DOMESTIC HOMICIDE REVIEW

The Case of AB

London Borough of Lewisham

Anthony Wills

With Laura Croom

April 2014

Contents

Domestic Homicide Review – AB

Executive Summary

Outline of incident

1. YZ knocked on his neighbour's door stating he had been locked out and needed to gain entry to the rear of his house. The neighbour gained access to the house YZ shared with his mother AB and found AB on the floor with blood around her. She had suffered stab wounds. The London Ambulance Service and the police were called and attended. AB was taken by ambulance to University Hospital, Lewisham, where life was pronounced extinct.

2. YZ was arrested at the scene and detained. He was charged with murder.

3. Psychiatric reports were obtained by both the prosecution and defence. They agreed that YZ was suffering from a mental illness at the time of the offence.

4. YZ pleaded guilty to manslaughter on the grounds of diminished responsibility and was sentenced to a hospital order under section 37 of the Mental Health Act 1983 and returned to the Bracton Centre to remain under the care of a consultant forensic psychiatrist. The judge ordered that in addition he was to be made subject to a restriction order under Section 41 of the Mental Health Act 1983 for the protection of the public.

5. The Review Panel extends its sympathy to the family of AB and YZ at this difficult time.

The review process

6. 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 March 2013 to consider the circumstances leading up to this death.

7. The DHR was established under Section 9(3), Domestic Violence, Crime and Victims Act 2004 and was conducted in accordance with Home Office guidance.

8. 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.

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

Terms of Reference

10. The full terms of reference are included at Appendix 1. The purpose 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.

Methodology

11. The approach adopted was to seek Individual Management Reviews (IMRs) for all organisations and agencies that had contact with AB 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.

12. This approach was undermined and greatly delayed by incomplete information supplied by YZ's GP practice. Further information only came to light after a letter of concern from the Chair was sent to the practice. This course of events is being investigated by NHS England.

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 London Borough of Lewisham or any of the agencies involved in this case. Anthony Wills retired in the course of this review and Laura Croom, an Associate of Standing Together, stepped in to complete the report. She has no connection with Lewisham or any of the agencies involved.

Parallel reviews

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

Contact with the family

15. The Family Liaison Officer passed the Chair's letter explaining the purpose of the DHR to a member of YZ and AB's family. The family said via the FLO that they did not want to be involved in this process.

16. Contact with the family of AB and YZ was attempted again at the end of February 2014, as there had been a delay due to the NHS process with the GP and it was felt that they might have changed their minds. The FLO spoke to the family member who has been the spokesperson and he declined to be involved but said that he would consult the rest of the family. There have been no further responses to efforts to get in touch.

17. The family will be invited to comment on the final report before it is published.

18. Contact with the perpetrator has been sought. His medical team decided (in March 2014) that it would not be appropriate at this point in his treatment for him to be interviewed for this review.

19. Without this input from the family, the Panel has had to rely on reports from the professionals around the family. In some cases, professionals recorded the views of family members and where these are referred to, we note the source of the information.

Nevertheless, the absence of the views of those involved in this tragedy is a loss to this review.

Summary of the case

20. YZ, the adult son of AB, had returned to live with his mother at least a year ago. YZ was one of 9 children, 8 of whom are still alive. Due to his behaviour as a result of his substance misuse, he had lost contact with most of his siblings.

21. Prior to January 2011, AB had a history of drug and alcohol misuse and 7 convictions for 9 separate criminal offences, 2 adult cautions and 1 formal warning. Two of the convictions were for common assault, in 1998 and 2002. The others were for theft, public order offence, drug offences, drunk and disorderly and a telecommunications offence. The last of these was in 2009.

22. YZ approached his GP about his cocaine use in 2001 and was sign-posted to a substance misuse service. He did not contact the service. YZ made several visits to A&E as a result of injuries, head pain and, in 2004, what was described by the GP as a deliberate overdose.

23. In 2006 the police were called on three occasions about YZ's behaviour: he entered his neighbour's backyard and knocked on her window in his underwear, on a subsequent occasion he whistled at the same neighbour after banging on the partition wall. A member of the public reported at about the same time that YZ was following a woman in the street. The person reporting this thought YZ had a knife. YZ was stopped and searched by police but no knife was found

24. On these occasions, he was thought to be under the influence of drugs or alcohol. These incidents led to 2 harassment warnings and a Fixed Penalty Notice respectively.

25. His mother had chronic health problems, some as a result of her diabetes, and regularly attended her GP surgery and hospital clinics.

26. In April 2012 a son of AB (unnamed) rang the GP and was said to have angrily requested a home visit for his mother which was then provided. No information was gained at this time about AB's home situation.

27. In July of 2012, as part of routine enquiries about AB's health, she disclosed that she felt depressed sometimes. No further information was gathered at this time as to why she was depressed.

28. On the morning of 20 October 2012, the police were called to the home of a neighbour of AB and YZ, as YZ had appeared at his door insisting that the neighbour's house was his own, and had physically removed the neighbour from the house. The neighbour did not want to make any criminal allegations, so the police officers spoke to YZ. YZ was remorseful and said that he meant no harm. The conversation was in the presence of AB and the police advised AB to contact YZ's GP for further assistance and advice in relation to his behaviour due to concerns about his mental and emotional condition.

29. Later than day, YZ's sister rang the police to report YZ missing. He had left shortly after the police that morning and she was concerned about his mental health. She provided further information about his erratic behaviour. She believed that he had never tried to harm himself, but she was concerned for his safety, thinking that he could harm himself or others.

30. The police risk assessment graded this incident as medium risk and research and enquiries were undertaken as a result to locate him.

31. At 1am on 21 October YZ's sister confirmed to the police that he had returned home. The police later debriefed YZ. He stated that he had been for a walk and was ok. He did not wish to report anything to police. He was reported to be in good physical health with no physical signs of injury.

32. The sister also rang the Out of Hours (OOH) GP on 21 October to report her concerns and supplied details about YZ's behaviour and mental state. Based on her information, the OOH GP noted that YZ was suffering from 'possible psychosis' but thought that, as YZ was asleep, YZ's GP could follow this up later. The OOH GP and YZ's sister agreed that she would ring the surgery the next day for a home assessment if YZ's behaviour deteriorated or was concerning.

33. YZ's sister rang the surgery the next day to request a home visit. The GP gained information from the sister that YZ had been aggressive in the past and therefore they were afraid to question him. The GP also gained other information about the incident with the neighbour, YZ's reclusive and disturbed behaviour, and about AB being depressed about the situation.

