Norfolk County Community Safety Partnership

# DOMESTIC VIOLENCE HOMICIDE REVIEW

# OVERVIEW REPORT

REPORT INTO THE DEATH OF:

Mrs M age 34 years

on 13 June 2012

Report produced by:

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Date Completed: 26 April 2013
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# 1 Introduction:

1.1 This Review has been conducted in accordance with statutory guidance[1] under Section 9 of the Domestic Violence, Crime and Victims Act 2004. The Review was commissioned by the Norfolk Community Safety Partnership following the homicide of a Norfolk resident in circumstances which appeared to fulfil the criteria of Section 9 (3)(a) of the Act namely, the violence appeared to be by a person to whom they were related, or with whom they had, or had been in an intimate personal relationship.

1.2 This Domestic Homicide Review examines agency responses and support given to the victim Mrs M, a resident of Norfolk prior to her death following a serious assault at her home on 11 June 2012. Mr N the victim's husband was arrested at the scene and initially charged with Grievous Bodily Harm. Mrs M died from her injuries 2 days later on 13 June and Mr N was charged with murder and held in custody. The review will consider agencies contact and involvement with the victim and the perpetrator Mr N covering the 2 year period from when their relationship began up to her death.

1.3 The key purpose for undertaking Domestic Homicide Review (DHR) is to enable lessons to be learnt from homicides where a person is killed as a result of domestic violence. In order for these lessons to be learnt as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

### Timescales:

1.4 The Norfolk Community Safety Partnership Chair called a meeting of partner agencies on 21 June 2012 and the decision was taken that the circumstances of the case met the requirements to undertake a Domestic Homicide Review. The Home Office were notified of this decision on the 10 July 2012. The Review was concluded on 26 April 2013. The process was not able to be completed in the 6 months required by the statutory guidance due to the timing and conclusion of criminal proceedings.

### Confidentiality:

1.5 The findings of this report are confidential until the Review has been approved for publication by the Home Office Quality Assurance Panel. Information is available only to participating officers/professionals and their line managers until this time.

1.6 To protect the identity of the victim, the perpetrator, and family members the following anonymised terms have been used throughout this Review:

The victim: Mrs M, age 34 years at the time of her death.
The perpetrator: Mr N, age 39 years at the time of the offence.

Both Mrs M and Mr N were of white British ethnicity.

[1] *Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews*. Home Office 2011.

**Dissemination:**

1.7 The following recipients have received copies of this report:

Laura McGillivray, Chair of Norfolk Community Safety Partnership
Andy Jarvis, Director of Environment & Housing, A Norfolk District Council
Superintendent Julie Wvendth, Norfolk Constabulary
Jackie Schneider, Head of Quality & Patient Safety, Norfolk Clinical Commissioning Group
Michael Lozano, Patient Safety & Complaints Lead, Norfolk and Suffolk NHS Foundation Trust
Margaret Hill, Community Services Manager, Leeway Domestic Violence and Abuse Service, Norfolk
Peter Burnham, Head of Community Safety, Norfolk County Council
Marion Headicar, Independent Chair, Norfolk & Waveney CCG Cluster Clinical Quality & Patient Safety Committee
Clive Rennie, Mental Health & Learning Disability Lead Commissioning

**Terms of reference of the review:**

1.8 The purpose of the review is to:

- Establish the facts that led to the death of Mrs M on 13 June 2012 and whether there are any lessons to be learned from the case about the way in which local professionals and agencies worked together to safeguard Mrs M.
- Identify what those lessons are, how they will be acted upon and what is expected to change as a result.
- Establish whether the agencies or inter agency responses were appropriate leading up to and at the time of the incident on 11 June 2012.
- Establish whether agencies have appropriate policies and procedures to respond to domestic abuse and to recommend any changes as a result of the review process.
- To seek to establish whether the events of 11 June 2012 could have been predicted or prevented.
- This Domestic Homicide Review is not an inquiry into how the victim died or who is culpable. That is a matter for coroners and criminal courts.

**Terms of Reference:**

1. To review the events and associated actions that occurred up to the date of the death of Mrs M on 13 June 2012 and approximately the previous 2 years when the relationship with the alleged perpetrator began.

2. To review the quality and scope of action/s and services provided by the agencies defined in Section 9 of the Act which had involvement with Mrs M, her dependants, and Mr N (partner at the time of her death) and other individuals e.g. friends or extended family, as identified within the agencies' records, Individual Management Reviews (IMR) or other information sources as deemed appropriate by the Independent Chair of the DHR.

3. Agencies with knowledge of the victim in her early years when she was known by her maiden name, or the alleged perpetrator Mr N, are asked to provide a brief synopsis of their involvement.

4. To examine the knowledge and training of staff involved in relation to the identification of indicators of domestic abuse and appropriate risk assessment i.e. the DASH risk assessment checklist, and knowledge and use of appropriate specialist domestic abuse services.

5. Examine the effectiveness of single and inter-agency communication and information sharing, both verbal and written.

6. To assess the extent to which agencies relevant policies and procedures were followed, and whether these are up to date and fit for purpose in assisting staff to practice effectively where domestic abuse is present.

7. To involve the family and extended family of Mrs M and Mr N (partner at the time of her death). The overview report writer will be responsible for meeting with the family to invite their contribution to the DHR.

## Methodology

1.9 This Review has followed the statutory guidance for Domestic Homicide Reviews issued following the implementation of Section 9 of the Domestic Violence Crime and Victims Act 2004. On notification of the homicide agencies were asked to check for their involvement with any of the parties concerned and secure their records. A total of 11 agencies were contacted to check for involvement with the parties concerned with this Review. 6 agencies returned a nil contact, 2 agencies submitted Independent Management Reviews, and 3 agencies chronologies only due to the brevity of their involvement. The chronologies were combined and a narrative chronology written by the Overview Report Writer. The IMRs were written by authors independent of case management or delivery of the service concerned. The IMRs have informed the recommendations in this report.

1.10 General Practitioner and Mental Health services had involvement with the victim of sufficient duration which required Independent Management Reviews (IMRs) to be submitted. The IMRs summarised the victim's early year's involvement with their services. The IMRs identified gaps in recording on occasions and noted an absence in recording the rationale for decision making at times. This impeded the ability of the IMR writers to fully understand what was taking place during some parts of their review of actions taken. The IMRs have helpfully identified changes in practice and policies over time, and highlighted areas for improvement not necessarily linked to the terms of reference for this Review. As the victim's consultation with a Consultant Psychiatrist was undertaken in a private capacity the clinical notes were not accessed as part of the IMRs, however the management plan resulting from the consultation provided to the GP was available. The Review author contacted the perpetrator who gave consent to access his information and the Consultant has provided answers to questions submitted.

1.11 In addition to the 2 IMRs, documents reviewed during the Review process have included a Court report, Police Statement, Post Mortem report, and Probation Pre-Sentence Report and Assessment.

1.12 At the start of the process the Review terms of reference were shared with the family and they were in agreement with the content. The final draft of the report was shared with the victim's family to check for factual accuracy, and for any additional comments they wished to make or to have included.

1.13 The Review author has undertaken 8 interviews in the course of this Review. This has included 2 face to face interviews and 1 telephone interview with members of the victim's family; 1 face to face interview, 1 telephone interview and 1 Skype interview with friends of the victim. 1 telephone interview with a member of the perpetrator's family was undertaken, and a face to face interview with the perpetrator. The Review author is very grateful for the time and assistance given by the family and friends who have contributed to this Review.

### Contributors to the Review

1.14 The following agencies and their contributions to this Review are:

- Norfolk Constabulary - chronology concerning the incident
- Norwich City Council Housing Department - chronology
- NHS Norfolk & Waveney - chronology & Independent Management Review
- Norfolk and Norwich Hospital Trust - chronology
- Norfolk & Suffolk Foundation Trust – chronology & Independent Management Review
- Norfolk Probation Trust – assistance and provision of documents post conviction.

