
## Community Safety Partnership

# DOMESTIC HOMICIDE REVIEW

Into the death of Max

March 2018

## EXECUTIVE SUMMARY

Report Author

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The Domestic Homicide Review Panel and the members of the Hammersmith and Fulham Community Safety Board would like to offer their sincere condolences to the victim's wife, his children, and his family members both in the United Kingdom and abroad. The magnitude of his loss to his wife and children in particular cannot be under estimated.

The chair and Panel members are most grateful to the family member and the friends of the victim who have contributed to this Review. They have greatly enriched the content of this report and helped present the parties involved as individual people and not simply as a victim and perpetrator of a terrible crime.

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# EXECUTIVE SUMMARY

## 1 The Review Process:

1.1 This summary outlines the process undertaken by the Hammersmith and Fulham Community Safety Partnership Domestic Homicide Review (DHR) Panel in reviewing the homicide of Max who was staying in the Borough at the time of the fatal incident.

1.2 The following pseudonyms have been used in this review for the victim and perpetrator (and other parties as appropriate) to protect their identities and those of their family members:

The victim: Max aged 42 years at the time of his death.
The perpetrator: David, aged 32 years at the time of the offence.

1.3 Criminal proceedings were completed in August 2018 and following psychiatric assessments the perpetrator's plea of Manslaughter on the grounds of diminished responsibility was accepted. He was later sentenced to be detained in a secure hospital under a Hospital Order with Restriction under Section 37/41 of the Mental Health Act 1983[1].

1.4 The review process began with an initial meeting of the Community Safety Partnership on 27 March 2017 when the decision to hold a domestic homicide review was agreed. All agencies that potentially had contact with the victim and or the perpetrator prior to the point of the homicide were contacted and asked to confirm whether they had involvement with them. A total of 12 local providers of services were contacted and 6 confirmed contact with the victim and/or the perpetrator and they were asked to secure their files.

### Contributors to the Review

1.5 The following agencies and the nature of their contributions to this review are:

| Name of Agency | Chronology | Individual Management Review | Report |
|---|---|---|---|
| 1. West London NHS Trust (formerly West London Mental Health Trust) | √ | √ | |
| 2. Metropolitan Police Service | √ | √ | |
| 3. GP Practice | √ | √ | |
| 4. Shepherds Bush Housing | √ | | √ |
| 5.Hammersmith & Fulham Adult Social Care | √ | | √ |
| 6. London Ambulance Service | √ | | |

[1] A Section 37 Hospital Order made by the Court requires a person's detention in hospital. Section 41 is a Court Order preventing a person's transfer to a different hospital, granted leave or discharged without consultation with the Secretary of State for Justice, it is made if the Court considers it necessary to protect the public from serious harm. Anyone convicted of an imprisonable offence and the Judge considers the most suitable option is for the person to go to hospital can receive a Section 37/41. Section 41 is usually made without a time limit meaning that neither the hospital order nor the restriction order is renewed but continues indefinitely. Where there is a Section 41 order without a time limit, it is not possible to have the restriction removed from the order.

1.6 The authors of the Individual Management Reviews (IMRs) provided for the review were all independent of contact with the parties involved, and of line management of the professionals who had contact with Max and David and their family.

1.7 A family member and friends have also kindly contributed to this Review.

## The Review Panel Members

1.8 The following were members of the DHR Panel for this review:

| Name | Role | Agency |
|---|---|---|
| Gaynor Mears | Independent Review Chair and Report Author | |
| Felicity Charles | Victim's Programme Coordinator | Hammersmith & Fulham Borough Council Community Safety Unit |
| Russell Pearson | Review Officer (IMR author) | Metropolitan Police |
| Dr Pamini Ledchumykanthan<br><br>Dr Amisha Patel (2 Panels) | GP Mental Health Lead<br><br>Doctor - Registrar | The Family GP Medical Practice |
| Benn Keaverney | Chief Executive Officer | MIND Hammersmith & Fulham (Mental Health Support Charity) |
| DCI Sebastian Adjei-Addoh (1 panel) replaced by DI Nicki Beecher | Safeguarding Lead Tri-Borough | Metropolitan Police |
| Sally Jackson | Partnership Manager | Standing Together Against Domestic Violence (Specialist Domestic Abuse Charity) |
| Parminder Sahota | Director of Safeguarding Children & Adults | West London NHS Trust (formerly West London Mental Health Trust) |
| Angela Middleton | Patient Safety Lead Mental Health | NHS England |
| LaToya Ridge | Senior Operations Manager | Victim Support |
| Victor Nene | CCG Safeguarding Lead | North West London Collaboration of Clinical Commissioning Groups (NWLCCCG) |
| Peter Lowe (2 panels) | Neighbourhood Manager | Shepherds Bush Housing Group |
| Christopher Nicklin | Interim Head of Adult Safeguarding (IMR author) | Hammersmith & Fulham Borough Council |
| Dr Anna Wilson | Clinical Director & GP IMR author | Hammersmith & Fulham Partnership |
| Jeremy Mulcaire (2 Panels) | Social Care Lead for Mental Health Services (IMR author) | London Borough of Ealing |

1.9 The members of the panel were all independent of involvement with the parties to this review with the exception of the GP Mental Health lead who had seen Max in on two occasions, and his mother at one appointment to discuss her concerns about her son.

### The Author of the Overview Report

1.10 The chair and report author for this review is independent DHR chair and consultant Gaynor Mears OBE. The author holds a master's degree in Professional Child Care Practice (Child Protection) during which she made a particular study of domestic abuse and its impact, the efficacy of multi-agency working and the community coordinated response to domestic abuse. The author holds an Advanced Award in Social Work in addition to a Diploma in Social Work qualification, and it was her experiences of cases of domestic abuse as a Children and Families Team senior practitioner which led her to specialise in this subject.

1.11 Gaynor Mears has extensive experience of working in the domestic abuse field both in practice and strategically, including roles as county domestic abuse reduction coordinator; in crime reduction as a community safety manage working with Community Safety Partnerships and across a wide variety of partnerships and agencies, both in the statutory and voluntary sector. She was also regional lead for domestic and sexual violence at the Government Office for the Eastern Region and was a member of a Home Office task group advising areas on the coordinated response to domestic violence. During her time at Government Office she worked on the regional roll-out of IDVA Services, MARAC, Sexual Assault Referral Centres, and Specialist Domestic Violence Courts, supporting Partnerships with their implementation. As an independent consultant Gaynor Mears has undertaken research and evaluations into domestic violence services and best practice, and since DHRs were introduced in 2011 she has undertaken a large number of reviews. She has also served as a trustee of a charity delivering community perpetrator programmes. Gaynor Mears meets the requirements for a DHR chair as set out in DHR Statutory Guidance 2016 Section 4(39) both in terms of training and the experience required for the role. She has not previously worked for or had any connections with any agency in Hammersmith and Fulham.

### Terms of Reference for the Review

1.12 The purpose of the Review is to:

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

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

c) Apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate.

d) Prevent domestic violence and homicide and improve service responses for all domestic violence victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity.

e) Contribute to a better understanding of the nature of domestic violence and abuse; and

f) highlight good practice

The Domestic Homicide Review is not an inquiry into how the victim died or who is culpable. That is a matter for the coroner and the criminal court.

Specific Terms of Reference for the Review:

1. The review will identify and examine in detail agency contact with the victim and the perpetrator between January 2006 when he was referred to Mental Health Services and March 2018. Agencies with contact before 2006 are to give a summary of that involvement to provide context.

2. What risk assessment processes were undertaken with the perpetrator by services with whom he had contact to establish his risk to others and were risk assessments:

a) Thorough and in line with procedures; if not why not?
b) Informed by background history and information from other agencies?
c) Informed by information from any family members?
d) Reviewed regularly and when the perpetrator's circumstances or mental wellbeing changed were risks escalated, if so, how was this done and what decisions were made and recorded?

3. Are the risk assessment tools and procedures designed to support decisions and assessments judged to be effective by the practitioners using them, or are there any adjustments which may enhance practice?

4. How did liaison with family members take place concerning assessments, treatment and relapse plans, and any risks identified?

5. If the perpetrator is found to have rejected or resisted support from services what changes could take place to improve engagement in similar cases in the future?

6. Were any members of perpetrator's family identified as a carer and if so, were they:

(a) informed about carer's assessments and the support which might be available?
(b) offered a carer's assessment?
(c) signposted to appropriate voluntary or statutory services for support relating to their roles as carers, as victims of crime or domestic abuses?