34. The GP made a home visit on 26 October and spoke to YZ and then to his mother, AB, and brother. YZ had lost weight, explained that he had had a misunderstanding with the neighbour and that he had some problems with his family but he was sorting these out. He admitted to drinking when he had the money. He continually went in and out of the house during this visit.

35. The GP spoke to AB and a brother and they confirmed that YZ spends any money he has on alcohol and marijuana. They confirmed his erratic behaviour and that he lost his temper easily and had been violent to his brother and to neighbours. The GP noted that the family appeared to be afraid of him.

36. The GP arranged for a surgery appointment for routine tests to eliminate any physical basis to YZ's behaviour. The GP planned to reassess him and organise a psychiatry or Crisis Team referral with or without YZ's consent and noted that YZ was 'a danger to himself and to others'.

37. A brother brought YZ to the surgery for these tests on 31 October and the family were encouraged to ring the surgery or the police if they had concerns while they awaited test results. At the appointment, YZ admitted to seeing objects that told him to do things and gave him messages. He said that these messages always told him that other people were bad. YZ agreed to be referred to a psychiatrist but the referral was not made.

38. Concerns about the GP's practice and, in particular, about why YZ was not referred, have been raised by this Review and are being investigated by NHS England as the GP's responses are inconsistent.

39. The GP arranged an appointment for YZ to return for the test results. He did not come for this appointment so the surgery followed this up with a letter.

40. The next time YZ came to the notice of the police or the GP was in relation to the homicide of AB three months later.

Key issues arising from this review

41. Broad themes identified throughout this review are summarised below.

42. **Referral processes being incomplete or ineffective.** The effort by YZ in 2001 to get help for his drug misuse resulted in signposting rather than referral. YZ's substance misuse and mental health problems were known to his GP. The police had contact with YZ on various occasions, but did not have information about the threat that YZ posed to his family. YZ's chaotic behaviour and lifestyle, and the information from his family about his behaviour, suggest that he was unlikely to be able to access help himself.

43. Early responses to lessons from this DHR, as well as an established development process, have led to Adult Coming to Notice (ACNs) now being incorporated into the Multi Agency Safeguarding Hub (MASH) system in Lewisham. Through this multi-agency approach, agencies and practitioners will have better information to make decisions about sign-posting and referrals.

44. This system, however, does not relieve professionals from the responsibility to act when risks are identified. Knowing the risk YZ posed and having assessed that he might need a crisis referral without consent, the failure by the GP to complete the referral to mental health services is a serious lapse.

45. **Lack of understanding of the dynamics of familial abuse.** Families are often instrumental in assisting medical staff to assess and care for those with mental health problems. However, where a person has been violent to other family members, it is highly risky for those family members to challenge the abusive member and inappropriate for authorities to put them in a position of responsibility for him getting help. GPs need to understand the dynamics of abuse so that they can identify risks and, while acting to get their patients the help they need, also ensure that those around them are alerted to any risks and see that support for them is in place.

46. GP decision-making around referrals for mental health issues would be improved by mandatory adult safeguarding training that includes training on risk and a pro-active response when a patient poses a risk to others.

47. **Missed opportunities.** There were several opportunities to follow up requests for help and to ask more questions and gather more information about the situation in the home of AB, particularly by the health services. Gathering psychosocial information about a patient, including who shares their home and the support they have there, would inform health care as well as help professionals meet their safeguarding responsibilities.

Recommendations

Recommendation 1
Require adult safeguarding training for GPs so concerns about threats posed by patients as well as their vulnerabilities are considered in treatment plans, and risks to others are identified. Ensure training covers familial abuse and links GPs into the multi-agency responses to these complex cases.

Recommendation 2
Improve GPs' training on enquiry and recording of psychosocial information about patients.

Recommendation 3
Review guidance on self-referral and the thresholds for referrals to drug and alcohol services. Promote the use of GP Interactive, an on-line resource for GPs in Lewisham that includes clinical pathways and referral protocols.

Recommendation 4
The MASH Steering Group to review the MASH response to vulnerable adults in 6 months to ensure that new processes are effective.

Recommendation 5 (National)
Department of Health to provide guidance for healthcare professionals on recording information about third parties that is pertinent to their health and well-being, e.g. information about their family situation and carers.

Domestic Homicide Review – AB

London Borough of Lewisham

Overview Report

Introduction

1. YZ, the adult son of AB, had returned to live with his mother at least a year ago. YZ was one of 9 children, 8 of whom are still alive. Due to his behaviour as a result of his substance misuse, he had lost contact with most of his siblings.

2. **Outline of the Incident**
3. YZ knocked on his neighbour's door stating he had been locked out and needed to gain entry to the rear of his house. The neighbour gained access to the house YZ shared with his mother, AB, and found AB on the floor with blood around her. She had suffered stab wounds. The London Ambulance Service and the police were called and attended. AB was taken by ambulance to University Hospital, Lewisham, where life was pronounced extinct.

4. Her son, YZ, was arrested at the scene and detained. He was charged with murder.

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 March 2013 to consider the circumstances leading up to this death. Relevant agencies were asked to review and secure their files at the first meeting.

6. Psychiatric reports were obtained by both the prosecution and defence. They agreed that YZ was suffering from a mental illness at the time of the offence.

7. YZ pleaded guilty to manslaughter on the grounds of diminished responsibility and was sentenced to a hospital order under section 37 of the Mental Health Act 1983 and returned to the Bracton Centre to remain under the care of a consultant forensic psychiatrist. The judge ordered that in addition he was to be made subject to a restriction order under Section 41 of the Mental Health Act 1983 for the protection of the public.

8. The Coroners Office closed the case with no formal inquest following the conclusion of the criminal case. They stated that no formal report would be provided.

9. The Review Panel extends its sympathy to the family of AB and YZ at this difficult time.

10. **Domestic Homicide Reviews**
11. The DHR was established under Section 9(3), Domestic Violence, Crime and Victims Act 2004 and was conducted in accordance with Home Office guidance.

12. 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.

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

13. **Terms of Reference**

14. The full terms of reference are included at Appendix 1. The purpose 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.

15. The first meeting of the Review Panel was held on 23 May 2013. The Review Panel was asked to review events from two years prior to the homicide, i.e. **1 January 2011 to 6 February 2013**. Agencies were asked to summarise any contact they had had with AB or YZ prior to 1 January 2011 with a view to expanding the timeframe if information received suggested more detail was needed on prior events. The summaries sufficed for the purposes of the Panel.

