Safer Kingston Partnership

DOMESTIC VIOLENCE HOMICIDE REVIEW

OVERVIEW REPORT

Into the death of

Kathleen in June 2012

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Preface

A sudden and violent death is always difficult to come to terms with, especially when the victim is killed by a family member in whose company they have every right to feel safe. It is particularly poignant when the person who brought the perpetrator into the world has her life taken by her child as in this case. The Review Panel and the Safer Kingston Partnership would like to express their sincere condolences to the family members and friends of the victim whose death has brought about this Review. She is greatly missed by her family, her colleagues, and friends.

The independent chair and report author would like to thank those who have made contributions to this Review. It is a measure of the esteem within which the victim was held that 4 years after her death her friends were so willing to talk about her for the benefit of the Review despite the painful memories this invoked. The chair also wishes to thank the Review Panel and report authors for their time and thoughtful contributions.

The key purpose for undertaking a Domestic Homicide Review (DHR) is to enable lessons to be learnt where there may be links with domestic abuse. In order for these lessons to be learnt as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each death, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future. The victim's death met the criteria for conducting a Domestic Homicide Review according to Statutory Guidance[1] under Section 9 (3)(1) of the Domestic Violence, Crime, and Victims Act 2004, states that there should be 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".

The Home Office defines domestic violence as:

> *Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse: psychological, physical, sexual, financial, and emotional.*
>
> *Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour. Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim*

The term domestic abuse will be used throughout this Review as it reflects the range of behaviours encapsulated within the above definition, and avoids the inclination to view domestic abuse in terms of physical assault only.

[1] Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (Revised August 2013) Section 2(5)(1)

DOMESTIC HOMICIDE REVIEW

1. Introduction

1.1 This report of a Domestic Homicide Review (DHR) examines agency responses and support given to Kathleen a resident of the Royal Borough of Kingston upon Thames area prior to the point of her death in June 2012. The Review will consider agencies' contact and involvement with Kathleen, and Paul the perpetrator of the crime,

1.2 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. 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

1.3 The chair of the Safer Kingston Partnership[2] received notification by the Police of the death on 4 July 2012. In consultation with partners the Chair of the Partnership made the decision that the circumstances met the criteria for a Domestic Homicide Review and the Home Office was informed. However, agencies were not asked to confirm their involvement with the victim and perpetrator and to secure their records until October 2012.

1.4 The Review has been significantly delayed due to events. The perpetrator fled abroad to another country after the murder, however before his arrest and extradition as the main suspect for the crime could take place he committed another homicide, was arrested, stood trial, and was sentenced in that country. In agreement with the Home Office the Review was adjourned until such time as the perpetrator could be put on trial in the United Kingdom. He was returned to stand trial, found guilty of murder, and sentenced in June 2015.

1.5 The Review formally recommenced with a Panel meeting in January 2016. The process was partly delayed due to the original chair no longer being available and a new chair had to be appointed. Further delays were experienced in the months leading up to the Review's conclusion on 28 April 2017 which are outlined in the methodology section of this report. These unusual circumstances mean that it was not possible to complete the Review as required by statutory guidance within 6 months.

Confidentiality

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

1.7 To protect the identity of the victim, perpetrator, and other family members the following pseudonyms have been used throughout this report:

- The victim: Kathleen aged 58 years at the time of her death.
- The perpetrator: Paul aged 28 years at the time of the offence.

Kathleen and Paul were mother and son and were of white Irish ethnicity.

[2] The Safer Kingston Partnership is the name of the Community Safety Partnership in the Royal Borough of Kingston.

1.8 Dissemination

- Chair & Board of the Safer Kingston Partnership
- Commissioner (Chief Constable), Metropolitan Police
- Borough Commander for Kingston upon Thames, Metropolitan Police
- Deputy Mayor for London Policing & Crime
- Chief Executive of the Royal Borough of Kingston upon Thames
- Director of Adults & Communities, Royal Borough of Kingston upon Thames
- Chair & Chief Officer, Kingston Clinical Commissioning Group
- Chief Executive, Royal Free Hospital NHS Trust
- Chief Executive, I-Cope (Psychological Services)
- Chief Executive, South West London & St George's Mental Health NHS Trust
- Chief Executive, Kingston Hospital NHS Foundation Trust
- The GP Practices for the victim & perpetrator
- NHS England

Summary of Circumstances Leading to the Review

1.9 In June 2012 one of Kathleen's work colleagues became concerned as she had not turned up for work and had not called the office; this was very unusual. Two of Kathleen's colleague visited her home, but could not raise a response and noticed mail behind the door and that the television was on. This was uncharacteristic and due to concerns for Kathleen's welfare her colleagues called the Police. After earlier attempts to contact the occupant the Police forced entry later that afternoon and found Kathleen. The Ambulance Services was called but Kathleen was declared deceased.

1.10 It was known that Kathleen and Paul were close and that he visited her most days. Kathleen had supported Paul throughout his adult life both financially and emotionally due to his mental ill health for which he had taken medication for many years. Although neighbours heard screaming the evening before they had not called the Police as students living nearby were said to be frequently noisy. A large amount of money had been taken from Kathleen's bank account and Police enquiries linked Paul to cash withdrawals. On the discovery that he had fled abroad a European Arrest Warrant was applied for. However, before this was implemented Paul was arrested and bailed for a minor offence shortly after which he went on to murder a woman for which he was arrested and sentenced. The law in that country for this offence thus took precedence at this stage.

1.11 Paul was extradited to stand trial for his mother's murder in 2015. He pleaded not guilty to murder, but was found guilty by majority verdict of 10 to 1 in the summer of 2015. He was sentenced the following day to life imprisonment with a specified minimum term of 27 years and 3 months. The Court ordered that the defendant serve a mandatory sentence of imprisonment for life. Time spent on remand in a foreign jurisdiction and the UK was taken into consideration (total of 2 years 9 months, which includes 134 days on remand in the UK) when determining length of minimum term. After sentencing in the UK Paul was returned abroad to serve the remainder of his sentence for the murder he committed in that country.

1.12 Terms of Reference for the Review : Statutory Guidance (Section 2) states the purpose of the Review is to:

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

- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;
- Apply these lessons to service responses including changes to policies and procedures as appropriate; and
- Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

Specific Terms of Reference for the Review

1.13 In addition to the purpose of a DHR stated above the DHR Panel agreed the following terms of reference for this Review into Kathleen's death:

To consider:

1. Each agency's involvement with Kathleen and Paul between 1 June 2009 and Kathleen's murder in June 2012:

2. Whether, in relation to the two family members, an improvement in any of the following might have led to a different outcome for Kathleen:

(a) Communication between services - NB Of particular interest is whether Irish health records were transferred to Paul's GP or included in the medical notes when he registered with the practice.
(b) Information sharing between services with regard to the safeguarding of adults.

3. Whether the work undertaken by services in this case was consistent with each organisation's:

(a) Professional standards
(b) Domestic Violence policy, procedures and protocols

4. The response of the relevant agencies to any referrals relating to Kathleen or her son Paul concerning domestic violence, mental health concerns, substance misuse or any other factors that may lead to significant harm, from 1st June 2009. It will seek to understand what decisions were taken and what actions were carried out, or not, and establish the reasons. In particular, the following areas will be explored:

(a) Identification of the key opportunities for assessment, decision making and effective intervention in this case from the point of any first contact onwards.

(b) Whether any actions taken were in accordance with assessments and decisions made and whether those interventions were timely and effective.

(c) Whether appropriate services were offered/provided and/or relevant enquiries made in the light of any assessments made

(d) The quality of any risk assessments that may have been undertaken by each agency in respect of Kathleen and Paul.

5. Whether any Mental Health assessments were carried out where necessary and thresholds for intervention were appropriately calibrated, and applied correctly, in this case.

6. Whether practices by all agencies were sensitive to the ethnic, cultural, linguistic and religious identity of the respective family members and whether any special needs on the part of either family member were explored, shared appropriately and recorded.

7. Whether issues were escalated to senior management or other organisations and professionals, if appropriate, and in a timely manner.

8. Whether the impact of organisational change over the period covered by the review had been communicated well enough between partners and whether that impacted in any way on partnership agencies' ability to respond effectively.

9. Whether the services on offer were appropriate to the needs of the victim – on the basis that those services which are **not** accessed by victims are of equal importance in a DHR as those which were used.

The chair was responsible for contacting family and friends to invite their contribution to the Review.

Methodology

1.14 At the commencement of the Review in 2012 a first Review Panel was held on 19 November 2012 at which terms of reference were agreed. Correspondence from that time indicates that agencies were not approached to confirm contact with Kathleen and Paul and to secure their records until October 2012. The DHR Panel which reconvened in January 2016 had just two of the original members of the first Panel thus to all intents and purposes the Review was starting afresh.

1.15 Individual Management Reviews were requested at the first Panel in 2012, however, only those for the hospital, mental health services, and Kathleen's GP were completed before the DHR was adjourned. These IMRs were undertaken by authors who were independent of the case or the line management of staff involved. The victim's GP IMR was of a high quality with succinct analysis which has been very helpful to the Panel. This IMR represented a model of good practice: A chronology was compiled from medical notes and shared with the GP at interview; interview notes were sent to the GP for checking with points needing clarification; the IMR author stressed the need to implement learning quickly and not wait for the completion of the Review; the practice domestic abuse policy was obtained and reviewed.

1.16 The IMR for Mental Health Services was informed by interviews with the clinical team and a review of records shortly after the first starting of the Review. Following the reconvened Panel in January 2016 the IMR was assessed as requiring further questions to be answered. There was a delay of 6 months before the Panel received the IMR with answers to a majority, but not all of the questions raised. This was partly due to the original author having left the Trust midway through this period. The completion of the Review Action Plan was similarly significantly delayed by 3 months due to changes in staff at the Mental Health Trust.

1.17 An IMR was not requested from the perpetrator's GP at the start of the Review in 2012 with the agreement of the first Chair as the perpetrator was registered under the then Richmond Primary Care Trust and the medical records were not available as they were with the Police. Paul's GP was contacted at the resumption of the Review, however his GP was unavoidably away from the practice for some months which caused additional delay. Medical records were provided by the practice and were reviewed. The chair and a member of the DHR Panel undertook an interview with the perpetrator's GP at the end of

July 2016. Interview notes were shared with the GP to check for accuracy before the content was included in the report.

1.18 The previous provider of counselling services to whom Kathleen was referred in 2011 was contacted concerning her referral and to check for any relevant information arising from her conversations with them. Kathleen only had telephone contact with the service and did not follow up appointments offered, therefore information was limited.

1.19 Paul was in privately rented accommodation and checks were made with the letting agent for the property to seek information from his landlord. However, his landlord at the time no longer owns the property and it was not deemed proportionate for the Review to locate the previous owner particularly as they lived in another part of the country.

1.20 The chair contacted the psychiatrists who assessed Paul prior to the criminal trial, and sought their consent to access and cite their reports for the court. The chair is grateful for the assistance of Dr Philip Joseph, Consultant Forensic Psychiatrist, and Dr Mehdi Veisi, Consultant Forensic Psychiatrist for giving their consent.

1.21 The chair recognises the particular difficulty experienced by agencies when a long period of time has elapsed between a crime being committed and information or reports being requested. Perhaps there is procedural learning here. Whilst recognising the care needed to avoid compromising any future criminal proceedings, the adjournment of this Review at such an early stage impeded early learning and access to information both from records and from personnel who have long since moved on or left organisations. Section 10 of Statutory Guidance for Domestic Homicide Reviews states that where the suspect is arrested and charged the commissioning of the Review should be held temporarily until the conclusion of the criminal trial, but records should be reviewed and a chronology drawn up to identify immediate lessons to be learnt and lessons acted upon. In this case the suspect was unable to be arrested and charged as he had fled abroad.

1.22 Organisationally much has changed in the 4 years since Kathleen's death, however, it is a shame that the learning from this Review could not have been achieved earlier to inform those changes. Whilst Reviews such as this where the suspect has fled abroad before being arrested and charged are uncommon, it would be helpful for Review Panels to have the benefit of advice in statutory guidance regarding how such delays can be avoided in future.

Involvement of Family, Work Colleagues, Neighbours and Wider Community

1.23 In liaison with the family liaison officer, the chair wrote to two of Kathleen's family members enclosing the family version of the Home Office DHR leaflet. One of Kathleen's children who is an adult and who lives abroad was contacted via emails, but no response was received. The Police had contact with this member of Kathleen's family during their investigation and information provided by them during those enquiries which has relevance to the Review has been included.

1.24 Kathleen's brother agreed to contribute to the Review and a telephone interview was conducted with him and the terms of reference for the Review were explained and agreed. He has provided helpful background information which is included in the report for which the chair is most grateful.

1.25 The final draft of the Overview Report was shared with Kathleen's brother during a visit by the chair. He had no additions or amendments to make after reading the report and was content with the pseudonyms used.

1.26 The perpetrator's information has been accessed in the public interest and in the attempt to learn from this Review to prevent similar crimes. It was not possible to seek consent due to Paul's imprisonment abroad. He was also not contacted for his views for the same reason.

1.27 Kathleen's former work colleagues and friends have also contributed to this Review. Prior to telephone interview the Home Office leaflet for friends and colleagues was provided, however, only one received this information as they had moved abroad since their last contact with the Police who had provided their contact details.

1.28 The chair is most grateful for all their contributions which have helped to draw a picture of Kathleen, and to some degree of Paul, which was not available to practitioners.

Contributors to the Review

1.29 Of 10 agencies contacted 6 agencies confirmed contact with Kathleen and Paul. The nature of their contributions to the Review are:

- South West London & St George's NHS Trust - chronology & Individual Management Review (IMR)
- Kingston Hospital NHS Trust - chronology & IMR
- Metropolitan Police - Report concerning the incident
- GP Practice for the victim - chronology, interview & IMR
- GP Practice for the perpetrator - medical notes & information via interview
- Kingston Rightsteps Psychological Services - records and information

Neither Kathleen nor Paul were known to Adult Social Care. Kingston Child & Adolescent Mental Health Services checked microfiche archived records and found no record of having seen Paul when he was younger.

