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Safer Derbyshire
Domestic Homicide Review
Mrs D, 2019
Overview Report

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Domestic Homicide Review Overview Report

1. Introduction

1.1 This report of a domestic homicide review examines agency responses and support given to Mrs D, a resident of Derbyshire prior to the point of her death in early 2019.

1.2. In addition to agency involvement the review will also examine the past to identify any relevant background before the homicide, whether support was accessed within the community and whether there were any barriers to accessing support. By taking a holistic approach the review seeks to identify appropriate solutions to make the future safer.

• Summary of Circumstances Leading to this Review

1.3. Mrs D lived with her husband, Mr D. The couple's grandson, David who was in his mid 20's, had lived with the couple intermittently for the last 10 years. On the day of the homicide, in the early hours of the morning, David killed his grandfather's dog, using a crossbow and a knife. He then proceeded to stab his grandmother, Mrs D multiple times.

1.4. When Police arrived, David told the officer he had killed his dog and grandma. Very sadly, despite efforts by Police and ambulance staff to resuscitate Mrs D, she could not be revived. The death certificate recorded the cause of death as stab wounds to chest.

1.5. In the Police interview that followed, David confirmed his intention had been to kill the dog and then kill his grandmother. He believed that the dog had been changed and that his grandmother was someone else who was trying to hurt him and his grandfather.

1.6. The review will consider agencies contact and involvement with Mrs D and David from July 2015 until February 2019. These dates cover the point at which David self-referred to a mental health service provider of psychological therapies and the end date being the date of Mrs D's death. The review also considered relevant events outside of this timeframe where they provided background context as relevant to the terms of reference.

1.7. The key purpose for undertaking DHRs is to enable lessons to be learned from homicides where a person is killed as a result of domestic violence and abuse. In order for these lessons to be learned 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

1.8. This review began on 18th March 2019 and was concluded on 23rd October 2019.

• Confidentiality

1.9. The findings of each review are confidential. The detail of information is available only to participating officers/professionals and their line managers.

1.10. Specific addresses have been generalised to protect the privacy of the family. The pseudonym of 'Mrs D' applies to the victim, and 'David' the grandson and perpetrator. These pseudonyms were chosen by the victim's daughter who is also the mother of the perpetrator.

2. Terms of Reference

• Methodology

2.1. Safer Derbyshire received a referral from Derbyshire Police, notifying them of a domestic abuse related homicide investigation. Safer Derbyshire convened a panel that confirmed the circumstances met the statutory requirement for a Domestic Homicide Review.

2.2. Safer Derbyshire had carried out initial information gathering to assess what involvement Mrs D and David had had with agencies. This established that Mrs D had not had any extensive involvement with services. David had had some limited historic contact with mental health services. Neither Mrs D or David had had any involvement with domestic violence organisations, Multi-Agency Risk Assessment Conference (MARAC)[1] or Multi-Agency Public Protection Arrangements (MAPPA)[2].

2.3. Following a second panel meeting and in consultation with family members, the following terms of reference were agreed:

Terms of Reference: Key Lines of Enquiry
1. What is known about any barriers to accessing services and receiving support, including access to services for mental health, drug and alcohol misuse and domestic violence? 2. Were reasonable steps taken to engage the victim and perpetrator in care and support (where indicated) and to sustain engagement? 3. Were there any equality and diversity issues that required special consideration? 4. What was known by agencies about the circumstances of the perpetrator, victim and their family including whether they were adults in need of care and support (including as a carer) and/or 'adults at risk' 5. Were any previous episodes of domestic violence known? If there were, were opportunities taken to canvas the victims/perpetrators perception of danger and to act on this? Were patterns of behaviour looked for rather than each incident seen in isolation?

[1] A MARAC is a meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs), probation and other specialists from the statutory and voluntary sectors

[2] MAPPA stands for Multi-Agency Public Protection Arrangements and it is the process through which various agencies such as the police, the Prison Service and Probation work together to protect the public by managing the risks posed by violent and sexual offenders living in the community

6. Was there any information to suggest the victim's decision making was impaired due to cognitive impairment and/or coercion and control?
7. What were the key relevant points/opportunities for assessment and decision making in this case in relation to the victim and perpetrator? What was the quality of any multi-agency assessments?
8. Did actions accord with the assessments and decisions made and were appropriate services offered/provided or relevant enquiries made, in the light of assessments?
9. Was appropriate professional curiosity exercised by those professionals and agencies working with the individuals in the case, this includes whether professionals analysed any relevant historical information and acted upon it?
10. Were there any previous concerns, incidents, significant life events or indications which might have signalled the risk of violence to any of the subjects or given rise to other concerns or instigated other interventions?
11. Was there any indication that the perpetrator's decision making was impaired and that a mental capacity assessment was required?
12. Prior to the index offence, was there at any indication that the perpetrator had a mental disorder within the meaning of the Mental Health Act 1983 (2007) and that compulsive intervention under that Act should be considered?
13. Were there any issues, in communication, information sharing or service delivery, between services?
14. Was there sufficient management accountability for decision making? Were senior managers or other organisations and professionals involved at points in the case where they should have been?
15. Was the work in this case consistent with each organisation's policies and procedures for safeguarding and promoting the welfare of adults, and with wider professional standards?
16. What lessons for individual agencies and for the multi-agency partnership?

Through involvement of the family, the review also sought:

17. An understanding of the background history including any factors pre-scope period that are relevant to the review
18. To identify whether there had been any previous incidents of domestic violence within the family or other aspects of risky behaviours.
19. Identify from the family's perspective any missed opportunities for preventative support to the victim, the perpetrator or to the perpetrator's Mother that may have reduced the likelihood of a homicide occurring
20. To understand any barriers to accessing services for the family including knowledge of services that may have helped the victim, perpetrator and/or other family members
21. To canvas the family's recommendations to improve the way in which professionals and organisations work together to safeguard victims

- ## Involvement of Family, Friends, Work Colleagues, Neighbours and Wider Community

2.4. The involvement of family and friends is an essential aspect of understanding the circumstances surrounding homicides and drawing on their experiences to identify learning. The DCSP involved Mrs D's husband, two daughters and grand-child (David's grandfather, mother, aunt and half-

sibling) from the outset, informing them of the review, providing written information about DHR's and inviting their contribution. The family were consulted about the terms of reference for the review and decided on the pseudonym that would be used in the final report. The Independent Author/DHR Chair interviewed Mrs D's husband, two daughters, grand-child and also spoke with Mrs D's friend, Miss T to try and gain an additional understanding of Mrs D's perspective.

2.5. The review recognises that discussing the circumstances of a loved one's death by a family member, is likely to be a very painful experience. The Chair is grateful to Mrs D's family and her friend Miss T, who all contributed to the review in order that learning may help others. Their contribution greatly aided our understanding of the circumstances surrounding Mrs D's death.

2.6. The Chair wishes to thank the Police family liaison officer for his role in initiating the interviews with the family and for on-going communication with the family during the review. The family were also supported through the National Homicide Service Victim Support.[3]

2.7. The family reviewed the draft report and had the opportunity to make comments and suggested amendments. The family asked for some minor changes for clarity and these were made within the final draft. The family accepted the findings from the review and supported the recommendations made.

2.8. The review was able to access David's account through information from the Police interviews following his arrest and two assessments carried out by Consultant Forensic Psychiatrists during his period on remand. An offer was made to David to meet with the author to contribute to the review but was not taken up by him.

2.8. Mrs D was not in employment in recent years. David had been self-employed and there were no specific colleagues identified to consult with.

2.9. David's mother and father had not lived together and he had had limited contact with his father within the scope period.

- ## Contributors to the Review

2.10

Participating Agencies and Individuals and Context of Involvement

Family and Friends:	**Relationship:**
Mr D	Husband of Mrs D
Mrs D's eldest daughter	Daughter of Mrs D and mother of David
Mrs D's youngest daughter	Daughter of Mrs D and aunt of David
Mrs D's Grand-child	Grand-child of Mrs D and half-sibling of David
Miss T	Friend of Mrs D

[3] **Guidance for domestic homicide review chairs - support for families (June 2019)** https://www.gov.uk/government/publications/guidance-for-domestic-homicide-review-chairs-on-support-for-families/guidance-for-domestic-homicide-review-chairs-support-for-families Accessed July 2019

Agencies requested to produce a full internal management report and chronology	
Agency:	**Nature of Involvement:**
Derbyshire Healthcare NHS Foundation Trust	Provided one episode of mental health care to David
Insight Healthcare	Provided three episodes of mental health care to David
NHS Derby and Derbyshire CCG – (GP's)	Provided Primary Care to Mrs D, Mr D, David and David's Mother.
Agencies requested to produce a summary report	
Agency:	**Nature of Involvement:**
Derbyshire Constabulary	Had some involvement with the family prior to the homicide and the Police force responsible for the homicide investigation
Derbyshire Secondary School (redacted)	School attended by David and his half-sibling
Derbyshire Community Health Services NHS Foundation Trust	Provided some podiatry community healthcare to David
Derbyshire County Council - Adult Social Care	Minimal involvement with Mrs D but no direct contact
Derbyshire Recovery Partnership	Received a referral for David but no direct contact
EMAS	Minimal contact with Mrs D prior to the homicide. Attended the homicide
High Peak Borough Council - Housing	Received housing applications for David's Mother's household and for David.
Agencies that confirmed no/no relevant involvement with Mrs D or David	
Chesterfield Royal Hospital NHS Foundation Trust	Derbyshire Domestic Abuse Support Service
Derbyshire Domestic Abuse Support line	Derbyshire Fire and Rescue Service
Derbyshire, Leicestershire, Nottinghamshire and Rutland Community Rehabilitation Company	Derbyshire County Council – Children's Services
National Probation Service	Pennine Care NHS Foundation Trust
Stockport NHS Foundation Trust	University Hospitals of Derby and Burton NHS Foundation Trust

2.11. Agency reports were based on their records, interviews with relevant staff and having taken account of relevant national and local policies, procedures, standards and wider systems factors that were relevant at the time. The authors of these reports had not had any direct involvement in services provided to Mrs D or David and so were independent.