16. **Independence**

17. 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 London Borough of Lewisham or any of the agencies involved in this case. He has chaired several DHRs in Lewisham. Anthony Wills retired in the course of this review and Laura Croom, an Associate of Standing Together, stepped in to complete the report. She has no connection with Lewisham or any of the agencies involved.

18. **Parallel Reviews**

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

20. **DHR Methodology**

21. The approach adopted was to seek Individual Management Reviews (IMRs) for all organisations and agencies that had contact with AB 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.

22. IMRs were provided by the Metropolitan Police Service's Specialist Crime Review Group, NHS SE London – General Practice and University Hospital, Lewisham, as they were the only agencies or services known to have had contact with the victim and/or the perpetrator in the two years prior to the death of AB.

23. London Probation Trust, South London and Maudsley NHS Foundation Trust, and Victim Support, Lewisham, reviewed their files and notified the DHR Review Panel that they had no case involvement with either AB or YZ and therefore had no information for an IMR. Victim Support noted that they had offered their support to the family after the homicide but it was declined. YZ was not referred to mental health services.

24. The Review Panel members and chair are:

- Standing Together, Chair
- Metropolitan Police Service (Public Protection, Lewisham, and Specialist Crime Review Group)
- London Borough of Lewisham Community Services Directorate
- London Probation Trust
- Victim Support
- Lewisham Clinical Commissioning Group, Drug Misuse Lead
- University Hospital, Lewisham
- NHS Southeast London
- South London and Maudsley Hospital

25. The IMRs were undertaken by an agency member not directly involved with the victim, perpetrator or family member.

26. The IMRs provided were comprehensive of the material they had access to, identified lessons to be learned and made recommendations for improvement. They included chronologies of each agency's contacts with the victim or perpetrator.

27. 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.

28. In the course of the second Panel meeting, the Panel requested that a letter to YZ's GP surgery was written enquiring about the apparent lack of follow-up to the OOH GP's report. The surgery and the GP responded after what was meant to be the last Panel meeting.

29. The response from the GP surgery included information that was not originally available to the IMR writer and therefore required another Panel meeting at which it was discussed and a decision was taken to escalate the Panel's concerns to the NHS.

30. The Responsible Officer for NHS England was asked to establish why information was missing from the record when the original IMR was prepared (this same information was not available to the police at the time), to discover whether there was more information which had yet to be disclosed, and to understand the actions of the GP and why the agreed psychiatric referral was not made.

31. This investigation provided the information that is included in this report but disclosed a number of anomalies that are highlighted here. Further action is being taken by NHS England. Pursuing these anomalies delayed this report by about 5 months.

32. The chair wishes to thank everyone who contributed their time, patience and cooperation to this review.

33. **Contact with family**

34. The Family Liaison Officer passed the Chair's letter explaining the purpose of the DHR to a member of YZ and AB's family. The family said via the FLO when this review commenced that they did not want to be involved in this process. Contact with the family of AB and YZ was attempted again in February 2014, as there had been a delay due to the NHS process with the GP and it was felt that they might have changed their minds. The FLO spoke to the family member who has been the spokesperson and he declined to be involved but said that he would consult the rest of the family. There have been no further responses to efforts to get in touch.

35. Without this input from the family, the Panel has had to rely on reports from the professionals around the family. In some cases, professionals recorded the views of family members and where these are referred to, we note the source of the information. Nevertheless, the absence of the views of those involved in this tragedy is a loss to this review.

36. The family will be invited to read and comment on the final report.

37. Contact with the perpetrator has been sought. His medical team decided (in March 2014) that it would not be appropriate at this point in his treatment for him to be interviewed for this review.

The Facts

38. AB was 79 at the time of her death and lived in Catford where she had moved with her family in 1999.

39. AB was YZ's mother. YZ was 43 at the time of the homicide and he had lived with his mother for at least a year, though reports vary. No one else lived at that address.

40. On 6 February 2013, YZ knocked on his neighbour's door, stating that he had been locked out and needed to get into his own house. He had blood down the front of his tracksuit. The neighbour entered the house and found AB on the floor. She had been stabbed several times.

41. The neighbour rang the London Ambulance Service who then rang the police. AB was taken to University Hospital, Lewisham where life was pronounced extinct at 2.21pm.

42. YZ was found outside the address and was arrested.

43. On 7 February 2013, a post mortem found that AB had died from haemorrhage from 3 stab wounds.

44. YZ was examined by a forensic medical examiner and was deemed fit to be detained and interviewed without an Appropriate Adult.

45. A toxicology report found no alcohol and a very small amount of cannabis in YZ's system.

46. On 7 February, YZ was charged with the murder of AB and remanded in custody.

47. Psychiatric reports were obtained by both the prosecution and defence. They agreed that YZ was suffering from a mental illness at the time of the offence.

48. YZ pleaded guilty to manslaughter on the grounds of diminished responsibility and was sentenced to a hospital order under section 37 of the Mental Health Act 1983 and returned to the Bracton Centre to remain under the care of a consultant forensic psychiatrist. The judge ordered that in addition he was to be made subject to a restriction order under Section 41 of the Mental Health Act 1983 for the protection of the public.

49. On 11 March 2013, the Southwark Coroner's Court opened and adjourned an inquest into the death of AB pending the police investigation. The Coroners Office closed the case with no formal inquest following the conclusion of the criminal case. They stated that no formal report would be provided.

50. Information relating to AB

51. AB was born in Portland, Jamaica and moved to England and married. She moved with her family to Catford in 1999. AB was widowed.

52. AB had 9 children, eight of whom survived her, and many grandchildren.

53. **GP Report – pre and post January 2011**

54. AB was diagnosed with diabetes in 1990 and this was managed by diet alone initially.

55. She attended the GP surgery regularly to manage her diabetes and blood pressure. In recent years, AB suffered from persistent pain in her feet that was felt to be due to a complication of her diabetes.

56. She regularly attended hospital clinics and had minor surgery for several issues over the years.

57. On 30 April 2012, AB had a telephone consultation with the GP that was followed by a son (unspecified which son) apparently angrily (noted in the GP record) requesting a home visit because he did not think the telephone consultation had been sufficient. The GP made a home visit. The name of the son was not recorded and no enquiries appear to have been made or additional information gained as a result of that visit about AB's situation at home.