7. All agencies are to examine communication and information sharing between and within their agencies to establish whether:

(a) it was adequate, timely, and in line with policies and procedures?
(b) there were any gaps in information sharing or breakdown in systems which impeded the effective treatment or management of the perpetrator's behaviour and health?
(c) effective information sharing was undertaken to inform a safety plan to protect family members?

8. Were there any resource issues, including staff absence or shortages, which affected agencies' ability to provide services in line with procedures and best practice? Include caseloads, management support of staff, supervision, and any impact of changes due to restructures or to service contracts.

9. Had the staff in contact with the perpetrator and family members undertaken domestic abuse training which included, adult family abuse, risk assessment, safety planning, and how and when to refer to MARAC? What training had they received on their own agency's policies and procedures?

10. Are there any cultural issues or barriers which may have impacted upon the family's engagement or interactions with services and were these given due consideration?

11. Over the period of time covered by this Review two criteria applied for assessing an adults' vulnerability. Up to March 2015 a 'vulnerable adult' was defined by the Department of Health 'No Secrets' guidance as:

> *"An adult (a person aged 18 years or over) who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or serious exploitation." No Secrets, Department of Health 2000*

Under the Care Act 2014 which was enacted in April 2015 the term 'an adult at risk' was adopted. An 'adult at risk' is considered in need of safeguarding services if she/he:

> *a) has needs for care and support (whether or not the authority is meeting any of those needs),*
> *b) is experiencing, or is at risk of, abuse or neglect, and*
> c) *as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.*

Were any family members or the perpetrator assessed as a 'vulnerable adult' pre 31 March 2015 or an 'adult at risk' post 1 April 2015? If not were the circumstances such that consideration should have been given to such an assessment?

## 2. Summary Chronology:

2.1 Max lived in Spain with his wife and children, but he came to London for approximately two weeks in every four for his work. On these occasions he stayed in his mother's home, where his half-brother David, the perpetrator, also lived. On his last visit Max had arrived on 26 February 2018 for 2 weeks work in and around London.

2.2 Max had two elder half siblings, and two younger half siblings. There was a 10 year age gap between him and David. A family member describes Max as bright, meticulous, and driven. He was successful at school, going on to university where he gained a 2:1 degree in business. He worked for a software company, working remotely in Spain as well as coming to the UK on a regular basis. Max met his wife during a gap year when he was around 17 years old and they have two children together. He is described as a caring father who always looked after his children. His friends describe Max as very loyal to his friends without exception; if someone was in trouble, he would be the first to offer assistance, no matter the effect on him. Max could be a private person and he did keep certain elements of his family background away from the wider group of his friends, but the impression his best friend had from Max was that he looked after David when he could.

2.3 David, the perpetrator, has a history of mental ill-health and long-term use of cannabis. He first became known to mental health services in 23 February 2006 when he presented to Hammersmith & Fulham Emergency Psychiatric Service. This was a short contact which ended the following day. There was a second presentation to the Service on 20/21 April 2006 following which he was referred to the former West London Mental Health Trust[2] Crisis Resolution Home Treatment Team. David had a 2 year history of increasing withdrawal, increasing isolation and reduced appetite. He had symptoms of depression

[2] Since the Mental Health Trust's contact with David the name has changed to West London NHS Trust. This name will be used within the Review.

and suicidal thoughts which had become worse over the previous 2 months. David reported that several months prior to the Crisis Resolution Team involvement he thought about grabbing a knife with a view to stabbing himself in the heart. He was diagnosed with Schizophrenia, prescribed Fluoxetine 40 mg and Olanzapine 20mg, and discharged to the Community Mental Health Team with an allocated care coordinator under the Care Programme Approach.

2.4 During the period of November 2006 and September 2010 David had 8 contacts with the Police. On 6 occasions David was stopped and searched due to acting suspiciously, on one occasion a member of the public approached Police who reported that a male answering David's description had been approaching women in a lift at a tube station trying to start conversations with them. The women appeared uncomfortable with this. David was seen nearby and spoken to about his behaviour. He said he did not remember doing this as he had a disorder. David was advised about his behaviour and no further action was taken. The remaining contact related to David contacting the Police about missing items from his bag that he had retrieved from a lost property office.

2.5 David frequently ceased taking his medication whilst receiving care by the Mental Health Team, and there is an indication of the tension this caused in the family when in November 2006 mental health records show that David's older half-brother attempted to force him to take his medication and an assault ensued. David was punched in the face and had a bleeding nose; there were no other injuries. There is no record of a referral as a result to Protection of Vulnerable Adults (now referred to as Safeguarding Adults). A few weeks later David's mother and sister reported a further deterioration in his mental health, for example his thoughts seemed confused and if asked to repeat himself he became irritable, and he was sitting on the floor in a corner of the sitting room. His mother agreed to a mental health assessment, however she felt he might resist being admitted to hospital.

2.6 There followed a Mental Health Team professionals' meeting which David's mother attended. Her eldest son was staying for a while to encourage David to take his medication and his mother reported that his mental state improved as a result. Frequent visits by the Crisis and Home Resolution Team took place.

2.7 In December 2006 a home visit took place by two doctors and a change in medication was agreed as David was not responding to treatment; he was refusing to engage in conversation or comment on his auditory hallucinations and was irritable. A few days later David became increasingly hostile and at one point told the Mental Health Team staff "I'll kill you". He was also hostile and challenging towards his mother. His elder brother tried to calm the situation. A decision was made that staff would only visit David in pairs. On the 23 December David was seen at home in the presence of his mother, and his brother Max and his wife who were visiting. He was taking his medication with prompting and agreed to team visits.

2.8 At a home visit on 27 December 2006 it was noted that David's psychotic episodes had reduced or were lacking, but he presented as low and unpredictable at times. He felt abandoned by a father figure and resentful of help. There remained a low, but unpredictable risk of harm to others which could be managed by not confronting him if he became irritable; he could become angry when asked to take his medication. The plan was to review David if risk or his symptoms increased, or if he was non-compliant. It was noted that David's family, especially his mother, tended to minimise the risks and problems.

2.9 In February 2007 three members of the Crisis Resolution Home Treatment Team made a home visit. There is further evidence of tension in the family when another altercation between David and his elder brother who was feeling 'wound up' by David's behaviour was reported. David's mother was tearful when the team members arrived. David appeared unable to take in suggestions for avoiding such incidents. The family were advised to call

the Police if the situation escalated, and David's care coordinator was to look into alternative accommodation for him.

2.10 Following a mental health assessment in April 2007 David was found to be suffering from the early onset of mental illness. As doctors were concern that he would harm himself or others, the Police were asked to assist with an escort, however, this proved unnecessary. David was detained under Section 3 of the Mental Health Act in a mental health ward where he remained until July 2007. On discharge from hospital he and his mother had a holiday in Spain and on their return, he was again supported by the Community Mental Health Team. David was to remain under the care of the Community Mental Health Team for the next 12 years.

2.11 During 2007 David had a number of sessions with a psychologist. A recurring theme was his lack of insight into his illness and a wish to have nothing to do with the Mental Health Service. The psychologist felt David's psychotic symptoms were linked to his cannabis use, which he said he had stopped. He was asked if he would mind his mother attending a session to gain a different perspective, but David said she was at work during the day and would be unlikely to be able to attend.

2.12 Care Programme Approach (CPA) meetings took place at regular intervals. David's mother attended on a few occasions, but meetings were mainly attended by professionals and David. Efforts were made to encourage David into various activities, for example for a short time he attended a college twice a week to study English and Maths in preparation for GCSEs, and a voluntary organisation's afternoon course, but he did not sustain his attendance. In 2009 he undertook voluntary work with the mental health charity MIND; he withdrew from this in early 2010 as he said the hours offered were not long enough. The hours were about to be increased, but David would not stay. He was referred to a MIND worker for motivational work but did not attend any of the appointments. Despite being offered a variety of options ranging from a horticulture course to football run by a top London team, David would not engage with any daytime activity or training; he did not view this as a problem. Efforts to achieve David's participation in activities ceased in late 2011. Mental Health Service staff took an assertive approach[3] to working with David in an effort to maintain his compliance with medication and engagement with support.