2.12. The Independent Author/DHR Chair also had access to two psychiatric reports completed whilst David was on remand following his arrest for the homicide. This was an Independent Psychiatric Report from an Independent Consultant Forensic Psychiatrist in April 2019, prepared following instruction by David's legal representatives and an Independent Psychiatric Report from an Independent Consultant Forensic Psychiatrist in July 2019, prepared following instruction by the Crown Prosecution Service

- ## The Review Panel Members

2.13. The DHR Independent Author and Chair was aided by a DHR panel who brought additional expertise and scrutiny to the review. The panel met three times. The panel members had not had any direct involvement in services provided to Mrs D or David. The panel membership is as follows:

Name	Job Title and Organisation
Sylvia Manson	Independent Chair and Author
Christine Flinton & Alison Boyce	Head of Community Safety & Domestic Abuse Manager Derbyshire County Council – Safer Derbyshire
Michelle Grant	Designated Nurse Adult Safeguarding, NHS Derby and Derbyshire CCG
Sharon Dove	Lead Named Nurse for Safeguarding Adults, Derbyshire Community Health Services NHS Foundation Trust
Rosalie Weetman	Public Health Lead for Substance Misuse, Derbyshire County Council – Public Health, Substance Misuse
Zoe-Rodger Fox	Head of Safeguarding, East Midlands Ambulance Service
Dr Munawar	Principal Clinical Lead & Psychologist, Insight Healthcare
David Smith	Community Safety & Enforcement Manager, High Peak Borough Council
DI Steve Shaw	Detective Inspector, Derbyshire Constabulary
Jill Ryalls	Group Manager, Derbyshire County Council – Adult Social Care
Vicki Baxendale	Head of Nursing, Derbyshire Healthcare NHS Foundation Trust
Karen Billyeald	Assistant Director Safeguarding Adults, Derbyshire Healthcare NHS Foundation Trust
Dr Deepak Sirur	Consultant Psychiatrist and Named Doctor for Safeguarding Adults, Derbyshire Healthcare NHS Foundation Trust; Consultant Psychiatrist to Derbyshire Recovery Partnership
Marie Tann	Head of Safeguarding, Chesterfield Royal Hospital NHS Foundation Trust

- ## Author of the Overview Report

2.14. The DHR commissioned a Chair and Author who was entirely independent having no prior personal or professional connection with Safer Derbyshire, any of the agencies or panel members that contributed to the review.

2.15. The review Chair and Independent Author was Sylvia Manson of Sylman Consulting. Sylvia Manson is a registered Social Worker and has many years' experience in Health and Social Care senior management roles, specialising in mental health and safeguarding adults. She has held national roles within the Department of Health leading on NHS Safeguarding Adults policy and currently is a specialist member of the Mental Health Tribunal. Sylvia Manson has significant experience in leading independent statutory reviews.

- ## Parallel Reviews

2.16. At point of commencing the DHR, the Coroner's Inquest had been adjourned. The Coroner did not view the DHR as interfering with any coronial matters and did not object to publication.

2.17. The DHR was commissioned prior to the criminal proceedings relating to David being concluded. The Senior Police Officer on the DHR panel advised on any disclosure issues and liaised with the Senior Investigating Officer throughout to ensure no conflict presented.

2.18 During the period of the review, David pleaded guilty to manslaughter through diminished responsibility. He received a sentence of 15 years 4 month sentence, to serve 10 years 4 months and be on licence for the remaining 5 years.

- ## Equality and Diversity

2.19. The terms of reference include consideration of the Equality Act 2010.

2.20. Mrs D was in her 70's and David was mid 20's at the time of the fatal incident. Both were of white British heritage and of heterosexual orientation. Mrs D had no significant physical or mental health condition, impaired cognition or other disability. David had two toes amputated as a result of a road traffic accident but this did not significantly impair his mobility. He did not have any other known physical health condition but had a history of depression and anxiety.

2.21. Sex was a relevant characteristic given the perpetrator was male and victim female, reflecting the significantly higher incidence of male to female domestic homicide.[4] Research indicates that matricide, though rare is most commonly perpetrated by adult sons.[5] Sex was also a relevant characteristic in the role of carer that Mrs D provided to David.[6] The review also recognised that age is a relevant factor in how adults access information and the need to provide different formats without sole reliance on the internet.

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[4] Home Office Domestic Homicide Reviews: key Findings from Analysis of Domestic Homicide Reviews 2016. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575232/HO-Domestic-Homicide-Review-Analysis-161206.pdf [Accessed June 2020]

[5] Heide KM, Frei A. (2010) '*Matricide: a critique of the literature. Trauma Violence Abuse.*' Jan;11(1):3-17. doi: 10.1177/1524838009349517. Epub 2009 Oct 28. PMID: 19875385. https://pubmed.ncbi.nlm.nih.gov/19875385/

[6] Carers Uk https://www.carersuk.org/news-and-campaigns/features/10-facts-about-women-and-caring-in-the-uk-on-international-women-s-day [Accessed June 2020]

- Dissemination

2.22. The report will be shared with family members and the contributing agencies. Subject to approval by the Home Office, the report will be published on the Safer Derbyshire website.

3. Background Information and Key Episodes

3.1. Family Perspectives

3.1.1. Mrs D's family described her as a very caring person who was always there for her family. It was within this context that David came to live with his grandparents.

3.1.2. David was brought up by his mother. His parents had had a short-term relationship but never lived together and David had limited contact with his father. David and his younger half-sibling (referred to from here on as his sibling) lived with their mother in a house that was next-door to David's grandparents, Mr and Mrs D until David was approximately seventeen years old. The families lived in a small town in rural Derbyshire. Family members described their home area as having limited access to specialist services or facilities for young people.

3.1.3. David's sibling described her brother as a very sweet boy who had '*loved their dog to bits, loved horses and the family rabbits*'. She remembers them going for lots of walks with their grandfather as David '*always loved outdoorsy things.'*

3.1.4. However, David was also a troubled young person. He and his sibling described their childhood as difficult. Alcohol had been a big factor in their household and there was a poor relationship between David and his mother.

3.1.5. David's sibling recalled there were multiple times when arguments would occur between David and his mother. On occasions, David's mother would call the Police due to his behaviour. At times, David would go and stay next door at his grandparents. Mrs D always had a lot of involvement. David's sibling described their grandmother as taking the role of peacekeeper '*Even if we'd fallen out, she would always be there to make it better – baking cakes, making us food. She'd never be sitting down. Just a grandma really*.'

3.1.6. David recalls being bullied in his primary school years. He also referred to himself as being dyslexic. When he reached secondary school, David made friendships that his family referred to as '*being in the wrong crowd'* – young people who used psycho-active substances. David reports that he began using cannabis at age sixteen but this was not to any significant degree. However, his family believe he began using various psycho-active substances from around **2008** when he was age fourteen.

3.1.7. David's use of alcohol and psycho-active substances appeared to have a significant and problematic influence on his life thereafter.

3.1.8. Family recall he regularly was given detentions at school due to his behaviour. His sibling believes school saw David as a disruptive young person but questions whether they tried to

understand the reasons behind his behaviours. David's mother thought his school were aware of his substance misuse. She recalled asking school for advice in managing his behaviour but they could not offer any.[7]

3.1.9. When David was sixteen years old **in 2010**, he moved to live with his grandparents on a more permanent basis. This followed a significant altercation between David and his mother. David's grandfather recalled David had had a big party and that it had been difficult at the time but '*they are family when all is done and we couldn't see him out on the streets.'*

3.1.10. Approximately a year later **in 2011** when David was seventeen, his mother moved away to live with a new partner. Initially neither David nor his grandparents knew where she had gone. David's sibling believes this affected David and that he didn't know how to let his emotions out. His grandfather had bought him a punch bag to help him with this. David remained with his grandparents for the majority of the time thereafter. He had his name on the Housing list but his application was removed two years later as he hadn't responded to the annual review.

3.1.11. David's grandfather, Mr D, recalled a physical altercation between David and himself in **2011**. This arose because David would not get out of bed when asked - this was a common theme as David spent a long time in bed during the day. During the argument David picked up a pool cue and was threatening his grandfather with it. His grandfather took the pool cue away and David left the house. The Police were called and Mr D did not want to pursue the matter. Police recorded the call as a Domestic Incident and completed a DASH form as standard risk i.e. 'current evidence does not indicate likelihood of causing serious harm.'[8]

3.1.12. In **2011**, David had a motorbike accident which resulted in him losing two toes. David received specialist medical treatment and the loss of his toes did not limit his mobility. There are no records to indicate he was helped with the psychological impact from his injuries. He told family the injury did not bother him but his mother and aunt feel he may have minimised the emotional impact of the injury.

3.1.13. In **2012**, David received £36,000 compensation from the motorbike accident. He moved out from his grandparents into rented accommodation. Family describe him as having parties every night. Within 6 months, all his compensation was spent and he had to give up his tenancy - he returned to his grandparents. Housing records from this period note that David had a three-month period living in supported accommodation – it is not clear whether this was the same episode. He appeared to manage this tenancy well and left the property to move to be an outdoor pursuits instructor in Cornwall. However, this job only lasted a short period and he moved back to live with his grandparents.

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[7] It should be noted that this could not be confirmed with the school as they have retained no records regarding David due to record retention policies. Opportunities for early intervention are considered within section 4

[8] A DASH risk assessment tool is a nationally applied Domestic Abuse, Stalking and Harassment and Honour Based Violence (DASH, 2009-16) Risk Identification and Assessment and Management Model. The form in use at that time included an initial risk classification of standard/medium/high risk. Standard risk is defined as 'Current evidence does not indicate likelihood of causing serious harm' https://www.dashriskchecklist.co.uk/wp-content/uploads/2016/09/DASH-2009-2016-with-quick-reference-guidance.pdf

3.1.14. Verbal arguments continued between David and his mother and on two occasions, one in **2013** the other in **2014**, Police were called. DASH forms were completed and assessed as Standard Risk for David's mother.

3.1.15. Around **2014**, David's aunt sought out a service called SPODA, (Supporting Parents Of Drug Abusers). The service worked with David and his grandparents and also with David and his mother, visiting every 2-3 weeks and phoning in between. David's mother recalls this help lasted around 6 months. At first, they found it very helpful. David talked more openly about what substances he had been taking and his mother was able to talk to him more constructively about his substance use. However, as time went on David began missing appointments and not answering the phone.