58. On 9 May 2012, a son of AB again requested a home visit as AB had pain down her left leg. This request was carried out and a son, DB, whose name was noted in the file, took AB to hospital for an x-ray that led to a diagnosis of arthritic changes in her back.

59. The record shows that her daughter CB took AB to the physiotherapist in May 2012.

60. In July 2012, a nurse asked as part of a routine check-up whether AB felt depressed and it is recorded that AB replied 'sometimes'. But this comment is not explored further by the nurse, nor referred to the GP.

61. There is very little overall information about AB's psychosocial situation in the GP's file.

62. **NHS Trust**

63. AB had a number of health problems, including the diagnosis of diabetes mellitus in 1990. Within the two years specified for this review, AB had 13 contacts with University Hospital, Lewisham for her diabetes and weight control. Her chronic pain was managed through visits to the Orthopaedic Clinic, sessions of physiotherapy and prescribed

medication as well as an epidural injection. She had several routine appointments at the Ophthalmology Clinic and several other investigations for assorted concerns.

64. In November 2012, AB attended an appointment for another epidural injection for her back pain but was unable to have the treatment as she did not have an escort as requested. There is no evidence that this was followed up by the hospital or the GP.

65. Her last attendance at the hospital was for the multiple stab wounds from which she died.

66. **Police**

67. There are no police records regarding AB prior to her death.

68. **Information from family**

69. In police interviews with the family after AB's death, they said that AB felt she needed to look after her son because he had become isolated and withdrawn from the rest of the family and she had allowed him to come and live with her at least a year before her death.

70. **<u>Information relating to YZ</u>**

71. YZ is the youngest of 9 siblings; he is one of 5 brothers and 3 sisters still living. He was in touch with only two of his siblings at the time of the homicide, according to police interviews with the family after AB's death.

72. **GP – previous to Jan 2011**

73. AB and YZ attended different GP practices. As a result, their GPs did not have had direct access to information about the other family member.

74. In May 1990, it is noted that YZ suffered from a facial injury and in December of the same year he tripped and required dental attention. There are no further details about these injuries.

75. From the subsequent entries it would appear that the facial injury resulted in facial scarring that was to cause YZ enough concern to seek advice and treatment from a plastic surgeon. YZ underwent surgery in May 1999 to repair his facial scarring.

76. YZ also had a nasal deformity that may have dated from his original facial injury. YZ had sought surgical correction (January 1997), but the ENT surgeon did not feel YZ would benefit from corrective surgery.

77. In 1992 YZ attended the GP surgery for a health promotion. He was noted to be 'an unemployed builder', a smoker with an alcohol intake of approximately 14 units a week. YZ reported that 'since I left school, it's been stressful all the way'. This comment is not followed up, nor is a drug history specifically commented on.

78. In December 1995, YZ was involved in a fight that required sutures to a head wound.

79. In 1999, YZ presented to his GP with gastric symptoms. YZ said then that he was a 'hyper person' and 'I can't relax'. Although he had been an electrician's mate, he was unemployed at the time. The GP noted YZ was very anxious.

80. In February 2001, YZ attended the GP surgery complaining of low mood. He disclosed to the GP that he had been using cocaine irregularly for 10 years and wanted to come off the drug as he felt it was affecting his life and his job. He noted that he was living

with his mother then. He was given a medical certificate for a week, a call was made to the local drug and alcohol service and YZ was given the number to contact for further help.

81. Several visits to A&E followed where he reported head pain and intermittent chest pains. During the next decade YZ had sporadic contact with medical services, attending with head injuries, acne and an attendance at University Hospital, Lewisham A&E with a deliberate overdose in November 2004.

82. **GP – in time period examined**

83. On 21 October 2012 YZ's sister, CB, made contact with the Out of Hours (OOH) GP service on his behalf. CB was concerned that YZ was 'acting strange'. The OOH's entry notes state that YZ had been living in the spare room of his mother's house for over a year.

84. The OOH GP noted that CB reported concerns that YZ was behaving strangely: that he sat by himself in the dark for long periods and talked to himself, initiated bizarre conversations with his mother, e.g. 'let's talk about monkeys', would not otherwise hold conversations but would get angry if challenged and did not sleep well. He wandered outdoors at night and was very dishevelled. She told of YZ throwing the neighbour out of his own house (more below at para 144ff in police records) and accusing the neighbour of having stolen his house. She reported that YZ apologised, disappeared and returned many hours later without his shoes.

85. The OOH GP noted that CB said YZ had used cannabis in the past but she did not think he could afford it any longer. She believed that he spent his unemployment benefit on alcohol.

86. From CB's information the OOH GP noted that it was possible that YZ was suffering from 'possible psychosis' but no immediate action was deemed necessary as he was asleep. The OOH GP left it to the GP to follow up and agreed with CB that CB would call again the next day if YZ's behaviour deteriorated or was concerning for home assessment or for 'sectioning'.

87. The next day, 22 October, CB, YZ's sister, phoned the surgery to request a home visit. The GP's notes record the following information gained from her: that YZ had moved back to his parents' house several years before, the incident when he threw the neighbour out of this house (see below), that the family are afraid to question him about his behaviour as he has been known to be aggressive in the past. The notes also record that YZ had been reclusive and had been noted to sit and smile to himself. The GP recorded that AB is depressed about the situation at home, that YZ's father had died the previous year and that YZ had moved into his room. The GP records that she will visit YZ the next day.

88. The GP's notes show that this home visit did not take place until 26 October. There is no explanation given for this delay. The GP noted that they had not had any previous entries of psychoses or psychotic treatment. The GP did note the previous overdose. During this visit, the GP spoke to YZ, AB and another son of AB. The GP noted that YZ had lost weight. YZ told the GP that everything was fine. He said that there had been a misunderstanding with his neighbours but that was now fine. He also reported that there were some problems with his family but that he was sorting things out. He admitted to drinking when he had money. During this visit, YZ continually went in and out of the house.

89. The GP spoke to AB and the brother after speaking to YZ, and recorded that they reported that YZ spends any money he gets on alcohol and marijuana. They said his leaving and returning to the house was typical behaviour. They reported that YZ was often irritable, lost his temper easily and has been violent to his brother and his neighbours. The GP observed that the family appeared to be afraid of YZ.

