DOMESTIC HOMICIDE REVIEW OVERVIEW REPORT

REPORT INTO THE DEATH OF Mrs Adult 1 on 20th June 2011

This report is produced by Barnet DHR Panel, authored by Davina James-Hanman, Independent Chair, October 2012.

The Domestic Homicide Review examined the events leading up to the murder of Mrs Adult 1 in LB Barnet. Key individuals involved comprise the following:

Mrs Adult 1: The deceased DOB: 22.05.51 DOD: 20.06.11
Mr Adult 2: The defendant, husband of Mrs Adult DOB: 16.03.46
Mr Adult 3: Son of Adult 1 & 2
Mrs Adult 4: Wife of Adult 3
Mr Adult 5: Younger son of Adult 1 & 2

INTRODUCTION

This report of a Domestic Homicide Review examines agency responses and support given to Mrs Adult 1, a resident of LB Barnet prior to the point of her death on 20th June 2011. This report is set out using the guidance provided in the Multi-Agency Guidance.

The review considered agencies contact/involvement with Mrs Adult 1 and Mr Adult 2 from January 2009 – June 2011

The key purpose for undertaking DHRs is to enable lessons to be learned from homicides when a person dies 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.

It should be noted that this death only technically falls within the definition of a domestic homicide because the perpetrator and victim were married to each other. In all other respects, this case lacks the essential features of domestic violence. There was no history of abuse disclosed to either family members or any local agency. Two psychiatrists – one for the defence and one for the prosecution – agreed that Mr Adult 2 had had a psychotic episode.

Mr Adult 2 has been tried for Mrs Adult 1's death. Criminal proceedings have completed and Mr Adult 2 was unanimously cleared of murder by reason of insanity following a two-day trial at the Old Bailey in December 2011.

TIMESCALES

This review began on May 2012 and was concluded on October 2012. The start of the DHR was delayed due to administrative errors and staff vacancies meaning that the need for a DHR was not identified for some time.

The DHR process began with an initial meeting in May 2012 of all agencies that potentially had contact with the victim prior to the point of death.

CONFIDENTIALITY

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

DISSEMINATION

All DHR panel members have received a copy of this report along with the two adult sons of Mrs Adult 1.

ABOUT DOMESTIC VIOLENCE IN LB BARNET

Despite underreporting, domestic violence makes up a significant proportion of crime. In the current strategy it is reported that domestic violence offences (1,575) accounted for 30 per cent of total reported violence against the person in LB Barnet, 25 per cent of total reported violent crime, and 6 per cent of total reported crime.

Nationally, repeat victimisation accounts for around two-thirds of domestic violence incidents. Over a two year period in Barnet, 7,068 DV incidents were reported to police. 34 per cent of these victims reported more than one offence, and 50 of the 7,068 victims accounted for 5 per cent of all incidents.

Domestic violence has a serious effect on children, with domestic violence noted as a factor in an increasing number of cases being dealt with by Barnet's Children's Service. Domestic abuse is also a significant issue for Adult Social Services – abuse by a family member constitutes around 40 per cent of all their cases involving older adults, those with learning disabilities, physical disabilities and mental health problems.

To provide a co-ordinated response to domestic violence, LB Barnet has a multi-agency domestic violence strategy[1]. Its strategic priorities aim to ensure that the needs of victims, perpetrators and the wider community are met. They are consistent with national, regional and local priorities, including the key strands of prevention, provision and protection identified in the Government strategy to end violence against women and girls.

Current strategic objectives are as follows:

1. Raise awareness of domestic violence across all agencies and among the public to change attitudes, enable early-intervention and help to prevent violence.

2. Ensure safe and effective provision that enables domestic violence survivors, including vulnerable adults, and any affected children to continue with their lives.

3. Understand, identify and safeguard the needs of children and young people whose lives are affected by domestic violence.

[1] This can be downloaded here: http://www.barnet.gov.uk/downloads/200036/domestic_violence

4. Deliver an effective criminal justice system to ensure perpetrators are held accountable for their actions in a way that maximises the safety of survivors and their children and reduces repeat victimisation.

5. Ensure a proactive response through co-ordinated action across all agencies, based on consistent and well-informed policy, systems, resource sharing and leadership.

