enhanced and relevant training package to the multi-agency workforce.	The partnership to undertake a comprehensive assessment and exploration of options for learning i.e. e-learning packages for borough-wide staff	CRS – Ade Solarin LSCB – Marinda Beaton SAB – Brian	Following the LSCB audit of training within ASC completed in May 13, responses have been collated and returned to LSCB. Further training needs to be identified and commissioned following meeting with LSCB June 13.		Training needs to be identified June 2013
To deliver training to ensure all practitioners have a good understanding of the dynamics of domestic violence and appropriate responses. This case must be used as part of the development of an enhanced	The partnership to undertake a comprehensive assessment and exploration of options for learning i.e. e-learning packages for borough-wide staff	CRS – Ade Solarin LSCB – Marinda Beaton SAB – Brian			

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Recommendation	Action to take	Lead	Key milestones achieved in enacting recommendation	Target Date	Date of completion and outcome
training package for practitioners which addresses safeguarding issues and includes domestic violence and abuse in its broadest sense.					
Theme 4 – Commissioning					
Ensure that within the commissioning framework for Supporting People contracts, domestic violence expertise is utilised to inform and advise the commissioning process. **(Also for Brent)**	SP provider policies to be collected and sent to AS and KW for assessment. Oversight. New service specifications to include appropriate DV reference. Draft Specs to be discussed with KW/AS during development. Relevant Action for LB Brent to be shared with their CSP.	LBL SP – Fiona Kirkman LBB SP – TBC All commissioned providers – Dee Carlin Ade Solarin	Discussion at SP contract monitoring meeting Discussion/agreement at the Framework Operational Group Sharing of new service specifications Discussion had with DV Lead, LB Brent regarding sharing of relevant Action. Correspondence sent.	June 2013 July 2013 July/August 2013 July 2013	September 2013 September 2013
Commissioners to visit, assess and review services using the Quality Assessment	Ongoing SP service reviews to highlight the H&S and risk and	LBL SP – Fiona Kirkman	Agreement of process at contract monitoring meeting	June 2013	Sample testing of reviews. Quarterly basis.

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Recommendation	Action to take	Lead	Key milestones achieved in enacting recommendation	Target Date	Date of completion and outcome
Framework as part of the Supporting People contract process. **(Also for Brent)**	assessment planning process. To review provider training ensure it contains appropriate DV training. Relevant Action for LB Brent to be shared with their CSP.	LBB SP – TBC All commissioned providers – Dee Carlin Ade Solarin	 Discussion had with DV Lead, LB Brent regarding sharing of relevant Action. Correspondence sent.	 July 2013	
Lewisham Clinical Commissioning Group and Public Health to consider piloting or commissioning a borough wide system to improve the response of primary care to patients who are experiencing domestic violence, such as Project IRIS.		CCG – Dee Carlin			
Theme 5 – Miscellaneous					
Safeguarding Adults to conduct a case audit of referrals to establish the extent of adult cases with a domestic violence dynamic present and consider future practice and training needs.		ASC – Joan Hutton	ASC Audit in progress report to follow.		August 2013

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Recommendation	Action to take	Lead	Key milestones achieved in enacting recommendation	Target Date	Date of completion and outcome
This DHR to be shared with The London Borough of Brent Community Safety Partnership for consideration especially in relation to the three recommendations highlighted above.		CRS – Ade Solarin	Executive Summary and Recommendations to be shared with the London Borough of Brent	July 2013	
Department of Health to recognise the issues of transferring patient notes and records from one practice to another and the dangers inherent in the current system. (The system does not support clinicians in gaining knowledge of their patients, to be proactive in seeking out patient information or the provision of quality patient care.)	The Safer Lewisham Partnership recognises this issue as relevant, however, this issue is to be raised with the Home Office as the context is of a broader and wider issue, than a local one.	CRS – Ade Solarin		July 2013	

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