90. A visit was arranged for YZ to attend the surgery on 31 October for routine tests to determine if there were physical bases to his unusual behaviour. The GP also noted that YZ would be reassessed then and the GP would organise a psychiatry or Crisis Team referral with or without his consent. The GP notes that he is 'a danger to himself and to others'.

91. YZ's next GP contact was on the 31 October 2012. His brother brought him to the surgery and his blood pressures, weight and smoking habit were recorded and a number of other tests run. The GP noted that YZ admitted to seeing objects that told him to do things and gave him messages. The messages always told him that other people were bad. He agreed to be referred to a psychiatrist.

92. The GP's letter in response to further queries says that the GP advised the family to get in touch if they were concerned or call the police if they felt threatened while they waited for the results of the tests. In a further letter the GP says that, in contradiction to the notes as described above, YZ was 'not psychotic when I saw and interviewed him'.

93. The GP has been asked directly why YZ was not referred for a psychiatric assessment and the explanations given are not consistent. These inconsistencies are the subject of further investigations by NHS England.

94. The GP stated that YZ did not attend the booked appointment to discuss the results of the tests and the family did not get in touch again. The surgery followed the missed appointment with a letter and there is no note of any response.

95. **NHS Trust – before and after January 2011**

96. Before the time period being reviewed, 3 outpatient attendances were recorded for YZ between 2001 and 2003 for facial scars and other skin problems.

97. In 2006, YZ attended A&E for back pain following a fall. He was provided with pain control and discharged. An attendance for a head injury and bleeding occurred in September 2008, but YZ did not remain in the department long enough to be assessed and therefore a cause of this injury was not established, nor any other information gathered. There is more on this A&E attendance in the police record (see para 180 below).

98. There are no records for YZ after 1 January 2011, the starting date for this review.

99. **Police – prior to January 2011**

100. Prior to the time covered by this review, the police had many recorded incidents regarding YZ's behaviour.

101. YZ had seven convictions for nine separate offences, two adult cautions and one formal warning. The first of these dates back to 1988 when YZ was 18. He had two convictions for common assault, in 1998 and 2002, both alcohol-related. As a result of the first offence he received an 8-week prison sentence. YZ had a conviction for theft, one for a public order offence, three convictions for drug offences, one for drunk and disorderly and one telecommunications offence. The last of these was in 2009.

102. In February and March 2006, YZ's neighbour reported two separate incidents: in the first, YZ entered a neighbour's back garden wearing only his underwear, and knocked on the neighbour's window. When police attended YZ's home, they found him naked and watching a pornographic film. He appeared to be under the influence of drugs. YZ apologised and was issued with a harassment warning.

103. On the second occasion YZ whistled at the same neighbour as she entered her home. He had also been banging on the partition wall. There was a suspicion that his behaviour was influenced by drink or drugs. YZ was issued with a further harassment warning. The neighbour wanted YZ warned about his behaviour, but did not want to take it further.

104. In June 2006, a member of the public called police saying they had seen YZ following a woman in the street and carrying a knife. YZ was stopped and searched, but no knife was found. He told police that he had followed the woman from a pub in Lewisham as she looked at him and 'wiggled her bottom'. He was arrested for being drunk and disorderly and issued with a Fixed Penalty Notice for his drunken behaviour.

105. When YZ attended the A&E in September 2008, he was intimidating and threatening to staff there (attendance noted in NHS report above) and the police were called. YZ was searched and found in possession of cocaine and cannabis and was charged, convicted and fined for this.

106. **Police – from January 2011**

107. On 20 October 2012 at 7.14 am, police were called by YZ's neighbour stating that YZ had come to the front door and when he answered the door had been physically removed from his house by YZ who stated, 'This is my house.' The neighbour did not wish to make criminal allegations but was concerned and wanted YZ spoken to about his behaviour.

108. Officers spoke to YZ at his and AB's home in the presence of AB. He was remorseful and said he had meant no harm. Officers advised AB to seek advice from a GP as YZ's behaviour caused concerns regarding his mental and emotional condition.

109. Later on 20 October 2012 at 5.20pm police were contacted by YZ's sister, CB, who reported that YZ was missing and had not returned home since police left that morning at 8.30am. She was concerned that he had no money or phone and had not eaten all day. She had concerns about his mental health. She said that he would not seek help and she felt that his mental health was deteriorating. AB and CB stated that YZ spent most of his time in his bedroom or on the living room sofa. They said he walked up and down the hallway for long periods of time talking to himself. They believed he had never harmed himself or attempted suicide, but had concerns for his safety and that of others, believing he may harm himself or other people.

110. The police undertook a risk assessment designed to assess the risk that a missing person poses to himself or others. The risk was graded as Medium, which was confirmed upon review by a supervisor. Research and enquiries to locate YZ were undertaken.

111. At 1am on 21 October CB reported to the police that YZ had returned home safe and well. She confirmed her intention to contact his GP about his mental health.

112. An officer from the Missing Persons Unit subsequently debriefed YZ at home. YZ said that he had been for a walk around Catford and that he was 'ok' and did not want to report anything to the police. He was reported to be in good physical health with no

evidence of marks or bruising. The Panel noted that this was an example of good practice.

113. The next contact the police had with YZ was 3 and a half months later when they were called to the scene of the homicide.

114. **Information from the family**

115. In gathering evidence after AB's death, the police were told by the family that YZ was in touch with only two of his siblings at the time of the homicide. The police understand that the others were not in contact as a result of YZ's cannabis and alcohol use and because they thought he was stealing from AB.

116. The family suggested to the police that YZ had become isolated and withdrawn. He spent much of his time alone in his room or pacing the corridor talking to himself. He did not socialise regularly.

Analysis

117. There are three themes that come out of this narrative:

118. **Referral processes being incomplete or ineffective.** There were early efforts by YZ and later efforts by his family to get him help. YZ's substance misuse and mental health problems were known to his GP. The police had contact with YZ on various occasions, but did not have information about the threat that YZ posed to his family. Better information-sharing between agencies about vulnerable adults would have improved decision-making about referrals. The obvious risk that YZ posed should have resulted in a referral by his GP for a mental health assessment.

119. **Lack of understanding of the dynamics of familial abuse.** YZ's GP recorded that he was a danger to himself and others and knew that he had been violent to a family member and others in the past. Where a family member has been violent to other family members, it is highly risky for them to challenge the abusive member and inappropriate for a professional to put them in a position of responsibility for him getting the help that professionals have identified that he needs. GPs need to understand the dynamics of abuse so that they can identify risks and, while acting to get their patients the help they need, ensure that those around them are alerted to any risks and see that support for them is in place.