The strategy is implemented via Barnet Domestic Violence Strategic Board which produces an annual action plan setting out in detail the actions including timeframes and lead agencies. The Strategic Board is also responsible for developing a commissioning strategy. Barnet currently spends £1.2m each year on preventative efforts and responding to cases of domestic violence. This does not include costs in terms of employee time, governance arrangements, and use of other services necessitated by domestic violence for organisations such as the Police, Probation, Courts, Prison Service, voluntary sector, NHS Barnet, Children's Service and the Drug and Alcohol team.

Local services include a Specialist Domestic Violence Court; an advice and advocacy services (working with all risk levels); specialist support for children exposed to domestic violence and a perpetrator programme. LB Barnet also provides some financial assistance to Barnet Asian Women's Association who, amongst a range of issues affecting Asian women in the borough, also respond to domestic violence.

OUTLINE OF THE CASE

Mrs Adult 1 and Mr Adult 2 were married for 37 years. While visiting family in Pakistan in February 2011 the mother of Mr. Adult 2 died suddenly. Mr. Adult 2 suffered a heart attack in March 2011 and was admitted into the Royal Free hospital when he was also diagnosed with non-malignant cancer of the Lymph nodes. He was diagnosed by Dr D1 as suffering from mild depression soon after this.

There was telephone contact from the Mrs Adult 1 on 19th June 2011 to the GP (Dr D1) saying that she was concerned as she thought that the medication was not agreeing with Mr. Adult 2 and he had stopped taking them. That evening, Mr. Adult 2 attempted to take several sleeping tablets (attempted suicide). As he was still agitated the next day, his wife again phoned Dr D1 who phoned to say that he would see him soon.

Dr D1 was also called about 10.30am by Mr. Adult 2 who claimed his wife was trying to get him out of the house. Dr D1 reported he had no concerns at this time,

On Monday 20th June 2011 police were called to an address at 11.24 am. The address is a semi detached house in a quiet residential street occupied by Mrs Adult 1 (the deceased), her husband Mr. Adult 2 (the defendant) and her eldest son Mr Adult 3 and his wife Mrs Adult 4. Mrs Adult 4 had dialled 999 and told the operator that her father in law was killing her mother in law and that Mrs Adult 1 had been stabbed.

Police arrived on scene and saw Mr Adult 2 standing at the front door. He was covered in blood and was holding a knife in his right hand. He was told to drop the knife which he did and he was handcuffed and detained. Inside the premises officers found Mrs Adult 1 on the kitchen floor; she had been subjected to a frenzied attack, she had been stabbed numerous times on her torso, neck and legs. The officers administered first aid and an ambulance service was called. The paramedics moved Mrs Adult 1 to the garden so that they could continue the treatment but life was pronounced extinct at 12.25pm.

Mr Adult 2 was arrested on suspicion of murder by PC C at 11.38am and taken to Colindale Police Station

Examination of the scene revealed that the attack site appeared to be the small kitchen at the rear of the premises. A knife was found on the floor on the kitchen and the officer who commenced first aid provided evidence that he removed this as it was resting on the victim's stomach and was hindering his first aid attempts. A second blood stained knife was found by the front door; this is the knife dropped by the suspect on the command of the police.

Mrs Adult 4

Mrs Adult 4 says that her father in law spiralled into a deep depression following a heart attack in March 2011; he did not sleep and changed from being a happy man to one who constantly moaned. She says that during the early hours of 20th June her father in law was trying to take lots of sleeping tablets, she said they managed to take the tablets from him and everyone went back to sleep. Just after 11am she was in the house with her in laws, her husband had gone to work. Mrs Adult 1 rang the family GP Doctor D as she was concerned for her husband's welfare and was worried that he was trying to kill himself. Following the telephone conversation Mr. Adult 2 went into the kitchen followed by Mrs Adult 1. Mrs Adult 4 said he was looking for something sharp; he then went to the draining board and picked up a sharp vegetable knife. He grabbed Mrs Adult 1's arms, she struggled and he began moving the knife across her throat. Mrs Adult 1 said "Mrs Adult 4 save me!" She said that she tried to help but Mr. Adult 2 pointed the knife towards her and she ran screaming from the house. She called Mr Adult 3 and the police; she could hear her mother in law screaming. Her husband arrived and Mr. Adult 2 appeared at the front door and said "I have killed your mum" he had blood on his hands and was holding a blood stained knife. The police arrived and Mr. Adult 2 was detained.