Review Panel Members

1.30 Between the first Review Panel in 2012 and the Review Panel meeting to recommence the DHR in January 2016 Panel membership not unexpectedly changed. The Panel members had no involvement with the parties or line management responsibilities for staff in this case. The following were Panel members:

Name	Role & Agency
Davina James Hanman Gaynor Mears	1st Independent Chair at start of Review (2012) Independent Chair for Reconvened DHR & Report Author
DI Vicky Washington	Metropolitan Police Service - Kingston
Helen Raison	Consultant in Public Health, Royal Borough of Kingston
DS Janice Cawley	Critical Incident Advisory Team, Specialist Crime Review Group, Metropolitan Police Service
Jonathan Hildebrand	Director of Public Health, Royal Borough of Kingston
Jonathan Mason	Director of Kingston and Richmond Mental Health Services, South West London and St Georges Mental Health Trust
Kelly Shirley (original Panel Member)	Domestic and Sexual violence Services Co-ordinator, Safer Kingston Partnership

Marion Todd (original Panel Member)	Relationship Manager, Safer Kingston Partnership
Sarah Connor (1st Panel only) Sarah Giggs	Deputy Director of Nursing & Patient Experience, Kingston Hospital Foundation Trust
Sarah Lawton	Group Manager, Community Housing, Royal Borough of Kingston (RBK)
Stephanie Royston-Mitchell	Drug and Alcohol Strategy Manager, Public Health
Stephen Taylor	Head of Adult Social care, RBK
Vicky Bourne	Wellbeing Co-ordinator, MIND in Kingston
Caroline Birkett	Head of Service West & South London, Victim Support
Peter Warburton	Lead Nurse for Adult Safeguarding, Kingston Clinical Commissioning Group
Darren Welsh	Head of Housing, Royal Borough of Kingston

Chair & Author of the DHR Overview Report.

1.31 The chair of this Review and author of this DHR Overview Report is independent DHR chair and report author Gaynor Mears OBE. The author holds a Masters Degree in Professional Child Care Practice (Child Protection) and an Advanced Award in Social Work in addition to a Diploma in Social Work qualification. The author has extensive experience of working in the domestic abuse field both in practice and strategically, including roles at county and regional levels. Gaynor Mears has experience in undertaking previous Domestic Homicide Reviews, and research and evaluations into domestic violence services and best practice. She has experience of working in crime reduction with Community Safety Partnerships, and across a wide variety of agencies and partnerships. Gaynor Mears is independent of, and has no connection with, any agencies in the Kingston upon Thames area.

Parallel Reviews

1.32 A Coroner's Inquest was opened and adjourned. There were no other Reviews undertaken.

2. The Facts

2.1 Kathleen lived in a flat within the Royal Borough of Kingston. She lived there on her own, but it is believed her son Paul lived with her periodically and at times he lived independently. He was living in his own rented flat at the time Kathleen was killed for which she had provided the rent deposit. He visited her almost daily when Kathleen returned from work; he had a key to her flat. It is here that Kathleen was found murdered.

2.2 In providing a synopsis of the murder it is acknowledged that there were no witnesses to the fatal incident; information regarding the murder comes from Paul himself and cannot be corroborated. He reported that he had been drinking the day of the murder and arrived at his mother's flat around 10pm. He alleged that they had an argument; he had asked for money for food and he said his mother refused. Paul alleged that his mother called him stupid and crazy and he felt humiliated. He maintains he remembers nothing about the murder itself, just that there was blood and his mother was not breathing. Paul then took his mother's bank card and fled aboard.

2.3 Kathleen's body was discovered when the Police forced entry to her flat after her work colleagues raised concerns about her welfare. Her body was found on the sofa; she had severe facial injuries and marks around her neck. Ambulance staff declared Kathleen's life extinct at 17.57hrs that evening, although it is thought that she was killed the evening before. Investigations revealed that Paul had fled abroad, and the Police applied for a European Arrest Warrant; Paul was the only suspect in relation to Kathleen's murder. Further details will be given in the chronology below.

2.4 The Post Mortem held in June 2012 gave the cause of Kathleen's death as asphyxiation and compression to the neck.

2.5 As far as can be ascertained from the information available neither Kathleen nor Paul would have been considered 'vulnerable adults' as defined by the Department of Health 'No Secrets' guidance in place at the time. Neither would have met the threshold for community care service. Aside from this 'official' consideration of vulnerability, Kathleen could be viewed as vulnerable due to her longstanding wish as a mother to support her son and this may, not unsurprisingly, have overridden her ability to view Paul's behaviour and any risk arising from this objectively.

Equality and Diversity

2.6 No equality or diversity issues arising from the Equality Act 2010 were found to apply during this Review. Both Kathleen and Paul were offered and able to access services if they wished. However, this should not be taken to mean that there were no barriers of a different kind which may have prevented them from seeking support. For example Kathleen appears to have accessed her GPs infrequently and only when necessary. She also did not access other services offered or suggested for support. Her first GP explained that this is not unusual for patients who have come from Ireland as health care there attracts financial cost. The GP also noted that culturally patients from Ireland tend to be more stoical.

3. Chronology - Background prior to 2009

3. 1 This background provides information concerning the Mental Health Service intervention with Paul. It is detailed to demonstrate the level of provision he received and to give context to the review period which follows from 2009.

3. 2 Kathleen came to England from Dublin with her family when she was 5 or 6 years old, but she returned as an adult to study at Trinity College, Dublin from where she obtained a degree. Her brother describes her as being extremely intelligent. After university Kathleen travelled a great deal, spending long periods living abroad. Her first husband was from the Middle East and during this time she had an affluent lifestyle; when the marriage ended in divorce Kathleen is described as being financially comfortable.

3. 3 Kathleen's former partner and father of her two children was from Germany and for some time the couple lived in Spain. Paul was born in London. When he was approximately 2 years old the couple separated and his father now lives in another country. It is understood that Paul has no contact with his father; the last time he saw him was in 1997. Kathleen's brother reported that she lived in many countries, but her main concern was for her children to have a good upbringing.

3. 4 In information disclosed during his interviews for his psychiatric assessments with Dr Joseph and Dr Veisi in the Spring of 2015 for the court, Paul reported living in London,

Spain and Dublin; he spent most of his childhood and adolescence in Dublin with his mother and grandmother. Paul reported that he was bullied at school. It was during his mid to late teens that mental ill-health was first recognised. He described being relatively normal before that age and not having any major problems. He confirmed to both doctors that he was not physically or sexually abused during his childhood. Paul said his mother was always shouting at him a lot because she was stressed, but he denied being physically disciplined or being 'grounded' substantially. Paul reported a family history of psychiatric illness on his father's side, and that a female cousin suffered from bipolar affective disorder.

3. 5 Paul described to Dr Joseph that things started to go wrong around the age of 13 years when he said his mother made him move school for reasons unknown to him. He maintained that at his previous school he had friends and did well in exams, but although he still had friends his exam results were not as good at the new school. Paul reported to Dr Joseph that his mother moved him to a third school when he was 16 years which he did not want to go to. He described having a fight at the school after which he stormed out and was then excluded. Paul thought that this incident set him down the wrong path. He reported to Dr Joseph that "it was not until years later that he realised the significance of it and he felt resentful towards his mother for moving him to different schools". Paul went on to relate how at 16-17 years of age he had feelings of anger and aggression which became worse as his mental health deteriorated. He admitted to smoking cannabis around this time.

3. 6 Paul is reported to have been diagnosed in Ireland as suffering from schizophrenia; in the absence of medical notes from Ireland this was confirmed by Kathleen during an assessment in England in 2007 when he was diagnosed with bipolar affective disorder. Paul's GP confirmed that they had not received a copy of his medical notes from Ireland. Kathleen described Paul as becoming socially withdrawn and introverted from when he was 15 years old, and there was a significant change in his behaviour and personality. He stopped seeing his friends, became more irritable, and began mixing with people in a nearby "rough area". Paul has never been admitted to psychiatric hospital due to his illness, but he has been prescribed anti-psychotic medication for many years which appeared to have kept him stable as long as he took his medication routinely.

3. 7 Records show that Paul registered with a GP practice in London on 10 January 2007. His medical notes record reference to "Unspecified schizophrenia no specific diagnosis as yet" dated 12 January 2005. On the 11 January 2007 there are a number of entries on his records by his new GP namely: Ethnic category Irish; Mental health personal health plan; Psychiatry care plan; Psychiatric referral (urgency level routine). Paul was entered onto the GP practice national service framework Severe Mental Illness register. This was good practice.

3. 8 Between 12 February 2007 when Paul was referred by his GP and 7 November 2008 he was receiving care from the Richmond Community Mental Health Team. The first assessment report from the team to Paul's GP received on 20 February 2007 reported that he was accompanied by his mother Kathleen during his initial assessment at which it was explained that Paul had had a psychotic episode 2 years previously where he believed that the television and food were weakening him. He was wandering outside at night, was hostile and drinking excessive alcohol. He had been started on Olanzapine with a good response, however due to weight gain this was changed to Aripiprazole[3]. Since that time Paul had been feeling stable in mood, but a few months before the assessment he had

[3] Aripiprazole is an anti-psychotic medication. It works by changing the actions of chemicals in the brain. Abilify is used to treat the symptoms of psychotic conditions such as schizophrenia and bipolar I disorder (manic depression). https://www.drugs.com/abilify.html. accessed 07.07.16

tried to reduce his dose of Abilify[4] as he said he did not want to be on medication long term. Kathleen had noticed that Paul was becoming suspicious and irritable and it was then that she found out that he was not taking the prescribed dose. She persuaded him to resume his dose of 20mgs which helped to stabilise his mental state.

3. 9 During the Community Mental Health Team's involvement with Paul his GP received a copy of the initial assessment report, reviews of his progress and medication needed, and eventually a closure report and plan. His contact with his GP was minimal at this time. There are noted to be gaps in Paul's records in his GP notes concerning his treatment and progress.

3. 10 There are two mental health review records to note in his GP record. On 23 July 2007 Paul unilaterally increased his dose of Escitalopram[5], and on 7 August 2008 it is recorded that Paul says "he feels fine, says he ran out of Escitalopram a few months ago and decided not to take as he felt better without". The plan was to observe. There is no record of these changes in the Mental Health IMR chronology. On both these occasions Paul was seen by a different doctor to his regular GP. There is no evidence that his alteration of his medication was shared with the Community Mental Health Team.

3. 11 The personal history taken during the initial assessment included information given in previous paragraphs and his educational attainment as achieving 10 O Levels and 2 A Levels. Paul reported that he studied accounting whilst working in that field for one year and achieved a certificate of high-tech in computerised accounting. He later attended an advanced course in accounting, but was unable to complete this due to his illness. However, he stated that he did obtain a City & Guilds in photography during his illness. In his interview with Dr Veisi Paul was asked about his first job and explained that he worked in an accountancy firm, but was sacked after 5 days. He said the woman there did not like him. Paul added "I always get the feeling that people don't like me and take offence when they see me". He said he continued travelling to and from work for a month as he was ashamed to tell his family that he had lost his job.

3. 12 Paul returned to London with his mother and his sibling in September 2006 as Kathleen thought there would be better job prospects for her children there. Kathleen had a cousin in London, but Paul had been refusing to see them due to his concerns about being judged. The mental health assessment report described how Paul had a temporary job until January 2007 at Kew National Archives for 3 months, but although the job demands were easy he found it stressful as it was full time. At this time it was reported that he had worked in different supermarkets for 2 years, but he was unemployed and in receipt of Job Seekers Allowance and living with his mother.

3. 13 Regarding his personal life Paul reported in his initial assessment and later to Dr Joseph and Dr Veisi , that he had no previous intimate or sexual relationships. He revealed to Dr Veisi that he slept with 20-30 prostitutes and stated it was easier to sleep with a prostitute than being in a relationship because, “You are not obliged”.

3. 14 Paul was assessed as presenting no evidence of positive psychotic symptoms, however he was lacking in motivation, socially isolated and needed prompting with his self-care. Kathleen was described in the report as "very supportive and she provides continuous monitoring and prompting him to participate in doing some housework and looking after his self-hygiene". Paul preferred to be alone and stay indoors since he had been unwell. The assessment found that Paul lacked self confidence and he believed people were

[4] Abilify trade name for Aripiprazole - see above

[5] Escitalopram is used in the treatment of major depressive episodes, panic disorder with or without agoraphobia, social anxiety disorder (social phobia), generalised anxiety disorder, obsessive-compulsive disorder.

"judging him". He denied having suicidal or violent thoughts. Paul who was 22 years old at the time of this assessment, was judged to be low risk to himself and others.

3. 15 The Plan for Paul following assessment was:

- To remain on Aripiprazole 20mgs and Escitalopram 10mgs and he was advised that he needed to stay on the anti-psychotic medication for the long term.
- He was to be referred to a vocational support worker and a newly established service for Early Intervention Service in Psychosis.
- The assessing consultant psychiatrist was to discuss the case at the multi-disciplinary team meeting to allocate a care coordinator to support Paul with his social needs and request a carer assessment for his mother.

3. 16 Paul was seen with Kathleen by a mental health social worker on 28 February 2007; he was reported as 'doing very well', and Kathleen expressed relief that there were no concerns regarding his mental health at that time. Paul agreed that he needed to develop strategies to overcome thoughts of worthlessness and isolation. A referral was to be made for cognitive behavioural therapy (CBT).

3. 17 Paul was reviewed at an outpatient clinic on 16 March 2007 by the same psychiatrist who undertook the initial assessment. A CBT therapist was also present, and at the same time the social worker undertook a carer assessment with Kathleen which was good practice. The content of the carer assessment was:

- Kathleen needed to be in touch with Mental Health Professionals to know what is going on, and also to get some advice on how to deal with problems that might arise with her son.
- She would need a break. She is aware of this, and would let the team know. The team would then make an application to the Local Authority for some funding. Not requested.
- Kathleen would make contact with Richmond Carers' Centre for further advice and support.

The carer assessment did not cover any questions about domestic violence or abuse at that time. The Mental Health Trust confirms that the assessment now contain such questions.

3. 18 On 20 March 2007 Paul was seen for his first CBT session and seemed quite withdrawn. His main problem appeared to be developing relationships with others generally. Options for new hobbies were suggested such as book clubs or chess, but Paul saw these as 'nerdy'.