2.13 In January 2011 David moved into a flat in a supported living project. His care coordinator assisted him with grant and benefit applications, and he registered at a new GP practice. His new patient details noted that he did not have a carer. David's mental health appeared stable at this time. At a CPA meeting in June 2011 David acknowledged that he had not been taking his medication other than occasionally since living independently. He also admitted to drinking at weekends with friends, and after a period of abstinence used cannabis again which had resulted in hearing voices and feeling 'weird'. After drinking he felt like hitting things, but he said he had no thoughts of harming others or himself. David had a new care coordinator and there were concerns that he had not yet built up a relationship with them to share his medication and drug issues. Twice weekly meetings with the care coordinator were to take place. David was offered medication via an anti-psychotic depot injection, but he refused.

2.14 David's GP received information from Mental Health Services on 11 June 2011 arising from the CPA meeting. This included:

- poor concordance with taking medication.
- high consumption of alcohol after which he feels like hitting things.

[3] The assertive approach entails frequent and repeated contacts with the service user, both via telephone and visits in person in the home or away from the home. The approach was developed in the United States of America. Initially used in a team for those difficult to engage, the approach has now been assimilated into individual practitioner's practise. Practitioners may have a lower case load to enable them to accommodate this intensity of work.

- specific comment made that he did not have thoughts of harming others.
- previous cannabis consumption noted, and he had retried this recently after which he had "unusual experiences" and hearing voices.

2.15 During June and July 2011 David had contact with the Police. He was stopped and spoken to with another male on 18 June when it was noted that he appeared nervous and smelt of drugs. David told the officer he had a slight mental health problem and was living alone for the first time. He reported that a male had been using his flat, but he had managed to get rid of him. David was noted to be of small build and may be taken advantage of by drinkers and those using drugs. This suggests he may have been a victim of 'cuckooing' whereby his flat was taken over for drug dealing. Police gave David a direct number to call and the security officer at the building made aware to control access to the accommodation as a preventative measure. On the 1 July 2011 David contacted the Police to report seeing a man on scaffolding outside his flat. There were no independent witnesses, forensic or CCTV evidence, therefore no further action could be taken.

2.16 On 15 July 2011 David saw GP7 and was issued with a repeat prescription. He informed the GP that he had been on the medication since diagnosis, has a social worker, is under the Recovery Team, and was sectioned a year ago (this was incorrect, he was sectioned in 2007). The GP appeared unaware of his involvement with Mental Health Services and made a note for the Community Mental Health Team to be contacted for information. This suggests that no contact had been made with the GP by the Team and no previous notes had arrived from David's previous GP practice since he transferred 5 months previously, or, his notes had not been uploaded for the GP to see which included the information described in paragraph 2.13 above. On 29 July 2011 the GP practice notes record information from the Mental Health Service regarding an urgent review following David's medication inadvertently being increased which had caused him to suffer side effects. His social worker's name was given, and that David was on mental health review Enhanced Care Programme Approach (CPA) level. On 9 August 2011 the GP practice recorded information from the Mental Health Service that David had not attended a psychiatry review and his care coordinator would be arranging further reviews 'as required'.

2.17 In July 2011 David went to stay with his younger sister in the Midlands. Following this she had conversations with David's care coordinator about the possibility of him moving to live with her. Issues around transferring him there were discussed, but eventually not pursued.

2.18 By December 2011 a CPA review learnt that David was spending increasing amounts of time at his mother's home instead of his flat. This was his choice, but his independence was considered compromised. He reported feeling very well mentally, he was not drinking much or smoking cannabis. David was noted as compliant with his medication.

2.19 On the 8 April 2012 David's care coordinator had a discussion with him and his mother. They were now doing very little for him in terms of maintaining his mental health. The next stage of his recovery i.e. entering employment or training needed to have a certain willingness on David's part, but he had not shown this. David's mother did not want him to be discharged but understood that keeping him on an enhanced care plan could not be justified given the pressure on the services. At a home visit on 10 July 2012 David's care coordinator spoke to his brother who was staying with his mother at that time. It is presumed that this was Max, although this is not recorded. His brother reported that David was fine and mentally stable but did not wish to be associated with Mental Health Services.

2.20 In November 2012 following a discussion of David's case in a team meeting, his care coordinator telephoned his mother. She said that although David did not want Mental Health Services, he did require some help. She reported that he had again been having issues at his accommodation with various individuals turning up and drinking etc. David had a Blackberry stolen which she had reported to the Police who are investigating, but he

did not want to go to the Police for fear of reprisals. The care coordinator said that although David was to be discharged it would be good to have another meeting which she could attend. She would be informed of the time and date. However, there is no indication that David's mother was informed of the appointment.

2.21 Following a discussion between his care coordinator and their supervisor on 10 January 2013 the decision to discharge David to the care of his GP was confirmed. A final CPA review discharge meeting took place on 17 January 2013. In attendance was David, his care coordinator, and a psychiatrist. There is no record of 'Carer View' in the notes of the meeting.

2.22 In January 2013 David was discharge from the Community Mental Health Team to the care of his GP. However, he was resistant to engage with the Mental Health Lead GP for routine assessments and reviews required to monitor his mental and physical health.

2.23 The discharge letter to David's GP was not typed up until 28 February 2013. It was received by the GP practice on 4 March 2013. The letter contained minimal instruction for his ongoing care or a relapse plan, no background history, or his level of engagement with the service. The content merely informed his GP that his mental state was stable, and the plan was:

- He is discharged back to your care.
- To prescribe Amisulpride - 100mg as repeat prescription.
- GP to kindly re-refer David back if there are any concerns in the future

2.24 David requested medication from his GP practice on 27 February 2013. The following day GP7 undertook a review of his medication and issued a repeat prescription. There was a gap in between prescriptions meaning that he would have run out on 19 January. This gap is not commented upon. It was noted that he was staying with his mother temporarily and that he was discharged from the Mental Health Service one month ago. No letter was noted, and this was to be followed up. The discharge letter was not received until 4 March. Repeat prescriptions were issued throughout 2013. An appointment reminder was sent to David on 20 November 2013, but it is not recorded whether this was attended.

2.25 During an appointment with GP1 on 22 January 2014 a discussion took place about David thinking about training or work. He said he was doing voluntary work (not known where and there is no agency record of voluntary work), and ideally, he would like to work again but he felt he had few skills. He was given a MED 3 certificate signing him off work for 3 months. At an appointment in May 2014 a summary of his health was given for the Job Centre as requested by GP2. The practice routinely texted David to remind him about GP appointments.

2.26 On 10 June 2014 David saw GP3, the practice lead GP for mental health. He requested a medical certificate as this had run out on 22 April; he asked that it be started from that date. GP3 explained that as he was discharged from the Psychiatric Team this may not be appropriate; discharge indicated that his symptoms were controlled therefore why could he not seek work and why was the practice giving a certificate saying he was not fit to work. The issuing of a short certificate on this occasion and to review further at the next appointment was discussed. David said he only wanted a certificate from 22nd April to that day. He said that if his certificates stopped, he would stop taking his medication. The GP explained that this was using the threat of non-compliance with medication to manipulate the practice to issue further certificates. An appointment was offered with the primary care mental health worker[4] to discuss mental health medication, additional

[4] The primary care mental health worker is a mental health practitioner employed by the Mental Health Trust. They work alongside GPs in primary care, but are not employed by, or clinically supervised or managed by the practice.

support, and ability to work, but David declined. A medical certificate was issued up to 10 June and he was advised to see a different doctor to discuss further medical certificates.

2.27 David missed a GP appointment on 24 June 2014 despite the usual two text reminders. He was texted to cancel in future if he could not keep his appointment. David did attend on 21 July 2014 when he saw GP4 for a review, a different GP to the one seen in May. He refused blood tests to monitor for medication side effects as part of the review. He was issued with a medical certificate covering up to 22 October 2014 with the specific condition noted as psychotic disorder. At his next appointment on 16 October 2014 with GP5 David was advised to have blood tests, but again he declined. He was issued with a medical certificate for a further 3 months off work.

2.28 David continued to have regular GP appointments throughout 2015 seeing a different GP in the practice each time. At a January appointment he complained of poor sleep and having hallucinations. He was given advice, and the problem resolved, but he was advised to return if there was a reoccurrence. Medical certificates were issued, and he continued to refuse blood tests to monitor for side effects from his medication. On one occasion he said this was because he did not like needles.

2.29 In February 2016 the practice tried to contact David to arrange a blood test and review in the mental health clinic. Telephone calls failed and a letter was sent. On 21 April 2016 David saw GP3 as he needed a medical certificate, and again he refused a blood test and examination saying he did not know why doctors kept trying to do these things. The reasons were explained to him, and he agreed to be called to have the tests done. A follow up call was not answered, and a phone call on 3 May resulted in David saying he did not want an ECG done. The following day a letter was sent requesting he book an appointment for a mental health review.