120. **Missed opportunities**, particularly by the health services, to follow up requests for help, to ask more questions and gather more information about AB's and YZ's home situation.

121. **GP – AB**

122. Although there is nothing in AB's medical record to suggest she was at particular risk of domestic abuse, there were three missed opportunities to explore her personal situation – during two home visits, as well as when the nurse enquired into her low mood.

123. As part of the Quality Outcomes Framework, patients with diabetes are screened for depression on an annual basis. Unfortunately when the nurse made enquiries about AB's mood, she recorded the answer and did not make more specific enquiries. Because these enquires are part of GPs' targets, there may be a tendency to record the response, rather than act on the response. GPs and their staff need to be more pro-active when possible underlying low mood is identified. AB's reply of 'sometimes' should have been explored further.

124. AB's son (unidentified in the notes) phoned the surgery and angrily asked for a home visit. As this response was felt to be out of proportion to the issue, the GP could have made enquiries during the visit as to why the son became so angry. This might have led to information about the situation at AB's home. The GP may well have asked this question but failed to record AB's answer.

125. The GP record of contacts would be improved by regular recording of the name and relationship of family members who contact the surgery on behalf of a patient.

126. Further, although AB suffered from chronic diseases and attended clinics on a regular basis, there is very little information regarding her psychosocial situation in her GP-held record. Often GPs are aware of their patients' social situation (especially patients who have regular contact because of a chronic disease), but they do not necessarily record it in the GP-held record. As understanding of (and recording) a patient's social situation informs how a patient copes with their chronic illnesses, more systematic enquiry might have uncovered information that would have suggested further support for AB.

127. There is uncertainty amongst some health staff about the legal issues of confidentiality and data protection in recording information about third parties that is discovered as a result of enquiries about the psychosocial situation of patients. Department of Health guidance on this would help practitioners to record such information more confidently to the benefit of patient care.

128. **GP – YZ**

129. The GP-held record for YZ suggests that he attended the surgery fairly often and was comfortable enough to disclose his drug use and his wish at one point to stop taking the drugs as he could see it was damaging his life. The notes show him as isolated and unemployed, as a drug user with mental health problems.

130. YZ is noted to be unemployed in the GP record. This is a risk factor for poor mental health and also drug/alcohol abuse – more formal enquiries might have been made in these areas affecting his overall health. These are also risk factors for domestic abuse.

131. When YZ suggested he was ready to address his cocaine use in 2001, the GP signposted him to services. Signposting does not require regular follow-up and YZ did not make contact with those support services on his own.

132. GP decision-making around referrals and signposting includes consideration of safeguarding issues and whether there are significant mental health problems. GPs also need to consider the specialist agencies' own processes and whether they accept self-referrals. In 2001, the GP does not appear to have had enough information to refer rather than signpost YZ to the specialist drug services.

133. In November 2004, YZ deliberately overdosed and was seen at A&E and discharged home. There is no record of GP contacts in relation to this and this to appears to be a missed opportunity to engage YZ in help for his drug use.

134. During the OOH GP's contact with YZ's sister, she provided information that YZ was unpredictable and the OOH GP concluded that YZ probably suffered from a significant mental illness.

135. The GP's subsequent, and delayed, assessment at YZ's home and at the surgery identified that YZ had serious mental health issues and concluded that YZ was a danger to himself and to others. Given YZ's chaotic behaviour and mental state, it was unlikely

that he would attend appointments or respond to letters. As stated above, GP decisions around referrals are influenced by safeguarding concerns and mental health issues, both of which are apparent here. A crisis intervention was mooted and YZ agreed to a referral. Yet the referral was never made.

136. There is a significant gap between the GP appointment on 31 October 2012 and AB's homicide, which occurred in February the following year. Though the family and YZ made no further calls to the GP after the end of October, their engagement on 21 October and in the aftermath of that event, their accompanying YZ to his appointment on 31 October, in their ringing the GP and providing information to the police and the GP, show they were trying to get YZ the help that he needed. The ability of his family to continue to assist this process is likely to have been reduced by their fear of him based on his previous violence. So the GP's reliance on them to get him to appointments or to report further concerns in order to move the referral process on, appears not to recognise the risk to them in doing so.

137. These findings suggest the need for GP training on the dynamics of abuse and a pro-active referral process for those with mental health problems that pose a threat to others.

138. The activity within the GP practice in relation to these events is being considered further outside of this review. Records that became available later to the Panel were not available to the IMR writer or the police previously. Failures in the management of this GP's records has come to light during this review and continues to be the subject of discussion between the practice and NHS England. Most significantly for this review, explanations for the non-referral for a psychiatric referral have been inconsistent and therefore unconvincing.

139. This failure to ensure an expert assessment of YZ's mental health is a significant factor in this review. The Panel concluded that if YZ had been assessed at this time, it is likely that such an assessment would have provided YZ with appropriate treatment and support that could have prevented the homicide of AB.

140. **Metropolitan Police Service**

141. The three contacts YZ had with the police in 2006 were dealt with by harassment warnings and a Fixed Penalty Notice. These all involved harassment of women, and were characterised as a result of drink or drug use. The police did not have enough information from these incidents to take further action, but the information was recorded as intelligence.

142. The incident in October 2012 again suggested that YZ had mental health problems. This was the only time a concern was recorded that YZ might harm himself or others and the police were not aware of all the information that was later supplied to the OOH GP or the GP. It may be that YZ's sister did not know about the deliberate overdose. At the time there were no formal information-sharing processes between the MPS and partners around mental health or vulnerable adults.

143. This risk area has been identified and acknowledged by the MPS and partner agencies. Processes and procedures in relation to mental health issues were looked at in the recent Independent Commission for Mental Health and Policing, led by Lord Adebowale. Included in the Report's 28 recommendations are professionalising the role of police Mental Health Liaison Officers (MHLO), improve working practices with partners and ensure adequate training is given to staff and improve information recording and sharing. (The MHLO post will no longer be available under the Local Policing Model proposed.)

144. The Multi-Agency Safeguarding Hub (MASH) was launched in Lewisham in December 2012. A MASH is a group of agencies co-located to triage incidents and referrals to ensure that the right agencies are involved and in touch with each other from the start of agency involvement with children. In April 2013, the Metropolitan Police took the decision to include Adults Coming to Notice (ACNs) in the MASH process so that vulnerable adults could benefit from the process too. The Merlin database[1], a Metropolitan Police Service computer system, now includes information about ACNs.