3.1.16. David's aunt also recalls looking into drug and alcohol rehabilitation services at this time but believed the waiting lists were very long so this was not pursued. (this is considered further in section 4.3).

3.1.17. In **2015** David moved back to live with his mother for a brief period. However, they argued over him paying for board and lodging and smoking cannabis in the house. After one volatile incident, David's mother recalls running out of the house as she felt frightened of him '*he had me on the floor.'* David then '*trashed the house*' His mother phoned the Police who arrested David. She told the Police she was scared to return to the property and was also concerned about David's frame of mind due to his drinking and drug taking.

3.1.18. David was arrested and he admitted criminal damage. His mother did not want to pursue charges so a restorative justice disposal was agreed that David would write a letter of apology, seek his own accommodation and treatment for his anxiety and anger (David was in-fact already seeking help for this). Police recorded a Domestic Incident and submitted DASH risk assessment tool which identified David's mother as a Medium Risk.[9] Police offered her a referral to Crossroads, the local organisation to help people break free from domestic abuse. However, this was declined. David moved back to his grandparents once more.

3.1.19. David had one further period of living away from his grandparents. This was believed to be in **2016** and was described by family as supported accommodation that aimed to help young people to step up to independent living. The service offered accommodation for up to six months with the aim of helping the person secure independent living accommodation afterwards. This was not achieved and so David moved back in with his grandparents.[10]

3.1.20. David had some episodes of employment – the most positive being his period in 2012, working as an outdoor pursuits' instructor. His family believe he did not use drugs during this time but sadly this employment was short lived. Subsequently David had various jobs, usually self-employed in casual labour. David's grandfather recalled he got good feedback for his work '*people would tell me he was a good grafter*' but unfortunately, these too were short-lived.

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[9] DASH risk assessment tool medium risk 'there are identifiable indicators of risk of serious harm. The offender has the potential to cause serious harm but is unlikely to do so unless there is a change in circumstances'

[10] Family could not recollect specific dates or the name of the Housing provider. It has not proved possible to locate the provider of this accommodation to gather further information from them.

3.1.21. Throughout this time, all family members confirm David always had a good relationship with his grandparents. His grandfather was described as stricter about his behaviour. He would '*get stroppy*' with David as he was always disappearing off, coming in late and not eating the food his grandmother had made for him. David's mother described Mrs D as very soft on him '*spoiling him really.*' David was particularly close to his grandmother and the family believed she was the last person that he would wish to hurt. Although at times he was described as behaving badly and was argumentative, there was never any violence between them and he would always apologise to her after an argument.

3.1.22. Mr D described his wife taking a very caring and nursing role with David. Mrs D was very protective of everyone involved for example; it was only after her death that Mr D found out his wife had washed David's sheets everyday day due to his lifelong nocturnal enuresis. She wanted to protect David's feelings and her husband's worries as he had high blood pressure.

3.1.23. Mrs D did confide in her close friend Miss T who she met each week. Mrs D had in the past also turned to her youngest daughter (David's aunt) for support and advice but stopped doing this when this daughter had family difficulties of her own, saying '*she had enough on her plate.*'

3.1.24. Mrs D's family and friend paint a picture of Mrs D supporting and protecting all family members without thinking about asking for help in doing this or considering her own needs. As David's sibling stated, '*there is nothing my grandparents didn't try.*' Although Mrs D was protective of David, his mother believes Mrs D would have told her if she had ever felt at risk from him.

3.1.25. David's sibling felt that as he got older, he became much more of a closed book and stopped talking about his feelings. His mother and aunt referred to him having bouts of depression. It was not clear what brought these episodes on. They thought he went to the GP about this and questioned what treatment Doctors gave him. However, they also acknowledged that David didn't help himself as he didn't turn up for appointments.

3.2 Agency Involvement from 2015

3.2.1. During this period David did try to seek help for himself. **In July 2015** he self-referred to Insight Healthcare, disclosing thoughts of self-harm. David described feeling everything had got on top of him. He had had previous thoughts of '*jumping off something*' but no plans to do this. He identified his grandmother as a protective factor.

3.2.2. David was offered an appointment in **August 2015** but he did not attend. The Insight Healthcare practitioner tried to phone him but was not successful. They sent David a letter requesting he arrange another appointment but as no contact was made, the service discharged him.

3.2.3. **In Sept 15,** David attended his GP and was referred to Insight Healthcare due to his recurrent low mood and long-standing concerns regarding relationships.

3.2.4. David was contacted by Insight Healthcare and was seen in **November 2015**. David reported his main problem was recently becoming homeless. This followed the incident described in 3.1.17

above of being arrested for criminal damage to his mother's house. David discussed his anxiety and depression and that he wanted therapy to help understand angry outbursts, reduce low confidence and negative thoughts. David was diagnosed as having mixed anxiety and depressive disorder. The practitioner made an appointment for David with the Council housing team although there is no record of his attendance.

3.2.5. David was also offered a series of weekly Cognitive Behavioural Therapy (CBT) sessions, throughout **Nov 2015 – Jan 2016**. He attended six out of the seven sessions offered; one being missed due to illness. Throughout all CBT sessions there were no risks to himself or others reported.

3.2.6. **Jan 2016**: When the CBT course was completed, David was discharged from Insight Healthcare. The CBT appeared to achieve a positive outcome. He reported feeling more in control of his anger and had reduced his drinking. He had no suicidal ideation and no thoughts of harming others.

3.2.7. However, later that month David phoned his GP. He had been researching on the internet and was worried that he may have a borderline personality disorder or bi-polar disorder and thought he needed to be back on anti-depressants which it appears he had stopped taking without being medically advised. (David had first been prescribed the anti-depressant Sertraline in July 2015)

3.2.8. His GP saw him two weeks later in **Feb 2016**. David thought the counselling he had received had helped but felt worse since stopping his anti-depressant, sertraline.[11] David expressed feeling low and having difficulties in relationships with friends and his mother. He thought life was not worth it but did not have any suicidal ideation or intent. David named his grandmother, Mrs D, as a protective factor. The records noted that David felt paranoid around people, used cannabis occasionally to help him sleep and often spent all of his wages in one go.

3.2.9. The GPs assessment was that David was clearly suffering with depression and anxiety. The GP noted there was no evidence of delusions, psychosis or grandeur but noted the possibility of an underlying personality disorder/bipolar disorder. David was advised to stop cannabis use and reduce alcohol intake. He was also encouraged to restart his anti-depressant and was given self-help websites to work through. The GP planned to review David's progress in 2-4 weeks and refer to Community Mental Health Team if he was not progressing.

3.2.10. David was seen again by his GP for a planned appointment 2 weeks later. He had been taking his medication and was feeling better though still felt he had 'hyper episodes.' He did not have any suicidal thoughts and there was no evidence of delusions, psychosis, or mania. David's sleep had improved and he had cut down on alcohol and cannabis. He was much more positive – thinking about doing some training courses and had aspirations to make some money and have a family.

[11] **Sertraline** is a type of antidepressant known as a selective serotonin reuptake inhibitor (SSRI). It's often used to treat depression, and also sometimes panic attacks, obsessive compulsive disorder (OCD) and post-traumatic stress disorder (PTSD). https://www.nhs.uk/medicines/sertraline/ Accessed July 2019

3.2.11. David was advised to continue his medication, contact Insight Healthcare for therapy and the Citizens Advice Bureau to explore funding for college/courses he wanted to do. The plan was to review David's progress in 1-2 months or earlier if he felt worse. The GP diarised a medication review for 6 months' time and allocated a named accountable GP.

3.2.12. Five weeks later in **March 2016**, David phoned the GP practice and spoke with an Advanced Nurse Practitioner. He reported he had started a course of CBT but had been having anxiety attacks and was asking if he could increase the sertraline. He did not have any suicidal ideas and thought he was '*doing ok'* and did not need an urgent appointment. His sertraline was increased from 50mg to 100mg and he was advised he could see any GP sooner if unwell, or the Practice's lead mental health GP in two weeks.

3.2.13. David phoned again in **May 2016** and spoke with the Advanced Nurse Practitioner. It seems he was living in his own tenancy at that time. He had lost his job, lost motivation and felt stressed about the mess his house was in. He had not followed through with his appointment in March with the Practice lead mental health GP and was advised to set an alarm to remind him of his appointment.

3.2.14. Two days later, David was seen by a GP due to suicidal ideation. They discussed his background and current circumstance and his alcohol and cannabis use. The GP assessed he had severe depression, possibly compounded by alcohol and cannabis which was being used as a coping strategy rather than addressing the route of the problem. David had no plans of suicide.

3.2.15. The GP noted problems with home life and lack of social support '*although does have protective factors these are frail elderly grandparents*.'[12] David agreed to be referred to the crisis team and advised to contact his GP or Emergency Dept if he was not able to keep himself safe over the weekend.

3.2.16. The Crisis team contacted David the same day by phone and then had two face-to face contacts including an assessment with the team's Consultant Psychiatrist**.** Their assessment was that his primary problem was drug use and alcohol. The plan was to continue with his anti-depressant and David was advised to contact drug and alcohol services and Talking Mental Health – psychological therapy service. He was discharged from their service.

3.2.17. During this same period (**May 2016)**, Mrs D had a fall having lost her footing whilst out in her garden. She was conveyed to hospital. David's mother recalled he was very concerned about her injury. Mrs D's family supported her on discharge.

3.2.18. In **June 2016**, David drove a car into a wall and then abandoned it. He had consumed a lot of alcohol before the Police interviewed and charged him. He was subsequently convicted of Driving without Due Care & Attention.

3.2.19. In **July 2016** David's GP followed him up with a phone call. David reported he had had some ups and downs. He was occupied with his grandmother's recent hip operation. He was also coping with the death of a friend but described himself as managing.

[12] Note – this is a direct quote from the clinical records. Mr D expressed surprise that they had been referred to as frail as he describes himself as very fit and able

3.2.20. David next saw his GP in **March 2017**. He described his mood as better though still had anxiety. He had changed jobs. He had weaned down his anti-depressant as he felt better. He had used cocaine recently and smoked cannabis most nights. His alcohol consumption at this time was sixty-three units a week. The GP spent time talking to David about his drug and alcohol use as being the likely cause of his problems and advised about cutting down. David wanted to try and address this himself so they agreed his progress was to be reviewed in 1-2 months unless there were changes or concerns. David did not make the follow-up appointment however.