Mr Adult 3

Mr Adult 3 is the eldest son of Adults 1&2 and lives at the family home with his wife. He considers himself to be fortunate to be part of such a close loving family. He never witnessed any violence or serious rows between his parents. He confirms that following a visit to Pakistan in March 2011 his father suffered a heart attack and underwent a series of tests for cancer (these were negative). He says that this together with the death of his mother had a detrimental effect on his father's health and well being. He suffered from insomnia and depression and was prescribed medication for these. He became increasingly insular and would not engage in conversation; he describes him as being a shadow of his former self. He confirms that during the early hours of Monday his father was taking a number of sleeping tablets and his mother was concerned. He went off to work just before 9am and he had a conversation with his mother regarding his father's health and it was apparent that she thought he might try to harm himself. She even considered hiding the knives. At about 11.15am he received a phone call from his wife asking him to come home as his father was attacking his mother with a knife. He immediately drove home and as he tried to enter the front door his father opened the door. He said that his father had his right hand behind his back and he said "Are you going to stab me, I'm your son" his father replied "She's my wife". Mr Adult 3 then saw that his father was holding one of their kitchen knives and it was covered in blood; there was also blood on his hand and sleeve. The police arrived and detained his father' he ran into the premises and saw his mother covered in blood on the kitchen floor.

Mr Adult 5

He is the younger son and does not reside at the family home; he lives with his wife and children elsewhere. He provided back ground information but no evidence of the offence.

Dr G

Whilst in custody at Colindale police station Dr G carried out an examination of Mr Adult 2 and samples were taken from him. During the examination Mr Adult 2 said "I think I tried to kill her today" he was referring to his wife. This was witnessed by two Police officers. Dr G assessed that Mr Adult 2 was fit to be interviewed.

Dr D1

Doctor D1 is the GP for Mr Adult 2. He says that he was rarely seen at the surgery prior to 2011 but was aware that he was distressed about being unable to sleep and was suffering from depression and was anxious about his physical fitness following his heart attack. He was prescribed medication for his heart attack but also Zopiclone and Mirtazapine to help him sleep and for his depression. He was referred to Dr H from the Barnet Mental Health Trust for some specialist advice and he was advised to continue on the current medication. On 20th June 2011, at some point before 11am, he received a phone call from Mrs Adult 1 who was clearly concerned for her husband. He also spoke to Mr Adult 2 and in Dr D1's opinion he did not sound as distressed as usual. He formed the impression that Mrs Adult 1 was concerned about her husband harming himself. He suggested that he be referred to the Mental Health Team for an assessment again and this was agreed.

Mr Adult 2 (the defendent)

The police investigation found Mr Adult 2 to be a respected member of the community with a loving family. He has two sons and two grandchildren. He was married to Mrs Adult 1 for 37 years. There is no reported history of domestic violence and both sons speak of a loving home. It is apparent that Mr Adult 2 spiralled into depression following the death of his mother, a heart attack and suspected cancer. He is on medication for his heart, sleeping pills and depression. His family were becoming more concerned for his welfare and he was examined by the mental health team at Barnet where he was diagnosed as having low moods and depression.

He was interviewed at Colindale Police station on 20th June 2011 in the presence of a solicitor and an appropriate adult; he was very vague in his answers but said that he would not have hurt his wife; he could not remember making the comment to the doctor.

Mr Adult 2 was further interviewed at Colindale police station on 21st June in the presence of a solicitor and an appropriate adult; he made no direct admissions or denials he kept saying "Why do you keep saying I have killed my wife" and "How can you say that"

POST MORTEM

The special post mortem was held at Finchley mortuary on Tuesday 21st June 2011. The post mortem was conducted by Dr C. The cause of death has been given as multiple stab wounds.

Mr Adult 2 was charged with murder at Colindale police station on Tuesday 21st June 2011, the charges were read over and he was cautioned at 5.39pm; to which he replied "I didn't do anything!"

A Mental Health Review was undertaken last summer. This concluded that there were some minor changes to be made to recording practices but otherwise there were no significant lessons to be learned that could potentially influence the outcome of similar cases. A copy of this Review is available on request.