1.15 The following agencies were contacted, but recorded no involvement with the victim or perpetrator:

- Leeway Women's Aid – IDVA & Refuge Services
- Orwell Housing – IDVA & Refuge Service
- Norfolk Fire Service
- Norfolk Probation Trust
- Matthew Project Drug & Alcohol Service
- Norfolk & Suffolk Trust Alcohol & Drug Service (a referral was made but not taken up)

1.16 The Review Panel members are:

Laura McGillivray, Chair of Norfolk Community Safety Partnership
Andy Jarvis, Head of Environment & Housing, a Norfolk District Council
Superintendent Julie Wvendth, Norfolk Constabulary
Jackie Schneider, Head of Quality & Patient Safety, a Norfolk Clinical Commissioning Group
Michael Lozano, Patient Safety & Complaints Lead, Norfolk and Suffolk NHS Foundation Trust
Margaret Hill, Community Services Manager, Leeway Women's Aid, Norfolk
Peter Burnham, Head of Community Safety, Norfolk County Council
Gaynor Mears, Independent Chair & Overview Report Writer

### Author of the overview report:

1.17 The author of this DHR Overview Report is independent advisor and consultant Gaynor Mears. The author holds a Masters Degree in Professional Child Care Practice (Child Protection) and an Advanced Award in Social Work in addition to a Diploma in Social Work qualification. The author has extensive experience of working in the domestic violence field both in practice and strategically, including roles at county and regional levels. Gaynor Mears has undertaken Domestic Homicide Reviews, and research and evaluations into domestic violence services and best practice. She has experience of working in crime

reduction, with Community Safety Partnerships, and across a wide variety of agencies and partnerships in the statutory and voluntary sectors. Gaynor Mears is independent of, and has no connection with, any agencies in Norfolk.

**Parallel Reviews:**

1.18 A Coroner's Inquest was opened and adjourned. Following the conviction of the perpetrator for manslaughter the Coroner closed the Inquest proceedings.

## 2 The Facts:

2.1 At the time of her death the victim Mrs M lived with her husband Mr N in a village in Norfolk. She was 34 years old, her husband was 39 years. The couple met in August 2010 through a mutual friend, although they had been acquainted some years before. After two months together Mrs M left and the couple did not see each other for several months, however their relationship resumed and in December 2011 Mrs M moved back to Mr N's home and they were married in March 2012.

2.2 In the incident leading up to the homicide it is reported that on 11 June 2012 Mrs M wished to start decorating the house. Mr N came in from his workshop at the back of the property and became annoyed when he found that she had moved some of his possessions out of the way. An argument ensued which is described as turning into a 'massive row' during which Mrs M threw a mug of tea which resulted in china breaking on the floor. In his statement to the Police Mr N said he slipped pushing Mrs M onto the dining room floor where he strangled her with his hands. At some point shortly after this action he obtained a large ballpane hammer and used the tool to strike Mrs M three times in the head and facial area causing severe and substantial injuries. Mr N then went to his workshop and informed his work colleague what he had done. The Police and ambulance were called and Mr N was arrested at the scene and held in custody. On Crown Prosecution Service advice he was charged with grievous bodily harm.

2.3 Mrs M was sedated at the scene by paramedics and taken to the Norfolk and Norwich Hospital. On 12 June she was transferred to the Neuro Critical Care Unit at Addenbrooke's Hospital in Cambridge where she died of her injuries on the 13 June 2012. The Post Mortem showed that Mrs M died from severe head injuries. Mr N was charged with her murder and remanded in custody to stand trial.

2.4 Mr N and Mrs M lived together at their home with regular stays taking place by their children from their previous relationships. No children were present at the time of the incident which led to Mrs M's death. There were no Safeguarding procedures regarding the children in place and none had been in place in the past.

2.5 A Domestic Homicide Review is asked to consider if any person involved in the case is a 'vulnerable adult' as defined by Department of Health. *No Secrets* (Department of Health & Home Office 2000) defines a vulnerable adult as:

A person aged 18 years or over who is or may be in need of community care services by reason of mental health 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 from harm or exploitation.

Neither Mrs M nor Mr N was considered to be a vulnerable adult at the time.

2.6 Mr N's trial commenced on 3 December and concluded on 14 December 2012. The jury found him guilty of manslaughter due to loss of control. He was sentenced 25 January 2013 to 11 ½ years imprisonment, reduced by 4 years for pleading guilty to manslaughter.

## 3 Chronology:

### Background Information:

3.1 To give context to the life of Mrs M and to identify any learning which might stem from her earlier experiences or contact with agencies, a brief background of the circumstances surrounding her life before her relationship with Mr N is helpful especially in light of her mental ill health and the services she received.

3.2 Mrs M had a troubled early childhood and adolescence. Her parent's relationship ended when she was 4 years old, and although regular contact was arranged her father frequently failed to keep to the arrangements. This caused her great unhappiness. In 1985 when Mrs M was 8 years old the family GP made a referral for therapeutic support due to relationship difficulties between her mother, stepfather and Mrs M. This involved just two sessions for Mrs M as the focus of this episode of therapeutic support moved to Mrs M's siblings. In November 1989 another GP re-referred Mrs M and her mother to Child & Family Service due to behavioural problems, however, Mrs M's mother reported an improvement in her behaviour, renewed contact with her biological father, and the service was not required. At school Mrs M was bullied and found being accepted and making friends difficult, and despite being bright she under achieved at school.

3.3 In October 1990 aged 13 years Mrs M was admitted to hospital having taken an overdose of Aspirin thought to be following an argument with her 17 year old boyfriend. She was seen by a Psychiatrist and given a follow up appointment 3 days later then discharged. Although the 1989 Children Act had only recently come into being no child protection procedures appear to have been used despite the significant age gap between Mrs M and her boyfriend. Mrs M's behaviour became increasingly difficult for her mother to manage during her adolescence and she sought social work support. For a brief period between April and July 1991 Mrs M was in the care of Children's Social Services.

3.4 In November 1991 at the age of 14 years Mrs M was admitted to the Norfolk and Norwich Hospital following a further attempted suicide. This appeared planned and to be a serious attempt. A variety of reasons were given including the loss of her relationship with her biological father, splitting from her boyfriend, and she had been expelled from school for assaulting another pupil. A family member recalls that Mrs M was bullied by a group of girls and struck out at one of them.

3.5 A referral was made to the Children's Psychiatric Service and a therapist appointed to see Mrs M for follow up sessions at home. Between mid December 1991 and mid March 1992 Mrs M was at home for 2 out of 4 arranged appointments and reported an improvement in her mood and with her relationship with her mother. On 16 March Mrs M's mother contacted the therapist to report that Mrs M had been excluded from school once more due to a further assault on a female fellow student. Mrs M showed no remorse for the

assault and was reluctant to explore other ways of managing her anger. Mrs M commented to her therapist that teachers and students appeared scared of her. Mrs M was seen once more in June 1992 and the plan had been to contact her in school in the next term. This did not take place; the therapist closed the case in August 1992.

3.6 For a short period of time after returning home from residential care Mrs M's behaviour improved and she settled down in school, but at 15 years old she started disappearing at weekends, attending raves and taking illicit drugs. On one occasion she disappeared for 2 weeks. Her mother was in regular contact with the Police about these absences. At 16 years old Mrs M left home. Her mother supported her with her rent and food until she was able to support herself. During this time Mrs M also attended a tutorial college and achieved GCSEs in Maths, English and Art.

3.7 In 1995 when she was 18 years old Mrs M formed a relationship which resulted in the birth of her first child. During a second relationship Mrs M gave birth to two further children. She is reported to have had post natal depression following these births. This relationship ended in 2004. Mrs M moved out of the family home, and began a relationship with another man. She continued to receive financial support from her youngest two children's father which included the provision of a house to live in with the children.

3.8 On 2 March 2006 Mrs M registered with a GP with whom she remained until 17 May 2012. During 2006 Mrs M saw her GP on 4 occasions for anxiety and depression. She was already on anti-depressant medication when she moved to this surgery although there is no record in her previous clinical notes as to when and why this prescription started. In an October 2006 appointment Mrs M showed a high score on the Hospital Anxiety & Depression Scale (HADS) and was referred to the Community Mental Health Team having her first appointment with a Mental Health Link Worker on 9 November 2006. Mrs M requested Cognitive Behaviour Therapy, but she was advised by the link worker that this would not help with her presenting problem. She was recommended to self refer to Relate for counselling and was also referred for solution focussed counselling via MIND. Mrs M was advised by her GP that counselling was unlikely to take place before January in the New Year and her anti-depressant dosage was increased. In late January 2007 the GP received a letter from MIND reporting that they had decided not to go ahead with counselling at this stage and would require a further referral if Mrs M wished to be seen again. There is no information to indicate the reason for this decision or of any alternatives offered for Mrs M.