3.3. The Year Preceding Mrs D's Death

3.3.1. David's mother thought that in the months preceding the homicide, David's mood had been variable. He had had some work and though he was thought to still be using cannabis, this was intermittent use rather than daily.

3.3.2. David's family recalled an incident in **May 2018,** when David had an episode of very strange behaviour. He had gone missing and rang his grandparents to say he was in the West Country and that his car had broken down, he had no money and had walked some twenty miles. His grandparents paid for him to stay in a local hotel and then drove to collect him the following day. When they found his car, it was not broken down. It contained two bottles of spirits and a bottle of methadone, David's phone and large sums of money.

3.3.3. David was described by his Mother as being very paranoid at the time. He believed the Masons were after him as was a friend of his uncle's and if he didn't join the Mason's they would kill him. He referred to demons talking to him. He insisted his family couldn't say anything as '*If you tell anyone, they'll get me*.'

3.3.4. David was due to follow his grandfather in convoy back home but on route, he disappeared. He was missing for a few days living rough before returning to his grandparent's house. David's mother had phoned the Police, worried about him and then phoned back to report his return. Police signposted her to the Samaritans and to agencies that could offer support with drug use. Police also advised her to take David to see his GP.

3.3.5. Three weeks later, in **May 2018**, David attended his GP. He was presenting with acute onset of anxiety and low mood.

3.3.6. David told the GP he had lost his job and that he was homeless (although he was living with his Grandparents). The GP identified that he was very anxious but not feeling suicidal. He had good insight into his problems which related to money and security of accommodation. His GP prescribed him citalopram[13] with the plan to review this in 2 weeks. David was referred to a podiatry clinic and also consented to be re-referred to Insight Healthcare due to his acute anxiety.

[13] Citalopram is a type of antidepressant known as a selective serotonin reuptake inhibitor (SSRI). It's often used to treat depression and also sometimes for panic attacks. Citalopram helps many people recover from depression, and has fewer unwanted side effects than older antidepressants. https://www.nhs.uk/medicines/sertraline/ Accessed July 2019

3.3.7. In the phone call by Insight Healthcare to follow up the referral, David indicated he may be a risk to himself. A practitioner made extensive attempts to contact him. When they spoke to him the following day, David confirmed he had some thoughts of suicide but no specific plans. He again identified his grandparents as a protective factor. There were no risks to or from others identified. At this stage, David was consuming nearly fifty units of alcohol per week. They agreed a safety plan and to arrange counselling sessions.

3.3.8. David had a follow up appointment with his GP two weeks later in **June 2018**. He had stopped taking the citalopram due to side effects and was waiting his first appointment with Insight Healthcare. He had good eye contact, was well presented and was now self-employed.

3.3.9. Insight Healthcare attempted to contact David to arrange the counselling appointments. Two weeks later, David responded and an appointment was made however, David did not attend. Insight Healthcare contacted him to arrange a further appointment which he attended the following week (**July 2018)**. David discussed his history and inter-personal feelings around his lack of self-worth. He completed a patient health questionnaire (PHQ-9)[14] that indicated over the last two weeks, on most days he had thoughts that he would be better off dead, or had thoughts of hurting himself in some way.

3.3.10. David was out of work and was anxious about the stability of living with his grandparents. He discussed heavy use of alcohol with his friends but said he did not take drugs. This was an early morning appointment and the Counsellor noted that David smelt strongly of drink. David agreed to a referral to Derbyshire Recovery Partnership - Alcohol Service and this was made on the same day.

3.3.11. Derbyshire Recovery Partnership contacted David on the same day and offered David an appointment ten days later. David did not attend and was discharged.

3.3.12. David also missed his next appointment with Insight Healthcare and was discharged. In **August 2018**, the GP was sent a discharge summary from Insight Healthcare, noting that David had suicidal thoughts but no intent and a risk management plan had been agreed with him.

3.3.13. This was the last contact that David had with agencies in the months leading up to the homicide.

3.3.14. David's mother recalled that during this period, there were occasions when David would appear scared of lots of things and make odd statements. She recalled an occasion David visited her at her house. David was again very preoccupied with the fears about the Masons and his cousin's involvement with them. She wasn't sure if he was under the influence of drugs or alcohol at the time.

3.3.15. David's mother also recalled that in the weeks leading up to the homicide there was an occasion when she had gone to her parent's house to clean David's bedroom and found he had sprinkled

[14] NHS (2018) The Improving Access to Psychological Therapies Manual Appendices and helpful resources https://www.england.nhs.uk/wp-content/uploads/2018/06/iapt-manual-resources-v2.pdf

salt across his bedroom door threshold and across his window ledge as he was apparently scared of demons. David's mother believes her mother, Mrs D was also aware of this behaviour. No other family members or professionals were aware of this.

3.3.16. David's mother reflected that though David had periods of odd behaviours, there were also weeks when David would be his usual self. Consequently, she was not too concerned about him. In the week before the homicide, she spent time with David on two occasions and had no concerns about him.

3.3.17. Mrs D however was concerned about David. About a fortnight before the homicide, Mrs D had talked to her friend Miss T about being worried regarding David. She said that David believed he was being followed, was hearing voices and thought people were out to get him. Mrs D told Miss T that she needed to get David back to clinic and told her that he had missed appointments. Miss T presumed that Mrs D was referring to David attending clinics at that time although it is now recognised that this was likely to be referring to his involvement with Insight Healthcare or Derbyshire Recovery Partnership some seven months earlier.

3.3.18. In the days immediately before her death, Mr D recalled that he and his wife had told David that he couldn't continue to live with them. He was not paying anything for board and lodgings and '*he was making us ill and we decided he had to go*.' Mrs D's daughters believe she had been talking to someone about alternative accommodation for him but no further details are known and Housing have no records of this.

3.3.19. David's mother recalled that a few days before the fatal incident, David had drunk a whole bottle of brandy that belonged to his grandfather. After this, his grandparents removed the alcohol and hid it in their bedroom. It was thought that David had no money to buy alcohol or drugs.

3.3.20. In **Feb 2019,** the day before the homicide, David and his grandmother went to the local town to try and sell his X-Box as he didn't have any money – this was unsuccessful. That afternoon David texted his sibling a message '*is there something wrong with Grandma*?' This was the first contact that David's sibling had had with him for two years. She rang him and described him as behaving very oddly saying '*Grandma is a witch. People keep saying she's done something wrong and she's a bad person.*'

3.3.21. David's sibling thought he was joking about in the same way as he had about random things when they were younger. She ended the call but then rang him back. He was very different and made no further references to their grandmother being a witch. They were on the phone for about two hours talking through lots of issues about his past life and the problems he now had including feeling very down. His sibling encouraged him to seek help from his GP to which he responded that he had in the past but it was no good. His sibling also encouraged him to move closer to her area so he could find work.

3.3.22. David told her he wasn't taking any drugs and hadn't been for some months although his sibling was not convinced of this. When David's sibling asked about their grandparents, David just said they were fine. David's sibling was left with the happy impression that their conversation was a great breakthrough for their relationship as David had begun to open up to her.

3.3.23. Later that day David said he did not want his tea as he thought his grandmother was trying to poison him.

3.3.24. In the early hours, Mr D was woken up by his dog yelping. Mr D saw David killing his dog – he shouted and hit David but was pushed out of the way. David went into his grandmother's bedroom. When Mr D got to the bedroom, David was stabbing Mrs D saying "*She's a witch, she's a witch.*" Mr D phoned 999 and commenced cardio-vascular resuscitation on his wife.

3.3.25. David then walked back downstairs and poured himself some wine. When a Police Officer arrived, and asked David what had happened, his response was '*I've killed my dog and my grandma*"

3.3.26. Police and, on their arrival, ambulance crew, continued to try and revive Mrs D. Very sadly, despite these efforts, she could not be resuscitated, and the paramedic pronounced her as life extinct.

3.3.27. David was charged and remanded with the murder of his grandmother and criminal damage against his grandfather's dog. During the Police interviews David admitted he had intended to kill his grandmother and their dog. David described that things '*had been weird lately*'. He believed his grandmother had said she wanted to hurt him and also hurt his grandad. He said that he loved his grandad and didn't want his grandad to get hurt. David explained that his grandmother wasn't his grandmother and believed she was someone else. A search by the Police of David's room found a number of knives and crossbow. David said he had not bought these with any intent to harm anyone.

3.3.28. The day after the incident**,** David was remanded to prison. During the period of remand, David was assessed by two Independent Consultant Forensic Psychiatrists who presented their findings regarding the state of his mental health and the impact of his mental health in relation to the homicide.

3.3.29. At his trial, David pleaded guilty to manslaughter through diminished responsibility. He received a sentence of 15 years 4 month sentence, to serve 10 years 4 months and be on licence for the remaining 5 years.

4. Analysis

The following section provides analysis of the events. The analysis and learning are grouped under three themes:

- David's mental health at time of the homicide
- Opportunities for Early Help
- Opportunities for Intervention by Agencies

4.1. David's Mental Health at the time of the Homicide

4.1.1. The expert opinion of forensic Consultant Psychiatrists[15]was that David was experiencing a serious psychotic illness in the form of a persistent delusional disorder when he killed his grandmother and that this was the explanation for the homicide. His reasoning was distorted due to his mental disorder. He was aware of what he intended to do and felt justified as he believed the person was not his grandmother, but a witch.

4.1.2. David's account during the psychiatric assessments indicated that he had experienced delusionary thoughts regarding his grandmother for some time prior to the homicide. David reported feeling overwhelmed and apprehensive every night and had barricaded his bedroom door to try and prevent her entering. He came to believe that killing his grandmother was the only way in which to protect himself and his family from being harmed by her.

4.1.3. Both Consultant Forensic Psychiatrists concluded that David had been mentally unwell prior to the offence, at point of the offence and since conviction. At the time of the second psychiatric assessment in July 2019, David maintained his persistent delusional beliefs regarding Mrs D.