3. 19 The follow month on 20 April 2007 there was a Care Programme Approach (CPA) Review. Paul reported feeling stable in his mood. He had commenced his CBT and was seeing the vocational support worker to update his CV and they were exploring voluntary job options. His medication appears to have changed slightly at this point; the Aripiprazole had increased from 20mgs to 30mgs. Paul was to be reviewed regularly by his social worker and CBT therapist. His next CPA Review was to be in 2 months time.

3. 20 On 21 May 2007 an initial assessment appointment for family therapy had been arranged, but Kathleen did not attend. A phone call was made to her and a rescheduled appointment was arranged for a morning 10 days later, however, Kathleen did not attend this appointment either. On 20 July 2007 the IMR chronology shows that a clinical psychologist wrote to Kathleen; notes record "wrote to mother acknowledging that it wasn't the right time for her to start any family work, but invited her to make contact if and when she wishes to engage". There is no recording to establish why the second

appointment was missed, why family therapy was offered, or Kathleen's reasons for this "not being the right time".

3. 21 On 23 July 2007 a GP consultation record notes that Paul has been taking his medication, is stable and has no other problems. He had increased the dose of his Escitalopram to 15mgs and reported feeling fine with it. It is noted "advised to inform the CMHT about this", followed by "he will tell his CPN about this". His mother said he was fine as long as he was taking his medication. This suggests that Kathleen was at this appointment. There is no record in the Mental Health IMR chronology of a CPN being informed that Paul increased his medication.

3. 22 Paul had his final CBT session on 1 August 2007 and presented with no psychotic thoughts; he was seen to have a bright mood, and he was working and socialising. A relapse prevention plan was developed should he be discharged from the Community Mental Health Team if he or his family identified him becoming unwell. This included calling his GP, the Samaritans, or he could call his CBT therapist if he wanted to continue sessions. Finally, Paul set himself some long term goals which he identified as living alone, but near to his family, doing a job he enjoyed and having a wide circle of friends. Paul is recorded as acknowledging that he had made changes and understood the reasons why therapy was ending, although he could re-refer himself at any time. By this time Paul had been seen for 12 1hour CBT sessions. The Trust was asked if the relapse plan was shared with Kathleen as Paul's carer; it was confirmed that there is no evidence of this taking place.

3. 23 A CPA Review after 2 months is missing from the mental health chronology, however at the next review which took place on 7 November 2007 Paul is recorded as saying he has been well since his last review in June. Therefore it appears there was a gap in recording. Paul saw a different psychiatrist at this appointment and he reported that he was not currently working, but he was renovating his property indicating that he may be living alone. Paul reported no problems with his level of medication which he was happy to continue; his mood was good, and he had no suicidal ideation or psychosis. The plan was for Paul to continue to be reviewed by his care coordinator and continue his medication. There was no review of the relapse plan given that he appeared to be now living alone; his family had been part of the plan to identify if he became unwell.

3. 24 In early February 2008 Paul had a first meeting with his new care coordinator. He was 20 minutes late and so the coordinator phoned his home number and spoke to his mother who said he was on his way. Kathleen reported that Paul was 'doing okay' and she wondered whether he actually had schizophrenia. Kathleen was told that if Paul consented she would be welcome to attend one of his future appointments. It is not recorded whether Paul's consent was sought and/or given. It is not clear whether the call to Paul's home was his address or whether he had now moved back once more to live with Kathleen. Paul was seen and said he was doing well and he presented accordingly; he had started looking for jobs.

3. 25 When Paul was seen by his care coordinator on 14 March 2008 he was judged to be physically and mentally well, but lacking in motivation to build his life and attend job interviews. When he was seen again the following month on 3 April the same situation was noted, although he said he was looking for a job with little luck.

3. 26 Paul was reviewed by a doctor in the Richmond Early Intervention Team on 16 June 2008. Again he appeared well. During the appointment he asked a series of questions about what his diagnosis was. There is no record of a formal diagnosis. The plan from this meeting was to continue medication as before and to arrange a meeting to transfer his care fully to the Early Intervention Service. This transfer from the Community Mental Health Team took place on 11 July 2008. Paul is recorded as being anxious about the

change of care coordinator and felt that the team did not think he was making a recovery and progress. He was reassured as to why the change was happening i.e. the new service was set up to address the early onset of illness. At this time Paul was working 16 hours a week at a national supermarket which he said he enjoyed. He felt he no longer needed a care coordinator; he felt able to do things himself e.g. contact the Jobcentre etc. He said he was on the housing list and a supportive letter had been sent by his GP.

3. 27 Due to the progress made Paul was judged to need only a Standard CPA care plan, but if issues arose he had access to support from the service. This change of care plan took place and on 8 August 2008 and Paul moved to 3 monthly reviews with a psychiatrist in the Early Intervention Service. It is not recorded whether consent was obtained from Paul to share information with his mother, but the Mental Health IMR suggests that as his care plan was shared with Kathleen then it has been assumed that consent was sought and obtained.

3. 28 At his next CPA Review with the same psychiatrist on 7 November 2008 it was observed that Paul had been entirely stable for the previous 6 months. He was recorded as having increased his working hours to almost full time and he denied any current symptoms. A gradual reduction in his medication was discussed, and it was pointed out to him that it would be prudent to meet more often if changes were made. Paul was reluctant to consider this due to work commitments. Relapse indicators were discussed with him; his last psychotic episode had been 4 years ago when he experienced what he described as "negative thinking". It is noted that Paul felt he no longer needed contact with mental health services. The plan set out by the psychiatrist stated:

1. For the present he had agreed to continue taking Aripiprazole 30mgs per day.
2. For the future he could consider reducing his dose to 20mgs per day, staying on this dose for a number of months whilst reviewing his mental health.
3. As he has had only one previous psychotic episode, I feel it would be reasonable to consider reducing and stopping medication over the coming months, particularly as he has been taking an anti-psychotic for over three years.
4. He was also advised that the Early Intervention Service would be happy to see him again if the need arose in the future.
5. Letter sent to GP outlining all of these points. (A letter including the above information and the plan was sent to Paul's GP on 10/11/2008 with a copy to Paul)

There were questions arising from this information in the IMR and for clarity, transparency and ease of reading they are included here:

Q1. Regarding point 2 of the plan - Who would be reviewing his mental health if he was discharged from the service, especially given his previous history of deterioration when reducing his medication himself?

A1. The patient.

Q2. Would the patient's GP be updated on a regular basis by the Early Intervention Team or just at the end of an intervention?

A2. Just at the end of the intervention. (previously the Community Mental Health Team had sent the GP reports at each review assessment.

Q3. Would contact be made with his carer at this point to inform her of the plan?

A3. Only if the patient consented.

Q4. Given that the Services were aware that the patient was looking to move into his own home at some stage, would the letter to the GP also include advice re: management of the patient when he moved into independent accommodation?

A4. No.

3. 29 There was a gap in update reports from the Community Mental Health Team to Paul's GP between a report of 7 November 2007 and the final report of 10 November 2008.

Chronology from 2009

3. 30 Paul is understood to have lived briefly on his own in 2009, but he moved back in with Kathleen a year later because he could not manage financially to live independently. He then moved out again in 2011 and lived about four miles away, but he saw Kathleen regularly.

3. 31 Following his discharge from the Early Intervention Service in November 2008 Paul's care returned to his GP. He continued to receive repeat prescriptions. He had a mental health review on 3 March 2009 when it was noted that he had been on his medication for a long time, he was coping well, had a neutral mood, and no psychotic symptoms, just a fine tremor of his hands; it was noted that this could be a side effect of his medication.

3. 32 Up to 5 May 2010 Kathleen was registered with the same GP practice as Paul; she registered with a different practice after moving area. Kathleen's medical notes prior to the review period whilst registered with her previous practice included a past history of depression. A note was made in those medical records that "son has schizophrenia" and Kathleen was having 'family therapy'. However, the Mental Health Service IMR records that Kathleen did not attend family therapy sessions (see paragraph 3.20). No medical records were made for Kathleen between 1 June 2009 and 4 December 2009.

3. 33 On 28 May 2009 Paul saw a GP with a history of a few weeks of feeling anxious and low level depression. He was not suicidal and there were no psychotic symptoms. It was noted that he had seen a psychiatrist and the plan was to gradually decrease his dose of Aripiprazole. Assessment using PHQ9[6] and GAD-7[7] scored 20 (= severe) and 19 (=severe anxiety) respectively. Paul was working at the time and was able to concentrate at work. He was advised to try Citalopram[8] 10mgs for 2-3 weeks and then return for review.

3. 34 A GP review of all Kathleen's medical notes was undertaken by a new GP in June 2009, one month after Kathleen joined her new surgery. The summary stated "of significant note were her longstanding history of episodic depressive illness" and various other physical illnesses. There was no indication in the GP summary that there were any concerns about her son. During her time with the practice Kathleen was seen by a number of doctors rather than one consistently. Her contacts with her GP practice were for physical ailments

[6] PHQ-9 - The Patient Health Questionnaire is not a screening tool for depression but it is used to monitor the severity of depression and response to treatment. However, it can be used to make a tentative diagnosis of depression in at-risk populations. Depression Severity: 0-4 none, 5-9 mild, 10-14 moderate, 15-19 moderately severe, 20-27 severe. http://patient.info/doctor/patient-health-questionnaire-phq-9. accessed 08.06.16

[7] The GAD-7 originates from Spitzer RL, Kroenke K, Williams JB, et al; A brief measure for assessing generalized anxiety disorder: the GAD-7. Arch Intern Med. 2006 May 22;166(10):1092-7. Scores of 5, 10, and 15 are taken as the cut off points for mild, moderate, and severe anxiety, respectively. When used as a screening tool, further evaluation is recommended when the score is 10 or greater. http://patient.info/doctor/generalised-anxiety-disorder-assessment-gad-7.accessed 08.06.16.

[8] Citalopram is an antidepressant in a group of drugs called selective serotonin reuptake inhibitors (SSRIs). Citalopram is used to treat depression. https://www.drugs.com/citalopram.html.

some of which required treatment at the local hospital and for her long term history of depressive episodes for which she was prescribed medication.

3. 35 Paul was seen at his practice for a review of his anxiety and depression by a different GP on 19 June 2009. He is recorded as feeling much better on 10mgs of Citalopram, he was sleeping well; he had no suicidal thoughts; he was not experiencing any tremor or abdominal upset. His notes record that "he would like to increase Citalopram". This was discussed and he was advised to try an increase, but to be aware of possible manic symptoms and to be reviewed in 2-3 weeks or if needed.

3. 36 On 13 July 2009 Paul was seen by a locum GP with a 2 week history of chest pain which started after using nitric oxide (recreationally). As a precaution Paul was referred to the Rapid Access Chest Pain Clinic and was seen on 15 July for examination and tests. His ECG test was normal.

3. 37 Paul was reviewed by his GP on 18 September 2009 and was found to be very well with no side effects from his medication. He reported working full time and was in good physical health. Paul's next mental health review was on 26 August 2010 when he was again recorded as well.

3. 38 The most significant health event for Kathleen was in September 2010 when following diagnostic tests at the beginning of August 2010 she was diagnosed with a rare form of cancer. On 23 September her GP notes record that Kathleen "is tearful, with 'reactive affect' but not suicidal". She was prescribed an anti-depressant and was to return in 2 weeks for review. Kathleen did not return for the review.

3. 39 In an appointment with his GP on 22 October 2010 Paul is recorded as being stressed at work (for a car park); he felt his chest was tight and it was difficult to breathe. It was also recorded that his mother had been diagnosed with cancer. He had a past history of depression and having panic attacks; a planned increase in his Citalopram to 40mgs was made with a review in 2 to 3 weeks. At this time Paul had been off work for 3 weeks. At the review on 12 November 2010 Paul was noted to feel better, but not yet able to return to work. He was coping and not suicidal. To review in 3 weeks was recorded.

3. 40 On 28 November 2010 Kathleen was admitted to hospital where she had extensive surgery for the removal of the cancer with which she had been diagnosed in September. She was in hospital for a month returning home on 23 December.

3. 41 On 11 January 2011 Paul saw his GP for a depression interim review. He was well, but said he would like a little more time (off work); he planned to return to work in February. He was noted to be "still looking after mum". A suicide risk assessment undertaken resulted in "not suicidal" being recorded. He was to be reviewed again in 1 month.

3. 42 The following day on 12 January 2011 Kathleen was admitted to hospital via ambulance due to shortness of breath/pneumonia. Her GP IMR notes that hospital letters were being sent to her former GP practice at this time, possibly because records had not been updated at the hospital.

3. 43 Paul attended a planned review appointment with his GP on 1 February 2011 where he presented as well and "doing okay on medication", but he was not ready to return to work. It was noted that he plans to do so on 20 February; notes were given; his mood was normal, with appropriate affect. A suicide risk assessment determined he was not suicidal.

3. 44 Kathleen had a post operative review at her GP practice on 16 February 2011, and on the 25 March she had an appointment where she requested the restarting of antidepressants (she had stopped the medication in October 2010 as she was having surgery). A prescription for one month's supply of Citalopram was issued as she was feeling low. It was noted on her GP records 'Approaching return to work'. There was no discussion about her son.

3. 45 Paul was reviewed by his GP on 6 May 2011 and it is recorded that he "felt much better since stopped work" and he was helping his mother at home. He seemed much better and his mood was stable. Paul had resigned from his job at a supermarket. When Dr Veisi asked in his interview why he had left his job Paul replied "I had enough of that. It was not a good job. It was paying little money. It was exploitation. It was not enough to get a flat in London. All that energy and effort for what?" Paul told Dr Veisi that he had no thoughts of a career "I never had any of that aspiration". From this point Paul was in receipt of Job Seekers Allowance.

3. 46 On the 16 May 2011 Kathleen revisited her GP practice reporting low mood. The GP made a record that "has a son with psychiatric history living with her (bipolar)". This is the first mention at this practice that she has a son who has a serious mental health illness and the first written record that he is living with her. On the 17 May her GP practice faxed a referral to the Right Steps Counselling services which included the information "She also has a son with a longstanding psychiatric history with bipolar disorder living with her, who complicates issues further at home". A letter was sent the same day to Kathleen by Kingston Right Steps psychological service acknowledging the referral and inviting her to phone to arrange an assessment.

3. 47 On 19 May 2011 Paul was seen by his GP with symptoms of depression, but was not suicidal. It is recorded "feels too low to go back to work" and "planning training for a new job".