3.9 In November and December 2006 Mrs M had contact with the Police when she was involved in a verbal argument and then a further argument and assault on her former partner with whom she had had a relationship for the past 2 ½ years, but which her partner had ended 4 to 6 months previously. At the time Mrs M was intoxicated and using cocaine. During the incident on 3 December 2006 it was alleged that Mrs M had head-butted her ex-partner and marks and injuries on him were recorded. Mrs M was cautioned for damage to property and common assault. At 07.45 hours the next morning she attended Accident and Emergency at the hospital by ambulance reporting that she had been head-butted and had hit her head on a wall, but she was unwilling to discuss the assault. X-rays showed no fractures and she was discharged at 09.00 hours with a friend who was recorded as going to be looking after her.

3.10 There is an indication of Mrs M's vulnerable mental state when on 16 March 2007 at 17.30 she was seen in an Essex hospital Accident and Emergency

Department following an overdose of Anadin, Paracetamol and alcohol. She was away for the weekend and had taken cocaine and alcohol the previous day. The explanation for the overdose was depression. A psychiatric review was arranged. However, Mrs M discharged herself on 18 March before the review could take place. Essex Police contacted Norfolk Police on 19 March to check on her safety and wellbeing. She was seen safe and well and this was reported back to Essex. It is understood that she was collected from the Essex hospital by her eldest child's father and returned to Norfolk. The Essex Hospital faxed the Mental Health Crisis Resolution Team in Norfolk and an initial Care Programme Approach (CPA) assessment of Mrs M was carried out at her home on 17 March 2007. An onward referral was made on 19 March 2007 for assessment to the Assessment and Brief Intervention Team and Alcohol and Drug Services. The assessment noted that Mrs M had children, but no reference is made considering a referral regarding their welfare.

3.11 An Occupational Therapist and Psychologist discussed Mrs M's referral to the Assessment and Brief Intervention Team and decided that she would need to address her substance use prior to their involvement. The implementation of a Dual Diagnosis Policy had not taken place at this time. However, Mrs M did not keep the 2 appointments offered to her at the Trust Alcohol and Drug Service. There is no guarantee that Drug and Alcohol Services would have accepted Mrs M as a client as evidence suggests that her drug and alcohol use was recreational rather than an addiction, nevertheless an initial assessment was unable to take place to ascertain this.

3.12 Mrs M saw GP1 on 12 April 2007 with continuing depression and use of alcohol and drugs. Reference is made to Mrs M seeing a counsellor, but there is no information as to who this was or communication between the counsellor and the GP. The GP telephoned the Drug and Alcohol service and requested a further appointment for Mrs M. This was followed up with a letter.

3.13 On 16 April 2007 Mrs M was involved with the Police once more after she broke into her previous partner's home whilst he was on holiday, accessed his emails and took his laptop computer. She later contacted the Police, admitted the offence and returned the laptop. Mrs M was bailed by the Police, but no complaint was made and no further action taken.

3.14 On 18 April 2007 Mrs M was again seen by GP1 accompanied by her mother. She reported weekend use of cocaine and alcohol when not caring for her children. She also reported driving while under the influence and was advised that this was an offence. Mrs M confirmed that she was attending Narcotics Anonymous and had an appointment with Drug and Alcohol Service the following week (which she did not keep and she was discharged from this service). The welfare of Mrs M's children was discussed; an entry notes that Mrs M rarely misuses drugs while caring for them. In the following month on 10 May 2007 Mrs M's clinical notes indicate that she decided to revert to her previous anti-depressant.

3.15 On 11 June 2007 Mrs M was taken to hospital by ambulance following an accident whilst riding her motor bike. She sustained a fractured humerus and dislocated shoulder for which she had surgery. Mrs M discharged herself from the hospital and did not keep follow up appointments. In interview for this Review Mr N reported that Mrs M informed him that this incident was a suicide attempt and not an accident. However, Mrs M's mother reports that her daughter told her the incident was an accident; Mrs M had described how she had to take avoiding action when the car in front braked suddenly and her motor bike and she had skidded into an oncoming bus.

3.16 Mrs M was seen by GP2 on 14 February 2008 and said that she had weaned herself off her medication, but was now feeling anxious and short tempered. A referral was made to the practice based counsellor. On 28 February the counsellor recorded on the notes that Mrs M had not attended her first counselling session and had not provided any reason. There is no record of any follow up arrangements.

3.17 In 19 February 2008 the Police received a call from an operator reporting that Mrs M had threatened suicide during a phone call to eBay complaining about some money she had lost. She had suggested the methods by which she would commit suicide. A previous call from Mrs M and previous overdose monitoring led Police to call to check all was well. Mrs M appeared amused that the Police had called.

3.18 At some point during 2007/2008 Mrs M had a relationship which led to an engagement and plans to marry. However, the marriage did not eventually take place.

3.19 Apart from brief involvement with Police and attendance at hospital Accident and Emergency Departments the only other agency which appears to have involvement with Mrs M during these years is the Local Authority Housing and Council Tax Departments. These contacts relate to moving addresses and council tax payments.

3.20 Mrs M and Mr N first met through mutual friends during 2007. They were acquainted, but both were in relationships at the time.

3.21 Between the closing months of 2008 and November 2009 the Council Tax Department records indicate that Mrs M moved from her address in Norwich in November 2008, but in July 2009 contact regarding council tax shows Mrs M reporting that she was the sole occupant of the address once more as of 18 April 2009. For part of this time she was living with her then fiancé with her children. During 2009 Mrs M set up an events enterprise, successfully organising and scripting an event for an independent television studio. A family member describes this as Mrs M's most creative period. However, at its conclusion there was a void in her life.

3.22 Mrs M was taken to hospital by ambulance from her Norwich address on 28 November 2009 suffering from a painful head and wrist following a fall whilst intoxicated. There were no fractures and she was discharged. The Hospital recorded that she was living alone at this time (although this is not correct), and her mother was listed as her next of kin.

### Chronology from 2010 to June 2012:

3.23 In July 2010 Mrs M had gone on holiday abroad with one of her children. When she returned a family member describes her as looking on edge and with an expression which experience showed indicated that she was about to go into 'a low'. Mrs M asked her relative to look after her children on 6 August as she had an interview in London and wanted to go down the night before. This was arranged, but before the time Mrs M was due back she emailed another relative to say that she was abroad and was going to stay there to live the simple life. She had left letters behind to explain. Whilst Mrs M's relative was aware that she made fast and ill-considered decisions this was completely unexpected. Arrangements were made for the residence of the children to pass formally to their fathers and the property she lived in had to be vacated. However, Mrs M's

stay abroad was short lived and one day in September she suddenly returned to Norfolk.

3.24 Mrs M was seen by GP3 on 15 September 2010 for depression. It is noted that her children were now in the custody of her 'husband' (this may be an assumption by the GP as Mrs M was not married to her children's fathers), and she was feeling suicidal. She was also estranged from her family. Mrs M declined further medication. There is no apparent referral resulting from this appointment.

3.25 On 28 September 2010 Mrs M emailed the Council concerning her council tax arrears and referred to having had a severe breakdown in June and she had left the country. She had returned, but had no possessions, no job and nowhere to live. Mrs M stated that she intended to pay back the arrears.

3.26 It was during September 2010 that Mr N became reacquainted with Mrs M and he offered to help her by giving her a place to stay for a while. During her stay their friendship developed into an intimate relationship and Mr N reports that they discussed marriage. However, in November 2010 Mrs M suddenly moved out. Mr N has described this as a mutual decision to slow things down and start a more conventional relationship, whereas in his Probation reports he described Mrs M having changed emotionally and moved out. Mrs M reported to a friend at this time that she felt pressured and the relationship had become too heavy too quickly. Within a month they resumed their relationship, however it did not last and ended when Mrs M met someone else. A relative reports that Mr N was deeply hurt by this. Mr N later started another relationship, but this ended in April 2011.