2.30 On 26 May 2016 GP7 had a discussion with David's mother who wanted him to be seen by a primary care nurse at the practice. She reported that he would not come to the surgery, but she would like to speak to GP3 who may then refer to a community psychiatric nurse. David's mother saw GP3 the following day and expressed her concern about his behaviour; he was increasingly withdrawn, not going out, not coming out his room, and he was not eating and losing weight. He said he did not want to talk to her, he was smoking skunk and not sleeping. David's mother reported that she did not think he was hearing voices, but she thought he would not engage due to fear of being sectioned. David's mother was also concerned that he would be taken away from her. GP3 explained that if David did not engage and continued to deteriorate they may not have much choice but to refer to the Community Mental Health Team, but there were options before that. He could see GP3 (mental health lead GP); a health check was booked with GP3. Despite text message reminders David did not attend the health review with GP3 on 1 June 2016, but on 7 July he requested medication and a prescription for one month was issued.

2.31 The practice used a system of texts reminders, phone calls and letters to David prior to appointments, however, he did not respond, or cancel appointments. On 9 August 2016 David requested medication and he was called by the practice pharmacist to advise him that he needed to attend a mental health review. David hung up during the conversation. A prescription for one month was issued.

2.32 On the 28 October 2016 David saw GP7 for a medical certificate. The GP noted his history and noted his outstanding tests and mental health review and took the opportunity to use the appointment to explore his symptoms. It was noted that he was living with his mother, was taking his medication and was stable. David admitted that he still heard voices, but he was reluctant to say what they told him. He had no thoughts of self-harm. The plan was for him to see GP3 for review. Again, despite reminders, David did not keep the review appointment. His prescriptions were issued on a fortnightly basis.

2.33 On 29 November 2016 David's mother called the surgery to report that David had put recent letters regarding his mental health review into the bin as it mentioned mental health. She asked that another letter be sent which did not include reference to mental health. GP3 sent a handwritten letter in the format requested, but despite this and voicemail messages left on his phone he did not respond. During this time he was collecting prescriptions.

4.1. In her statement to the Police during the investigation into Max's death his wife described a visit they made in December 2016, when on returning to the home address she noticed swelling under Max's eye. He told her that David had punched him after an argument about the washing up. This was not reported to the Police. Max's wife told the Police she stopped visiting the family home with their children after July 2017 as she felt afraid of David and for the children, describing how David would just stand and stare at them.

2.34 Max registered with the family GP practice used by David on 6 February 2017. There had been no agency contact with or by Max before that date as far as the enquiries for this review is aware. Max's contact with his GP was minimal and records show standard GP care for minor matters. There are no references to his brother David during consultations, and no references which could imply a potential risk to Max by his brother.

2.35 On the 15 March 2017 the mental health lead GP, GP3, undertook a 'virtual review' of David's case noting his repeated failure to engage with follow-up appointments, but still requesting medication. His medication was removed from repeat on the basis of his poor engagement. Letters requesting David make an appointment for review continued to be sent in January, February, March, May, September, and November 2017. Text message reminders were also sent on a frequent basis, but these repeatedly resulted in a message of delivery failure.

2.36 On the 16 March 2017 Max was staying at his mother's home when following an argument about the washing up David had punched Max in the face. David had then gone up to his room and returned with a samurai sword which he had waved at Max. He then returned to his room and locked himself in. Max phoned the Police reporting that David had threatened him with a sword, was suffering from mental health problems, and he was not sure that he was taking his medication. The Police and London Ambulance Service attended, but the ambulance staff decided neither David nor Max needed medical attention. David was taken into Police custody where he was assessed as suffering from mental illness, he had consumed alcohol, but was not obviously drunk, and he required medication during detention.

2.37 David was examined by a Police healthcare professional following his arrest for Affray and Common Assault. He reported having been sectioned in the past, but could not remember when, that he had been experiencing visual hallucination and hearing voices on a daily basis for a very long time. David found them funny rather than frightening; he did not have feelings of self-harm. He admitted to drinking 250ml of vodka and energy drinks before being arrested but denied being alcohol dependent although his intake had increased in recent weeks. David was judged fit to be detained with 30 minute checks and fit to be interviewed after 22:00hrs in the presence of an appropriate adult.

2.38 David was detained overnight and seen by a custody psychiatric liaison nurse next morning. He described his mental state as stable at that time, with no suicidal thoughts. He said he had feelings of anger towards his brother during the argument but had no thoughts of harming him at that moment. He admitted that the incident took place after he had been drinking, but he did not want to be referred to services; he would just stop drinking. He also admitted his hallucinations when not on medication. He did not wish to have support from Mental Health Services. David was given a 24 hour helpline card and was advised to

call it if he had thoughts of self-harm or of harming others, and he was advised to see his GP. His GP was to be emailed regarding the interview, but there is no evidence that this was sent. Max gave a statement to the Police in which he said this was the first time David had done anything like this and did not believe another incident would take place. He did not support a prosecution and he was happy to have David back home.

2.39 A Vulnerable Adult MERLIN[5] was risk assessed as Green[6] on the 'London Continuum of Need', and after further risk assessment using the Metropolitan Police Service Vulnerable Adult Framework, this was shared through the borough Multi-Agency Safety Hub with Hammersmith & Fulham Adult Social Care on 23 March 2017. The Police CRIS[7] record notes that the investigating officer would be speaking to David's Mental Health Team, but there is no record of such contact being made. The incident was recognised as domestic abuse and a DASH[8] risk assessment was judged to be 'Standard' risk, Max said that normally David was calm and kind, but when not taking his medication or drinking alcohol he could become verbally aggressive. He also stated that David's mental ill-health condition had not been clarified, but he was on anti-psychotic medication which, when he was on them, makes him 'normal'. Max thought he smoked cannabis occasionally. No further action was taken against David.

2.40 Mental Health Services were made aware of David's arrest for Affray and Common Assault via the Police custody psychiatric liaison nurse, and the Single Point of Access (SPA) received the Police MERLIN report on 23 March 2017 about the incident forwarded by Adult Social Care who had recognised David as previously known to Mental Health Services. However, the SPA did not inform the GP practice of the incident as the information from the psychiatric liaison nurse stated that they had informed the GP which they had not.

2.41 David continued to be resistant to appointments for GP review regarding his mental health. His prescriptions were reduced to one week's supply. On 26 September 2017 he saw GP8. This was a pre-booked appointment not a review. It was noted that he only used his medication when the voices became too much, and he saw things every day which were not real, but this had become natural to him. He admitted to seeing an image in front of him at that time. David denied any suicidal ideation but admitted drinking which he was advised to reduce. There was no current apparent risk to self or others. The practice did not know of the assault in March, and David did not mention it. A medical certificate was issued and a prescription for 1 week. This was the last record of a prescription being issued. A mental health review was booked with GP3.

2.42 On 29 September 2017 David's mother phoned the surgery asking for a backdated medical certificate to run from January to September 2017 thus confirming David's lack of GP appointments during this time. David's mother said she looked after his appointments and would make sure he attended the review with GP3. He did not attend or cancel the appointment.

2.43 At 21:08hrs and 23:16hrs on 2 December 2017 David called the Police to report having seen two people being raped at an address in the Borough. The Police attended David's home and he said he had witnessed the offence whilst lying in bed. Officers believed he was suffering from mental ill-health, but not a risk to himself or others at that time. A MERLIN/ACN[9] was risk assessed as Green by the Borough MASH and shared with Adult

[5] MERLINs were also brought in as a result of Lord Adebowale's report recommendations on 2 April 2013 the Adult Come to Notice MERLIN (ACN) record was brought in which is shared with Adult Social Care via the Multi-Agency Safeguarding Hub (MASH).

[6] The London Continuum of Need has four levels of classification - Green is Level 2 Low risk of being vulnerable. This level can be referred to the MASH (Multi-Agency Safeguarding Hub) manager for consideration.

[7] Crime Reporting and Information System

[8] Domestic Abuse Stalking and Harassment - An evidence based risk assessment tool used in addition to professional judgement to assist risks faced by victims of domestic abuse.

[9] Adult Come to Notice notification

Social Care on 5 December 2017. There is no record that the MERLIN was forwarded to Mental Health Services by Adult Social Care as before.