3. 48 On the 3 June 2011 Kathleen called the GP because she was feeling dizzy and she said she had already been to A&E. GP records state that Kathleen said A&E put her on medicine for dizziness. The GP advised her to take another medicine over the weekend and call again if not better. No A&E letter was received by the practice and there is no A & E attendance noted in the hospital IMR.

3. 49 Also on the 3 June 2011 Kathleen had a telephone triage assessment by a trainee psychological wellbeing practitioner from Right Steps psychological services. Kathleen reported that her depression started 10 years previously when her mother became ill. Her current episode had started 4 months ago and she felt her medication was not working. It was recorded that she had a son diagnosed with bi-polar disorder who did not live with her (Kathleen's GP referral stated her son was living with her. it is possible the Paul had moved out once more by this time). Kathleen admitted feeling suicidal several years ago, but said the thought of her children had stopped her acting on those thoughts. It was noted that she was not happy to work in groups. Kathleen said she wanted to deal with the issues that made her depressed rather than the depression as such. Kathleen's GP practice received confirmation from Right Steps of the referral acceptance.

3. 50 Kathleen attended her GP for review on 13 June 2011 and it is recorded that she was not well enough to cope with her job. The GP issued a MED3 certificate for her to remain off work until 12 July 2011. Kathleen asked to continue her antidepressants as she said they "keep her off edge". Also of note; again there is no record of any mention of her son to the GP at this time. This was the last appointment Kathleen had at her GP practice before she was killed. The IMR author notes this visit to the GP was around the time of her son Paul's birthday.

3. 51 What remains in Kathleen's medical notes are copies of letters sent to her by the same trainee psychological wellbeing practitioner dated 17 June 2011 from Kingston Right Steps following a further phone call to Kathleen in response to a message left by her. There were a total of 4 separate letters written in technical terms sent on the same day: Letter 1 sent to Kathleen offered an appointment with a clinician as soon as one was available, but there was a waiting list; letter 2 sent with a booklet about antidepressant medication; letter 3 enclosed contact details of private psychotherapy clinics 'as requested', and letter 4 about exercise on prescription. There was no information on Kathleen's notes as to whether any of these options were taken up.

3. 52 On 24 June 2011 Paul was reviewed by his GP and found to be doing well; his mood was neutral. He was also seen for a cough at this appointment. Paul was next reviewed on 11 August 2011 when it was noted that his mood was much better whilst he was off work. He reported that he was helping his mum with the house, and he had stopped drinking as he 'felt that got allergic reaction with chest to beer'. He is recorded as 'objectively euthymic[9]' and he was planning to start training.

3. 53 On the 19 August 2011 a telephone call was made by Right Steps to Kathleen to arrange an appointment, but she said it was not convenient to speak and she would call the office. A further phone call to Kathleen took place on 22 August to arrange an appointment, but she was unable to make the time offered as it was in working hours. She said that she would like to do a Stress Management Course as an alternative. A letter was sent to Kathleen that day offering her a place on the Stress Management Course, including course dates and the fact that participants did not have to speak in the group unless they wished. There was the option to talk to a counsellor at the end of each session. Kathleen appears not to have replied to the offer of the course as the final letter from the service to her dated 14 September 2011 stated that as she had not responded it was assumed that she no longer wish to participate and she was discharged back to GP. Her GP received copies of letters sent to Kathleen.

3. 54 At a patient review with his GP on 6 October 2011 Paul was noted as doing well and he felt ready to go back to part time work. He was due a Work Capability assessment in a few days. His next GP review was to be in 2 months time.

3. 55 On the 7 December 2011 Kathleen's GP practice received a copy of a letter confirming that her 1 year follow up CT scan undertaken after her operation in 2010 showed no recurrence of cancer. Kathleen was also discharged from the hospital Respiratory Clinic at the end of February 2012 where she had been followed up after her breathing difficulties the year before.

3. 56 On 15 December 2011 Paul's GP practice received a Work Capability Assessment Outcome Notification from Jobcentre Plus dated 9 December. This informed his GP that Paul had been assessed as capable of work from and including 9 December 2011. The letter confirmed that his GP no longer needed to issue medical certificates for Employment and Support Allowance for him unless he appealed the decision, but they may need to do so again if his condition worsened significantly.

3. 57 Paul was seen by a different GP in his GP practice on 19 December 2011 when he was noted as doing well on Citalopram and he had no suicidal thoughts. A PHQ-9 assessment for assessing the severity of depression was undertaken, but the results were not recorded. It was noted that Paul was looking for a job. This is the last GP appointment recorded for Paul before the murder.

[9] euthymic = neutral mood

3. 58 Throughout his history with his GP practice following his mental health assessment in 2007 Paul received repeat prescriptions for his anti-psychotic medication Ariprprazole, and Citalopram to treat depression and anxiety. However, the last repeat prescription issued was on 13 February 2012. There are no records to suggest that this was queried or that Paul was contacted for review. Photographic evidence from the Police murder investigation seen by Dr Veisi of Paul's flat revealed several boxes of his medication unopened.

3. 59 In June 2012 Kathleen's work colleagues contacted the Police due to concerns that she had not come to work, and uncharacteristically she had not phoned the office. They were unable to raise a response when they visited her flat and called the Police. At a second visit later that day the Police forced entry and found Kathleen. She was pronounced deceased by ambulance staff who had been called to the scene. The subsequent murder enquiry implicated Paul who had fled the country. A European Arrest Warrant was issued. Subsequent actions have been described in paragraphs 1.10 and 1.11. The Review Panel observed that the fatal incident took place around the time of Paul's birthday.

4. Overview

Summary of Information Known to Agencies:

4.1. Kathleen and Paul were both known to health services via their GPs and hospital based services, although hospital contacts were not of relevance to this Review. Paul was also known to the Richmond Community Mental Health Team and the Early Intervention Service, but had not been seen or reviewed by them since 2008. Therefore the most significant service for both Kathleen and Paul was their GP practice.

4.2. Kathleen's GP practice was aware that she suffered from a long history of depressive episodes prior to and during the period under review for which she received repeat prescriptions of medication; from the Right Steps records Kathleen identified her depression starting following her mother's illness 10 years previously. Her medical notes from her previous GP practice which she shared for a while with her son Paul, suggested she was having family therapy during the period of her registration with them, however, the Mental Health Service IMR indicates that this was not actually taken up, and we have been unable to establish why Kathleen felt unable to accept this service. We have been unable to establish why family therapy might have been arranged; it is mentioned in the Mental Health IMR as offered among other services to Paul. The previous practice notes also record that her son had schizophrenia.

4.3. The first record in Kathleen's last GP practice notes that she had a son with mental illness is not until an appointment on 16 May 2011, a year after she registered at the practice. This noted that she "has a son with psychiatric history living with her (bipolar)". It is at this appointment that she was referred to Right Steps psychological services in relation to her low mood, however Kathleen did not take up the group work offered and apart from a telephone assessment she was never seen face to face by this service before being discharged. Kathleen was last seen by her GP practice on 13 June 2011, a year before she died although the practice received correspondence from her follow up hospital appointments the last of which was in February 2012.

4.4. Paul's GP practice and Community Mental Health Team were aware of his mental health history and his treatment plans. However, Paul's report to his GP that he increased his medication in July 2007 does not appear in Mental Health records, and there is a gap in reports by the Mental Health Team to the GP between November 2007 and the discharge report sent in November 2008. Dr Veisi noted this gap in his report for the court. He

observed that Paul had continuously shown a desire to come off his medication which was agreed as part of his discharge plan of November 2008; at some point Paul was brought to the attention of the Community Mental Health Team and he was put back on his regular medications.

4.5. From September 2009 Paul saw the same GP for his appointments and reviews, apart from his last attendance on 19 December 2011. The practice was not fully informed about his mental health assessments between 2007 and 2008 when he was discharged from the Early Intervention Service. From discharge by mental health services in November 2008 Paul attended the following with his GP:

Mental Health Reviews	Other Mental Health Related Appointments & Follow up
1. 3 March 2009 *	28 May 2009 *, 19 June 2009*
2. 18 September 2009	
3. 26 August 2010	22 October 2010
4. 12 November 2010	
5. 11 January 2011	1 February 2011
6. 6 May 2011	19 May 2011
7. 24 June 2011	
8. 11 August 2011	
9. 6 October 2011	19 December 2011*

* Different GP seen on each of these occasions

4.6. Neither Paul nor Kathleen were known to the Police before the fatal incident.

Other relevant facts or information

4.7. The psychiatric reports undertaken for the court by Dr Joseph and Dr Veisi provide valuable additional information which is relevant to this Review. Dr Joseph undertook one interview and read extensive supporting documentation, and Dr Veisi interviewed Paul on 3 occasions and also had supporting background documents. It must be acknowledged however, that unless Paul had been under close supervision or even surveillance it is highly unlikely that some of this information would have been known to agencies.

4.8. Paul admitted that he had stopped taking his medication a few months before the fatal incident when he saw his mother in June 2012. It may be reasonable to surmise that he may have stopped taking his medication more than a few months previously since his last prescription was the 13 February 2012 and unopened boxes of medication were discovered in his flat.

4.9. Paul reported sleeping very little at the time of the offence and that he did not have enough money to eat, pay his TV licence, and he had no electricity. He had threatening letters from the water company, and his Job Seekers Allowance had been stopped because he said he made a tiny mistake on the form. The last time he 'signed on' at the Job Centre was 29 May 2012. He was refused food from a food bank as he did not have a 'Red Card' and was told to apply for a crisis loan. Paul stated that he returned to the Food Bank 2½ weeks before the fatal incident and was told that that his crisis loan had not been refused, therefore he was not eligible for food. He said despite this he had a lot of energy.

4.10. When asked about his relationship with his mother Paul told Dr Joseph that until the age of 26 years old he got on with her "okay"; he said he then slowly began to realise that she did not have his best interests at heart. He appeared to expect that his mother would

support him financially, but also felt trapped because he had no money and was dependent on her. He said he had asked her twice for money and she had refused. Paul appeared to be angered when he thought people were judging or disrespecting him. When Dr Veisi asked Paul if his mother had ever disrespected him he replied “When I started living in 'X' (the area he moved to live independently), she started hating my guts. She always hated my guts on some level. How could she refuse giving me money when I have never stolen from her or taken drugs or been violent to her? How could she let her son starve? There was food at her flat that I could have. After a while she stopped buying food and started buying special diet food that I hated". It is likely that Kathleen's change of diet was linked to her recovery from her cancer, but Paul probably did not think of this or appreciate his mother's health needs.

4.11. During Police enquiries a text was found in the draft folder on Kathleen's mobile phone dated 29 May 2012 at 00:49hrs which was not showing the planned recipient. If it was to Paul, which is likely, it suggests a tension between them: “Do not spend any of my money. Leave my card in the flat. U r a totally selfish pig. The only i ask is that u leave early on a week night and u would not do”. Kathleen was known to be very punctual for work each day and perhaps Paul was staying at her flat later than she wished as she had to get up early for work. Whilst the reference to leaving her card in the flat indicates Paul might have been using it without Kathleen's explicit permission, information available to the review found no evidence to suggest financial abuse or coercion by Paul. Kathleen appears to have been a caring mother who was trying to support her son financially as far as she was able, for example providing money for a rent deposit, and saving him money by providing meals on a regular basis. Kathleen may have felt that she should have been able to leave her bank card at home and trust Paul not to use it. He clearly had the PIN number to use the card although there is no information available to show how he obtained this. The unsent text message found on Kathleen's phone suggests that supporting him financially may have been an increasing strain as Paul continued to remain unemployed and was not receiving benefits. However the review was unable to find evidence to emphatically suggest that Paul was financially abusing or coercing his mother, other than taking advantage of her strong desire to support her son.

4.12. Paul described his lifestyle before the offence as 'chaotic'; he was not working, he was under stress and feeling chaotic. On the day of the murder he had been drinking. He had not taken illegal drugs or prescribed medication. He had let himself into the flat before his mother returned home from work and taken her bank card to buy tobacco, put back the card and left before returning later. Paul told Dr Joseph that he had drunk some alcohol in the street on the way back to his mother's home and was feeling drunk. He related how he felt pains in his stomach and telling his mother that he wanted to go to hospital. He thought she might be poisoning him, but he did not accuse her of this. Paul maintained that he asked his mother for money and she became abusive towards him and an argument ensued. He said he felt hemmed into a corner; he had never been violent to her before and would walk away from previous arguments. Paul said he did not know why he did not walk out on this occasion, but said it all became too much. He maintained he had no memory of the attack.

4.13. Witness statements made available to Dr Veisi describe Paul's behaviour after mid February 2012 as strange and he was possibly on drugs or mentally unwell. There were examples of unusual behaviours such as registering with a gun club and then leaving it abruptly, and an incident of sexually inappropriate and threatening behaviour to a woman. He was seen walking up and down streets looking dishevelled, and he himself described walking for hours during the night shouting or rapping. However, Dr Veisi found no reports to suggest that there were domestic disputes or violence previously involving Paul and his mother Kathleen.

4.14. Dr Veisi contrasted Paul's years of deterioration in social communication and isolation as well as early delusional ideas, with his behaviour prior to the offence when he had more delusional ideas that his mother was poisoning him, deliberately removing food, refusing funds and as he viewed it, insulting and humiliating him. He had high levels of energy, grandiose delusions as well as paranoid persecutory beliefs about being followed by homosexuals and hated by women. Thus coupled with his disinhibited behaviour, Dr Veisi concluded that at the time of the offence Paul was suffering from a bipolar affective disorder, and was manic with psychotic symptoms. Dr Joseph (for the Defence) was less emphatic; although initially sympathetic to the same diagnosis. In his view the absence of reference to previous symptoms of hypomania in Paul's medical records cast doubt on a diagnosis of bio-polar affective disorder. Whilst in prison Paul was treated with Olanzapine 5mg a minimal dose of anti-psychotic medication, and although his mental state had improved a number of symptoms persisted i.e. a sense of self-importance, grandiosity, delusional ideas about being persecuted by homosexuals and his hatred for being humiliated.