3.27 On 1 December 2010 following the split from Mr N, Mrs M saw a housing advisor at her local council and made a request for support with accommodation. The housing request shows that at this time Mrs M was of no fixed abode and living with friends; her children were living with their fathers; she had an insecure job in a restaurant which was affecting her ability to rent accommodation. The documentation also records Mrs M having been previously 'in care', and that she was suffering mental illness for which she was receiving weekly counselling paid for by a friend. This counselling was paid for by Mr N. She also confirmed having a 'massive breakdown' that summer. Mrs M disclosed to the housing advisor that there was historical domestic abuse with an ex-partner as part of her own history of offending. She had no support agencies involved at this time. The main focus of the advice given to Mrs M concerned housing, and child custody arrangements with her children's respective fathers. She was not offered housing following this. However, Mrs M managed to find employment and eventually rented a house.

3.28 A relative of Mrs M received an email from her sometime in the winter of 2010 saying that she had been diagnosed with Personality Disorder and as being a little bipolar. It is not known who made this diagnosis, but Mrs M's relative assumed it must have been the counsellor she was seeing that Mr N was funding. This is the first mention of a formal mental health diagnosis concerning Mrs M albeit outside of the formal NHS assessment process.

3.29 Mrs M gradually regained a relationship with her family and children. In April 2011 she and a close relative agreed to share the cost of private sessions with a Clinical Psychologist. Mrs M told her relative that the first session was fantastic and made her feel really good. She attended several sessions and her behaviour changed; there were no alcoholic binges, or lots of going out and she was trying to live within her means. On 19 May 2011 the GP surgery received a

letter from the private Clinical Psychologist confirming that Mrs M was being seen with a history of difficulties within personal relationships and a feeling of being disconnected. She was described as feeling that she had had a breakdown and was trying to improve her psychological wellbeing. It was confirmed that the consultations were being self funded.

3.30 In July 2011 Mrs M returned abroad for a holiday with one of her children. During the holiday she met a man who paid for her to return there and spend a further week on her own. She left on 3 September and was due to return on the 12 September 2011. However, she did not return until 19 September and as a consequence she lost her job. A family member describes her as being on a high at this time. For a few weeks between the end of September and mid October 2011 Mrs M was in receipt of benefits, but this was very brief as she achieved employment from 10 October. During this month Mrs M and Mr N resumed their relationship. Mr N reports that they talked about how things could be different this time, but he said that Mrs M warned him that a relationship with her could be destructive, but he thought it would not be.

3.31 On 5 November 2011 Mrs M's mother saw GP1. The appointment had been booked for Mrs M and her mother to see GP1 together following a discussion between them about Mrs M's life-long ups and downs and her spur of the moment decision making. Mrs M's mother mentioned to her that she could be bipolar and she could get help and support to manage this and she suggested seeing the doctor. Mrs M was worried about taking medication because when she was on a high she was creative and energised and she did not wish to lose that, but she agreed to a doctor's appointment. Mrs M did not keep the appointment. However, due to her worries about her daughter her mother kept the appointment and described Mrs M's history of misuse of alcohol and cocaine and self harm to GP1 and expressed her concern that she was a generally unstable personality with bipolar tendencies. The GP advised that Mrs M be encouraged to make an appointment herself and gave a Wellbeing leaflet to Mrs M's mother. This leaflet provided information about the voluntary sector agency MIND and the support available for carers.

3.32 On the 9 November 2011 the GP surgery received a further letter from the Clinical Psychologist Mrs M was seeing privately stating that Mrs M had attended 6 sessions the focus of which was to move away from destructive patterns of behaviour. Due to losing her previous employment Mrs M was unable to continue to fund the therapy. A request was made for the GP to explore NHS alternatives. No further action on this request was found in the clinical notes. Mr N described how much better Mrs M was when she was seeing the Clinical Psychologist. She had expressed her guilt to him that she felt she was a bad mother, but she was now seeing her children regularly and her attitude towards him was good. However, he reports that Mrs M thought something destructive seemed to happen every 2 years and that 12 years old had been a key age for her. What she meant by this is not clear from any information provided for this Review.

3.33 In December 2011 Mr N and Mrs M decided to get married. There are conflicting views about this decision among the couple's family and friends. Some picked up reservations on Mrs M's part; at one time she is reported to have said that she could learn to love him because he was a very caring person and Mr N could offer her stability; then on another occasion to someone else she expressed feelings of happiness and how much she loved him. There were also expressions of concern for Mr N as Mrs M's behaviour was thought to be 'not quite right' for example she seemed to mentally leave a conversation for some time and then shake herself and 'come back' to the company. There were

also recollections of how Mrs M had hurt him before early in their relationship. Plans continued and the wedding took place on 3 March 2012.

3.34 On 14 May 2012 Mrs M went to see GP1. Mr N reports that he accompanied her to this appointment to gain help and support for them both, but his attendance is not recorded in the clinical notes. His attendance is confirmed however, by Mrs M in a conversation with her mother which took place on 28 May. Mr N reported that he attended 2 appointments with Mrs M at her GP surgery, but these surgery clinical notes do not record his attendance. Whilst attending another service not in connection with her own health, it had been recommended to Mrs M by a Consultant Psychiatrist that she would benefit from seeing a Psychiatrist. The GP clinical notes record that a discussion took place with Mrs M that previous interventions were not productive. She was advised to continue to avoid drugs and alcohol and a referral was made to a Psychiatrist on 16 May, but Mrs M was advised that this may have to be a private appointment. It is unclear why this advice was given. In her conversation with her mother on 28 May Mrs M said that she and Mr N found the GP unhelpful and there had been a lack of eye contact for most of the consultation. Mr N made similar comments when interviewed.

3.35 It would appear that the GP referral to a Psychiatrist was superseded by Mrs M seeking advice from another Mental Health professional about a suitable Psychiatrist who might provide a private consultation. This seems to be how Mrs M accessed the private introduction to the Consultant Psychiatrist. The GP referral for her to see a Psychiatrist would have gone through a different route. During the conversation with the Health professional Mrs M cited her new husband as being 'very supportive'. There was no reference to any controlling or abusive behaviour.

3.36 On 17 May 2012 Mrs M contacted the local GP surgery in the area in which she now lived with Mr N. She was seen on a temporary resident basis and received a home visit by a doctor for severe abdominal pain. She was prescribed antibiotics for an infection.

3.37 Mrs M had her private consultation with the Consultant Psychiatrist on 23 May 2012. Mr N paid the fees for the consultation, but he did not accompany Mrs M. The Consultant Psychiatrist has confirmed that Mrs M's purpose in having the consultation was to obtain a diagnosis. She did not seek the involvement of a carer or family member. Mrs M had sought the referral urgently promising that a GP referral would follow. The referral did not arrive, however the referral from her GP made on 16 May would have gone to a different organisation under the current pathway. In their consultation Mrs M told the Consultant Psychiatrist that she had a history of being violent to others, being vindictive and finding abusive partners. A close relative of Mrs M's was surprised to learn that Mrs M had told the Psychiatrist that she found abusive partners. To their knowledge her previous partners had not been abusive, had been supportive, and the relationships had ended as Mrs M's behaviour 'drove them away', or because she had left the relationship. Mrs M did not describe the nature of her relationship with her husband to the Psychiatrist, nor did she describe Mr N as being abusive in any form. The Consultant Psychiatrist reports that the only suggestion that something might not be well in their relationship was Mrs M's description of her own past behaviour. The Psychiatrist had no knowledge of Mr N's mental health. The Consultant Psychiatrist has confirmed that it is not uncommon to make such a diagnosis after one consultation in the NHS and private sector.

3.38 On 24 May, at Mrs M's request and with her consent, the Consultant Psychiatrist spoke to Mrs M and Mr N by telephone. This was to inform Mr N of the diagnosis and the treatment plan that had been agreed. The Consultant Psychiatrist confirmed that no guidance was given to Mr N on how to manage his wife's diagnosis as such 'training' is not possible in a telephone call nor had Mrs M consented to this. A letter dated 25 May was written by the Psychiatrist to the GP1 identified by Mrs M as her GP at the time.

3.39 On 25 May an application was made for Mrs M to join the practice list of the surgery in the area she now lived with her husband, and a request was sent by the practice to the Primary Care Trust for her medical records from her previous General Practitioner.