2.44 At 08:06hrs on 19 December 2017 David called Police again to report that his neighbour had told him she was being 'pimped out' and he could hear her screaming through the walls. When officers attended and spoke to David there was no evidence of any incident having taken place, but David said that prostitutes had told him and that they were talking in his head. He said he was schizophrenic but was not taking any medication at present. He was not assessed as needing immediate care or control in his home. No further action was taken other than to give David words of advice regarding his use of 999. It is not clear from the record whether anyone else was at the home with David. A MERLIN/ACN was risk assessed as Green and shared via the MASH with Adult Social Care on 20 December 2017. The MERLIN recommended that David "received at least a home visit from a mental health professional to assess his medication" and that while at the time of attendance David "was not in need of immediate care or control, but there are longer term issues which need to be addressed". There is no record that this MERLIN was forwarded by Adult Social Care or received by Mental Health Services.

2.45 The GP practice tried unsuccessfully to phone David on 3 January 2018 to arrange an appointment with GP3. A letter was sent to him. A text reminder was sent to David on 29 January to come for review. A letter was recorded on 30 January for a completed Department of Work and Pensions report; David's poor engagement was included in the report. This is the last entry in David's GP notes.

2.46 At 08:06hrs on 22 January 2018 David called Police saying his daughter had spoken to him in his mind telling him that she had been abducted and taken to an address with the number 12 on the door. Whilst being spoken to on the phone by Police David could not give details of his daughter (date of birth, where born, where living, etc). He said that he last spoke to her in his mind 15 years ago and rang Police then, and he had not seen her since. Police did not attend as previous similar calls were identified. Instead information was sent to the Hammersmith & Fulham Borough Police 'Grip and Pace Control'[10] with a request that the Local Police Team make a follow-up visit. This was judged to be the correct and proportionate response. The same day an officer passed the request for a follow-up visit to the dedicated ward officers by e-mail, and this contact was entered on the record notes. There is no record of the result of this request on Police systems. No MERLIN was submitted for this call.

2.47 During February 2018 Max came to London to work and as usual he stayed in his mother's home. One day in March he returned to the house from work, and as he went up the stairs he was met by David. David produced a knife and inflicted a single stab wound to Max's chest. Soon after their mother returned home from work and discovered the scene and she called 999. The call was logged by the Ambulance Service at 17:40hrs. It was reported that one son had killed the other. Several vehicles, including the Helicopter Emergency Medical Service (HEMS) were dispatched between 17:40 and 18:50, the first arriving at the address at 17:44. The Police were called to the address by the London Ambulance Service at 17:42hrs. Paramedics immediately made efforts to resuscitate Max which continued under the guidance of the Helicopter Emergency Medical doctor on their arrival. Treatment continued until life was pronounced extinct at 18:20hrs.

2.48 David was arrested and taken into custody. He made admissions that he had stabbed Max but refused to say why or give more detail. The following day David was charged with the murder of Max and detained to appear at court. At his trial in the summer 2018 David's plea of Manslaughter on the grounds of diminished responsibility was accepted. He was

[10] Grip and Pace Control is the name given to the borough control room which received requests and calls at the time of the incidents.

sentenced in the Autumn of 2018 to be detained in a secure hospital under a Hospital Order with Restriction under Section 37/41 of the Mental Health Act (1983).

## 3. Key Issues Arising from the Review:

### Treatment Resistant Service Users who do not Engage with Support Services

3.1 David was ambivalent, and at times hostile to Mental Health Service involvement. The fact that he managed to achieve a stable status during his period of support by the Community Mental Health Team was due to the assertive practice by the professionals who supported him during that time. Regular CPA meetings, home visits, and persistence by care coordinators worked to achieve this. Although despite their best efforts and imaginative offers they could not engage him in daytime activities, training, or work. These he rejected.

3.2 Once transferred to the care of his GP his noncompliance with mental health reviews and medication reappeared. Despite the GP practice policy of using various methods of reminders and follow ups these proved ineffective. He did not keep appointment, and the GP practice did not have the resources or structure to do close monitoring, follow up home visits, or the assertive practice used by Mental Health Services. David refused an appointments with the mental nurse attached to the GP practice, but from the minimal contact there was he appeared to have capacity and was not judged a risk to himself or others.

### Risk Assessment where Mental Illness and Substance Misuse Coexist

3.3 The additional risks brought about by the coexistence of psychosis or schizophrenia and substances misuse, particularly long-term cannabis use was under appreciated or not recognised. David was known to be a user of cannabis since at least his mid-teen, and also used the stronger variant of skunk.

3.4 Research in 2015[11] by the Institute of Psychiatry, Psychology & Neuroscience at King's College London, found that 24% of all new cases of psychosis were associated with the use of high potency 'skunk-like' cannabis. Research such as the Dunedin 2002 research[12], which followed a large cohort from birth and which supports the findings of an earlier large cohort historical study[13], found that whilst there may yet to be an emphatic proven causal link, there is an association between cannabis use and an increased risk of experiencing schizophrenia symptoms. The research found early cannabis use by the age of 15 brings a greater risk for schizophrenia outcomes than later cannabis use by the age of 18. It is suggested that the youngest cannabis users may be most at risk as their cannabis use becomes longstanding. In the Dunedin research of those using cannabis by age 15 a tenth developed schizophreniform disorder by the age of 26 compared with 3% of the remaining cohort.

3.5 The Dunedin research cited above also found that young male cannabis users were nearly 4 times more likely to be violent than non-users, the risk for alcohol users was around 3 times. Violence appeared to be linked to the psychosis or the withdrawal from the drug.

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[11] Di Forti, M. et al. 'Proportion of patients in south London with first-episode psychosis attributable to use of high potency cannabis: a case-control study' published in *Lancet Psychiatry* DOI: http://dx.doi.org/10.1016/S2215-0366(14)00117-5. Accessed 19.01.18

[12] Arseneault L, Cannon M, Poulton R, Murray R, Caspi A, Moffit T E, "Cannabis use in adolescence and risk for adult psychosis: longitudinal prospective study" BMJ. 2002 Nov 23; 325(7374): 1212–1213. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC135493/#B4. Accessed 19.01.19

[13] Zammit S, Allebeck P, Andreasson S, Lundberg I, Lewis G "Self reported cannabis use as a risk factor for schizophrenia in Swedish conscripts of 1969: historical cohort study" BMJ. 2002 Nov 23; 325(7374): 1199. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC135490/ Accessed 19.01.19

According to David he had recently stopped taking cannabis and started using alcohol. The Dunedin cohort study found parents and siblings may be injured and homicides were not uncommon[14]. For context, analysis of UK Domestic Homicide Reviews (DHRs)[15] found that of the 40 Reviews analysed, 7 were familial homicides: All the homicides were committed by a male perpetrator, mental illness was an issue in all 7 cases, and substance use by the perpetrator was present in all but one case. The victims in these cases were mothers and one a father. Other analysis of DHRs[16] makes similar findings with a quarter of the Reviews being familial homicides; 5 cases involved sons killing mothers (matricide), 2 cases involved sons killing fathers (patricide) and 1 case involved a brother killing his brother (fratricide).

3.6 The risk assessment tool used by the GP practice as part of the mental health assessment template they are required to complete was inadequate in its content to guide practitioners, particularly where mental illness and illicit drug use and alcohol were concerned and risk to family members. The Mental Health Service risk assessment was more comprehensive but would benefit from placing substance misuse in a more visible format. All need to be aware of the research cited here which should be supported by dedicated training.

### Information Sharing

3.7 Information sharing failed at crucial points when Police MERLINs failed to be opened due to a problem with the secure email system used by Adult Social Care for receiving them from the Police. Thus, important MERLINs were not forwarded to Mental Health Services which would have alerted them to David's clearly deteriorating mental health in December 2017. A further opportunity was lost when no MERLIN was completed by the Police following his worrying hallucinations in January 2018.

3.8 There was a failure to follow procedures when information about David's assault of Max and threat with a samurai sword which was not shared with David's GP. Mental Health Services did not forward the information from the MERLIN they received to the GP because they assumed that the Police liaison nurse had emailed the GP as they stated in their report of their interview. However, the email was not sent. This meant that David's GP practice had no knowledge of these concerning contacts with the Police.

### Support and Involvement of Family Members

3.9 Although there is evidence of involving David's mother in CPA meetings and discussions early in the Mental Health Service's involvement, she did not attend many meetings and David did not want her there at times. An invitation to attend his final meeting before discharge was overlooked, and there were occasions where it was noted that she did not reply to phone calls. However, David's mother worked and replying to calls from an office open between 9am to 5pm may have been difficult for her.