About the Victim and the Perpetrator

4.15. Despite Paul's rather negative description of his relationship with his mother when he was interviewed, Kathleen's brother described their relationship as very close. During her illness with cancer and her successful recovery her brother said Kathleen "sang his praises" for the support and care he gave her at that time. Her illness brought on depression for which she was prescribed medication; this often made her feel drowsy. As this side effect diminished Kathleen was able to return to work.

4.16. Kathleen's brother reported that she had been in the process of selling her flat and returning to Spain to live, but the company she worked for asked her to stay. Their offer changed her mind and she had intended to remain in London. Kathleen was intelligent and resourceful; she bought properties, renovated and then sold them. When last seen by her brother Kathleen was described as cheerful. Paul was not present, but he had been on the previous visit. His uncle described him as a very quiet, gently person. After Kathleen's recovery from cancer Paul returned to living in his own accommodation.

4.17. Kathleen's work colleagues describe her as a really caring, sensitive person. She was part of a tight knit team. At work she was very professional, calm and considerate and she was very good with people and very good at dealing with clients. Kathleen was said to be a very positive person who found good in people and she was very supportive of others. One of her colleagues said Kathleen was over the moon when she was given the all clear from her cancer before her death.

4.18. At Kathleen's workplace everyone had to complete a 'death in service' information form stating their next of kin; Kathleen put Paul down and her colleague thought Paul knew this. Her colleague was aware that Paul would go round to Kathleen's flat each evening around 5pm to have a meal. Sometimes he would take friends with him too and they would drink. Paul drank, smoked and dabbled in drugs. He also had debts. Kathleen's colleague was aware that she was going to sell her flat and was considering moving back to Spain to teach, or move to the south coast; she liked to be by the sea, and she wanted to enjoy life; she was seen to have a very positive outlook after her all clear from cancer. Kathleen was going to use some of her money from the sale of her flat to help Paul with his debts, but this changed when she decided to take the flat off the market and to stay in her job. Her colleague thought Paul was angry about this.

4.19. Paul was described as a 'Jekyll and Hyde' character; he could be soft and cuddly when sober, but he could be angry when drunk. In the opinion of her colleague Kathleen just wanted to help her son. Her colleague was aware that Paul could be violent; he had once been in a brawl in a night club. She thought Kathleen was nervous of him at times and

knew what he was capable of. Her colleague thought he knew that he was Kathleen's next of kin and she would leave her assets to him.

4.20. It was Kathleen's colleagues who called the Police. Kathleen was always at work before 9am, but on this day she was absent, this was very out of character which is why after several texts and phone calls remained unanswered, they went to her flat to see how she was. They described looking through the letter box and seeing bed unmade and clothes on the floor. Kathleen was a very tidy person so they suspected something was wrong. When they looked through the window shutters they could see the TV was on and magazines were on the floor. This is when they called the Police, they knew something was wrong.

4.21. Kathleen's friend and colleague said Kathleen had more to contend with than they knew and they now realise she kept a lot to herself. Her death was a massive shock.

5. Analysis

5.1 The following analysis considers the events known to agencies and the findings within the IMRs and information provided to the Review. The analysis will be structure around the terms of reference for the DHR.

5.2 ***Term of Reference 1:*** *To consider each agency's involvement with the family members between 1 June 2009 and the murder in June 2012:*

5.3 Background information prior to the above dates has proved crucial in setting the context for agency involvement with Kathleen and Paul therefore this has been given more detail rather than a summary. The chronology and overview section of this report addresses this term of reference and will not be repeated here. The following terms of reference will further consider agencies involvement with Kathleen and Paul.

5.4 ***Term of Reference 2:*** *Whether, in relation to the two family members, an improvement in any of the following might have led to a different outcome for Kathleen:*

(a) Communication between services - NB Of particular interest is whether Irish health records were transferred to Paul's GP or included in the medical notes when he registered with the practice.
(b) Information sharing between services with regard to the safeguarding of adults

5.5 Paul's GP records in Ireland were never received by his UK GP therefore they are not recorded in his English records. The psychiatrist who saw him in 2007 had requested a copy of correspondence from his psychiatrist in Ireland, but there is no record of this being received. The psychiatric assessments completed for the court also make no reference to them. Therefore Paul's history seems to be verbal only provided by Kathleen and himself.

5.6 It is not possible to emphatically state that communication between services could have led to a different outcome for Kathleen in terms of preventing her death. However, there are some aspects of communication which could have supported her more in her caring role for her son, and thereby equip her with an accessible route to support and protection which she may have felt able to use.

5.7 There is a sense that even though Kathleen was recognised as Paul's carer at the start of his treatment with mental health services in 2007 she was very much on the periphery. She could only be involved with Paul's care plan if he consented, and yet she was tasked with monitoring him taking his medication. The fact that she was given a carer

assessment was good practice, however, this assessment put the onus very much on her i.e. Kathleen "needs to be in touch with Mental Health professionals to know what is going on", but how does she do this if Paul withholds consent? And she needed to "get some advice on how to deal with problems that might arise with her son" and "make contact with the Carers Centre". The assessment does not feel as though it was caring for the carer, it was adding to her responsibilities.

5.8 Whilst recognising the imperative of patient confidentiality which informs how professionals in the Health Service work, had a truly coordinated approach been promoted, and patient consent gained to communicate from the start between mental health services and both Paul and Kathleen's GPs in the interests of both, perhaps a fuller picture of the stress Kathleen was under supporting Paul, and the growing risks posed by Paul's deteriorating mental health might have been identified and a timely intervention made. Nevertheless, it is acknowledged that Kathleen had not visited her GP or any agency during 2012, and Paul had not visited his GP during 2012 apart from collecting a repeat prescription in February. Paul's GP observed that communication between GP practices is an ongoing issue which was difficult at the time under review, however this is thought to becoming easier with the introduction of the nhs.net secure email. The author is aware of previous DHRs where a perpetrator and victim are close family members who have separate GP practices, and she understands the challenges of inter-practice sharing of information, however the consequences of silo working with families in cases such as Kathleen's can be, and sometimes are, tragic.

5.9 It is acknowledged that the Community Mental Health Team had not had contact with Paul since 2008, but it is arguable that someone with his diagnosis should not be the sole responsibility of their GP. There is a case to be made that an annual review by a mental health professional should take place of patients who have been previously known and managed by the service under the Care Programme Approach, or where there is a history of a serious mental health condition which requires ongoing medication. This would ensure at least annual review and communication between the specialist mental health service and primary care who have the ongoing care of the patient.

5.10 There are gaps in communications between mental health services and Paul's GP which appear to coincide with his move to the Early Intervention Service, and also with a change in care coordinator. Before November 2007 there was good practice with the GP receiving regular letters outline reviews and plans. A question was asked of mental health services arising from their IMR as to whether GPs are updated on a regular basis or just at the end of an intervention. The answer was that they are only updated at the end of an intervention. This could be particularly unhelpful for GPs and for mental health services particularly as treatment and interventions are reliant on patient's reporting truthfully on such matters as how they feel and the level of their medication. There are two examples of patient led changes in medication within the chronology which appear not to have been communicated to mental health services by Paul or the GP he saw at that time; there is a need for more communication between the services rather than less in such cases to provide some degree of corroboration of a patient's self reported progress.

5.11 The final care plan in the Early Intervention Service discharge letter to Paul's GP in November 2008 gave the opinion that it would be "reasonable to consider reducing and stopping medication over the coming months". A question arising from the Mental Health IMR for the Panel was who would be reviewing Paul regarding any step to reduce or stop his medication as he had been discharged from mental health services, and especially given his previous history of deterioration when reducing his medication himself? Paul's GP also felt the discharge letter was unclear in terms of his medication and whose responsibility it was to monitor any reduction in medication. The answer to this question was the patient would be responsible for his own review. With Paul's history of relapse

when he stopped his medication this seems unduly optimistic. There was no further communication between Paul's GP and mental health services following his discharge.

5.12 Paul's GP reported that in their experience communication between community psychiatric nurses and Mental Health Teams is always difficult, and GPs would like more and clearer correspondence, especially regarding risks and past history. They suggested that practice would also be improved if the GP knew who their patient's social worker or community psychiatric nurse was along with their contact details to enable easier communication concerning patients[10]. Paul's GP reported that there used to be 3 monthly meetings with a psychiatrist from the Mental Health Team which were very useful, but these ceased. It was their view that it would be useful to see such meetings reinstated.

5.13 A further worrying aspect is that Paul's GP reported that they did not realise that he was prescribed an anti-psychotic medication along with his other regular prescription of anti-depressants. His GP stated that they, and others in the practice who saw him, were reviewing Paul on the basis of depression rather than a psychotic illness. This is borne out by his medical notes. He presented as very stable and his GP reported having no details of previous history, triggers, or violence. Paul could manage a job, and there was no change noted in him when he stopped working. Although information on triggers or history of violence may not have been readily available, the report to his GP in 2007 by Paul's psychiatrist did describe his mental health history, early diagnosis in Ireland, and the fact that he would need to be on Aripiprazole anti-psychotic medication for the long term. The lack of past history awareness suggests that this comprehensive report was forgotten, not read by subsequent GPs, or not easily accessible on Paul's notes. Nevertheless the GP had followed best practice and entered Paul on their serious mental illness register in January 2007. In the GP's experience it is very unusual for a patient on Aripiprazole not to be overseen and reviewed by mental health services. Other similar patients on the practice list on the same medication are reviewed in this way. Possibly because he presented as stable in comparison to the other patients and attended regularly for reviews until the end of 2011, Paul seems to have slipped through the mental health review net.

5.14 The IMR author for Kathleen's GP found there was very little flow of information about Kathleen's depression between the GP and Right Steps psychological services when she was referred in May 2011, bearing in mind this was the first appointment where Kathleen mentioned that she had her son living with her who had a serious mental illness. At this time Paul was not working and this might have presented additional strain on Kathleen following her surgery and the ensuing complications during January and February of that year. If the referral had been more comprehensive the triaging process may have categorised her as having a higher need, and there could have been the opportunity for her to raise any issues about her son that she may have had given that her son was living with her at the time of the referral. By the time Kathleen had her triage telephone assessment in June 2011 she stated that her son did not live with her; this change between referral and assessment could have been pursued in the conversation with Kathleen. A system to ensure transfer of a useful level of information between GPs and the psychological services in Kingston is needed.

5.15 Communication from the hospital where Kathleen had her operation was sent incorrectly to her old GP practice. If the information had contained material about her mental health or concerns about her son, then there would have been an unnecessary time lag between sending and receiving this information to the correct GP practice. The hospital had enquired about her adult children (although no concerns were raised). Systems to ensure addresses are updated at all hospital trusts are needed.

[10] The author would recommend that the contact details include a secure email address and that these are recorded in an easy to find place on the patient's notes.

5.16 There were no occasions for sharing information with regard to safeguarding of adults as neither Kathleen nor Paul was identified as in need of safeguarding. There had been no Police callouts to incidents of abuse before the fatal incident, and due to the lack of information available regarding Paul's mental health and his contact with Kathleen there were no opportunities to assess risk.

5.17 ***Term of Reference 3:*** *Whether the work undertaken by services in this case was consistent with each organisation's:*

(a) Professional standards
(b) Domestic Violence policy, procedures and protocols

5.18 The Mental Health IMR completed in 2013 states that the standard of care and interventions provided to Paul appear to have been in line with standards expected by Trust policies, and standards of practice. The Mental Health IMR did not address whether the service had a domestic violence policy at the time of their involvement with Paul during 2007 to 2008, but stated that there were no reported incidents of domestic violence and there was no evidence from Kathleen that she had been subjected to any violence or abuse at that time. However, at the time of her carer assessment it is not known or recorded whether Kathleen was asked about domestic abuse. Since the introduction of the Care Act 2014 information provided for the restarted Review confirms that carer assessments are expected to explore all issues relating to the person's role as carer, including risk from the person for whom they are caring, which would include questions about domestic violence. Of note is the fact that carer assessments are not shared with carer's GP.

5.19 The Mental Health Trust does not have a separate domestic abuse policy and referral pathway to guide practitioners if a patient or carer discloses domestic abuse during an assessment.

5.20 Kingston Hospital confirmed that in 2012 there were domestic abuse guidelines for staff in the form of a flow chart showing the actions to take which was available for all staff on the intranet. In addition a Victim Support Independent Domestic Violence Advocacy Service referral form, and a document entitled Domestic Abuse is a Health Issue containing various facts including types of domestic abuse and its impact and the role of Health was available online. A separate domestic abuse policy was added to these documents in 2015. This includes the expectation that all staff will have domestic abuse training, and helpfully outlines key points for managers. Practical guidance on questions to ask is provided as is a copy of the DASH risk assessment and referral to MARAC information. The policy would benefit from strengthening the section on pages 10 and 11, with the addition of the impact of domestic abuse on mental health to acknowledge the strong correlation between mental ill-health and increased risk of experiencing domestic abuse[11]. Further information in the drug and alcohol paragraph would also assist staff's understanding of substance misuse by victims as a coping/self medication response to abuse, or substances used as a controlling device by an abuser. However, the Review author recognises that the hospital had no necessity to use their domestic abuse procedures when they saw Kathleen in relation to her medical conditions. The context of her appointments would not have given rise to any concerns which might suggest domestic abuse.

5.21 The IMR for Kathleen's GP assessed that there was good practice by the GP practice in that they saw Kathleen in a timely manner and were treating her depression appropriately

[11] Trevillion K, Oram S, Feder G, Howard LM (2012) Experiences of Domestic Violence and Mental Disorders: A Systematic Review and Meta-Analysis. PLoS ONE 7(12): e51740. doi:10.1371/journal.pone.0051740

with antidepressants and had referred her for counselling. They honoured her request not to share her medical data on the national NHS data system, and they also offered follow up appointments although these were not always attended by Kathleen.

5.22 Paul's GP confirmed that the work with him was in line with practice for working with patients with depression. His GP had not been fully aware of psychosis, and as far as they were aware there had not been any evidence of psychosis since his referral to the Mental Health Trust in 2007. It was confirmed that the practice has a domestic abuse policy, but there were no occasions arising during Paul's care, or during the time when Kathleen was also a patient, when their presentation gave rise to concerns. There were no occasions when domestic abuse was suspected.

Areas for improvement are:

5.23 A small amount of paperwork was not uploaded onto Kathleen's GP electronic systems before it was destroyed, for example the reverse page of Kathleen's opt out form for sharing her medical records, so potential information that had been recorded on this form, including any concerns, was lost.