A trial was also held and Mr Adult 2 was assessed by both a defence and prosecuting psychiatrist. Both concluded that in their professional opinion, Mr Adult 2 was temporarily insane and unfit to stand trial. As part of the investigation, both adult sons were interviewed about their parents' marriage. Mrs Adult 4, who lived with the victim and perpetrator and who was present at the time of the murder, was also interviewed. All three were emphatic that this was out of character and described a long and happy marriage entirely devoid of abuse.

Nevertheless, a DHR Panel was formed and enquiries made to a much wider range of agencies from both the voluntary and statutory sector. We have found very limited additional agency involvement for either the victim or the perpetrator and none of these contacts relate to a history of domestic violence.

The DHR Panel Chair wrote to the two adult sons informing them of the Review and inviting their participation. They responded via the Family Liaison Officer stating that they have no objections to the review and as far as their participation is concerned, expressed regret that they had not been offered the opportunity to meet with the Mental Health Trust during their review last summer.

The Mental Health Review undertaken last summer appeared to have covered all relevant grounds. As such, a letter was sent to the Home Office to scale down the DHR. This was refused and a full DHR was subsequently carried out.

The family have been sent a copy of this report but to date no response has been received.

TERMS OF REFERENCE OF THE REVIEW

Victim – Mrs Adult 1: DOB 22/05/1951

Perpetrator - Mr Adult 2**:** DOB 06/03/1946

The London Borough of Barnet as the lead agency with its partners intends to use Domestic Homicide Reviews as a management tool to identity opportunities for learning that in turn, reduce the risk to future victims and any children involved.

Except in exceptional circumstances, this review will not apportion blame or vilify any person or agency. This undertaking should allow a free flow of information, cooperation and improved outcome for potential victims.
The review will be conducted in an open and transparent manner with information shared with partners and a public synopsis will be produced.

The legal requirement is set out under Section 9(3) of the Domestic Violence, Crime and Victims Act (2004).

In Barnet this review, its process and final draft is the responsibility of Barnet Safer Communities Partnership Board (BSCPB). In Barnet this board fulfils the statutory duties under the 1998 Crime and Disorder Act and subsequent legislation.

The nominated agencies will share all information in accordance with section 115 Crime and Disorder Act 1998 and do so without prejudice.

Terms of Reference

These terms of reference were developed principally to identify any lessons from this particular case. The intention was to set the direction and minimal requirements of the investigation. However, they do not place any restriction on enquiries that the Chairperson and panel or Barnet Safer Communities Partnership Board or Domestic Violence Strategy Board (DVSB) feel would add additional useful information and opportunities for learning.

The DHR will examine how effectively Barnet's Borough's statutory agencies and Non-Government Organisations work together.

We aim to:

- Establish whether there are lessons to be learned about the way in which local professionals and agencies worked together to safeguard domestic violence victims and their children
- Clarify what any lessons are, how they will be acted upon and what is expected to change as a result, and
- Improve inter-agency working and improve protection for domestic violence victims and their children.

Guidance Notes

Purpose:

The Review seeks to safeguard potential victims by

- reviewing policies and processes to improve inter-agency partnership working
- analysing gaps in information and practice
- identify and sharing lessons on behalf of the Domestic Homicide Panel Members
- recommending areas for improvement
- updating partner agencies accordingly

Confidentiality, disclosure and information sharing:

All DHR Panel members are bound by a signed confidentiality and information sharing protocol as defined in the Crime and Disorder Act 1998 (as amended by the Police and Justice Act 2006).

A disclosure statement was signed by all parties at the first meeting. No disclosure outside of the Domestic Violence Homicide Review group was permitted unless the owning agency - the BSCPB or DVSB had agreed this in advance in writing. No requests were received.

Principle Responsibilities:

- Establish chronological order of events

- Analyse organisational links within the partnership
- Assess the quality and quantity of available information from across the partnership
- Examine the effectiveness and suitability of relevant protocols
- Critically evaluate partnership working practice
- Formally notify the family of this Review process

Process:

The Government's approach to tackling violence against women and girls including domestic violence is set out in the strategic narrative *Call to End Violence Against Women and Girls* (published on 25th November 2010) and the supporting Action Plan (published on 8th March 20111).

As part of the supporting Action Plan, the Government committed to the following action: • *Implement section 9 of the Domestic Violence, Crime and Victims Act (2004), putting in place statutory domestic violence homicide reviews.* Domestic Homicide Reviews (DHRs) were established on a statutory basis under section 9 of the Domestic Violence, Crime and Victims Act (2004). This provision came into force on 13th April 2011.