4.1.4. David was known to historically have used various psycho-active substances, the side effects of which can include feelings of confusion, anxiety and paranoia, agitation, aggressive behaviour, delusions and hallucinations. [16]

4.1.5. At the time of the review, there was not any psychiatric opinion as to what degree, if any, his use of alcohol and substances was likely to have had on his mental disorder e.g. whether his beliefs were due to the acute pharmacological effects of substance or whether he was suffering from a drug induced psychotic state which may have given rise to an underlying mental illness.[17]

4.1.6. What is clear from the agency reports, interviews with family members and Mrs D's friend, is that prior to the homicide, no-one had identified that David presented a risk to his grandmother or that his mental health difficulties may lead to him harming anyone. Family commented on how much David and his grandmother had loved each other. The concerns that were held, were of risk to David from self-harm or suicide.

4.1.7. David's mental disorder appears to be the primary factor that led to him killing his Grandmother. The following sections consider possible contributory factors and whether there were opportunities to intervene to reduce risk of harms arising and potentially alter the sad chain of events.

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[15] Two independent Psychiatric Reports commissioned for Court hearing 2019
[16] NHS: Cannabis the Facts https://www.nhs.uk/live-well/healthy-body/cannabis-the-facts/
Mephedrone, https://www.talktofrank.com/drug/mephedrone#the-risks ; NHS UK
https://www.nhs.uk/conditions/anabolic-steroid-misuse/
[17] World Health Organisation Mental and behavioural disorders due to psychoactive substance use (F10-F19) https://apps.who.int/classifications/apps/icd/icd10online2003/fr-icd.htm?gf10.htm+

4.2. Opportunities for Early Help

4.2.1. David's background history indicates a number of adverse childhood events. There is a substantial body of research[18] regarding the long-term effect that adverse childhood events have on physical and mental health problems in adulthood. David discussed his troubled childhood as being at the root of his anxiety and depression and his difficulty in emotional and social functioning. Throughout his life, his grandparents appeared to be a strong protective factor providing a source of stability and security.

4.2.2. Research also indicates that young people make an active choice to use alcohol and substances. There are multiple functions that young people may look for when using substances, for example, to help socialise and to enhance activity. Alleviating depressed mood was the reason a high proportion (86.8%) of young people gave.[19]

4.2.3. It seems that David began using alcohol and psycho-active substances from around fourteen years old. This began within a peer group and developed into a coping strategy - sadly, it had the opposite effect. Research found that daily cannabis use was associated with increased odds of psychotic disorder compared with never users, increasing to nearly five-times increased odds for daily use of high-potency types of cannabis.[20] The study highlighted that '*In the context of the well reviewed epidemiological and biological evidence of a causal link between heavy cannabis use and psychotic disorders, our findings have substantial implications for mental health services and public health. Education is needed to inform the public about the mental health hazards of regular use of high-potency cannabis, which is becoming increasingly available worldwide*.'

4.2.4. The Department of Health mental health strategy, Future in Mind,[21] recognised that too often children and young people's mental health and emotional wellbeing was not being given the attention it needed.

4.2.5. During David's school years, Child and Adolescent Mental Health services were delivered through a four- tier strategy; tier one being for less severe problems with services provided by non-mental health specialists such as GPs, school nurses, teachers and voluntary agencies.

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[18] The Lancet, Public Health (2017) The effect of multiple adverse childhood experiences on health: a systematic review and meta-analysis https://www.thelancet.com/journals/lanpub/article/PIIS2468-2667(17)30118-4/fulltext

[19] Understanding reasons for drug use amongst young people: a functional perspective *Health Education Research*, Volume 16, Issue 4, August 2001, Pages 457–469, https://academic.oup.com/her/article/16/4/457/558793 Accessed July 2019

[20] Di Forti M et al, (2019) *The contribution of cannabis use to variation in the incidence of psychotic disorder across Europe (EU-GEI): a multicentre case-control* The Lancet Volume 6, Issue 5, P427-436, MAY 01, https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(19)30048-3/fulltext

[21] Department of Health (2015) Future in mind Promoting, protecting and improving our children and young people's mental health and wellbeing https://webarchive.nationalarchives.gov.uk/20170422110702/https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/414024/Childrens_Mental_Health.pdf Accessed July 2019

4.2.6. David's GP did refer him to the GP Practice counsellor when he was 17 years old and then onto a College Counsellor which appeared to be some help to him.

4.2.7. In his earlier adolescent years, it would have been a reasonable expectation for schools to be vigilant for concerns such as bullying, dyslexia and indications of alcohol and substance abuse. Schools should have been well versed in looking beyond disruptive behaviours to identify reasons for the behaviours - providing welfare support to the young person and their family and signposting to more specialist agencies where necessary.

4.2.8. It has not been possible to identify what help if any David was provided with in these earlier years. There are no records of any intervention from child health. The fact that his secondary school did not retain records indicates the school did not have any child protection concerns and that David had no special educational needs plan. David's mother's recollection was that she had approached David's secondary school for help but they were unable to give her any advice.

4.2.9. Mrs D's family feel that early intervention may have helped David's mental wellbeing and reduced the likelihood of David's problematic use of substances and alcohol. However, it is conjecture as to whether this would have sufficiently altered the course of events and prevented Mrs D's homicide. Nonetheless, addressing young people's mental health is rightly recognised as a priority area to improve wellbeing and reducing the likelihood of long-term mental health problems and associated risks.

4.2.10. NHS England's Long Term Plan includes priorities for expanding Children and Young People's Mental Health Services (CYPMHS) over the next 10 years.[22]

4.2.11. Derbyshire County Council and the Office of the Police and Crime Commissioner has commissioned a 16-25-year-old outreach service. The service was commissioned in response to requirements for a specific harm reduction-based service which tackles changing drug trends and drinking cultures amongst 16 to 25-year-olds across Derbyshire. The service targets specific areas such as the night-time economy, festivals, further and higher education, and specialist community outreach.[23] This community-based initiative is likely to have a positive impact on some of the challenges for young people in rural environments such as the area David grew up in.

4.3 Opportunities for Intervention by Services

• Intervention with David

4.3.1. Early intervention is a key enabler to prevent further deterioration of mental health problems. The chronology of David's involvement with health services from 2015 indicates that he had some insight into his difficulties. Though he struggled to try and address his problems, he did have positive periods of engaging in treatment. It appeared to services that David could be

[22] NHS Long Term Plan (2019) https://www.longtermplan.nhs.uk/wp-content/uploads/2019/01/nhs-long-term-plan-june-2019.pdf
[23] https://www.changegrowlive.org/young-people/1625-outreach

proactive in seeking out help, for example making appointments with his GP and with Insight Healthcare. However, information from Miss T, Mrs D's friend indicates Mrs D may well have taken an active role in prompting David to seek help and ensuring he attended appointments.

4.3.2. David's main coping strategy seemed to be the use of alcohol and substances although sadly, as noted it had the adverse effect. It appears to have negatively impacted on his mood and core social structures including relationships, finance, housing and employment. It also led him to have a somewhat chaotic lifestyle including missing many appointments with the services that could have supported him.

4.3.3. Despite David's presenting mental health difficulties, there was nothing to indicate that David lacked mental capacity to make decisions for himself. Nor was there any reason to consider that he may need compulsory intervention under the Mental Health Act 1983 (revised 2007). There was therefore no legal basis to provide David treatment without his consent. There was also nothing to suggest David's presentation met the criteria for Derbyshire's Vulnerable Adult Risk Management[24] so there was no multi-agency assessment of need.

4.3.4. A question for the review was whether the agencies involved took reasonable steps to try and engage David in treatment and provide appropriate responses.

- **Police**

4.3.5. The Police had agreed with David that he should seek treatment as part of a Restorative Justice response to the domestic incident between David and his mother in 2015.[25] David had in-fact already approached his GP for help prior to this incident. However, the Restorative Justice response is likely to have been a useful intervention by the Police and may have helped David to sustain engagement in the CBT treatment that followed.

4.3.6. A further incident when Police prompted treatment for David was in their response to David's mother in May 2018, when David went missing. This was responded to appropriately as a concern for safety and followed through with signposting to the Samaritans, drug services and advice to take David to his GP.

- **GP Practice**

4.3.7. The majority of David's involvement was with his GP. Nine out of ten adults with mental health problems are supported in Primary Care settings.[26] David had periods of suicidal ideation and

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[24] **Vulnerable Adult Risk Management (VARM)** process was implemented in 2013. The Derbyshire Safeguarding Adults Board agreed the need for a process to manage risks which may arise within specific circumstances when working with adults deemed to have capacity to make decisions for themselves, but who are at risk of serious harm or death through self-neglect (Care Act 2014), risk taking behaviour / chaotic lifestyles or refusal of services
https://www.derbyshiresab.org.uk/professionals/vulnerable-adult-risk-management.aspx

[25] Restorative Justice is no longer in use by Derbyshire Police Force for partners/ex-partners but may be used for domestic abuse matters involving 'non intimate partners' (e.g. mother & son) if approved by an officer of the rank of inspector.

[26] NHS England The Five Year Forward View for Mental Health (2016)
https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf

expressing feelings of anger. Research examining the relationship between homicide-suicide[27] highlighted that mental disorder, particularly depression is common. The research referenced '*The key factor associated with homicide–suicides is the individual's lack of resilience and inability to cope with stressful events, evidenced by their reaction to previous similar experiences, either responding violently towards themselves or other people. Despite this recorded history of high risk behaviour and emotional instability these factors were not commonly explored by GPs through routine enquiry. Previous research has highlighted a reluctance to discuss emotional problems with patients in fear of opening 'Pandora's box'. However, such discussions are necessary to differentiate between emotional distress and a diagnosis of mental disorder requiring referral to specialist mental health services*.'

4.3.8. The study concluded that though GPs could not reasonably be expected to prevent homicide–suicide directly, they could reduce risk generally, via the treatment of depression and recognising the risks associated with domestic violence. This highlights the importance of GPs opening up discussions regarding emotional problems; using professional curiosity to understand the person's circumstances, levels of resilience and risk factors, including risks to others.