5.24 There was no proactive GP follow up of Kathleen after she was discharged from the counselling service without being seen after triage. Discussion between the named GP and IMR author in June 2013 found that it is usual practice not to re-contact the patient, because follow ups would be too time-consuming for a busy practice where the patient may have improved, may not want to comply, or was not a suicide risk. However, follow up may have been appropriate for a woman with depression and cancer, and with caring responsibilities for a son with a serious mental illness. GPs should review their procedures for history taking and follow up of people with multiple physical and mental health problems and caring responsibilities for people with serious mental illness.

5.25 There were some areas for improvement for Right Steps identified by Kathleen's GP IMR author. These appear under Term of Reference 6. However, since Kathleen was referred to Right Steps the provider of this service has changed.

5.26 There was no indication that Kathleen's GP practice needed to implement their domestic violence policies and procedures. At the meeting between the IMR author and Kathleen's named GP in June 2013 it was confirmed that the practice had a current domestic violence policy which was seen by the IMR author (there was no date of publication on the policy). The practice should ensure all staff understand the domestic violence policies and procedures. It was also established that the practice does not use the IRIS[12] system for identifying and referring cases of domestic violence.

5.27 ***Term of Reference 4:*** *The response of the relevant agencies to any referrals relating to Kathleen or her son Paul concerning domestic violence, mental health concerns, substance misuse or any other factors that may lead to significant harm, from 1 June 2009. It will seek to understand what decisions were taken and what actions were carried out, or not, and establish the reasons. In particular, the following areas will be explored:*

(a) *Identification of the key opportunities for assessment, decision making and effective intervention in this case from the point of any first contact onwards.*
(b) *Whether any actions taken were in accordance with assessments and decisions made and whether those interventions were timely and effective.*

[12] The IRIS system was devised to achieve closer working between GPs and Domestic Abuse Services to provide a coordinated referral pathway for patients identified as experiencing domestic abuse.

(c) Whether appropriate services were offered/provided and/or relevant enquiries made in the light of any assessments made
(d) The quality of any risk assessments that may have been undertaken by each agency in respect of Kathleen and Paul.

5.28 The IMR for Kathleen's GP found that there were opportunities for assessment during Kathleen's consultations with her GP about depression, including one where she disclosed her son had a serious mental illness. Further exploration, which may have led to a risk assessment, was not recorded and therefore we can assume was not undertaken.

5.29 Paul's first contact with his new GP and the initial assessment by the Community Mental Health Team in 2007 were unable to be informed by his previous history as his records were in Ireland. The doctor noted at the end of his assessment that he had requested a copy from the previous psychiatrist in Ireland, but it does not appear that these were received. It would seem that Kathleen raised concerns which brought him to their attention and it was her verbal history of his past mental health which informed early assessments. Subsequent care plan reviews, and his ongoing GP mental health reviews presented key opportunities for assessment. The focus appears to have been solely around his mental health and his risk of suicide; his initial assessment in 2007 states he 'denied suicidal/violent thoughts'. It is not clear whether 'violent thoughts' applied to thoughts of violence towards others.

5.30 All Paul's GP reviews mention an assessment of his risk of suicide, but not risk to others. His GP explained that when assessing Paul during reviews the Quality Assessment Framework (QAF) was used. In his GP's view this is a most useful tool, but it is being gradually phased out, although at the time of writing it is still in place and being updated annually. The QAF includes questions about risk to self, but not to others, and there are no standard questions about domestic abuse or consent to share information with carers. Paul's GP suggested the framework might be amended in light of this Review and to include a recall system and risk to others for such patients should be mandatory. The Review author supports this suggestion.

5.31 Decisions appear to have been made with the aim of stabilising Paul's mental health through medication, and changing his thought processes to reduce his social isolation and to enable him to achieve work. Decisions made with Paul by his GP also appear to be concerned with managing his anxiety and depression and maintaining a stable mood.

(b) Whether any actions taken were in accordance with assessments and decisions made and whether those interventions were timely and effective.

5.32 Following good practice, the doctor Kathleen saw suffering low mood post 2009 did elicit whether she was at risk of suicide, which she always denied. However, a more detailed exploration of the reasons for her depression, anxiety and repeated consultations may have been appropriate. The referral to Right Steps by her GP was timely, but not effective. The quality and timeliness of the response by Right Steps is discussed under Term of Reference 6.

5.33 Prior to 2009 it is worth commenting that during his contact with the Community Mental Health Team Paul's care plans were informed by assessments, and the medical and social support he received was timely and appeared effective. When he was taking his medication and interventions were regular he reported feeling well, however, his motivation to maintain a job proved elusive. The decision in his final plan of November 2008 to reduce and then stop his medication seems dubious, given his initial assessment was brought about by a relapse when he stopped taking his prescription. When Paul completed his cognitive behavioural therapy in 2007 action was taken to ensure he had a

relapse plan. However, there is no evidence that this plan was shared with Kathleen so that she knew what steps to take should this happen.

5.34 Care coordination from the Mental Health Trust during 2007-08 was very good, however gaps in recording on occasions marred what was potentially an excellent piece of work. Key among these recording gaps is the reason why family therapy was assessed as being a service to offer, especially in light of Paul's later negative view of his mother, why Kathleen declined family therapy, and whether the relapse plan was shared with her as Paul's carer. Case recording is a key pillar of good practice and needs to be full enough to inform decision making and assessments.

5.35 It needs to be recognised that from November 2008 Paul was being supported by his GP who was reliant on self reported progress by Paul. There was no corroboration from external independent sources such as Kathleen or other agencies to confirm or contradict what he reported. His GP appears to have undertaken regular mental health reviews and was available to provide timely interventions when Paul needed appointments or medication. However, there are three areas of concern:

1. Firstly, there appears to be no communication with mental health services when Paul changed his medication; he was advised to tell his community psychiatric nurse (CPN). This should also have been done by the GP to ensure that the information was delivered.

2. On 9 December 2011 Paul's GP received written notification that he had been assessed as fit for work and his benefits were to be withdrawn. This was not raised with him when he had an appointment 10 days later. Given his fragmented employment history and mental health issues it is not unreasonable to suspect that this change might cause him additional stress and worsen his mental state. He had no CPN or social work support to help him through this period of change. With the benefit of hindsight we now know that this change had a significant impact in that he lost his benefits due to completing a form incorrectly and he was in debt and without electricity. This at a time when his mother was still in recovery from her cancer; she was not given the 'all clear' until December 2011

3. Despite the 5 years of medication Paul had required there was no follow-up to the lack of repeat prescriptions being ordered or picked up after the last prescription dated 13 February 2012, and there was no follow up to come in for a review even though Paul was on the practice severe mental health register. Paul's last review was October 2011, although he had been seen by a different GP to his usual one on 19 December for a minor ailment and he was also assessed using the PHQ-9 for his level of depression, the results of which are not recorded. There was no timely intervention to address this sudden disengagement by Paul. His GP confirmed that there is no trigger for further action if a patient does not collect a repeat prescription. Paul's GP confirmed that this would be discussed at a practice level with Significant Event analysis and recalls set up.

(c) Whether appropriate services were offered/provided and/or relevant enquiries made in the light of any assessments made

5.36 It needs to be recognised that Kathleen had received a diagnosis of cancer, and the physical issues and worries related to cancer will have complicated the way she felt, how she appeared to the GPs she saw, and may have influenced how her depression and anxiety were interpreted. Her GP made an appropriate referral to Right Steps for counselling and she received a telephone assessment from that service, however she was never seen for a face to face consultation. There were no follow up enquiries about her caring responsibilities or her relationship with her son by the Right Steps trainee worker.

5.37 When under the care of mental health services between 2007 to 2008 Paul was offered and accepted appropriate services. It is not known why family therapy was assessed as appropriate and offered. Kathleen was contacted by phone by the therapist to make enquiries about the missed appointments and she explained that it 'was not the right time'. Such a personal follow up to missed appointments was appropriate and good practice.

5.38 Kathleen's carer assessment included a recommendation of contact with a Carers Centre for further advice. It is not recorded whether mental health staff referred her, but as the onus is on the carer for other aspects of the carer assessment it is reasonable to assume that she was not referred. There is no information available to confirm whether Kathleen accessed the service back in 2007 or after.

5.39 It is not known whether agencies such as the benefits agency, Job Centre, or utility companies were aware of Paul's mental ill-health and were able to make allowances for any additional support he may need with managing his finances. Kathleen helped him in the past; we know that she provided a rent deposit for him to have his own flat, and she regularly provided him with meals when he visited her when he was living independently. However, her worries about her own serious health problems may have prevented her being the support she once was. Paul appeared to assume that his mother had money, he reported to the psychiatrists who interviewed him that he had seen how much was in one of Kathleen's accounts when he took money from it, and he appeared to expect his mother to support him. In 2008 Paul had commented that he did not need the support of a care coordinator any longer and he felt able to contact the job centre and claim benefits on his own. However, at that stage he had been stable for many months on his medication. From his interviews with psychiatrists for the court losing his benefits and the build up of debts appear to have increased his stress levels and exacerbated his mental health problems. The cessation of his medication in early 2012 can only have compounded the effects on his behaviour.

(d) The quality of any risk assessments that may have been undertaken by each agency in respect of Kathleen and Paul.

Mental Health Risk Assessment:

5.40 Prior to 2009 the Mental Health IMR states that 'risk assessment shows a low risk of harm to self and to others and there were no incidents recorded on risk history'. However, there is no evidence to suggest on the final plan outlined in the content of the discharge letter of 10 November 2008 that a risk assessment had taken place at that point. Other than discussing Paul reviewing his own mental state whilst reducing his medication, the only contingency plan appears to be the facility to return to the service again if the need arose. The dubious decision of reducing and stopping his medication given his relapse symptoms in the past when he unilaterally stopped his medication has already been highlighted in this section.

5.41 From 2009 onwards risk assessments of Paul by his GP record his risk of self harm/suicide. As previously mentioned the Quality Assessment Framework tool used with him does not mention risk to others.

5.42 No risk assessments were undertaken by Kathleen's GP practice except an assessment of her suicidal intent which was appropriately undertaken when she attended suffering from low mood. A similar assessment took place during triage by Right Steps.

Domestic Abuse Risk Assessment:

5.43 There were no risk assessments relating to domestic abuse as this was never raised by Kathleen. Paul's GP records show no evidence of an abusive relationship with his mother.

Risk to Carers:

5.44 The impact of caring for someone who has a mental disorder can result in a risk of the carer also suffering mental ill-health, indeed research shows that one third to one half of carers suffer significant psychological distress and experience higher rates of mental ill-health than the general population[13]. Carers who face unpredictable situations and behavioural problems from the person they are caring for suffer increased stress and anxiety, especially where patients cannot be successfully managed on a consistent basis. The literature cited in the paper by Shah et al (ibid) found that the frequency of behavioural problems exhibited is a more reliable predictor of caregiver burden and depression than are the cognitive and functional impairments of the individual being cared for. Carer anxiety has also been found to be associated with depression, stress, and physical ill health. Providing long-term care can be a source of significant stress, and Kathleen had been caring and supporting Paul since his diagnosis in his late teens.

5.45 The review undertaken by Shah et al concludes that it is now realised that developing constructive working relationships with carers and considering their needs, is an important part of considering a patient's needs, and is an essential part of service provision for people with mental disorders who require and receive care from their relatives.

5.46 Kathleen had been trying to support Paul for many years, but she had been through a very stressful time recovering from cancer, she was suffering from ongoing depression, and holding down a full time job. The text message found on her phone which was never sent suggests she was reaching the end of her tether coping with Paul and her resilience levels were running low. As her colleague acknowledged Kathleen kept her family life mainly private. She did not express what she was experiencing with Paul to her GP or seek support from the Carers Support Network, but the stress of being frequently in Paul's company and coping with his demands for financial support or food were probably beginning to take their toll.

5.47 Associating violence with those suffering from a mental disorder is contentious, and the vast majority of people with mental illness are not dangerous and are not violent. Research suggests that any link is 'likely to be mediated partially or fully by other variables such as substance misuse, co-morbidity, family circumstances, and deprivation'[14]. Paul had been drinking on the night of the murder, there appear to have been tensions between him and Kathleen over money, and he was struggling financially and practically i.e. his water and power had been cut off. Thus these variables applied at the time of the murder.

5.48 These factors accentuate the need for in depth enquiry about a person's caring role, the assessment of its impact, and any needs for support which take into account an holistic

[13] Aadil Jan Shah, Ovais Wadoo and Javed Latoo. *Psychological Distress in Carers of People with Mental Disorders.* British Journal of Medical Practitioners, 2010; 3(3). http://bjmp.org/files/2010-3-3/bjmp-2010-3-3-a327.pdf

[14] Mental Illness, Personality and Violence: A Scoping Review (2012) The Offender Health Research Network, Manchester. (p32) http://www.ohrn.nhs.uk/OHRNResearch/MIviolence.pdf

assessment of risks to health and their living situation and relationship with the care recipient, especially if the recipient has a mental disorder.

5.49 *Term of Reference 5: Whether any Mental Health assessments were carried out where necessary and thresholds for intervention were appropriately calibrated, and applied correctly, in this case.*

5.50 The IMR for Kathleen's practice found that GPs undertook mental health assessments at a number of consultations, but these were only briefly recorded in the notes suggesting a full history was not taken. This is not unusual in general practice, but a more thorough review of a complex patient such as Kathleen would have been preferable, and may have facilitated disclosure of any concerns to be aired.

5.51 The GP IMR author judged that whilst the IMR was not focused on Right Steps counselling services, and the Right Steps clinical notes were not investigated by them, there was enough material in the GP medical records to draw out some issues. It was unclear how effective the telephone triage of Kathleen was, partly because it was a telephone rather than face to face consultation. It was also noted that the triager was a trainee, but whether this is relevant is unclear. Of concern though is the confusing set of four letters all sent on the same day to Kathleen which had inconsistent terminology and which did not necessarily lay out a clear way forward. No one to one appointment was offered which suggests that Kathleen may not have been triaged as having a high enough need. It is also important to note she was discharged from the service without being seen in person, having been given only 2 or 3 weeks to respond. We do not know whether Kathleen made any disclosure about her son to Right Steps; there is no mention in the notes made the trainee triage worker to indicate that she did.