This guidance is available at the following web address:

http://www.crimereduction.homeoffice.gov.uk/domesticviolence/domesticviolence62.pdf

The process for this Review was multi-phased, involving four basic stages outlined below:

Stage 1

Establishment of a panel that will consider the following issues:

- Check all relevant agencies have been included and invited
- Agree the Terms of Reference
- Agree information sharing protocol underpinned by "serious risk to life" criteria
- Agree timeframes and remit of review. This is expected to be no more than six months
- Agree the timeframes relating to the case that the review will look at
- Agree Management Reviews
- Agree reporting and diffusion of findings (including reporting in wider public interest via media)
- How the criminal findings will shape the review
- Where independent advice will be sought.

Stage 2

Setting out a chronology of events

- Gather the relevant management reviews
- Gather relevant information from the family/interested parties (as primary or secondary sources)
- Convergent and divergent research relating to good working practice and gaps in service provision
- Summary of events, decisions, services offered and delivered.

Stage 3

Analysis of gathered information (e.g. management reviews, chronology, interviews)

- Clarifications or challenges to information
- Agreement relating to further work/research, if necessary
- Advice taken on cultural issues and sources for advice identified
- Agreement as to the report's formation and content
- Outlining actions for SMART action plan with leads and timescales for delivery.

Stage 4

Signing off the report

- Submission to BSCB for authority to disclose
- Submission to the Domestic Violence Strategy Board (DVSB) and Domestic Violence Operational Group (DVOPS)
- Formal feedback to partner organisations
- Ownership of the action plan
- Agreed monitoring process
- To provide the family with a copy of the report

Contributors to the review

Contributors to this DHR are the panel members listed below. Each was asked to complete an IMR, even if it was a nil return.

DHR PANEL AND CHAIR

The DHR Panel has met five times in May, June, July, August and October 2012.

The Independent Chair was Davina James-Hanman who also authored this report. Davina has over 25 years experience in domestic violence work and is considered a leading expert within the UK.

MEMBERS OF THE DHR PANEL

Barnet Asian Women's Association

Barnet Chase Farm Hospital

Barnet Homes

London Ambulance Service

London Borough of Barnet Adult's Services

London Borough of Barnet Children's Services

London Borough of Community Safety Unit

Metropolitan Police

North Central London NHS

Royal Free Hospital

Solace Women's Aid

Victim Support (Barnet)

No Panel member had any direct contact with the victim or perpetrator and nor were they the line managers of anyone who had contact. All Panel members were senior staff and both statutory and voluntary sector were represented including domestic violence specialists.

DIVERSITY ISSUES

Both Adult I & 2 were Asian. No information was uncovered which suggested that cultural issues played a role in this case. Issues of a sensitive nature were raised by both parties with health professionals. All local services specialising in working with the Asian population were contacted to confirm that they had had no contact with either Adult 1 or 2.

Both parties were also in their early sixties but, with the exception of the health issues documented here, did not seem to be vulnerable due to their age.

None of the remaining protected characteristics were relevant in this case.

CHRONOLOGY OF AGENCY CONTACTS

A full chronology is attached at appendix A. Key events are as follows:

February 2011: Mr Adult 2's mother dies.

March 2011: Mr Adult 2 has a heart attack in and is admitted into the Royal Free Hospital when he was also diagnosed with non-malignant cancer of the lymph nodes. He was diagnosed by Dr D1 as suffering from mild depression soon after this.

3 May 2011: Mr Adult 2 was referred to BEHMHT via the Mental Health Liaison for Older Persons, at The Royal Free Hospital.

1st June 2011: Mr Adult 2 and his wife attend the scheduled outpatient appointment. Mr Adult 2 was assessed as being moderately depressed but not suicidal. Mr Adult 2 was not displaying psychotic symptoms nor did he pose a threat to others at the time of his assessment.

19th June 2011: Mrs Adult 1 calls Dr D1 saying that she was concerned as she thought that the medication was not agreeing with Mr Adult 2 and he had stopped taking them. That evening, Mr Adult 2 attempted to take several sleeping tablets (attempted suicide).

20th June 2011: Mrs Adult 1 calls Dr D1 again who agrees to see him soon.