145. At the beginning of this review, a reliable process for the exchange of information between the police and mental health services was unresolved in Lewisham. However, by the third Panel meeting the Adult Social Care team was working with police. Following local discussion and operational agreement about the onward referrals of appropriate ACNs to Adult Social Care, this process is now in place. This is an example of early implementation of learnings from this review.

146. The incidents described in this report, if occurring today, would raise an ACN for YZ. However, unless the information held by the GP had also been available, a case like YZ is unlikely to have passed the threshold for a mental health social worker. Though YZ might have passed the therapeutic threshold for Improving Access to Psychology Services (IAPS), it is unlikely that IAPS services would have made a significant difference in this case.

147. The MASH process for adults coming to notice will provide the opportunity for professionals in partner agencies to review cases together with fuller information than they have at present.

148. Diversity

149. The Review Panel has considered the protected characteristics as defined by the Equality Act 2010, that is, age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation, equality and diversity issues to determine if they had any bearing on the services provided to the victim or the perpetrator. AB and YZ were Black African-Caribbean and AB was a regular attender at a local church. However, the Review Panel did not consider that these factors or any other protected characteristics had a material bearing on the responses of agencies to either AB or YZ and therefore there was no requirement for further action to address these characteristics.

[1] A Metropolitan Police Service database that is used to collect information on missing persons, found persons (sudden deaths), pre-assessment checklists, children protection register, youth non-recordable, prostitute cautions and now, adults coming to notice.

Conclusions and Recommendations

150. Preventability

151. YZ's family contacted the police and then the GP surgery with concerns about his deteriorating mental health. YZ had convictions for assault but the last assault charge was more than 10 years before the homicide. The information that the police had did not suggest that he was a risk to his family. Through these contacts with the police and the criminal justice system, there is no evidence that YZ was a threat to his family or friends.

152. The GP's investigations in October 2012 uncovered information that YZ was a danger to himself and others and yet the referral process was not completed for a mental health assessment. A mental health assessment is likely to have provided treatment and support that would have reduced his risk to himself and others.

153. This must mean that this failure to act was a missed opportunity (and probably the only one) that could have prevented the death of AB.

154. Issues Raised by the Review

155. These events describe a situation where an older and chronically unwell woman was living with an adult son with a history of aggression and inappropriate behaviour linked to alcohol and drug use and possible psychosis. This combination of vulnerabilities would have benefitted from greater understanding and involvement of the agencies in contact with them, particularly health services. The GP surgery should have taken more responsibility for getting help to YZ as he and his family were unable to do so.

156. The concerns raised about the individual GP's response are being pursued through an NHS investigation.

157. The significance of the failure by the GP should not obscure the systemic themes that have emerged. These are best addressed through training and improved processes.

158. ***Referral processes being incomplete or ineffective.***

159. The effort by YZ in 2001 to get help for his drug misuse resulted in signposting rather than referral. YZ's substance misuse and mental health problems were known to his GP. The police had contact with YZ on various occasions, but did not have information about the threat that YZ posed to his family. YZ's chaotic behaviour and lifestyle, and the information from his family about his behaviour, suggest that he was unlikely to be able to access help himself.

160. Early responses to lessons from this DHR, as well as an established development process, have led to Adult Coming to Notice (ACNs) now being incorporated into the Multi Agency Safeguarding Hub (MASH) system in Lewisham. Through this multi-agency approach, agencies and practitioners will have better information to make decisions about sign-posting and referrals.

161. This system, however, does not relieve professionals from the responsibility to act when risks are identified. Knowing the risk YZ posed and having assessed that he might need a crisis referral without consent, the failure by the GP to complete the referral to mental health services is a serious lapse.

162. ***Lack of understanding of the dynamics of familial abuse.***

163. YZ's GP realised that he was a danger to himself and others and knew that he had been violent to a family member and others in the past. However, the GP relied on family members to contact the surgery and/or bring YZ for appointments. Where a family member has been violent to other family members, it is highly risky for them to challenge the abusive member and inappropriate for authorities to put them in a position of responsibility for him getting the help that professionals have identified that he needs. GPs need to understand the dynamics of abuse so that they can identify risks and, while acting to get their patients the help they need, also ensure that those around them are alerted to any risks and see that support for them is in place.

164. GP decision-making around referrals for mental health issues would be improved by mandatory adult safeguarding training that includes training on risk and a pro-active response when a patient poses a risk to others.

165. ***Missed opportunities.***

166. There were several opportunities to follow up requests for help and to ask more questions about AB's depression and home situation in order to gather more information, particularly by the health services. Such enquiry might have led to disclosures that would have allowed authorities to act earlier to get help to YZ or protect AB. At least the collection of such information might have shown changes over time that could have informed health authorities' responses.

Recommendations

The recommendations flow from the above:

Recommendation 1
Require adult safeguarding training for GPs so concerns about threats posed by patients as well as their vulnerabilities are considered in treatment plans, and risks to others are identified. Ensure training covers familial abuse and links GPs into the multi-agency responses to these complex cases.

Recommendation 2
Improve GPs' training on enquiry and recording of psychosocial information about patients.

Recommendation 3
Review guidance on self-referral and the thresholds for referrals to drug and alcohol services. Promote the use of GP Interactive, an on-line resource for GPs in Lewisham.

Recommendation 4
The MASH Steering Group to review the MASH response to vulnerable adults in 6 months to ensure that new processes are effective.

Recommendation 5 (National)
Department of Health to provide guidance for healthcare professionals on recording information about third parties that is pertinent to their health and well-being, e.g. information about their family situation and carers.

Annex 1

Domestic Homicide Review Terms of Reference for AB

This Domestic Homicide Review is being completed to consider agency involvement with AB, and AB's son, YZ, following the death of AB on 6th of February 2013. 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:

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.

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

To review the involvement of each individual agency, statutory and non- statutory, with *AB* and *YZ* during the relevant period of time: 1 January 2011 – 6 February 2013.

To summarise agency involvement prior to 1 January 2011.

The contributing agencies/individuals to be as follows:

- Metropolitan Police Service – Lewisham Public Protection Desk and Specialist Crime Review Group SC&O21 (2)
- GPs
- Lewisham Healthcare NHS Trust
- London Probation Trust
- Victim Support Lewisham
- South London and Maudsley NHS Foundation Trust
- Lead GP for Substance Misuse

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

For each contributing agency to search all their records outside the identified time periods to ensure no relevant information was omitted, provide any necessary and/or pertinent information, and secure all relevant records.