3.40 The letter from the Consultant Psychiatrist arrived at GP1's practice on 31 May 2012. The letter informed that GP that Mrs M had provided her medical history and at the conclusion of the consultation it was the opinion of the Psychiatrist that Mrs M had Cluster B Personality Disorder with some level of depression. A management plan was provided which included that Mrs M had been provided with some Psycho-Education regarding her diagnosis and that she was likely to find it easier to manage as she moves towards middle age. She should not take illicit drugs or alcohol; she could have a referral to attend an emotional regulation group, and a recommendation for a trial of medication. The Consultant Psychiatrist was to write to Mrs M with the following self help books: Overcoming Childhood Trauma by Dr Helen Kennerly, and Overcoming Low Self Esteem by Dr Melanie Fennell. The letter concluded with an offer to see Mrs M again if the GP required, but no further appointments had been arranged.

3.41 The surgery practice manager confirms that the letter would have been sent to the Primary Care Trust for forwarding to Mrs M's new surgery. There is no date recorded on the summary sheet of the date of arrival at the new surgery, but clinical notes suggest it was not available at Mrs M's next appointment.

3.42 On 28 May 2012 Mrs M visited her mother and informed her of the diagnosis and that she had been told that by the time she was 40 years old she should be able to manage the condition. Her mother expressed relief that at last her daughter's mental ill health had been formally diagnosed. She praised Mrs M for her bravery in undertaking the assessment and said now she and Mr N would get the support they needed. Mrs M is reported to have been tearful during this visit and she expressed her worries about how difficult she was finding the adjustment to married life because they had both been used to their own space and ways of doing things. She acknowledged that she was going through a low phase and finding it difficult to get out of bed each day; she was doing some gardening, but her low mood was preventing her from doing some of the work in her husband's business which she was supposed to do since they were married. Following the retirement of Mr N's relative who did the business administration Mrs M had given up her job and the plan was that she would take over this role. Mrs M also confided that there were money worries. At one point in the conversation Mrs M is reported to have said that when she said she was going to visit her mother Mr N had said "Yeh, that's right **** off and see your mother". This came as a shock to her mother who had always thought of Mr N as a very supportive and caring person. She thought it could be due to him being frustrated with her as a carer.

3.43 Mrs M next saw a GP on 6 June 2012 after phoning the surgery at 13:39hrs where she had recently registered requesting a same day appointment because she was feeling low. A 20 minute appointment was booked and Mrs M, accompanied by her husband, was seen at 15.29hrs. She reported a long

standing history of mental health issues and said she had recently seen a Consultant Psychiatrist privately who had 'labelled her' as having a 'personality disorder' and depression. This made her unhappy. Mrs M was not taking any medication at this time. The doctor was informed of Mrs M's history of alcohol and drug abuse, but was told that Mrs M had not taken drugs for 2 months and alcohol for a month. Mrs M reported to the doctor that she felt suicidal earlier that day and was considering overdosing on Paracetamol. She had informed her husband of this, but she now felt calmer. Mrs M described having ongoing 'dark thoughts' and was concerned that although she saw her children from a previous relationship she felt that she was not a good mother to them. She reported that she was experiencing sad, unhappy and evil episodes lasting 2 to 3 weeks. The doctor felt that Mrs M was not actively suicidal at the time of the appointment and a plan was made with Mrs M and her husband for a routine referral to the Mental Health Care Trust for support. Mrs M had already booked a routine appointment with another GP in the practice for the following week and she agreed to keep this appointment. The doctor prescribed a 7 day supply of Lorazepam 1mg tablets for Mrs M's anxiety which Mr N agreed to administer. The couple were asked to return if anything changed. The appointment ended at 16:16hrs. A referral to the Mental Health Care Trust was faxed the same day at 16:21hrs. It was marked 'routine'. Protective factors were noted as being her husband, and that Mrs M reported no longer abusing substances. It also noted that Mrs M had been seen by a Consultant Psychiatrist privately. A letter was sent on 13 June 2012 by the Mental Health Care Trust with an appointment for Mrs M on 4 July 2012 with a mental health link worker. Mr N reported that while waiting to go in and see the GP Mrs M spoke about her fear of being 'Sectioned' and Mr N felt she minimised how unwell she really felt when she spoke to the GP.

3.44 On 11 June at 13:41hrs a friend of Mrs M's sent her a text. The friend had previously been texted by Mrs M on 21 May to say that her phone had been sent for repair for the next few days and to use Mr N's phone instead. The friend texted Mrs M again on 31 May to ask if her phone was fixed yet. There was no reply to this text. When the friend sent the text on 11 June at 13:41hrs saying "How are you is everything ok" a reply came back from Mrs M shortly afterwards saying "Things are really up and down at the mo, however I think it's under control, taking one day at a time. How are you? Can't wait until October" (October was the month they were to meet up again).

3.45 Around mid afternoon on Monday 11 June 2012 Police and the Ambulance Service attended Mrs M's and Mr N's home address. Mr N was arrested for causing grievous bodily harm to Mrs M. She had been strangled and then hit in the face and head by a hammer following an argument. Mr N made a detailed admission during interview concerning the incident in which he described Mrs M becoming verbally abusive and throwing cups of tea over him. Mr N said he was also very stressed over some work he was doing and had 'lost it'. The argument had concerned the movement of objects prior to Mrs M starting to decorate. Mrs M was still alive at the scene when the Police and Ambulance arrived. She was taken to the Norfolk and Norwich Hospital from where she was transferred to Addenbrooke's Hospital in Cambridge. She died 2 days later on 13 June 2012. Mr N was charged with her murder and remanded in custody.

## 4 Overview:

### About the victim:

4.1 Mrs M is described as a strikingly beautiful, bubbly, vivacious, woman who could be the life and soul of the party who would light up a room. She was considered to be a loyal and supportive friend who was a good listener. She was also very creative and artistic, and demonstrated a degree of resilience by managing to adapt and survive a number of setbacks in her life. At the same time her life could be an emotional rollercoaster with mood swings varying between creative and impulsive 'highs' to self-destructive 'lows' and depression, even suicide attempts. She could be confrontational and in her past she had been physically aggressive. However, her larger than life personality could also be used as a veneer to cover up her low self esteem; she needed reassurance and was vulnerable.

4.2 Mrs M's early adolescence was undoubtedly a troubled and self-destructive phase in her life over and above the normal challenges teenagers can present. Whatever the aetiology of this behaviour, as psychological assessments identified Mrs M had problems with relationships, particularly with men. On occasions she described her relationship with her husband as 'stifling' and 'suffocating', and once complained that Mr N had belittled her in front of the children. One friend recalled Mrs M saying that Mr N was trying to say she was an alcoholic which she was not, and he was clearing alcohol from the house, she also once told friends not to contact her as she did not want to be near alcohol. This may have been Mr N's attempts to stop her drinking which was recommended by her GP. However, a friend also recalls Mrs M being given espresso martini at home and becoming very drunk.

4.3 Friends and her family believed she had found a husband who was caring and supportive, but some had the impression that Mr N changed when they were married. Her Facebook page was closed, and when she was with friends Mr N would call her. In June just before she died she was saying to friends that she was thinking of leaving the marriage and was planning to seek advice about what steps to take, but she was concerned about what people would think as they had only been married 3 months.

4.4 In May 2012 Mrs M told friends and family that her mobile phone had been sent away for repair and that she was using Mr N's phone. Some of her friends say they thought Mr N was answering some of her texts, or there would be no response which was unlike Mrs M and this concerned one of her friends greatly as it was out of character.

4.5 Mrs M often spoke to friends and therapists of her deep sense of guilt that she was not a good mother, and she longed for stability and to be with her children. She was also conscious latterly of the impact of her behaviour and mental ill-health on her children and wanted to address this.

4.6 After years of mental ill-health she had at last achieved a diagnosis for her condition and had the possibility of treatment, support, and a future which offered the chance of the more stable life which she craved.

4.7 **About the perpetrator:**

4.8 Mr N has described his childhood as troubled, but also privileged. His mother was physically and verbally abusive and he now believes she suffered from an undiagnosed mental psychiatric problem. His father worked long hours and was

away from home a good deal. Eventually his parents were divorced and his father remarried. Relatives of both of Mrs M and Mr N believe his experience of his mother's behaviour and mental ill-health impacted on his relationship with Mrs M. On the one hand in respect of perhaps feeling that he was equipped to support and handle her condition, but underestimated his ability to do so, and on the other that his childhood experience made him less able to cope and hence the 'loss of control'.