10.30am 20th June 2011: Mr Adult 2 calls the GP claiming his wife was trying to get him out of the house. Dr D1 reported he had no concerns at this time,

11.34am: Daughter-in-law calls the police to report that Mr Adult 2 is stabbing Mrs Adult 1. Police arrive and disarm Mr Adult 2 who by then has stabbed Mrs Adult 1 120 times. Mrs Adult 1 pronounced dead at 12.25

INDIVIDUAL AGENCY RESPONSES

Agencies were asked to give chronological accounts of their contact with the victim prior to her death. Where there was no involvement or insignificant involvement, agencies advised accordingly. Each agency report covers the following:

- A chronology of interaction with the victim and/or their family
- What was done or agreed;
- Whether internal procedures were followed; and
- Conclusions and recommendations from the agency's point of view.

Individual Management Reviews (IMRs)

Confirmation of no record of contact prior to the murder was received from the following agencies:

Barnet Adult Social Care & Health
Barnet Asian Women's Association
Barnet Homes
Barnet Victim Support
London Ambulance Service
Metropolitan Police

Confirmation of contact and a completed IMR was received from:

Barnet, Enfield & Haringey Mental Health Trust
Chase Farm Hospital
Royal Free Hospital
NHS Barnet (re. involvement of the GPs for Adults 1 & 2)

Barnet & Chase Farm Hospital

There is record in February 2011 of an outpatient appointment for Mrs Adult 1 which she did not attend. There are a number of GP investigations including x-rays and blood tests carried out at Barnet and Chase Farm Hospital.

Analysis of involvement

There was limited involvement with Mrs Adult 1. There are a number of blood tests results and x-ray results recorded that are not associated with clinic appointments.

Mr Adult 2 had no attendances prior to the incident at Barnet and Chase Farm Hospitals. There is one attendance for a chest x-ray ordered by his Dr D1 in 2008.

None of the above contacts are related to the events leading up to the murder. As such, there are no recommendations.

Royal Free London Hospital

Involvement with the victim

Mrs Adult 1 was under the care of the endocrine and cardiology departments of the trust from July 2008 to August 2010. In correspondence from Dr D2 in 2008, significant past medical history indicated long standing history of depression (from 1985); referral to psychiatry due to depression / family and work stress. Patient was on anti-depressive medication.

Involvement with the perpetrator

Mr Adult 2 was initially referred to the trust on 2nd March 2011 for a PPCI procedure following an episode of chest pain experienced whilst returning from attending a funeral in Pakistan. Procedure was straightforward and Mr Adult 2 was discharged on 4/3/11.

Records indicate Mr Adult 2 was noted to be highly anxious, commenced on anti-depressive medication and referred to the cardiac Psychologist. In addition, following an angiogram on 3/3/11 Mr Adult 2 was found to have enlarged left enlarged axillary lymph nodes. Mr Adult 2 was referred to the haematology team for further exploration.

On 8/4/11 Mr Adult 2 was seen as an outpatient and on 19/4/11 was admitted as an elective patient for elective lymph node biopsy. Anti- depressive medication was stopped as was contraindicated to sodium levels.

During this inpatient stay, Mr Adult 2 complained of a continued bad smell through his nose, a heavy head and problems with short term memory. A brain CT scan was performed and was reported as normal.

Mr Adult 2 continued to express significant anxiety and was referred to liaison psychiatry team. An onwards referral to the Old Age Psychiatry team was made and the patient was reviewed on 27/4/11. Mr Adult 2 reported a history of increasing anxiety and irritation, particularly relating to his 65th birthday, however the psychiatrist felt that there was no immediate risk and Mr Adult 2 was referred to Barnet, Enfield and Haringey Community Mental Health Team for further follow up.

On 1/6/11 Mr Adult 2 attended an appointment with the cardiac counselling service and was seen by Dr FS. In attendance was Mrs Adult 1. During the appointment Mr Adult 2 indicated altered affect as previously (ie low mood, poor communication, high anxiety); however he and his wife also reported new behaviours of concerns (talking to himself / stamping his feet / biting his hand) , particularly when feeling helpless and frustrated. Mrs Adult 1 also reported that Mr Adult 2 threatened suicide. When questioned, Mr Adult 2 indicated that he did not have suicidal ideations or plans. Findings of the appointment were communicated in a detailed letter to Dr D1 sent 2/6/11.