For each contributing agency to provide an Individual Management Review: identifying the facts of their involvement with AB 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.

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

In order to critically analyse the incident and the agencies' responses to the family, this review should specifically consider the following five points:

- Analyse the communication, procedures and discussions, which took place between agencies.

- Analyse the co-operation between different agencies involved with the victim, perpetrator, and wider family.
- Analyse the opportunity for agencies to identify and assess domestic abuse risk.
- Analyse agency responses to any identification of domestic abuse issues.
- Analyse organisations access to specialist domestic abuse agencies.
- Analyse the training available to the agencies involved on domestic abuse issues.

And thereby:

- 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.

- 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.

- To improve inter-agency working and better safeguard adults experiencing domestic abuse.

- 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 AB or YZ in contact with their agency.

- To sensitively involve the family of AB in the review, if it is appropriate to do so in the context of on-going criminal proceedings. Also to explore the possibility of contact with any of the perpetrator's family who may be able to add value to this process.

- 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.

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

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

- To provide an executive summary.

- 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 via the Lewisham DHR Task and Finish Group, to the Domestic Violence Forum and the local MARAC, where appropriate.

Annex 2

Panel Members and Agencies represented

Anthony Wills, Chair	Standing Together Against Domestic Violence
DI Natalie Cowland	Metropolitan Police Service, Specialist Crime Review Group
DS Helen Flanagan	Metropolitan Police Service, Specialist Crime Review Group
Aileen Buckton, Executive Director	Community Services, London Borough of Lewisham
Geeta Subramaniam-Mooney, Head of Crime Reduction	London Borough of Lewisham
Paul Hodwon, Adult Safeguarding Lead	Lewisham Healthcare NHS Trust
David Davies, GP Drug Misuse Lead	Lewisham CCG
Lizzette Ambrose, Acting Assistant Chief Officer	London Probation Trust
Ade Solarin, DV Lead	London Borough of Lewisham
Dr. Nicola Payne, Deputy Medical Director	NHS SE London
Dee Carlin, Head of Joint Commissioning	London Borough of Lewisham
DCI Greg Pople	Public Protection Desk, MET Police, Lewisham
Anita Read, Divisional Manager	Victim Support
Wanda Palmer (and later, Lorraine Thompson), Assistant Director of Patient Safety	South London and Maudsley
Laura Croom, Associate	Standing Together Against Domestic Violence

Annex 3
Letter to the GP

Practice Manager
Woodlands Health Centre
4 Edwin Hall Place
London SE13 6RN

29 August 2013

Dear Sir/Madam,

I am the chair of a Domestic Homicide Review in Lewisham. The review process was set up under legislation and is not a statutory process. In the course of the examination of information about the alleged perpetrator we have found an anomaly that we feel should be brought to your attention for review.

The alleged perpetrator, Mr. YZ, is a patient of Dr. XX at you practice. His sister rang the Out of Hours GP on 21 October 2012 because she was worried about the behaviour of her brother. The police had been called to the house twice that day and YZ had gone missing for a long period. His sister explained her concerns to the Out of Hours GP, Dr. MM. The Individual Management Review we have reports that Dr. MM recorded: 'possible psychosis'. The next entry for YZ is that of the GP 10 days later on 31 October, where only his height, weight, and the fact that he is a smoker is recorded. We are concerned that an over-the-phone diagnosis of possible psychosis was not followed up by the GP more swiftly and in more detail as a routine process. Though the Panel agrees that this apparent lapse did not lead directly to the death of YZ's mother, this course of events remains concerning. As Chair of the Panel, I wanted to alert you to these events so that you can review the circumstances detailed above and the response within your practice.

We will continue with the review and have noted this concern within the overview report, and the fact that this letter has been sent to your practice. I would greatly appreciate a response to our concerns to further our deliberations.

Yours sincerely,

Anthony Wills
Chair of the DHR
Chief Executive, Standing Together Against Domestic Violence

Annex 4
Action Plan

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 Task and Finish meetings with updates from all agencies and provide reports to the Safer Lewisham Partnership.	Crime Reduction Service, Lewisham	The Domestic Homicide Review Task and Finish Group reviews and monitors progress of implementation of the recommendations of this review (including the completion of agency internal recommendations). Bi-annual report to a sub group of the Safer Lewisham Partnership, the Performance and Delivery Board.	Already ongoing	Complete
Theme 2 – Processes/systems /audits					
Review guidance on self-referral and the thresholds for referrals to drug and alcohol services. Promote the use of	Prevention and Inclusion Service, responsible for the commissioning of drug and alcohol	Crime Reduction Service, Lewisham		October 2014	

Recommendation	Action to take	Lead	Key milestones achieved in enacting recommendation	Target Date	Date of completion and outcome
GP Interactive, an on-line resource for GPs in Lewisham.	services in Lewisham, to review guidance on self referral. GP Lead for drug and alcohol misuse to assist in promoting the use of GP Interactive.	GP Lead for drug and alcohol			
The MASH Steering Group to review the MASH response to vulnerable adults in 6 months to ensure that new processes are effective.		Lewisham Safeguarding Adults Board		October 2014	
Theme 3 – Training					
Require adult safeguarding training for GPs so concerns about threats posed by patients as well as their vulnerabilities are considered in treatment plans, and risks to others are identified. Ensure training covers familial abuse and links GPs into the multi-agency responses to these complex cases.	Commission the IRIS Project as part of new VAWG service delivery from April 2015.	Crime Reduction Service, Lewisham	Consideration of the IRIS Project agreed in principle, with commencement date in April 2015.	April 2015	
Improve GPs' training on enquiry and recording of psychosocial information about patients.	Commission the IRIS Project as part of new VAWG service delivery from April 2015.	Crime Reduction Service, Lewisham	Consideration of the IRIS Project agreed in principle, with commencement date in April 2015.	April 2015	
Theme 4 – Miscellaneous					

Recommendation	Action to take	Lead	Key milestones achieved in enacting recommendation	Target Date	Date of completion and outcome
(National) Department of Health to provide guidance for healthcare professionals on recording information about third parties that is pertinent to their health and well-being, e.g. information about their family situation and carers.	Executive Director for Community Services, Lewisham to meet with Dept of Health directly in relation to this action.	Community Services, Lewisham		October 2014	