4.9 Mr N had a 13 year relationship from which he has children. The couple have remained friends and share custody of the children. There is reported to be no history of abuse in this relationship; the couple grew apart over time.

4.10 Mr N described in his statement how after the initial high of their marriage Mrs M's mood would change and he did not know from day to day how she would be. He reported that her mood swings were exacerbated by the use of drugs and alcohol and suicidal thoughts would surface. They had both decided to cease using these substances.

4.11 Mr N maintains he is not a violent person, is normally in control of his emotions and is usually calm in stressful situations. A family member has also reported that they had never seen Mr N loose his temper or be violent. Mr N did admit to damaging a kitchen drawer in an argument with Mrs M, and the couple did have an argument which once led to Mr N leaving the house with his children. Until he was convicted he ran his own successful business which could be stressful at times, but he reported that he always coped with the stress.

4.12 Mr N stated that Mrs M was having nightmares and her behaviour meant he had not slept for 3 nights, and in addition his work on the day of his attack on her was particularly stressful. He said he was aware that she had said she was thinking of leaving him, but then she had told him that she had changed her mind. Whilst Mr N takes responsibility for the death of his wife he minimises the level of his responsibility by citing Mrs M's behaviour as causing him to act out of character.

### Summary of information known to the agencies and professionals involved

4.13 From the information recorded by agencies there is nothing to indicate that domestic abuse was present within the relationship between Mrs M and Mr N nor was any potential risk of violence identified. Full details of the content of the psychiatric assessment consultation were not available to the Review author or IMR authors. However, questions from the Review author answered by the Consultant Psychiatrist by email as to whether there were any indications of control or abuse within the couple's relationship were said not to be evident, apart from the risk that Mrs M's own behaviour posed.

4.14 Gaps in information available to and between Health agencies have emerged in the course of this Review. Notably, information was not available to the GP to enable the GP to have full sight of outcomes and why decisions were made, for example decisions not to offer counselling or therapy. Where information was added to the GP notes by a primary care mental health link worker a copy is not made available within the client's hospital record leading to an incomplete picture of primary care interventions. Implementation of electronic records and new processes for recording patient interactions is reducing the risk of this happening in future.

4.15 Mrs M was new to the surgery when she saw a GP for the first time on 6 June. It does not appear that her clinical notes from her previous surgery were available to the new GP, and there is no date available for the receipt of the letter from the Consultant Psychiatrist at the new surgery after it was forwarded via the Primary Care Trust from her previous GP. It appears that the letter was not available for the new GP to see when the doctor saw Mrs M and Mr N on 6 June 2012.

4.16 Although there were at least 2 occasions when Mrs M's mental ill-health or admission of drug and alcohol should have raised the consideration of safeguarding issues for her children no Health professional made a referral to Children's Services. These occasions were her suicide attempt which resulted in her A & E admission to an Essex Hospital and onward referral to the Mental Health Crisis Resolution Team in Norfolk on 19 March 2007, and her disclosure to her GP on 18 April 2007. It is likely the children were having contact with their father or staying with grandparents at a weekend, however, checks should have been made as to their welfare.

### Any other relevant facts or information

4.17 A number of shortcomings in inter-agency practice were highlighted in the early part of the chronology. However, policies and practice has changed over the considerable time which is covered by the information provided for those early years. Therefore this Review will only comment on particularly salient areas, or where shortcomings have been identified affecting practice at this time.

On 23 March 2007 the absence of a dual diagnosis policy meant that Mrs M was not actually seen for assessment for a potential referral for services from the Mental Health Assessment and Brief Intervention Team because of her drug use. It would appear that this was due to information within an initial Care Programme Approach (CPA) assessment and she was perceived as having an addiction, rather than as evidence suggested, that she was a recreational user of substances. Equally, Mrs M did not attend her appointments with the Drug and Alcohol Service and so was not assessed for that service either. Whether Mrs M was ever aware of the importance of this appointment as the first step to receiving support from the Mental Health Trust is not known. The Trust Dual Diagnosis Policy 2008 updated bi-annually should mean a more collaborative approach to supporting patients is in place today.

4.18 There are no apparent equality issues in this case. However, there have been occasions during this Review when matters around Mrs M's drug and alcohol use do seem to have clouded the issue and affected her access to mental health services i.e. the referral to the Assessment and Brief Intervention Team mentioned above at 4.21. However, this should now be addressed by the existence of the Trust's Dual Diagnosis Policy. There is no indication that any of the agencies involved with Mrs M considered whether her substance misuse was a consequence of her mental health and anxiety problems.

## 5 Analysis:

5.1 The prominence of the mental health issues in this Domestic Homicide Review cannot be avoided as it is clear from the chronology that Mrs M's mental ill-health had affected her for many years and formed the person she was. Although she showed a degree of resilience she was also highly vulnerable, both in terms of the risk her interactions with others put her in, and in terms of her

ability to cope when she was very low and suicidal. Her tendency towards impulsive and ill-considered decisions and actions also placed her at risk.

5.2 This acknowledgment of her mental ill-health and vulnerability is in no way intended to excuse or mitigate the actions of her husband. He is solely responsible for his actions which caused her death. Whilst he had accompanied Mrs M to the GP to seek support there is no evidence that he requested help for himself or was assertive in pressing for a combined support service for them both, and there is no indication that he was offered support. He is an intelligent man and he had funded Mrs M's expensive private consultation with the Consultant Psychiatrist to obtain a diagnosis. Having received a diagnosis some people might use that information to gain further insight as to why their partner was behaving as they were, and for this to perhaps help alleviate any frustration they may have felt at times and also to have sought appropriate support. Alternatively, the diagnosis may raise a partners' anxiety about how they will cope. Their local surgery had been swift to offer a same day appointment on the 6 June and it seems reasonable to assume that if Mr N had called the GP for further immediate help this would have been available. He did not do this despite the fact that he said he was losing sleep because of Mrs M's nightmares and was finding it difficult to cope. Did he minimise these problems and exaggerate to himself his ability to cope? Or did he exaggerate Mrs M's problems in mitigation of his crime?

5.3 The route taken by Mrs M and Mr N to obtain a faster diagnosis of her condition was not through her GP; this meant that the Psychiatrist had no full history from her doctor, but the Consultant had this direct from Mrs M herself. Her GP had made a referral on 16 May 2012 for her to see a Psychiatrist, but that referral route would not have taken the GPs letter to the Psychiatrist she saw privately. There is no rationale as to why Mrs M's former GP would suggest that an NHS Psychiatrist's appointment might not be possible and may have to be private. However, the current client pathway does not usually enable a referrer direct access to a Psychiatrist. This is normally a stepped approach with Consultant appointments being assessed on need. As a result the GP referral letter was sent to a different organisation than the one at which Mrs M was seen by the Consultant Psychiatrist.

5.4 The diagnosis of Personality Disorder or any mental illness can represent a life changing event, and Mrs M had indicated to the GP that she was not happy with 'the label' she felt this represented. She was already unwell and her unhappiness with 'the label' as she perceived it, may have exacerbated her condition. It would be expected practice for further support to be offered for both Mrs M and her family at the time of diagnosis. Although the Psychiatrist made a follow-up phone call to Mrs M and spoke to Mr N with her consent concerning the diagnosis, it was admitted that 'training' for Mr N in connection with this was not possible over the phone. Following the consultation on 23 May 2012 a letter dated 25 May containing the Psychiatrist's management plan arrived by routine post 5 days after it was dated at the previous GP's surgery; this would have been 30 May. The plan did not include any support to be arranged for Mrs M's family or carers, and it does not appear to have reached her new GP in time for the appointment on the 6 June.

5.5 The timing of Mrs M's assessment with the Consultant Psychiatrist on 23 May 2012, and changing her GP surgery 2 days later, had the unfortunate result in important GP notes and the Consultant's letter not being available to the new GP at the time of her appointment on 6 June. This meant that although the GP had Mrs M's report of the diagnosis she had received, the GP was without knowledge of the management plan and the medication recommended by the

Consultant Psychiatrist. The amount of time these documents appear to take to move between services is unfortunate when one considers the importance of the information contained within them and the difference this can make to an assessment of a patient's needs. With modern methods of secure communication the existing method seems cumbersome to the outsider's eye.