It was noted that Mr Adult 2 had been referred to the community psychiatry team and that he had an appointment with a consultant psychiatrist at Barnet that afternoon. On 3/6/11 Dr FS followed up and confirmed that Mr Adult 2 had attended the appointment with the consultant psychiatrist (Dr A). It was confirmed Mr Adult 2 had attended and so he was discharged from the cardiac counselling service for more appropriate follow up with Barnet, Enfield and Haringey Mental Health Team.

Analysis of involvement

Both victim and perpetrator had been referred by their respective GP's for physical health reasons. There had been no involvement with the victim since August 2010.

The perpetrator was an inpatient in April 2011 and due to concerns raised by the patient, Mr Adult 2 was referred for CT to rule out organic causes. The CT was reported as normal. Due to his anxiety Mr Adult 2 was referred to the liaison psychiatry service (provided by Camden and Islington NHS Foundation trust). The trust followed all pathways in a timely manner and Mr Adult 2 was accepted under care of Barnet Psychiatric services.

On review of Mr Adult 2 in June 2011, concerns were raised at the cardiac psychology service. The clinician reported the concerns within 24 hours and checked that Mr Adult 2 had engaged with the psychiatry appointment that afternoon.

Lessons Learned

There are no lessons to be learned or recommendations to make.

Barnet NHS

Mr Adult 2 and Mrs Adult 1 were registered at different practices. This had been the situation since 2004. Prior to that, they had both been registered with the same practice. In 2004, the practices separated. Dr D1 and D2 were no longer in partnership and from then onwards worked at two different sites.

Mr Adult 2 remained with Dr D1 while Mrs Adult 1 moved with Dr D2 to another practice.

Mrs Adult 1 had significant on-going health problems which included diabetes and hypertension. She had a number of musculoskeletal problems and had previously been diagnosed with depression.

Dr D2 looked after her. She was only seen twice in the period in question. However, the appointments were always lengthy and covered most of her on-going concerns.

None of her problems were severe, her diabetes and hypertension were well controlled. In the late 1990's she had seen a psychiatrist and at that time, family therapy had been suggested. Mrs Adult 1 did not taken up the offer for family therapy. However, in recent years, her symptoms were fairly stable and she was appropriately managed in primary care.

At interview, Dr D2 stated that he managed her presenting symptoms by giving her time to ventilate the issues she had. He had continued to prescribe anti-depressants.

At interview, Dr D2 stated that he knew her well. He did not know any of her immediate family. He would offer her long appointments so that she would have the chance to ventilate her feelings and discuss her current situation. He thought this was an effective way to support her. When asked specifically, Dr D2 stated that Mrs Adult 1 had never stated that she was a victim of domestic violence. He had never had any concerns in regard to this and had never felt the need to ask this question directly.

Dr D2's clinical records are brief and limited. They do not describe effectively the actual events that occurred in the consultations he had with Mrs Adult 1. When asked about this directly, he stated that he was improving his record keeping.

In summary, while the records available are brief and limited, Dr D2 was clear that he knew Mrs Adult 1 personally and she had been a patient of his for many years. He was able to describe the clinical care provided to her in some detail and his descriptions suggest an acceptable level of clinical care.

There was nothing in the information that Mrs Adult 1 imparted to Dr D2 that could have provided any sort of warning about the impending events.

Mr Adult 2 was very well known to Dr D1. Mr Adult 2 had been registered at the practice for a considerable length of time. Prior to 2011, he had not had any major illnesses.

Dr D1 described 2011 as being a challenging year for Mr Adult 2. His mother had died unexpectedly, he had been on pilgrimage to Mecca and this had brought out some negative feelings.

Mr Adult 2 had had a myocardial infarct and had been unwell following this. He had also had an incidental finding of generalized lymphadenopathy that had needed investigation.

Dr D2 stated that Mr Adult 2 had become anxious and depressed about all these events.

Dr D2 gave a good account of his interactions with Mr Adult 2. He also knew Mrs Adult 1 and had remained under the impression that she was still registered with his practice. His description of the consultations he undertook was full and quite detailed, including a degree of contextual information and an understanding of Mr Adult 2 as a person.

Unfortunately, Dr D1's record keeping is very limited and cannot be considered to meet the required standard. However, for the purpose of this IMR, his first-hand account is more useful than the records. It is evident that Mr Adult 2 was appropriately treated by Dr D1.