Recommendation Arising

4.3.9. The National Institute for Health and Care Excellence, provides guidance for identifying and assessing mental disorders and sets out quality standards for treatment. There was good evidence within the records that the GP Practice worked through this assessment process and met national guidance e.g. NICE quality standards for anxiety management.[28]

Assessment:	The GP assessed David's anxiety and depressions and judged the severity of symptoms and degree of functional impairment. There was evidence of the GP listening to David's concerns about his mental health and assessing for the presence of any psychotic symptoms. On every occasion the risk of self-harm and suicide and risk to others was assessed. There were appropriate responses to David's disclosures of thoughts of self-harm and suicide. At no point was there any risk to others identified.
Psychological Intervention:	David was offered evidence-based psychological interventions through referral to Insight Healthcare -a provider of psychological therapy.
Pharmacological treatment:	David was prescribed anti-depressants with diarised medication reviews.
Monitoring treatment response:	The GP Practice considered and recorded David's response to treatment and scheduled review appointments. They emphasised the need for David to seek earlier help should his condition deteriorate and considered whether there was a need to refer on to specialist mental health services.

[27] Social Psychiatry and Psychiatric Epidemiology. 2016; 51: 877–884. Published online 2016 Apr 16. doi: 10.1007/s00127-016-1209-4
[28] National Institute for Health and Care Excellence: Quality Standard Anxiety (2014) https://www.nice.org.uk/guidance/qs53 Accessed August 2019

4.3.10. Overall, there was evidence of good practice in the interventions by the GP Practice. The records indicate the GP Practice tried to engage David in his care and were responsive to him including offering him appointments with the GP Practice lead GP for mental health. Unfortunately, David did not always make follow up appointments.

4.3.11. David's GPs also provided a holistic response – alongside medication and psychology, the GP provided him with self-help websites and talked through his social stress factors such as finance, employment and housing matters. The NHS has recently announced plans to extend the use of Social Prescribing Link Workers within Primary Care as part of developing personalised care responses and addressing wider social needs.[29] This is likely to have a positive effect in supporting the mental health of people in similar circumstances such as David's.

4.3.12. David's presentation was very variable. There were periods when he felt more positive followed by periods of feeling low, hopeless and at times having suicidal thoughts. There was a need for the GP Practice to consider the longitudinal picture of his presentation and risks. The GP Practice identified a nominated GP to provide some consistency in his care and David was seen the majority of time by the same GP. This was good practice.

4.3.13. The GP Practice also referred appropriately onto other services such as Insight Healthcare and Derbyshire Healthcare NHS Foundation Trust mental health crisis team.

4.3.14. The records from March 2017 note his GP discussing David's alcohol and substance use with him. The GP accepted David's preferred option of cutting down alcohol and substance use on his own so the plan was to review in 1-2 months' time. David did not follow up this appointment and by the time he did make a further appointment ten months later, there is no indication that his drug and alcohol use was discussed. David saw a different GP at that time and the discussion focused on his presenting anxiety and depression. Given the negative impact alcohol and substances was having, this should have featured more specifically in his treatment plan to be considered at each attendance. It is good practice that for every contact where substance or alcohol misuse is known historically, that brief motivational approaches based around harm minimisation are used to revisit the subject in a non-judgemental way. This is a learning point for the GP Practice to consider in their future management of patients with problematic drug and alcohol use.

4.3.15. In the event, this did not affect the outcome as a referral was made by Insight Healthcare to the Derbyshire Recovery Partnership. However, David did not attend.

4.3.16. The review also considered whether there were any missed opportunities by the GP Practice to identify symptoms of psychosis such as hallucinations and delusional thoughts including paranoid beliefs. Problematic substance or alcohol use should not preclude referral to mental health services where psychotic symptoms present. Reviews need to be mindful of avoiding hindsight bias i.e. where past events seem to be more prominent than they appeared at the time and where judgements are made on an outcome which could not have been foreseen.

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[29] NHS (2019) Personalised Care Social prescribing link workers: Reference guide for primary care networks https://www.england.nhs.uk/personalisedcare/social-prescribing/ Accessed August 2019

4.3.17. In February 2016, David had discussed with his GP worries of having a borderline personality disorder or bipolar illness. The records indicate the GP explored this with him, establishing David had some feelings of paranoia around people but was using cannabis (which may have given rise to these symptoms). David was also using alcohol and had stopped his anti-depressants. The GP's response to his presentation was appropriate. The GP recorded the potential for an underlying personality disorder/bipolar disorder and gave advice about stopping cannabis use and reducing alcohol intake. The plan was to review David's progress on medication with the potential to refer on for further assessment by specialist mental health services. David was followed up a fortnight later and appeared improved having taken anti-depressants and reduced his alcohol intake so no referral to specialist services was made.

4.3.18. Three months later, David attended the GP again having taken a downturn in his mental health. He had low mood and ideas of suicide. The GP also noted that he had been hearing voices talking about him. This was followed through appropriately through a referral to specialist mental health services – the crisis team.

4.3.19. David's last contact with his GP Practice was nine months prior to the homicide. In May 2018, David was seen by a GP at his Practice. This visit followed the episode three weeks earlier where David had gone missing and family described him as very paranoid with beliefs that the Masons were threatening his life. There is no evidence that the GP was aware of this information or that David disclosed any disordered thoughts during the consultation with his GP. David presented with acute anxiety and low mood. The response by the GP to prescribe an anti-depressant and refer him back to Insight Healthcare was appropriate given this presentation.

4.3.20. Had the GP been aware of his episodes of disordered thinking, this may have led the GP Practice to consider whether his anxiety may be ancillary to or a consequence of his disordered thoughts and persecutory beliefs and refer David onto the Community Mental Health Team or to the Derbyshire Early Intervention in Psychosis Service.[30]

4.3.21. It is important for Health and Social Care agencies to be accessible to family carers and to give clear messages about the benefits of carers assisting with assessments and plans. The management of confidential information can be misconstrued by members of the public. Although there are rightly restrictions on sharing confidential patient information, the GP would have been able to receive information from family members without disclosing any of David's confidential information. Information may also be shared with the patient's consent as well as disclosures made under certain circumstances. Involvement and information for carers/family members is considered further in the following section 4.3.39.

Recommendation Arising

[30] Derbyshire Healthcare NHS Trust Derbyshire Early Intervention in Psychosis Service https://www.derbyshirehealthcareft.nhs.uk/application/files/1215/5359/2704/early-intervention-psychosis-leaflet.pdf Accessed August 2019

- **Insight Healthcare**

4.3.22 Insight Healthcare appeared to engage David well. The CBT sessions that were offered in 2015/16 are an evidence-based treatment for anxiety and depression[31] and David appeared to respond well following the six sessions he attended. During these six sessions, the therapist did not identify any psychotic symptoms.

4.3.23. There is also evidence of Insight Healthcare taking reasonable steps to follow up David's non-attendance. In 2015, this was through a follow up phone call and then a letter. In 2018, the service repeatedly tried to contact David to check his safety and to arrange appointments with him. When David missed his first appointment, the service followed up to rearrange. Having attended an appointment, he again missed a further appointment and so the service discharged him.

4.3.24. The review considered whether reasonable efforts were made prior to discharging David in 2018, given that on his Patient Health Questionnaire he had indicated some thoughts of suicide although no plan. The service confirmed that their Did Not Attend policy is flexible according to presenting need and risk. The decision for discharge was based on the view that David may have needed to address his alcohol use before he was able and ready to commit to counselling. David had agreed a referral to Derbyshire Recovery Partnership and had a risk management plan in place. The risk assessment gave no indication of any risk to others and there is no indication that David was disclosing or exhibiting any symptoms of psychosis. Given these circumstances, the decision to discharge David following his non-attendance was reasonable.

4.3.25. Throughout their engagement, there was good communication between Insight Healthcare and David's GP.

- **Derbyshire Healthcare NHS Foundation Trust - Crisis Home Treatment Team**

4.3.26. The crisis team had only one episode of involvement with David. This was in 2016 for a five-day period. The team were responsive, contacting David to make an initial assessment on the same day as receiving the referral from his GP.

4.3.27. The records indicate extensive efforts to try to make further contact with him. He was seen face-to-face on two occasions. One of these occasions was an assessment by the team Consultant Psychiatrist. This appeared to be a comprehensive assessment that explored David's current symptoms and risk factors. It considered David's background and social circumstances including his relationships. The assessment also reviewed his use of psycho-active substances, alcohol and his prescribed anti-depressants along with interventions that had helped him in the past. There was no identification of psychosis and no concerns of any risk to others or plans for self-harm. The agreed plan was:

1. David to contact Talking Mental Health Derbyshire to help his depression – contact number was provided
2. David to ring Derbyshire Substance Misuse – contact number was provided

[31] Royal College Psychiatry Cognitive Behavioural Therapy https://www.rcpsych.ac.uk/mental-health/treatments-and-wellbeing/cognitive-behavioural-therapy-(cbt) Accessed August 2019

3. David to attend the Job Centre to find another job or to claim Jobseekers Allowance

4.3.28. David was discharged back to the care of his GP as he didn't meet the criteria for further Crisis Team Intervention. Records indicate that unfortunately, David did not follow through on making a referral to Talking Mental Health Derbyshire or Derbyshire Substance Misuse.

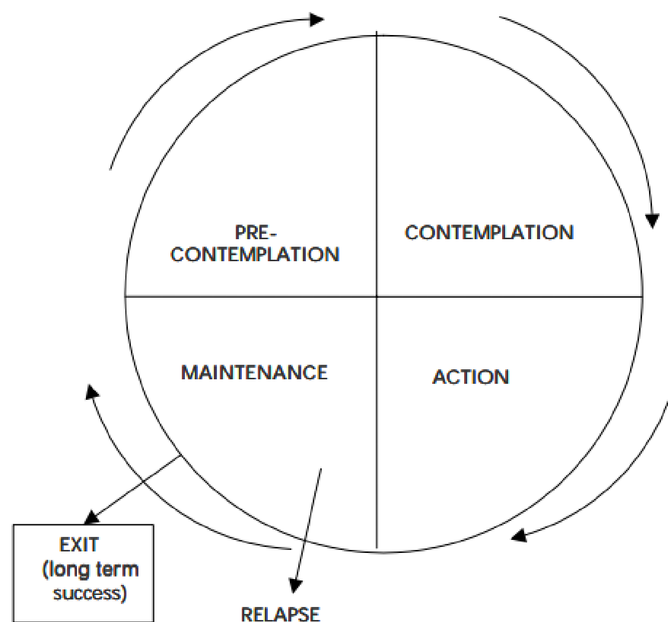
4.3.29. The response by the Crisis Team was in line with the expected response of their service and was reasonable and proportionate to David's presentation and the information available at that time. There was good communication between the team and David's GP.