5.6 The victim's family and friends thought Mr N was very caring and supportive and that he was trying to do the best he could for Mrs M. However, after they married some friends noticed a change. Whilst some of his behaviour such as regular phone calls when she was out with friends could be construed as demonstrating his care for her, some began to feel he was obsessed with Mrs M and was trying to stop her seeing them. Conversely, Mr N said he was trying to support her by keeping her away from bars to help her avoid alcohol as her GP had directed. In her text reply to a friend on the day she was attacked Mrs M said things were up and down; there is no way of knowing whether she was referring to her relationship with Mr N or her own mood at the time.

5.7 Domestic abuse did not feature in agencies notes or appear to be considered a potential risk factor and Mrs M did not report experiencing domestic abuse to any agency, indeed she herself admitted to a Housing Officer that she had a previous domestic abuse offending history. Nevertheless, A systematic review of research by Trefillion et al[2] shows 'consistent evidence that both men and women with all types of mental disorders report a high prevalence and increased odds of domestic violence..., with women more likely to experience abuse than men'. Lifetime median prevalence of domestic violence for women with depressive disorders was 45.8%. Women with Anxiety Disorder faced a median prevalence of domestic violence of 27.6%, and women with Dysthymia (chronic depression) had a 20% likelihood of experiencing lifetime partner violence. The presence of a mental disorder makes a woman not only more vulnerable to domestic abuse because of her illness, but if her behaviour as a result of the disorder is sometimes volatile this places her at increased risk of experiencing violence. It is therefore essential that these duel risks are understood when making assessments of risk.

5.8 The absence of any mention of domestic abuse in any agency notes is most likely to be indicative of the fact that no assessment ever included screening for this form of abuse. A study by Mezey[3] found when reviewing psychiatric patient notes, or notes of patients with a psychiatric history, that they were significantly less likely to be screened for domestic abuse/violence than non-psychiatric patients, despite the fact that they were at particularly high risk. This was clearly a gap in the assessment process for a vulnerable group. However, the Panel is advised that domestic abuse now forms part of assessment screening.

5.9 It is estimated that 10% of people have problems which could fulfil the criteria for a diagnosis of Personality Disorder, with rates among psychiatric outpatients as high as 80%; thus studies suggest that this condition should receive wider

[2] Trefillion K, Oram S, Feder G, Howard LM (2012) *Experiences of Domestic Violence and Mental Disorders: A Systematic Review and Meta-Analysis.(page 9)* PLoS ONE 7(12):Es1740.doi:10.1371/journal.pone.0051740 accessed 20.02.2012

[3] Mezey G., 'Domestic Violence in Health Settings '*Current Opinion in Psychiatry*,14(6) pp543-7, Lippincott, Williams & Wilkins, London ,November 2001cited in Shipway L., (2004) Domestic Violence A handbook for health professionals. Routledge, London

recognition especially given the high prevalence rates of domestic abuse within this population[4].

5.10 It is not possible to speculate as to whether Mr N would have been given immediate access to support had the GP received the Psychiatrist's management plan by the time Mrs M and Mr N were seen on 6 June. The management plan did not contain any suggestion of support for family or carer, although there may be a chance that the GP may have arranged this themself. It is highly unlikely that Mrs M would have been unwell enough to be detained under the Mental Health Act 1983 (as amended 2007) as Mr N said she feared, and for this to remove her from the family home for a period of time. For a different course of events to have taken place different actions would have needed to take place some years before in respect of earlier diagnosis and treatment for Mrs M, and the coincides which enabled Mr N and Mrs M to become reacquainted and start a relationship not to have happened.

### Examples of good practice:

5.11 In October 2006 good practice was demonstrated with the undertaking of the Hospital Anxiety and Depression Scale assessment with Mrs M and she was referred to the Community Mental Health Team. She also received continuity of care during her registration with the practice between March 2006 and May 2012.

## Conclusions:

5.12 A primary purpose of the Domestic Homicide Review in addition to identifying actions taken and lessons to be learnt is to determine whether the homicide was predictable and preventable.

5.13 Given the information available to the professionals at the time, it is unlikely that the incident could have been predicted. However the Panel identified the need for increased awareness around the potential risks to people with mental illness of suffering or perpetrating domestic abuse. This Review cannot say with any confidence that such a level of awareness exists at this time within the Health agencies with whom she came into contact. The author hopes this Review will engender a change in that awareness.

5.14 Mrs M's marriage to Mr N was of approximately 8 months duration, although they had been in a relationship before marriage. During this time, apart from Health appointments, they were unknown to any agency and there was no obvious cause for concern. Their relationship did not present any fears among family and friends of a nature which made any of them think about contacting an agency or seeking advice on her behalf. There appear to be a number of factors causing stress to Mr N including financial and business worries, not just Mrs M's mental ill health; however this does not excuse his actions. Many people face similar stresses without taking their partner's life. One cannot assess in hindsight whether, if Mr N had received support from an agency to help him manage his frustration with caring for his wife following her diagnosis, the outcome would have been any different. The only way of guaranteeing a different outcome would have been if they were not together. It is therefore not possible to say that her death at his hands was preventable by the actions of

[4] Alwin N, Blackburn R, Davidson K, Hilton M, Logan C, Shine J. (2006) *Understanding Personality Disorder: A Professional Practice Board Report*, The British Psychological Society, Leicester

agencies based on the information available to them. This does not mean that there are not lessons to be learnt however.

## Lessons to be Learnt:

5.15 The author has sympathy with the view expressed by the victim's mother that mental health (or mental ill-health) is central to this case. This Review highlights the need for wider awareness and understanding of the risk and prevalence of domestic abuse faced by those with mental ill-health, particularly women with conditions such as chronic depression, anxiety disorders, and personality disorder.

5.16 As Alwin et al[5] point out given that 10% of people have problems which could meet the criteria for Personality Disorder and rates among psychiatric out patients are in excess of 80%, a multi-agency, multi-disciplinary approach is needed to support this population, and they identify staff in a wide range of agencies that require some level of training to understand Personality Disorder ranging from basic awareness to specialist training. Agencies including Health, Social Care, Education, criminal justice agencies and the voluntary sector need this knowledge combined with awareness of domestic abuse and its high prevalence within this cohort. Domestic abuse support agencies routinely work in a multi-agency manner. Specialist Health services such as Mental Health would achieve enhanced services for their patients by following this lead.

5.17 The Norfolk and Suffolk Foundation Trust Domestic Abuse and Service Users Policy is dated 2013. As agencies in this case were not aware of domestic abuse or the potential for domestic abuse no one would have consulted this policy. Again this highlights the importance of training, to raise awareness and give staff the skills to identify domestic abuse and know how to work with specialist agencies collaboratively to support victims.

5.18 **Safeguarding:** Although practice will have changed since the early years of Health involvement with Mrs M, it is worth reminding Mental Health and GP practices of their duty to consider the welfare of children when they are assessing the needs of parents. Children are invariably affected by their parent's mental ill-health, and even if they are not put at risk by their parent's illness, in some cases they may become young carers and be entitled to support in their own right.

5.19 **Inter-Agency Communication:** Throughout the years of Health involvement with Mrs M there does not appear to have been a multi-disciplinary meeting at which a management plan was discussed. Very little information is recorded within GP notes making the transfer of vital information concerning a patient's care difficult. This lack of information also limits the assurance that inter-agency working was taking place.

5.20 There is a need for greater speed and efficiency in transferring clinical notes, management plans, and patient information securely between GPs, Health professionals seeing patients in a private capacity, and other sectors of Health to ensure continuity of care and patient safety. The receipt of important notes and correspondence should always be recorded to provide an audit trail and to ensure there has been safe delivery.