5.52 Paul was subject to mental health assessments during his period under the care of the Community Mental Health Team. His first full assessment in February 2007 was undertaken by a doctor who was a Locum Associate Specialist to the consultant psychiatrist and Paul was correctly placed on the Care Programme Approach. The same doctor carried out 3 further assessments and plans which provided consistency. A staff grade psychiatrist undertook a fourth assessment before Paul transferred to the Early Intervention Service. Treatment plans were appropriate and were shared with his GP. The mental health IMR comments that Paul engaged with all the treatments offered to him with the support of his mother.

5.53 *Term of Reference 6: Whether practices by all agencies were sensitive to the ethnic, cultural, linguistic and religious identity of the respective family members and whether any special needs on the part of either family member were explored, shared appropriately and recorded.*

5.54 Kathleen's nationality is recorded as Irish on her Right Steps assessment document and her religion as Roman Catholic. There is no indication that these parts of her identity resulted in any specific consideration by any agency, or indeed that there was a need to do so for the services she was accessing. As Kathleen was not seen in person by Right Steps it is not possible to say whether her religious affiliation would have had relevance to any counselling service offered. As mentioned in the Equality and Diversity section of this report, Kathleen's first GP observed that patients originating from Ireland can be stoical about their health and sparing in their access of services. This helpful information concerning a different 'health culture' may explain why Kathleen did not take up the services offered to her, and the few occasions she missed GP appointments. Paul is described as not religious in an assessment, and there is no sense that the services he received had need for additional sensitivities relating to this term of reference.

5.55 ***Term of Reference 7:*** *Whether issues were escalated to senior management or other organisations and professionals, if appropriate, and in a timely manner.*

5.56 There were no occasions identified where escalation to senior management or others was identified within organisations.

5.57 ***Term of Reference 8:*** *Whether the impact of organisational change over the period covered by the review had been communicated well enough between partners and whether that impacted in any way on partnership agencies' ability to respond effectively.*

5.58 No issues of organisation change were identified within agencies' IMRs or information gathered for the Review.

5.59 ***Term of Reference 9:*** *Whether the services on offer were appropriate to the needs of the victim – on the basis that those services which are* ***not*** *accessed by victims are of equal importance in a DHR as those which were used.*

5.60 The GP support and referral to Right Steps was appropriate. The lack of access to the psychological services in 2012, even though the referral was made and an initial triage undertaken, is of some concern. All contact with the service was by phone; Kathleen was never seen in person. The offer of a stress management group session by Right Steps which Kathleen initially accepted during a telephone call, but then subsequently did not confirm, may have been because in her initial assessment it clearly stated that she did not want group work. There are two possible reasons for this choice; given what Kathleen had been through with her own health she may have been unwilling to take part in a group in case there was a need to discuss this. We know that she had withdrawn from the Health data sharing process thus indicating that she was perhaps a private person by nature.

5.61 A second consideration is that, given the stigma attached to mental illness, had she had wanted to discuss her son and her relationship with him, this too may have made a group uncomfortable and inappropriate for her, especially as a first intervention. In addition Kathleen had also felt unable to take up one appointment offered as it was during working hours. She would have only recently returned to work at this point following surgery, and judging from her colleague's description of her as being a supportive team member, it would be understandable for her not to want to take further time off work. The Right Steps service did not meet Kathleen's stated need to deal with the cause of her depression.

5.62 Given her diagnosis of cancer it is somewhat surprising that there is no reference of a referral to the Macmillan Nursing service in her medical notes. Whilst Kathleen appears to have found accessing counselling services unappealing, she may have appreciated and benefited from this specific service at the time of her diagnosis and recovery.

5.63 There is no note that Kathleen had any access (via the GP) to carer's support or to any vocational or social support. She may have received this through other routes. It seems that the GP practice may not have been fully appraised of these issues and the fact that she was acting as a carer for Paul; Kathleen had only mentioned her son at one consultation.

5.64 Once the Care Programme Approach ended and Paul was no longer in receipt of specialist mental health services his only contact with a supporting service was with his GP, but the fact that Kathleen was Paul's carer was not appreciated by either's GP because they had separate GP practices. Kathleen appears not to have discussed her supporting role with her GP, nor did Paul disclose the support his mother gave him. Perhaps if details had been provided of local voluntary sector services or groups available this could have given both Kathleen and Paul an alternative route to support outside the more formal sector.

Paul's GP understands that mental health services do now give details of voluntary organisations to patients. It would also be helpful if GP practices reinforced this by also providing details of appropriate local organisations.

6. Conclusions

6.1 Paul's mental ill-health in his mid to late teens meant he was highly likely to require medical support and interventions long term, a view held by the psychiatrist who undertook his initial assessment. As his mother, instead of having a diminishing role as a parent when her son moved into adulthood, Kathleen was to find herself supporting him financially and practically, as well as trying to monitor his medication. In the latter years under review she was doing this whilst suffering from a rare form of cancer from which she was cleared just 6 months before she was killed. She also had a job in which her skills as supportive team member and for dealing with people were much appreciated by her colleagues.

6.2 When Paul last saw a GP he had just lost his Incapacity Benefit; he had been assessed as fit for work and said he was looking for a job. His last prescribed medication from his surgery was issued on 13 February 2012 and was enough to last 28 days, however from photographic evidence taken during the murder investigation of Paul's flat there were several boxes of his medication found which were unopened. When asked by Dr Veisi, the psychiatrist who assessed him for the court, when he stopped taking his medication Paul replied that he stopped it in 2011. He said "it was a chemical cosh. I was not crazy and I felt like dead on medication. Mum kept encouraging me to take it but I did not".

6.3 Kathleen's family member who lives abroad told the Police that Kathleen had recently mentioned that Paul was not taking his medication. It is arguable that if Kathleen had not noticed Paul's deteriorating mental health how could a GP who only sees a patient for 10-15 minutes, and especially if the patient is seen by someone other than their own GP who knows them? Because GP appointments are time limited, full in depth assessments of a patient's mental state will be difficult. Information comes from the patient themselves with no opportunity to seek corroboration if they are in the sole care of their GP. Unless a patient consents to information sharing, liaison with a carer or other agency is unable to take place. How many GPs seek such consent to enable them to involve a carer in the management of a patient's care when they have mental health problems is unknown. It is also especially difficult when family members/carers have separate GP practices. And yet sadly cases such as Kathleen and Paul's are not unique, but they cry out for a more pragmatic joined up approach from the medical profession.

6.4 Research shows that the risk of violence appears to be greatest in untreated individuals during a first episode of psychosis, and although matricide is fortunately infrequent it is considered to be committed by those with severe psychiatric disorders[15]. Research by Marleau et al[16] agrees with other literature that a 'majority of adult parricide offenders suffer from mental illness, specifically paranoid schizophrenia (56%). A correlation has also been found between the age of the offender and parental victimization; those between 20 to 50 years of age were most likely to kill their mothers[17]. Paul was in this

[15] Carabellese F et al (2013) 'Mental illness, violence and delusional misidentification: The role of Capgras' syndrome in matricide' in *Journal of Forensic and Legal Medicine 21 (2014) 9-1.*

[16] Marleau, J. D., Auclair, N., & Millaud, F. (2006). Comparison of factors associated with parricide in adults and adolescents. *Journal of Family Violence, 21,*321-325. in Rhona Mae Amorado1, Chia-Ying Lin, Hua-Fu Hsu (2008) Parricide: An Analysis of Offender Characteristics and Crime Scene Behaviors of Adult and Juvenile Offenders (page 6).

[17] Heide, K. M. (1993a). Parents who get killed and the children who kill them. *Journal of Interpersonal Violence, 8,* 531-544.(page 4) In ibid above.

age group. Recent analysis of Domestic Homicide Reviews[18] found of the 40 cases examined 7 homicides were familial with 6 concerning the killing of a parent by a son, 5 of the victims were mothers, 1 was a father. In the remaining case a grandson killed his grandfather. Mental illness was a factor in all 7 cases. Similarly, research of Domestic Homicide Reviews undertaken by voluntary sector domestic abuse service Standing Together[19] found the same proportion of what the research termed 'Adult Family Violence'. Of 8 cases of Adult Family Violence identified 5 victims were mothers killed by their sons, 2 were fathers killed by sons, and a brother was killed by his brother; mental ill-health and/or drug and alcohol use were common factors, as were caring responsibilities. A majority of the victims of Adult Family Violence were found to be carers.

6.5 Paul had been regularly monitored as a patient with serious mental illness since he registered with his GP practice in 2007, however after 2008 his reviews were for depression and anxiety, not for any signs or symptoms of psychotic illness. He had regular repeat prescriptions during all those years without any further reviews by mental health services, and yet when the prescriptions stopped no one thought this was out of character, that he may have relapsed, or that there may be something wrong. He had stopped his medication in 2007 with poor results for his health and his behaviour, but this had not happened since that time. He was viewed as being stable for over 5 years. Nevertheless, his lack of repeat prescriptions and further review appointments should have been noticed and followed up. He was after all on the practice register of patients with severe mental illness.

6.6 As previously mentioned Kathleen's family member told Police that she had become aware that Paul was not taking his medication. However, he was not living with her at this time, and whereas before she had instigated a referral to the Community Mental Health Team via their GP that did not happen this time. Perhaps she was not fully aware of the deterioration in his behaviour as she saw less of him. The fact that Paul had decided to stop his medication was not picked up by his GP practice; there were no repeat prescriptions after February 2012, but unless he had been supervised taking his medication to ensure his mental health was maintained, his actions could not have been prevented. It is unlikely that he would have met the threshold to be detained under the Mental Health Act.

6.7 Paul had been in fights whilst out socially, but this was unknown to agencies; the Police were not involved. He also reported erratic and disinhibited behaviour prior to the murder during his interview with a psychiatrist (paragraph 4.13), but this too was not known to agencies. He had never been violent previously as far as any agency knew, therefore it cannot be said that Kathleen's murder was predictable.

6.8 The review found no evidence or suggestion of prior domestic abuse by Paul towards his mother from agency records before the fatal incident took place. A colleague said that Kathleen could be nervous of Paul sometimes (paragraph 4.19), but she just wanted to help her son. It is clear that as a caring mother she also wanted to support him financially, and she had intended to help him with his debts if she had sold her flat (paragraph 4.18). Although the use of Kathleen's bank card by Paul on the night of the murder might be viewed as financial abuse, there is no evidence from other contributors to this review that he coerced Kathleen into giving him money in the past. Paul appears to have regularly taken advantage of Kathleen's wish to support him, a wish which may have been

[18] Domestic Homicide Reviews: Key Findings from a Comprehensive Analysis of Domestic Homicide Reviews. Home Office 2016.

[19] Sharp-Jeffs N, Kelly L. (June 2016) *Domestic Homicide Review (DHR) Case Analysis Report for Standing Together*. Standing Together Against Domestic Violence & London Metropolitan University.

reinforced by Paul's actions in caring for her when she was recovering from a serious illness, but also a wish which eventually appears to have put her at risk.

Lessons Learnt

The Role and Consideration of Carers:

6.9 The role and status of carers of those with serious mental illness is a key issue which this case suggests needs to be reviewed. It was stated in the Mental Health IMR that Kathleen would attend Paul's appointments as she believed he would not go on his own and it was her efforts that brought about his treatment. However, the records do not clearly show how many of those appointments she attended and there is mention of her only being able to attend if Paul consented. If mental health services are to rely on carers to monitor and support patients in the community as part of a care plan, the carer needs to be kept informed by the service; the onus should not be totally on the carer. Where a patient has a carer services need to gain consent from the patient at the start of treatment to share information with their carer, and to be able to corroborate patient self reports of progress by checking with those who are supporting them.

6.10 Kathleen was not well known to the GPs in her practice and her caring role for her son who had a diagnosed mental illness appears not to have been fully understood or appreciated. Although she is only recorded as mentioning once that her son who had Bi-Polar lived with her, her caring role should have been explored further and flagged in the practice carers register. This could have enable the GPs in the practice to be aware and appropriate support to be offered, in addition to highlighting possible stressors in her life which could impact on her own mental wellbeing. The GP who referred Kathleen for counselling appears to have recognised that Paul "complicates issues further at home", but that is as far as her caring responsibilities were recorded. Kathleen's carer assessment undertaken in 2007 when Paul was involved with the Community Mental Health Service was not shared with her GP so that they could be aware of this aspect of her life. The Review Panel have learnt that the carer assessment is for the carer only, although it may be used by a local authority to inform service provision. Given the impact caring can have on a care giver it seems reasonable that a copy should be sent to their GP so that their needs can be met holistically.

6.11 This review endorses the best practice identified in the research findings by Shah et al cited in 'Risk to Carers' (p38) which concluded:

> *'Carers face mental ill health as a direct consequence of their caring role and experience higher rates of mental ill health than the general population. This leads to negative effects on the quality of life of the carer and the standard of care delivered. Efforts to identify and treat caregiver psychological distress will need to be multidisciplinary, require consideration of the cultural context of the patient and caregiver, and focus on multiple risk factors simultaneously. The findings of the review underline the importance for early identification of carers, effective carer support, health promotion, monitoring high-risk groups, and timing appropriate interventions[20]'.*

[20] Aadil Jan Shah, Ovais Wadoo and Javed Latoo. *Psychological Distress in Carers of People with Mental Disorders.* British Journal of Medical Practitioners, 2010; 3(3). http://bjmp.org/files/2010-3-3/bjmp-2010-3-3-a327.pdf

Monitoring the Disengagement of Patients with Mental Illness:

6.12 Paul was on his GP practice severe mental illness register which was good practice. However, the fact that he was on anti-psychotic medication was missed; other patients in the practice on similar medication would have an annual review by mental health services, but this did not happen for Paul. Then when he stopped collecting repeat prescriptions this was not picked up and acted upon. Where a patient with a serious mental health condition suddenly disengages from a service, such as ceasing to collect repeat prescriptions of essential medication, processes should be put in place to contact the patient for review as quickly as possible. An escalation policy should be known to staff regarding steps to take in the event of no response.