3.10 The is a strong suggestion that the family did not fully understand David's mental health diagnosis, what to expect when he relapsed or did not take his medication, what risks there may be and how to identify them. In October 2008 David's care coordinator provided his mother with carer's information and of the carer's group, however, on discharge to his GP David's mother was not recognised as a carer even though he was known to be living with her and she was not offered a carer's assessment. The family were not provided with information on voluntary sector specialist services which they may have preferred to access

[14] Cannabis Effects & How It Works - How it works in the brain. https://www.cannabisskunksense.co.uk/the-facts/how-it-works-in-the-brain. Accessed 20.01.19

[15] Home Office (December 2016) Domestic Homicide Reviews: Key Findings from Analysis of Domestic Homicide Reviews.

[16] Sharp-Jeffs N, Kelly L (June 2016) Domestic Homicide Review (DHR) Case Analysis. Report for Standing Together.

for support. A range of specialist support services relevant to the issues in this case are given at Appendix A.

3.11 A family member suggested that David's mother may have been reaching the end of her tether in coping with his behaviour. This may have been one reason she raised her concerns about his deteriorating health in May 2016. However, his reluctance to have Mental Health Services involvement, and her worries that he might be sectioned again, appeared to persuade his GP not to re-refer to secondary care, but to continue trying to gain his attendance at appointments. Carer involvement in assessments is good practice, but a carer's lack of sufficient knowledge of their relative's diagnosis and the consequences of relapse can lead to concerns being minimised or reduced.

3.12 The Review learnt that previously a carer's support group had been shared with a neighbouring Borough and this meant some distance had to be travel by those in Hammersmith to reach the service. The Borough has now commissioned the Carer's Network to deliver the Carers Hub to support those over the age of 18 who provide unpaid care to residents of Hammersmith and Fulham.

3.13 The services the Carers Hub provide includes carers assessments, support plans and indicative personal budgets; legal advice; information, advice, guidance on a range of topics; and signposting to other services where appropriate. Referrals for an assessment can be made to the Carers Network from the Borough Council, other professionals or as a self-referral. Council social workers are also able to conduct carers assessments as part of their work with the cared for. Whether David's mother would have accessed such a service now that it is available locally is not known, but the fact that such support is provided locally is to be welcomed and should be publicised throughout the Borough.

## 4. Conclusions:

4.1. The death of a loved one is always tragic and painful, especially so when a young family is left without a husband and father. The killing of one brother by another brings an additional form of devastation for all the family. Max only stayed in the family home in the UK periodically, and when there he would be out at work during the day. David told the psychiatrist assessing him that he stayed out of Max's way as much as he could when he visited, thus Max may have been unaware of the extent of David's deteriorating mental health and the risk he posed.

4.2. As in so many Domestic Homicide Reviews and Serious Case Reviews, this DHR finds information which could and should have been shared was not, which resulted in professionals working in silos, without the information they needed to construct a full picture of what was taking place, in this case in the perpetrator's life, for the victim was practically unknown to services. The failures to deliver information where it was needed were partly individual oversight, but mainly systems failures.

4.3. The lack of full multi-agency understanding about the Police vulnerable adult MERLIN risk assessment notification system came to light during the Review. A lack of clarity regarding the MERLINs and the ability to share the information with third parties such as GPs was identified as in need of resolution. However, the most significant problem was the systems failure where MERLIN emails were not opened due to technical problems with secure email in Adult Social Care, plus the omission of the notification to the GP practice in March 2017 following David's assessment in custody for assaulting Max.

4.4. Current risk assessment tools for use with those living with mental illness are inadequate for guiding GP's assessments, particularly for assessing risk to others, and for assessing the additional risk where the co-morbidity of substance misuse and mental illness exists.

The additional risk and complexity which substance misuse and mental illness brings is well recognised in Domestic Homicide Reviews, both in cases of intimate partner violence and adult family violence, as referenced in this report. It is therefore important that this is recognised in risk assessments and the tools which guide all professionals working within the field of mental illness. Risk assessment tools are not an infallible remedy for judging risk however, and they are only really relevant at the time at which they are completed; risk changes over time. However, if well designed they are a useful prompt for the areas which need to be considered; they are not a replacement for experience and professional judgement which should be informed by knowledge of the research on these matters to augment that professional judgement. This in turn needs supporting with training which covers these areas.

4.5. The perpetrator's history shows that he was resistant to mental health treatment, avoidant of support, and fervently wanted nothing to do with Mental Health Services. Where this attitude came from we will never know. Only the assertive and persistent practice of his mental health care coordinators overcame this, although even their efforts were a qualified success since no practitioner managed to secure David a sustained placement in training, work, or any activity. Faced with the need for this level of support and persistence from a dedicated Mental Health Team, a GP practice was never going to have the capacity to replicate this practice. It is therefore not altogether surprising that a process of letters and phone calls would fail to achieve his engagement in the GP review system. This lack of engagement and failure to collect prescriptions should perhaps have warranted re-referral to the Mental Health Trust. Had the information from the Police MERLINs in December 2017 been known a re-referral would undoubtedly have taken place.

4.6. Unfortunately, neither Max's wife nor his mother felt able to contribute to this Review. However, from the information we have it appears that his mother and other members of the family, including Max, did not have a full understanding of David's mental health diagnosis and symptoms, any risks which might arise, or what to do if David relapsed. David's mother did not attend all his reviews and she was not invited to his discharge meeting by Mental Health. She was also not recognised as his carer by the GP practice and referred for a carer's assessment with the attendant support this may have offered. There is a need for a 'whole family approach' as it is clear from this case that David's mental illness impacted on everyone in the family, in the end with tragically fatal results. Family members need 'educating' about their relative's illness, and how and when to find support.

## 5. Lessons to be Learnt

5.1 The following learning emerged as a result of the review. There was also early learning during the process and some action has already been taken or commenced without waiting for the completion of the review.

### Information Sharing:

5.2 In common with the majority of DHRs this Review found that information sharing in its various forms was found to be inadequate or not to have taken place. This was either due to oversight by individuals or to a breakdown in systems, and that breakdown not being reported or picked up by management.

5.3 The importance of adequate patient discharge information by Mental Health Services to the receiving GP practice has been highlighted. GPs need to know about the nature of the support the patient has received, the level of their engagement in treatment, any relapse plan, and methods and thresholds for re-referral.

5.4 Since the perpetrator's involvement with Mental Health Services ended in 2013 discharge procedures to GPs has changed and improved as part of the Shifting Settings of Care programme which commenced in 2014. An intention to discharge letter is now sent to the GP, and the GP is given the opportunity to respond. However, the GP practice concerned was not fully aware of all of the changes, indicating that further publicity and updates are required for GP practices. Further improvements on this aspect of information sharing and discharge procedures were noted as early learning and form part of the recommendations, and the Mental Health Trust is already underway with a consultation on the content of their discharge template.

5.5 Opportunities to inform the perpetrator's GP of his contacts with the Police did not take place. This meant his GP was lacking information about David's behaviour and the incident which would have informed risk assessment. This was due to individual shortcomings and lack of supervisory oversight on one occasion i.e. no email was sent to the GP as per procedures; systems failures where emails containing Police vulnerable adult notifications could not be opened and forwarded, and the technical failure was not reported to management. The jigsaw of pieces which would have given a picture of the perpetrator's deteriorating mental health and concerning behaviour were not visible to Mental Health Services or his GP who could have acted in an attempt to manage and change his behaviour. The importance of sharing information in these circumstances cannot be overstated.

5.6 Practitioners rely on effective IT tools to help them do their jobs. In this case a crucial email system used by Adult Social Care's Intake and Advice Team to collect Police MERLINs failed to open. This meant vital MERLINs could not be assessed and forwarded to Mental Health Services which would have alerted them to the perpetrator's deteriorating mental health in the months leading up to the homicide. This problem should have been reported immediately to management to be remedied without delay.

5.7 The discovery of this problem formed another part of the early learning in this Review, and as mentioned in the Analysis section, it has already been acted upon and a new secure email system has been purchased. It is vital that such important IT systems work.

### The Importance of Mutual Understanding and Ownership of Multi-agency Processes:

5.8 It emerged midway through the Review that there was a lack of clarity about how the MERLIN system is perceived and understood by different professionals, agencies, and members of the public. The confusion ranged from whether the notifications were referrals through to the legality of being able to share this third party information. An assumption was held that all MERLINs were shared with GPs, but this turned out not to be the case.

5.9 There is a strategic level lesson here for senior management. When introducing a system which requires multi-agency information sharing agreements and protocols there is a need to engage and consult with partner agencies before implementation. Adults at risk and their families deserve support and protection, therefore the MERLIN system has an important role to play and should remain, but with a more error-proof and timely system understood and agreed by all.