[5] ibid

5.21 **Case Management:** There are a number of episodes of care when Mrs M was referred to other agencies, including to the Mental Health Trust, twice as a child and twice as an adult, one which was just before her death, and there are examples of a lack of information being shared with her GP i.e. from drug and alcohol services. This limits the GPs knowledge of outcomes. This may be mitigated in future by the launch in February 2013 of the Access and Assessment Team which will manage and collate all referral information. At the time of this Review it is not apparent that there is a framework to take into account an individual's presentation when deciding in which order a client's needs should be addressed and this can affect effective case management. Although only diagnosed formally with personality disorder just before her death, Mrs M had a long history of mental ill-health and substance misuse which would have benefited from a more coordinated approach. Patients with personality disorders and substance misuse problems can be challenging to manage and support, this makes inter-agency collaboration all the more important as failure to communicate can contribute to drop out and patients can be lost from services[6]. This appears to have happened to Mrs M in the past with her failure to attend appointments and periods of not accessing Health services. Best practice within the Care Programme Approach is for one identified worker to be the 'Care Co-ordinator'[7]. The gap identified between primary care notes and those available within a patient's hospital notes should be addressed with the implementation of patient electronic records.

5.22 **Referral to a Consultant Psychiatrist:** Mrs M was advised to see a Psychiatrist by another Consultant Psychiatrist in another branch of the Mental Health Services; she followed this advice by requesting a referral from her GP. This was done by the GP with the request that they be advised if this was not possible. No rationale was given as to why it would not be possible. The GP advised this may have to be a private appointment. The current pathway does not usually enable a direct referral to a Psychiatrist. It is a stepped approach with access to services assessed on need prior to onward internal referral. As a result it is unclear as to whether the GPs referral, sent to a specific Consultant, was seen by the Consultant or sent to a different part of the organisation for assessment of need. By arranging her own appointment and seeing the Consultant Psychiatrist privately Mrs M was taking responsibility for progressing her own care and to achieve this she asked the Psychiatrist to share the diagnosis with her GP. However, a member of the public may well not fully appreciate that by going down the private route they are outside the NHS system to such a degree and be aware of the changes to the management of care and ability for direct access to NHS services this brings.

5.23 The stepped approach pathway to access an assessment by a Psychiatrist appears to limit a GP's ability to navigate their way to obtaining an assessment from a Psychiatrist for their patient as the access point has to follow a given course. This may have influenced the GP's advice to Mrs M that she may have to go down the private route to see a Psychiatrist as there would have been no guarantee that the GP referral would have resulted in such an appointment. There does not appear to be an interface between professionals within the Mental Health service which could facilitate a more direct referral system. For example if the Consultant Psychiatrist who recommended that Mrs M saw a Psychiatrist could have liaised with the GP to add their opinion and

[6] Banerjee S, Clancy C, Crome I (eds) (2002) *Co-existing Problems of Mental Disorder and Substance Misuse (dual diagnosis) An Information Manual* . The Royal College of Psychiatrists' Research Unit

[7] ibid

recommendation to a referral, with a suitably flexible pathway a route to a psychiatric assessment could be enhanced. Similarly, if a process existed for direct referral from Consultant to Consultant Mrs M could have been referred by the Consultant Psychiatrist who made the recommendation direct to another Psychiatrist thus keeping her within the NHS system. From February 2013 a facility for GPs to access urgent advice from a Consultant came into being and GPs will have been made aware of this. This is most welcome. However, Mrs M's referral may not have been seen as urgent by her GP or a Consultant.

5.24 The national agenda for Mental Health is supporting the need to ensure that there is the ability for a GP, acting as a primary care commissioner on behalf of her or his patient, to make a referral to a Psychiatrist requesting they provide support to patients which does not require them to be managed on a whole pathway of care, but which offers specific and time limited intervention to review their care or diagnosis when this is most appropriate. It is most welcome that from February 2013 GPs will be able to access direct telephone advice from Psychiatrists for urgent cases. It would be most helpful if this type of access was to progress to include a responsive process which allows GPs to confer and request access to this level of support for all their patients where it is deemed necessary.

## Recommendations:

5.25 These recommendations arise from the Independent Management Reviews submitted to the Review and from the Review author.

5.26 **National Recommendation:**

5.27 **1.** That the National Institute for Clinical Excellence (NICE) review their Clinical Guidelines to include the following:

a) That with the consent of a person diagnosed with a mental illness their family or carer should be provided with information about local support groups at the time of diagnosis or as soon as practicable following diagnosis along with information for further help and advice.

(b) NICE guidelines[8] do not currently recommend a timescale within which primary care should be informed of a patient's discharge to their care. This Review would recommend that when a diagnosis of formal mental illness is provided to the patient for the first time information should be sent to the referrer or the person's GP using an escalation process to notify them of a significant finding or diagnosis within 24 hours to ensure that they are made aware at the first opportunity so as to be able to support the patient and family or carer.

**National Level and County Level Recommendation:**

5.28 **2.** Training for Health and Social Care professionals including Mental Health, Midwives, Social Workers, Drug and Alcohol Services, GPs and other primary care staff should include training about Personality Disorders and other mental health illnesses combined with the prevalence and risk of domestic abuse faced by patients with these disorders. This should include awareness of the

[8] NICE Clinical Guidelines 78 Borderline Personality Disorder: Treatment and management. Issued January 2009

possibility of a patient's volatile behaviour due to their illness placing them and others at increased risk of harm. This includes the welfare of any dependent children in line with NICE Clinical Guidance 78 January 2009. The training should include the identification of domestic abuse, risk assessment, and services available to support victims and should be mandatory. Issues around Dual Diagnosis should be included since substance misuse can also be prevalent in this cohort which can present an additional risk factor.

County Level:

5.29 3. All agencies should ensure that healthcare staff are aware of the need to consider the implications for children or other dependents of a person presenting with, or disclosing high risk behaviours, and take action to safeguard them against harm and/or to ensure that children have support in their own right. To this end agencies should conduct an audit of staff training and safeguarding knowledge to ensure that all staff carrying out an assessment or support role have up to date training and are confident in acting on and applying safeguarding procedures. This could be addressed in the personal development or appraisal process of staff.

5.30 4. All Health agencies should review their information sharing policies and practices to ensure that they have identified the referrer and/or case manager, and that accurate, full, and timely information is available to ensure that effective triaging and the ongoing holistic care of the client/patient can be achieved.

5.31 5. Timescales for the transfer of clinical notes between GP practices should be reduced to enable efficient, effective and safe continuity of care for patients.

5.32 6. Where a client has contact with a number of services a case manager or Care Co-ordinator should be identified whose role it is to review all information and follow up concerns and gaps in care. A pathway for the treatment of clients with Dual Diagnosis should include the criteria for the order in which a client is seen for drug and alcohol assessment and treatment, and mental health assessment and intervention. Decisions made should be documented and include the rationale for decisions reached. It should be clearly indicated where case management responsibility is held for every client.

5.33 7. It is most welcome that from February 2013 GPs will be able to access direct telephone advice from Psychiatrists for urgent cases. It is recommended that GP commissioners commission a service which gives them the option of bypassing the set pathway of care, and to opt for appropriate access to support or diagnosis for any patient the GP feels needs to see a Psychiatrist to ensure their patient's safety, wellbeing and best management of their care.

5.34 8. To back up staff training the Norfolk and Suffolk Foundation Trust should review its Domestic Abuse and Service Users Policy 2013 to ensure that it includes guidance to staff regarding the risk and prevalence of domestic abuse where Personality Disorder and other mental disorders are affecting clients/patients, and that this equips them with information relating to specialist agencies or practitioners with expertise in these dual areas. Collaborative working should be actively encouraged.

5.35 9. Any professional seeing a patient who has been given a mental health diagnosis should be aware of the following best practice:

(a) NICE guidelines[9] recommend that with the consent of the person diagnosed their family or carer should be provided with information about local support groups. As a result of this Review it is recommended that this is provided at the time of diagnosis or as soon as practicable following diagnosis along with information for further help and advice.

(b) NICE guidelines[10] do not recommend a timescale within which primary care should be informed of a patient's discharge to their care. This Review would recommend that when a diagnosis of formal mental illness is provided to the patient for the first time information should be sent to the referrer or the person's GP using an escalation process to notify them of a significant finding or diagnosis within 24 hours to ensure that they are made aware at the first opportunity so as to be able to support the patient and family or carer.

(c) Arrangements to follow up the client are made and shared with them before leaving the consultation.

Professionals should be cognisant of the fact that a mental health diagnosis may be a life changing event for the client who will require a speedy support package of care to mitigate the impact on their wellbeing and that of their family. This is particularly important for a mental health diagnosis where a patient may already be unwell.

[9] NICE Clinical Guidelines 78 Borderline Personality Disorder: Treatment and management. Issued January 2009
[10] ibid