The Need for Greater Awareness of Matricide & Patricide within Domestic Abuse:

6.13 The 2011 Pan London Safeguarding Adults policies and procedures highlighted the fact that 'Approximately one in five homicides in London are domestic related, with the murder of a parent by a son being prevalent' (p15). Therefore, it is important that all agencies are aware of this, and the recent research referenced in paragraph 6.4, and that these findings are taken into account in risk assessments. Practitioners need to suspend their disbelief that a close relative, such as an adult child, can cause harm to a parent who is caring for them and that mental illness can be an added risk factor. Neither Paul nor Kathleen would have been assessed as 'vulnerable adults' under the Department of Health definition in place in 2012. However, Kathleen could be viewed as vulnerable in her caring role due to her longstanding wish as a mother to support her son and this may, not unsurprisingly, have overridden her ability to view Paul's behaviour and any risk arising from this objectively. This needs to be taken into consideration when undertaking assessments of parent carers.

6.14 Neither Paul nor Kathleen would have been assessed as 'vulnerable adults' under the Department of Health definition in place in 2012. However, Kathleen could be viewed as vulnerable in her caring role due to her longstanding wish as a mother to support her son and this may, not unsurprisingly, have overridden her ability to view Paul's behaviour and any risk arising from this objectively. This needs to be taken into consideration when undertaking assessments of parent carers.

The Importance of Case Notes Recording:

6.15 Gaps in recording, not just the time which has elapsed in being able to restart the Review, have been shown to raise questions and cause ambiguity about what information was shared and why certain events took place. For example why family therapy was thought useful and why it was declined? Whether a referral was made or not? Who was present at appointments? Was risk to others assessed in addition to risk to self?

Provision and Design of Counselling Services:

6.16 If counselling services are to be successful in engaging those needing support they should be sensitive to the needs of service users and tailored accordingly. Inviting someone to attend a group as their first experience of the counselling service lacks insight into the nervousness that a service user might feel, and insensitivity to a person's need for confidentiality. Kathleen was recovering from cancer and coping with a son with mental illness; we do not know what she would have taken to a counselling session, but both these subjects would require sensitive handling on an individual basis in the first instance.

Recommendations

6.17 The following recommendations are the result of IMR recommendations, learning from the Review, and the Review Panel's discussions and deliberations.

National

Recommendation 1:
The Home Office are requested to provide instruction and guidance about how to proceed with DHRs where the perpetrator has fled the country resulting in long delays in coming to trial, to assist the DHR Panel in proceeding without compromising criminal proceedings or delaying dissemination of learning from the Review.

Local

Kingston & Richmond Mental Health Services, South West London & St Georges Mental Health Trust

Recommendation 2:
Mental health and primary care services should review how they engage and support carers of patients with serious mental illness, and adopt a proactive approach to carers involvement, gaining patient consent to share information, and including corroborating patient's self reports to inform reviews.

Recommendation 3:
Mental health services should ensure that carers are referred for a carer's assessment.

Recommendation 4:
Mental health services should ensure that case recording contains sufficient detail to establish outcomes of assessments and risk assessments undertaken, why decisions were made and their outcomes, and with whom information was shared.

Mental Health Trust & Clinical Commissioning Group:

Recommendation 5:
Commissioners and providers of counselling and psychological services should ensure that services are appropriately designed to enable service users to have a face to face assessment of their needs.

Kingston Safeguarding Adults Partnership Board

Recommendation 6:
The Safeguarding Adult Board should ensure that all agency staff involved in assessments should be made aware through training and other communication methods, of the research on the prevalence of matricide in domestic abuse homicides[21], the additional risk which serious mental ill-health can bring, and the need to factor these elements into all risk assessments. (NB see footnote for sources of research).

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[21] Nicola Sharp-Jeffs and Liz Kelly. (June 2016) *'Domestic Homicide Review (DHR) Case Analysis' R*eport for Standing Together
http://www.standingtogether.org.uk/sites/default/files/docs/STADV_DHR_Report_Final.pdf
Domestic Homicide Reviews: Key Findings from Analysis of Domestic Homicide Reviews. December 2016, The Home Office
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/575232/HO-Domestic-Homicide-Review-Analysis-161206.pdf

Kingston Clinical Commissioning Group re: G. P. Practices

Recommendation 7:
GP's should ensure that clinical IT systems clearly flag patient's mental health assessment and diagnoses, that care plans should be clear on mental health care and treatment and be easily accessible to practitioners consulted to inform reviews, assessments, and treatments.

Recommendation 8:
All patients on long term anti-psychotic medication should be clearly flagged on their patient record by their GP for annual review by mental health services and a referral triggered annually. This information should be on the Emis IT system, and if a patient is being prescribed medication by mental health or other services this needs to be clearly expressed to the patients' GP so that they can make a record on the patient's notes and care plan.

Recommendation 9:
GP practices should ensure that they are familiar with their domestic abuse policies and referral pathway to MARAC and what should trigger an enquiry. Policies should be dated and have a review by date inserted.

Recommendation 10:
All practices should be reminded to:

a) keep an up to date register of carers
b) ensure that carers are routinely reassessed.
c) reflect on the needs of patients with caring responsibilities who have co-occurring physical and mental health problems to ensure that any possible health repercussions arising from that role can be identified.
d) the carer is appropriately supported and offered referral to Adult Social Care and/or Kingston Carer's Network for a carers assessment at reviews if not already completed.
e) If not already available in the practice information on the rights of carers and the support available should be displayed in the public areas and on the practice website.

Recommendation 11:
Where a patient on the serious mental illness register suddenly disengages from a service, such as ceasing to collect repeat prescriptions of essential medication, or failure to attend reviews, processes should be put in place to contact the patient for review as quickly as possible. An escalation policy should be known to all relevant staff regarding steps to take in the event of no response.

For Perpetrator's GP Practice

Recommendation 12:
The practice should review its serious mental illness register 6 monthly to audit the ongoing support and medication required for those patients and whether mental health clinicians have been involved or need to be.

Kingston Adult Social Care Services

Recommendation 13:
All practitioners undertaking a carer assessment should seek consent to inform the person's GP that they are a carer and whether they are to be in receipt of support services, thus ensuring that their GP is aware of their caring responsibilities and able to include them on the practice register of carers. The current provider of carer assessment

services should be requested to make this change to their process, and the practice should be included in the future specification for the contract to provide carer assessment services.

Kingston Adult Social Care Services & Kingston CCG

Recommendation 14:

All commissioners should ensure that all commissioned services make their staff aware through training and other communication methods, of the research on the prevalence of matricide in domestic abuse homicides[22], the additional risk which serious mental ill-health can bring, and the need to factor these elements into all risk assessments. (NB for sources of research see footnote below).

Local Hospitals:

Recommendation 15:

Local NHS hospitals should be reminded to ensure that the patient information they hold is up to date, especially the patient's GP address, and that there is consistent sharing of information about patient contact with their GP. Addresses should not revert to default lists.

Kingston Hospital NHS Foundation Trust

Recommendation 16:

The hospital should review its domestic abuse policy to strengthen the information on drugs and alcohol and domestic abuse, and add information on the links with, and impact of, domestic abuse on mental health

[22] Nicola Sharp-Jeffs and Liz Kelly. (June 2016) *'Domestic Homicide Review (DHR) Case Analysis' R*eport for Standing Together http://www.standingtogether.org.uk/sites/default/files/docs/STADV_DHR_Report_Final.pdf
Domestic Homicide Reviews: Key Findings from Analysis of Domestic Homicide Reviews. December 2016, The Home Office https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/575232/HO-Domestic-Homicide-Review-Analysis-161206.pdf

Appendix A

SUPPORT FOR CARERS

The services listed below are those available as of April 2018.

Kingston Carers' Network

Kingston Carers' Network is a local registered charity, providing independent information, advice, advocacy and support to people who care for someone living in the Royal Borough of Kingston upon Thames.

They support carers of all ages, including young carers aged 5 to 18. Their service aims to ensure that carers:

- Enjoy good physical and emotional health and wellbeing
- Are recognised and respected as expert care partners
- Are given information about services and support available to carers
- Are listened to and supported by providing a 'listening ear'
- Have a life outside of caring through engaging in activities, outings and social events
- Are well-informed and know about their rights, benefits and allowances
- Have support to access benefits and allowances
- Can access training and information to meet their caring needs
- Receive regular support through groups and drop-ins
- Get equal access to services
- Are encouraged to recognise their own needs and to get their status acknowledged
- Are kept informed of national and local policies that affect carers
- Are consulted and have input to service planning and delivery

https://www.kingstoncarers.org.uk/support-us/
Tel: 020 3031 2757

Kingston Mind

Mind has an overall aim to promote the understanding of mental health issues and to provide a range of services in the Royal Borough of Kingston to people with support needs due to their mental health.

http://www.mindinkingston.org.uk/

Office opening times: Monday to Friday during office hours.
Telephone Number: 0208 255 3939.

Carers UK

Carers UK aims to make life better for carers. Their service provides a range of advice including on rights and entitlements, information and support.

https://www.carersuk.org

Tel:: 020 7378 4999

Kingston Borough Council:

On line Carer's Guide
https://www.kingston.gov.uk/info/200359/looking_after_someone/566/carers_guide/6

Home Office

Public Protection Unit
2 Marsham Street
London
SW1P 4DF

T: 020 7035 4848
www.gov.uk/homeoffice

Marion Todd
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Safer Kingston Partnership
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19 March 2018

Dear Ms Todd,

Thank you for submitting the Domestic Homicide Review (DHR) report for Kingston (Kathleen) to the Home Office Quality Assurance (QA) Panel. The report was considered at the QA Panel meeting on 21 February 2018. I apologise for the delay in providing the Panel's feedback.

The QA Panel would like to thank you for conducting this review and for providing them with the final report. The Panel concluded this is a well written, balanced and sensitive review which clearly articulates the chronology of events. The quality of the review has been enhanced by the contribution of family and work colleagues which gives a clear sense of the victim throughout the report. The Panel particularly commended the learning identified in other DHRs and how these are linked to the recommendations and outcomes in this report.

There were, however, some aspects of the report which the Panel felt may benefit from further analysis, or be revised, which you will wish to consider:

- It would be helpful if the report could more clearly articulate the type of abuse the victim experienced, such as financial abuse;
- You may wish to broaden recommendation 10 so that it relates to carers being routinely reassessed;
- The Panel felt the review could explore what support is available for carers when they are undergoing treatment themselves;

- You may wish to consider whether the review could more clearly draw out the additional risks in cases where two vulnerable individuals live together;

- It may be useful if the review could explain why a mental health assessment was not undertaken.

The Panel does not need to review another version of the report, but I would be grateful if you could include our letter as an appendix to the report. I would be grateful if you could email us at DHREnquiries@homeoffice.gsi.gov.uk and provide us with the URL to the report when it is published.

The QA Panel felt it would be helpful to routinely sight Police and Crime Commissioners on DHRs in their local area. I am, accordingly, copying this letter to the PCC for information.

Yours sincerely

Hannah Buckley
Acting Chair of the Home Office DHR Quality Assurance Panel

PLEASE SEE THE FOLLOWING PAGE FOR THE REVIEW RESPONSE AND HOW FEEDBACK TO THE QUALITY ASSURANCE PANEL HAS BEEN ADDRESSED

Response to Home Office Quality Assurance Panel feedback on the Review

1. It would be helpful if the report could more clearly articulate the type of abuse the victim experienced, such as financial abuse;

The review could not find any clear evidence or indication that the victim had experienced any forms of abuse from her son prior to the homicide. There were no disclosures to agencies and no agency recorded occasions where the victim had been asked about potential abuse. Interviews with friends indicated that the victim wanted to help her son financially; it was not possible to find evidence or ascertain with certainty whether there was any previous violence or coercion. The review felt to suggest otherwise would be speculation. However, additional clarifying text has been added to paragraph 4.11 page 21, and paragraph 6.6 page 35 of the Overview Report with regard to the question of financial abuse.

2. You may wish to broaden recommendation 10 so that it relates to carers being routinely reassessed;

An additional action has been added to recommendation 10 at (b) to ensure that carers are routinely reviewed and reassessed.

3. The Panel felt the review could explore what support is available for carers when they are undergoing treatment themselves;

An appendix (A) has been added listing the local services available as at April 2018.

4. You may wish to consider whether the review could more clearly draw out the additional risks in cases where two vulnerable individuals live together;

It needs to be noted that in recent years the perpetrator lived independently of the victim, although he visited her regularly for meals and stayed with her when she was recovering from a serious illness. At the time of the murder he was not living with her having returned to his own accommodation, but he was visiting in the evenings. However, a section on risk to carers has been added on page 31 (commencing paragraph 5.44) of the Overview Report and an additional comment added to the first paragraph of the Lessons Learnt section. The review considered vulnerability, however as paragraph 2.5 page 9 of the report states "As far as can be ascertained from the information available neither Kathleen nor Paul would have been considered 'vulnerable adults' as defined by the Department of Health 'No Secrets' guidance in place at the time. Neither would have met the threshold for community care service". The review author suggests that Kathleen's 'unofficial' vulnerability, outside the Dept of Health definition of the time, arises from her longstanding wish as a mother to support her son and this may, not unsurprisingly, have overridden her ability to view Paul's behaviour and any resultant risk objectively. This has been added to paragraph 2.5 for clarification and into the lessons learnt.

5. It may be useful if the review could explain why a mental health assessment was not undertaken.

It is not clear from this feedback comment whether it refers to the victim or the perpetrator.

The perpetrator did have a mental health assessment whilst under the care of mental health services, but after some years of stability he was referred back to the care of his GP where he received regular reviews. However, his failure to order or pick up repeat prescriptions was not noted, nor was he referred back to the Community Mental Health Team services for annual review as he should have been as his original diagnosis and the fact that he was on anti-psychotic medication became unrecognised over time. Also in comparison to others on the GP practice serious mental illness register he was deemed to be relatively stable. The review has already highlighted that due to the medication he was taking, he should have been under the Community Mental Health Team (CMHT) - a failure on both parts (GP and CMHT) was not to pick up on this. This has already been addressed in recommendation 8.

The victim did not have a formal mental health assessments by the Mental Health Trust services. She was prescribed anti-depressants by her first GP and this continued on transfer to her second GP. She had a telephone assessment by the counselling service to whom she was referred by her GP. It is likely that this treatment option was offered as she was not deemed suitable for referral to the Mental Health Trust services at that time. The fact that she did not engage with the support service offered is addressed in recommendation 5.