5.10 It is also important that MERLIN notifications are calibrated correctly, so the level of concern and the content of the MERLIN genuinely reflects the seriousness of a vulnerable person's situation. This would reduce any risk of complacency in the system.

5.11 As a result of this early learning the Interim Head of Safeguarding Adults (Adult Social Care) agreed to form a focus group with partners to explore improvements to the operational process of MERLINs.

Risk Assessment:

5.12 The risk assessment tool used by GPs forms part of the template they are required to complete when reviewing patients with mental illness; this was found to be inadequate in supporting practitioners to assess risk where mental illness and substance misuse coexist. The parts of the template guiding assessment of risk to others, particularly family members, is in need of a greater breadth of information to inform risk such as relationships, family stressors, family violence etc.

5.13 The Mental Health Trust risk summary has seen improvements particularly around the identification of domestic abuse. However, illicit drug and alcohol use are recorded within a 'dynamic factors' section. A more prominent display of these risk factors would be beneficial. The existing assessments for GPs and Mental Health Teams would benefit from review so that they take account of research on psychosis and schizophrenia with co-morbid substances misuse and family violence and abuse.

5.14 Risk assessments can only really provide a picture of risk at the time of their completion. They need regular review when circumstances change, or events suggest an alteration in a service users' mental health status. Professional judgement born out of experience also plays a vital part in assessing risk. This needs valuing and supporting with training, especially relating to changes in risk assessment tools, be backed up with knowledge of research, and management or peer supervision.

Practice Challenges when a Service User Disengages:

5.15 This Review has highlighted the difficulties practitioners face when confronted with a service user who rejects support, is resistant even to accepting routine health care connected with his diagnosis, and who disengages from all services. This is compounded when the person is not unwell enough to be compelled to accept treatment under the Mental Health Act, is deemed to have mental capacity, and is a self-determining adult.

5.16 The Review has made visible the challenges faced by GPs when trying to manage such a patient as David in general practice. In addition to his rejection of GP appointments, the mental health lead GP was in the dark about his contacts with the Police, the knowledge of which would have informed their risk assessment and re-referral to secondary Mental Health Services. Whereas David's earlier involvement with the Mental Health Service was able to achieve his engagement by assertive and persistent practice, home visits etc. this approach is not possible in general practice. GPs do not have the necessary specialist expertise and resources to manage such a patient with the level of complexity and attendant risk. The best alternative has to be to re-refer a disengaged patient who is on the practice serious mental illness register back to specialist Mental Health Services. However, the Review is advised that there would need to be identified risks and further reasons for a re-referral not just a failure to engage by a patient.

Training:

5.17 Most of the agencies in the Review report that domestic abuse training is a component of Safeguarding training, both safeguarding children and adults. The GP practice and some staff within West London NHS Trust had received a separate session delivered by the local specialist domestic abuse service Standing Together the focus of which was intimate partner abuse and children. Training in adult family violence and abuse is absent.

5.18 There is a need for local training dedicated to adult family violence which includes findings from research in this subject area, including the case studies from the analysis of DHRs cited in this Review. Given the strong links with mental illness and substance misuse in

family violence homicides, it is essential that Mental Health Trust staff and GPs, in addition to all those involved in assessments have this training.

### Family Support

5.19 The fact that family members appeared to be unclear about the perpetrator's mental illness diagnosis and the support he received in recent years, indicates the importance of taking a 'whole family approach', especially where the person with the mental illness is living within the family home.

5.20 Professionals working with those living with mental illness need the information and support of family members to assist with planning and the provision of effective care, but this needs to be a two-way process as identified by the Carer's Trust research and guidance Triangle of Care[17]. Family members need to be supported with education about their relative's diagnosis, managing symptoms and relapse, identification of risk, and who to contact about any difficulties or concerns. Whilst appreciating the ethos of, and need for patient confidentiality, if the patient is living within the family home, it seems only reasonable that the family should have all the knowledge they need to support their relative and to be able to recognise risk to themselves. This can be achieved if the information shared does not contain personalised data, for example explaining the diagnosis, providing information already in the public sphere, and the use of a carer's plan.

5.21 A family member contributing to the Review suggested that David's mother may have been reaching the end of her tether in the last few years. She and other family members had been coping with David's sometimes confrontational and difficult behaviour for at least 12 years since his diagnosis in 2006, and there are examples within the Review of tensions between David and his elder brothers resulting in assaults. In such circumstances it is not unexpected that this would take its toll and possibly result in carer stress, frustration, and inability to cope any longer. This needs to be recognised by services and meaningful support provided.

5.22 The Review learnt that previously a carer's support group had been shared with a neighbouring Borough and this meant some distance had to be travel by those in Hammersmith to reach the service. The Borough has now commissioned the Carer's Network to deliver the Carers Hub to support those over the age of 18 who provide unpaid care to residents of Hammersmith and Fulham.

5.23 The services that the Carers Hub provides include carers assessments, support plans and indicative personal budgets; legal advice; information, advice and guidance on a range of topics; and signposting to other services where appropriate. Referrals for an assessment can be made to the Carers Network from the Borough Council, other professionals or as a self-referral. Council social workers are also able to conduct carers assessments as part of their work with the cared for. Whether David's mother would have accessed such a service now that it is available locally is not known, but the fact that such support is provided locally is to be welcomed and should be publicised throughout the Borough. A range of specialist support services available for families and those experiencing the health issues in this case is available at Appendix A.

### Family Suggestion:

5.24 David may not have been considered a vulnerable adult or adult at risk, but his elder sister believed that in the early stages of his mental illness when he became socially isolated this

[17] The Triangle of Care Carers Included: A Guide to Best Practice in Mental Health Care in England. 2nd Edition 2013. The Carer's Trust.
https://professionals.carers.org/sites/default/files/thetriangleofcare_guidetobestpracticeinmentalhealthcare_england.pdf

could have been helped by having a mentor who was unconnected with Mental Health Services. She thought David's lack of social skills and isolation may have been gradually overcome with the help of a mentor, and this may have supported him into social activities, friendships, possibly into work, and his life and that of Max may have taken a different turn with earlier intervention. Ideally, he would have needed a mentor when he was 15 or 16 years old before his drug use became firmly entrenched. This was not an option offered to David as a teenager, however, it is a valuable suggestion and one which services could consider for young people who are in a similar position as David was years ago. Early intervention can be an effective strategy for reducing future harm.

## 6. Recommendations

6.1 The recommendations below have been developed from the learning arising from the Review analysis, Panel discussions, and the individual agency recommendations.

### National Level

#### Home Office:

**Recommendation 1:**
It is recommended that the Home Office provide a copy of all DHRs where mental ill-health is a component to the Secretary of State for the Department of Health and Social Care and the lead minister for mental health for their information and to inform policy and decision-making, and that they work on the specific area of domestic abuse and mental ill-health with the national Domestic Abuse Commissioner.

#### Department of Health & Social Care:

**Recommendation 2:**
The Secretary of State for Health & Social Care, and the lead minister for mental health to note the contents of this Domestic Homicide Review giving particular attention to the risk assessment of those with a co-morbidity of psychosis and substance misuse, and review the efficacy of current risk management tools, and the resources available to support this specific patient group.

**Recommendation 3:**
That the Department of Health & Social Care provide resources to support the safe and effective working of the Shifting Settings of Care policy by:

a) the provision of increased access to specialist mental health resources to support Primary Care in managing patients deemed sufficiently stable for this level of care.

b) the provision of resources to Community Mental Health Teams to increase their capacity to support Primary Care in their management of those with serious and enduring mental health treatment needs, and to facilitate threshold levels suitably calibrated for patients to be returned to their care who cannot be managed in Primary Care.

**NB** The Panel wish to commend the national project for all Emergency Departments called Commissioning for Quality and Innovation (CQUIN) Frequent Attenders. The project involves a health professional conducting home visits to vulnerable frequent attenders to A & E, and with close multi-agency working, aims to solve the patient's health and related social problems to prevent repeated contact with emergency services and A & E. Whilst the opposite problem was the case in this DHR i.e. failure to keep multiple appointments and concordance with medication was a problem, such a proactive assertive model as the

CQUIN Frequent Attenders would have been beneficial for the perpetrator and his family, as well as services.

## Local Level

### Multi-Agency:

**Recommendation 4:**
The current children's 'Multi-agency Safeguarding Hub' (MASH) and vulnerable adult 'Safeguarding Hub' arrangements within the Borough should be reviewed by September 2019 to ensure that a multi-agency information protocol is established to share information, which identifies risk to inform action by the appropriate agency. This should be compliant with current safeguarding and data legislation.