- **Derbyshire Recovery Partnership**

4.3.30. Derbyshire Recovery Partnership had no direct contact with David – the only referral made was in July 2018. The service offered an appointment within ten days but David did not attend so was sent a discharge letter.

4.3.31. The model of behavioural change is well established in alcohol and substance misuse services, recognising the person may be at different stages of the motivation to change cycle and that relapse is often part of this process.[32]

Model of Behavioural Change



4.3.32. This cycle could be seen in David's responses – at times feeling ready to try and address his substance and alcohol use but then not always able to follow this through to 'action' and 'maintenance.'

[32] World Health Organisation (2003) Intervention for Substance Use: Brief Intervention for Substance Use: a Manual for Use in Primary Care -Draft https://www.who.int/substance_abuse/activities/en/Draft_Brief_Intervention_for_Substance_Use.pdf Accessed August 2019

4.3.33. At the time of the referral to the Derbyshire Recovery Partnership, the service contacted David on the same day – this was good practice in using that moment of his motivation. The service also has an open access policy i.e. accepting self-referrals to try and encourage engagement.

4.3.34. The fact that David did not follow up on attending his first appointment is unfortunately not unusual for drug and alcohol services. He had made a capacitous decision (albeit an unwise decision) that was reflective of his contemplative stage of change. The Derbyshire Recovery Partnership did not have any written Did Not Attend policy in place but their practice at this time was to discharge when a first appointment was missed. The service has since changed their response. Their practice now for every 'Did Not Attend' is to contact the person to establish the reason and offer further appointments.

4.3.35. It is not possible to determine whether this new approach would have made any difference to David's motivation at that time. The new procedure is more individualised and is likely to improve assessment of the current situation and risks as well as maximising the potential for engagement. This new procedure would benefit from being formalised in the form of a policy.

Recommendation Arising

4.3.36. David's family's belief was that there was limited availability of drug and alcohol services in their area. Mrs D was not an internet user but her daughter, David's aunt had in the past tried to source local rehabilitation services but believed there were long waiting lists.

4.3.37. However, Derbyshire Recovery Service confirmed that there had not been any waiting lists for the Local Authority Public Health funded drug and alcohol rehabilitation services. The commissioner noted that some private drug and alcohol service providers market their service on the internet by portraying shortages in NHS funded care and long waiting lists. This was confirmed by the author. A Google search for 'Derbyshire support drug and alcohol' revealed the top four options linked into the Local Authority website and information about accessing the Derbyshire Recovery Partnership services. [33] However, other sites purported to offer information on drug and alcohol services in Derbyshire but marketed their private rehabilitation and gave biased and uninformed information, as demonstrated by the extract below:

[33] Derbyshire County Council Alcohol and Drugs Support https://www.derbyshire.gov.uk/social-health/health-and-wellbeing/your-health/drug-and-alcohol-support/alcohol-and-drugs-support.aspx Accessed August 2019

What Are the **Pros** and **Cons** of Free Addiction Treatment

Pros

- ✓ Free of charge
- ✓ Confidentiality
- ✓ Accessible to everyone
- ✓ Located in the local community
- ✓ Close to home and family

Cons

- ✗ Lengthy admissions process
- ✗ Might not be referred to residential rehab
- ✗ Patients may be asked to go to different clinics
- ✗ Recovery may be affected by life distractions
- ✗ Access to the personal therapist is more limited;
- ✗ Patients may not have the same therapist

To discuss your options further please enter your telephone number below and one of our highly trained team will be in touch as soon as possible:

4.3.38. Unfortunately, although the Local Authority has contacted and challenged these private providers about the incorrect content of their websites, this has had little effect. Access to services and information for families is considered further in the following section

• Intervention with Mrs D and her Family

4.3.39. What is striking in reviewing the chronology is the lack of information that agencies had regarding Mrs D and her needs. In all but one instance, the information that was held by agencies was with reference to her role with David.

4.3.40. This is reflected in the family's view of Mrs D. One of her daughters spoke of her mum trying so hard to resolve things for David. She felt that her mum needed to be heard and needed professional help but didn't receive it. Family said that Mrs D was always there for all of them but never really thought of her own needs. Although Mrs D's husband described her as taking a nursing role at times with David, she would not necessarily identify herself as a 'carer' as described in the Care Act 2014[34] – she was a wife, a mother and a grandmother. As her friend said '*a strong matriarch who saw it as her role to help her family*.' The over-riding picture of Mrs D was of a person who simply got on with things, quietly doing her best to support everyone around her. There is nothing to suggest her decision making was impaired at any time or that she was subject to any coercive control.

4.3.41. Mrs D's involvement with the GP and Community Health services was limited and was for age related conditions. Her only occasion of having a more significant need was in 2016 when she injured herself. Although Adult Social Care were notified that support may be needed on discharge, they were then informed Mrs D would be supported by her family so had no direct contact. There was nothing to indicate this should have been pursued further.

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[34] Care Act 2014 section 10 http://www.legislation.gov.uk/ukpga/2014/23/section/10/enacted

4.3.42. All the health agencies discussed in section 4.3 above, were aware that David's grandparents were providing him with support and that he had identified them as a protective factor. These agencies had considered risks to others, including carers within their assessments of David.

4.3.43. As noted in section 3, there had been four occasions where Police had completed a DASH risk assessment tool involving family members. It was good practice in those earlier years, that Police had recognised the need to use the DASH risk assessment tool. The incidents and risks identified were:

- 2011 verbal argument between Mr D and David when he threatened his grandfather with a pool cue. The DASH risk assessment tool indicated a standard risk to Mr D.
- 2013 and 2014 – verbal arguments between David and his mother. DASH risk assessment tools identified standard risk for David's mother.
- 2015 incident where David smashed his mother's house up. The DASH risk assessment tool identified David's mother had a medium risk – David's mother declined a referral to domestic violence services.

4.3.44. The risk identified in these incidents at that time, were not of the level to trigger protocols to share information with other agencies.[35] [36] The situation as it presented to the health agencies was of a young man with difficulties, living with and being supported by his grandparents. This was a sad situation with some complicated family dynamics but was not an unusual situation. What is now known is that his grandparents were struggling to cope.

4.3.45. Providing services to families living with mental health needs and problematic substance and alcohol misuse is an essential element of supporting family and carers, as well as supporting the recovery of the person. Mrs D's family reported that they hadn't known what support was available.

Recommendation Arising

4.3.46. The review considered how services involved Mrs D and family in David's care and whether Mr and Mrs D's needs as carers/family living with mental health needs and alcohol and substance misuse were considered by the agencies involved with David, as recommended by NICE guidance.[37]

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[35] For example through Multi Agency Risk Assessment conference MARAC https://www.saferderbyshire.gov.uk/site-elements/documents/pdf/marac-practice-guidance.pdf

[36] Current practice is that all High Risk incidents get referred into MARAC and to the Independent Domestic Violence Advisor (IDVA) Service. Medium and Standard risk victims, where consent has been given are passed to the DA Support line to follow up and offer support. The Supportline contacts all Medium risk and any standard risk where there have been repeats and/or there is additional information which indicates enhanced risk.

[37] National Institute for Health and Care Excellence: (2011) Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence https://www.nice.org.uk/guidance/cg115/chapter/1-Guidance Accessed August 2019
NICE (2011), *Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services*, https://www.nice.org.uk/guidance/CG136/chapter/1-Guidance#care-and-support-across-all-points-on-the-care-pathway Accessed August 2019

4.3.47. One of David's GP's did note in his record '*does have protective factors these are frail elderly grandparents*.' However, there was no evidence in David's records that support to the family was explored or whether David may consent to information being shared with his grandparents about how he was feeling.

Recommendation Arising

4.3.48. The review confirmed that had there been safeguarding concerns (including domestic violence) regarding David and his family, the GP Practice would have recorded this within the clinical records of family members involved. It was also procedure for the GP Practice to discuss any cases with safeguarding concerns within their multi-disciplinary team meetings. This is good practice but, in this circumstance, did not apply to Mrs D and David. As there were no safeguarding concerns identified, there was no cross referencing within Mr and Mrs D's GP records.

4.3.49. Insight Healthcare confirmed carers can be involved in the person's care where appropriate. The service asks for carer contact details, next of kin and consent to share information with them.

4.3.50. Derbyshire Healthcare Foundation NHS Trust confirmed they are proactive in trying to identify and involve carers. The Trust has invested in the Triangle of Care competency framework[38] - standards and resources to support mental health services to ensure carers are fully included and supported when the person they care for has an acute mental health episode. The Trust has also produced guidance for patients and staff regarding identifying carers and agreeing what information is shared with them and their involvement in care planning. This is good practice.

4.3.51. The crisis team did ask David about whether he provided care or was cared for. His response was he did not have a carer. He described poor or intermittent relationships with his mother and father and sibling but did describe his grandparents as a protective factors.

4.3.52 It is possible that neither David or his grandparents would necessarily associate their relationship as 'carer' or 'cared for.' Agencies need to be mindful regarding terminology used when seeking to identify family and carers, living with mental illness or problematic substance and alcohol use.

Recommendation Arising

4.3.53. The family had benefitted from the intervention of SPODA during 2014. All drug and alcohol misuse services had subsequently been evaluated in 2017 as part of a recommissioning process. As a consequence, services were brought under one umbrella of the Derbyshire Recovery Partnership. This included a service to families offering an accredited model of support and skills training.

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[38] Carers Trust (2013)The Triangle of Care; Carers Included: A Guide to Best Practice in Mental Health Care in England https://professionals.carers.org/sites/default/files/thetriangleofcare_guidetobestpracticeinmentalhealthcare_england.pdf

4.3.54. Bringing all substance and alcohol misuse services together provides opportunity for a holistic family orientated response. Sharing information with family members about the person with problematic drug/alcohol use is dependent upon consent unless in very specific circumstances.[39] Derbyshire Recovery Service confirmed that during the triage (initial referral) or the formal assessment of the person, they are asked about family and carer involvement, whether the person wishes them to be involved in their care plan and permission to provide information to family/carer about support services for them. This is good practice.

4.3.55. In David's circumstance, it appears he did not engage sufficiently to be able to ascertain this information. The new 'Did Not Attend' response by the service of making a follow up call where the person does not attend, provides an opportunity to ask about potential support needs of the family and seek permission to make contact. It would be helpful to include consideration of support needs of carers/family within a 'Did Not Attend' policy.

Recommendation Arising

4.3.56. Information about services for families and carers living with mental health problems is widely available on the internet.[40] Information about services for families and carers living with problematic alcohol and substance use is also available on Derbyshire Recovery Partnership's website and, as outlined in 4.3.37, is prominent when using Google search engine. However, Mrs D was not an internet user. Derbyshire Recovery Partnership confirmed they use different mediums for advertising their services including leaflets for families. Family had not seen this information.

4.3.57. Results from a recent Derbyshire citizen survey found that the majority of respondents accessed information through their GP practice. The Derbyshire Recovery Partnership had sent leaflets out to GP Practices but Derbyshire CCG highlighted the challenges for GP's in providing physical space on their premises for the many different health campaigns that a GP Practice tries to promote. However, the family's GP Practice confirmed information was available regarding drug and alcohol support within their waiting room and clinical rooms.

4.3.58. Learning from this review highlighted the need for the multi-agency partnership to support the communication strategies of the Local Authority and Health agencies about services available for people, their families and carers who are living with mental health needs and problematic substance/alcohol use.

4.3.59. Learning identified the importance of using different mediums to make information accessible and the value of agencies such as Police, mental health services and GPs using purposeful questioning to signpost to support. The development of Social Prescribing link workers within GP Practices[41] is a good opportunity to extend this response.

Recommendation Arising

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[39] Information Commissioners Office Guide to the General Data Protection Regulation (GDPR) https://ico.org.uk/for-organisations/guide-to-data-protection/guide-to-the-general-data-protection-regulation-gdpr/ Accessed August 2019

[40] Derbyshire Carers Association https://www.derbyshirecarers.co.uk/mental-health.php

[41] NHS (2019) Personalised Care Social prescribing link workers: Reference guide for primary care networks https://www.england.nhs.uk/personalisedcare/social-prescribing/ Accessed August 2019

4.3.60. Identifying ways to strengthen support to families is important learning. It is possible that had David's family received skills-based training in how to intervene with David's alcohol and substance mis-use, this *may* have improved his engagement and recovery. However, as highlighted in section 4.1, it is not clear to what degree if any, his substance and alcohol use contributed to his disordered thinking that was at the root of him committing the homicide.

4.3.61. Had David's family been provided with support for themselves, (either in relation to his alcohol/substance misuse, and/or his mental health needs), it is conceivable that this may have given them the knowledge they needed to recognise deterioration in his mental health, and the permission and confidence needed for them to share their concerns about his apparent delusionary thoughts and paranoid beliefs in the ten months preceding the homicide. This *may* in turn have led to further assessment and treatment of his mental health.

5. Conclusions

5.1. This Domestic Homicide Review has considered the tragic circumstances of Mrs D's death through a homicide perpetrated by her grandson.

5.2. What is clear is that Mrs D had been a constant source of support to David. All the evidence points to a loving relationship between them and that the homicide could not reasonably have been foreseen.

5.3. There seems little doubt that David was significantly thought disordered at the time of the homicide, believing his grandmother was someone else and that he needed to protect his grandfather from a person who he believed was an intruder. David's poor mental health is the primary factor at the root of the homicide.

5.4. The review has endeavoured to explore contributory factors that may have alleviated David's poor mental health and the associated risks. The review identified potential points in David's early years when early help may have helped his wellbeing and reduced the risks arising from stress, drugs and alcohol that are known to adversely impact on mental health. The review also considered whether agencies took reasonable steps to assess David's mental health and associated risks and how they worked to engage David in services. Finally, the review considered what services were available to Mrs D and her family, to support them living with mental health needs and problematic substance and alcohol use.

5.5. Notwithstanding the very tragic outcome, the review has identified aspects of good practice.

5.6. There have also been factors that gave rise to learning for agencies. Ultimately, it is not possible to conclude whether these factors were so significant that had they been addressed at the time, that this would have altered the course of events. Nonetheless, the learning is important to improve responses to others and this forms the basis for recommendations.

6. Lessons Learned

6.1. The lessons arising from this Domestic Homicide Review can be summarised as follows:

1. The importance of prevention through early help for young people's mental health and wellbeing.

2. The true nature of an individual's mental health difficulties can remain hidden, even to professionals with specialist skills in mental health. Families' views and perceptions about the person's difficulties are a crucial component of any assessment process. However, families may not feel able to or appreciate that they can share information to assist the assessments and plans of services who are in the best position to help.

3. The importance of a Think Family approach when supporting those with mental health, drug and alcohol needs and supporting families to understand the impact this can have on all. Agencies need to be proactive in identifying carers and families living with people with mental health needs and problematic substance and alcohol use and seek to involve them in the person's care wherever possible, subject to consent. Health and Social Care agencies need to help carers and families to understand how their information can contribute to the assessment without the individual's confidentiality being compromised.

4. Carers and families need to have information (that is accessible to different groups within the community), about where they can access support for themselves as well as the person experiencing difficulties.

7. Recommendations

7.1. The review has identified some new local and national initiatives that are likely to help address some of the lessons learned within this review, particularly around investing in young people's mental health and strengthening resources within Primary Care to address social factors.

7.2. None of the agencies that contributed to the review had made recommendations for their own agency. The review, having brought all the information together, has made the following recommendations:

Recommendations
Recommendation 1: Identifying and Supporting Carers and Family Members Derbyshire CCG, as part of their GP Practice quality assurance work, should review the availability of information to carers and family members who may be living with mental illness or problematic substance and alcohol use. Considering the impact of the individual's difficulties on any carer or family member disclosed by them and registered with the practice and the support that they may need for example, carer's assessment; guided help and education; signposting to support services; involvement of Social Prescribing link workers.
Recommendation 2: Communication Strategy for Substance and Alcohol Services The Derbyshire Domestic Abuse and Sexual Violence Governance Board should work with Derbyshire Local Authority and Derbyshire's NHS funded services to support their

communication strategies regarding services for carers and families living with mental health needs or problematic substance and alcohol use. The communication strategy should consider the use of different mediums to maximise accessibility for different groups within the community including those who may not use information technology.

Recommendation 3: Managing Non-Attendance

Derbyshire Recovery Partnership should introduce a written policy for Did Not Attend, to formalise their new working practices where a service user misses appointments. The policy should also outline factors to consider in relation to the impact on carers or family members of the individual who has not engaged and any actions required to address their needs.

Recommendation 4: Using Learning

Learning from this review should be used by agencies within the Safer Derbyshire partnership as part of ongoing learning and development.

Health agencies contributing to this DHR should use the learning to inform their work with carers and families specifically:

I. The importance of carer and family perspectives in gaining a full understanding of the person's circumstances and presenting risks
II. That family members may not identify themselves as 'carers.' There is a need for proactive engagement to identify and support family and carers living with mental illness and problematic substance and alcohol use.

Learning from the review may also be used for national learning purposes, communicated through the Home Office Public Protection Unit specifically:

I. That all Health and Social Care support services to take a Think Family approach in their assessments and plans for service users, particularly when assessing risk to others.

II. For NHS England to reinforce the need for GPs, when treating depression, to be mindful of risks associated with domestic violence and abuse and to use professional curiosity when exploring high risk behaviours and emotional instability of patients.

III. Bodies such as National Institute for Health and Social Care Excellence should consider incorporating into relevant Quality Standards (such as suicide prevention and coexisting severe mental illness and substance misuse) a risk assessment process for use when people do not attend appointments. The risk assessment should include information from carers or family members of the individual who has not engaged and the impact on them of the person's mental ill-health and any coexisting substance misuse.

Sylman Consulting

Date: June 2020

www.sylmanconsulting.com

Glossary

CCG Clinical Commissioning Group, commissioners of local health care

CBT Cognitive Behavioural Therapy is a talking therapy that can help the way the person thinks and behaves. It's most commonly used to treat anxiety and depression.

CMHT Community Mental Health Teams

Crossroads Derbyshire is a voluntary organisation helping people break free from domestic abuse.

DASH A DASH risk assessment tool is a nationally applied Domestic Abuse, Stalking and Harassment and Honour Based Violence (DASH, 2009-16) Risk Identification and Assessment and Management Model.

DCSP Safer Derbyshire

DHCFT Derbyshire Healthcare NHS Foundation Trust

DHR a domestic homicide review is a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by— (a) a person to whom he was related or with whom he was or had been in an intimate personal relationship, or (b) a member of the same household as himself, held with a view to identifying the lessons to be learnt from the death.

DEIPS Derbyshire Early Intervention in Psychosis Service

MARAC A Multi-Agency Risk Assessment Conference is a meeting where information is shared on the highest risk domestic abuse cases between agencies

MAPPA Multi-Agency Public Protection Arrangements is the process through which various agencies such as the police, the Prison Service and Probation work together to protect the public by managing the risks posed by violent and sexual offenders living in the community

Mental Capacity refers to whether someone has the mental capacity to make a specific decision or not at a specific time

NICE National Institute for Health and Care Excellence

Safeguarding Adults is used to describe all work to help adults at risk stay safe from significant harm. Safeguarding duties apply to an adult who has care and support needs and is experiencing or at risk of abuse or neglect and as a result of those care and support needs is unable to protect themselves from either risk of, or the experience of abuse and neglect.

SPODA Supporting Parents Of Drug Abusers

VARM The vulnerable adult risk management process was implemented in 2013. A process to manage risks which may arise within specific circumstances when working with adults deemed to have capacity to make decisions for themselves, but who are at risk of serious harm or death through self-neglect, risk taking behaviour / chaotic lifestyles or refusal of services

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