**Recommendation 5:**
All practitioners and their managers working in the community involved in the assessment and management of those with mental health treatment needs with co-morbidity substance misuse should ensure that assessments are; informed by family or carer contributions where safe and appropriate; take into account and consider research on psychosis, schizophrenia, and coexisting substance misuse in risk assessments. When circumstances change in such cases they should be discussed in supervision, or via peer support as appropriate to organisational structures.

**Recommendation 6:**
Training in adult family violence and abuse which includes DHR findings should be embedded in dedicated domestic abuse training in line with NICE Guidelines (2017)[18]. The course should include steps for practitioners to take, risk assessment, and referral to MARAC, whilst maintaining the issue as relevant to safeguarding. The training should be undertaken by all those whose role involves assessments, supporting service users or their carers who work in the Mental Health Services, GP practices, Children and Adult Social Care, and Housing provider staff.

**Recommendation 7:**
All Services, both statutory and voluntary, involved in supporting those with mental ill-health or their families should ensure that family members are given sufficient information about their relative's diagnosis which contains, how to best support them; a relapse plan including when and who to contact in the event of deterioration in the patient's mental health, and which explains and identifies risks.

### Adult Social Care:

**Recommendation 8:**
Awareness raising should be undertaken within the Borough by Adult Social Care with GP practices to publicise the criteria and pathway for a carer's assessment referral. This should aim to be completed by the end of 2019.

### West London NHS Trust:

**Recommendation 9:**
Mental Health Trust discharge letters to GPs to include a summary of the quality of the patient's engagement with the service, the patient's next of kin (or carer if different) and their level of involvement, whether a carer's assessment has been completed, and if not

[18] http://pathways.nice.org.uk/pathways/domestic-violence-and-abuse. NICE Pathway last updated: 03 August 2017 This document contains a single flowchart and uses numbering to link the boxes to the associated recommendations. It is designed to be used online.

why not. This will be dependent on the next of kin or carer's consent. Discharge summaries to include this information from July 2019 onwards.

### Recommendation 10:
That the West London NHS Trust review the current risk summary with a view to having specific questions listed on illicit drugs and alcohol which are easily visible, rather than recording these substances in the 'dynamic factors' section of the risk assessment.

### Recommendation 11:
Regardless of whether MERLIN information indicates that a GP has been informed, the Single Point of Access should notify a patient's GP that they have been assessed by a member of Trust staff and give details of the MERLIN content, the nature and place of that assessment, risk identified, and whether weapons have been involved in an incident.

### Recommendation 12:
That MARAC training is made available for all Team's staff and is arranged to be delivered by an external organisation on a two-year cycle. (IMR recommendation). (the author received confirmation this will be implemented by the Teams where it is not already arranged).

### Recommendation 13:
That West London NHS Trust Criminal Justice Liaison and Diversion Services implement their draft operational policy in order that their practitioners are clear regarding the obligation to inform GPs of their interventions with referred clients. This will be achieved by ensuring practice issues such as information sharing with GPs remains as a standing item at their monthly Clinical Improvement Group. Furthermore, that Rio documentation is also discussed and reviewed with practitioners at their monthly clinical supervision sessions. (IMR recommendation).

### Recommendation 14:
Where contact by telephone with carers has not been successful, then a letter and/or an email should be sent, with the details of any CPA meetings or reviews to which they are being invited. (IMR recommendation)

### West London NHS Trust & GP Practice:

### Recommendation 15:
A range of information resources (leaflets, websites etc) on specialist voluntary and statutory services which includes sources of support for family members should be given to the family of those living with mental ill-health and substance misuse, and also made available in waiting areas. Resources should be in place by July 2019.

### Clinical Commissioning Group:

### Recommendation 16:
Using the facilities of the Trust Transformation Work Programme, and in consultation with GP mental health leads and West London NHS Trust, CCG mental health leads to develop a protocol which can be rolled out to all GPs in the area to ensure consistency of approach which:

a) identifies when to escalate patients failing to engage with their GP.
b) determines appropriate thresholds,
c) agrees action/care plans, and ownership of risk.
d) agrees information to be shared

**Recommendation 17:**
When a review of the SystmOne database takes place it is recommended that the Clinical Commissioning Group takes steps to establish whether a page viewable only by GPs which records information giving a picture of accumulative risk factors to or from a patient could be included on the system to optimise risk assessments and improve visibility of risk factors. Consultation with GPs is recommended when this takes place

**Clinical Commissioning Group and GP Practice:**

**Recommendation 18:**
That the Mental Health Lead for the Clinical Commissioning Group (CCG) and GP Practice lead for mental health liaise regarding the most effective local structure for convening a quarterly Primary Care Network meeting of mental health professionals which should include West London NHS Trust, CCG, primary care mental health practitioners, and GP mental health leads in its membership, with the aim of facilitating knowledge sharing, updates in protocols, and partnership working. This Network meeting should aim to be in place by September 2019.

**Recommendation 19:**
That revisions take place to the GP Mental Health Assessment risk assessment page to provide a comprehensive list of areas to cover which includes substance misuse, domestic abuse, both as perpetrator and victim, and the quality of family relationships including any tensions.

**Metropolitan Police:**

**Recommendation 20:**
It is recommended that officers involved in the Grip & Pace and Local Policing Team (ward officers) are debriefed regarding the recording and completion of the home visit to the perpetrator on 22 January 2018. (IMR recommendation)

**Recommendation 21:**
It is recommended that Central West BCU Senior Leadership Team dip sample incidents handled within the Grip & Pace and completed by Local Policing Teams to ensure that this is effective, recorded properly and complies with MPS Anti-Social Behaviour policy. (IMR recommendation)

**NB**
The GP Practice made three recommendations which required a strategic level approach. Recommendations 3, 9, 16, 17 above have been developed with the aim of enabling the GP Practice recommendations to be achieved. The GP Practice recommendations concerned the following:

1. Clear guidance on what is reasonable practice in relation to patients with serious mental illness who do not engage with clinical review and treatment despite repeated attempts to make contact, and risk level is unknown was judged to be needed. This should consider the whole system around the patient, including primary care, who ultimately hold the risk of the non-engaged patient, notwithstanding the individual agency's duty of care in relation to risk.

2. There is a need for better information sharing with specific consideration for the current (unsatisfactory) system of separately held health agency clinical records. High importance inter-agency information sharing (for example a significant change in risk status or requests for action in relation to high risk patients or situations) need to be through mutually agreed safe systems with “closed” loops. This should ideally be through verbal communication to the relevant responsible individual (i.e. not simply the administrative part of the system)

supported by written communication. Confirmation of receipt should be sent by the relevant responsible person to the sender.

3. A single “care plan” with collated known risk factors, mitigations, and escalation plans should be used by all agencies with a duty of care to patients with serious mental health diagnoses. Ideally this would be held as a single clinical record.

APPENDIX A

## SOURCES OF SUPPORT FOR FAMILIES AND CARERS

### Support for those with mental illness and for family members:

- MIND - https://www.mind.org.uk/
- Rethink Mental Illness: https://www.rethink.org/about-us.
- Mental Health Foundation: https://www.mentalhealth.org.uk/
- Mental Health Support: http://www.mentalhealthsupport.co.uk/carers.html
- https://www.nopanic.org.uk/
- https://www.mentalhealth.org.uk/our-work/learning-disabilities

### Support for family/carers of those using drugs:

FRANK: https://www.talktofrank.com/get-help/worried-about-a-child
Helpline number: 0300 123 66 00

ADFAM: https://adfam.org.uk/

DRUGFAM: https://www.drugfam.co.uk
Helpline number: 0300 8883853

FAMILIES ANONYMOUS: http://famanon.org.uk/meetings/meetings-in-the-uk/
Helpline number: 0207 498 4680.

- Advice for families of drug users: https://www.nhs.uk/live-well/healthy-body/advice-for-the-families-of-drug-users/

### Support and Mentoring:

The Richmond Fellowship: Richmond Fellowship's services work hand-in-hand with the people they support to give them the confidence and self-belief that they have an important contribution to make in society.
https://www.hfemploymentandwellbeing.org.uk/about-us/

Family Friends - A charity a providing a network of trained volunteers who provide befriending and mentoring services to help families and children up to 16yrs living in Kensington & Chelsea, Hammersmith & Fulham and South East Brent.
https://www.familyfriends.uk.com/about-us