When asked specifically about domestic violence, Dr D1 was clear that this had never arisen as an issue with Mr Adult 2. He also went further to say that he has subsequently consulted with Mr Adult 2's wider family and none of them have raised this as an issue or a concern.

Mr Adult 2 was seen by Dr C from the beginning of May onwards. She was not interviewed as part of this IMR. However, her clinical records are full and detailed and it is evident that the clinical care provided was appropriate. She had arranged a referral to a psychiatrist and Mr Adult 2 was seen and assessed on the 1st June 2011. The letter from the psychiatrist describes a moderate depressive illness. There is nothing in this letter to raise concerns about a risk of violence or any suggestion that Mr Adult 2 may have a psychotic illness.

Mrs Adult 1 telephoned Dr D1's practice on the morning of the 20th June. The precise time is unclear. However, Dr D1 thought it was about 10.30am. [No mention of second call? And MHT report states no later than 10am] He states that he was in the middle of morning surgery. He spoke directly to Mr Adult 2. He states that Mr Adult 2 appeared calm. His assessment was around the possibility that Mr Adult 2 might self harm.

Dr D1's assessment was that this was not a risk and the key issue was to arrange a review with the psychiatrist sooner than planned. There was nothing to make him think that an immediate assessment was necessary.

The issue about the need to offer Mr Adult 2 an appointment or a home visit was discussed directly with Dr D1 at interview. His view was that it was not possible, even with the benefit of hindsight to know if this could or would have altered the outcome. There was no obvious pressing need for an immediate intervention and a home visit after morning surgery or even an appointment at the end of the session would have been too late for the events that unfolded.

There are concerns about the quality of the record keeping at both practices. However, both doctors were able to give a full and detailed account of the clinical care they provided. This account clearly indicates that the clinical care provided to both Mr Adult 2 and Mrs Adult 1 was of an acceptable level.

There was no evidence of any history of domestic violence. From the perspective of the general practitioners, there was no way that the event that occurred could have been foretold.

Lessons learned

The main lesson learnt from this IMR is that some consideration needs to be given to the record keeping at both practices.

Recommendations

This report should be shared with both practices.
The GPs should seek the support of NHS North Central London in developing an action plan around improving their record keeping.

Barnet, Enfield & Haringey Mental Health Trust

The investigation found that on the 1st June 2011, Mr Adult 2 was assessed as being moderately depressed but not suicidal. Mr Adult 2 was not displaying psychotic symptoms nor did he pose a threat to others

The assessing doctor concluded that Mr Adult 2 had a Moderate Depressive Episode, and appropriately prescribed treatment of anti-depressant. A prescription for two weeks supply of medication was given and a detailed follow up letter was sent to the patients GP on 7th June 2011.

The investigation identified no problems in the care and or service provided by the Older Peoples Mental Health Service Barnet CMHT. Given the available evidence, Mr Adult 2's actions on the day of the incident were not predictable.

The investigation found no root cause to the incident.

A possible contributory cause is a Moderate Depressive Episode, which despite appropriate treatment, escalated and resulted in a homicide.

A potential deficit relating to the patient's General Practice, overseen by NHS Barnet, is identified on the morning of 20th June 2011.

Mrs Adult 1 made contact with her General Practitioner. The GP reports that she is distressed and very upset, that her husband is arguing with her and had taken a lot of sleeping tablets.

The precise timing of this call cannot be confirmed. It can, however be confirmed that the call took place no later than 10am on the morning of 20th June 2011.

The GP determined that he would inform the Older Peoples Mental Health Service and he left a telephone message at 11:25am by which time the patient had killed his wife.

The report recommended that the Strategic Health Authority (NHS London) should determine if any further multi agency investigation should be undertaken.

Lessons learned

This review did not identify any deficit in care provision, offered or provided by Barnet Older Peoples Services.

Recommendations

Procedure for completing the 24 hour report system needs to be reviewed. The recording of information, so ensuring an audit trail is in place, confirming the notification of key stakeholders and regulators, has been identified as best practice.

It is recommended that the trust practice concerning Medical Secretaries not being permitted to enter information in RiO be reviewed. The Medical Secretary who took the call from the patients GP at 11:25am was required to write the message on scrap paper, as opposed to enter directly into RiO. Accurate recording of the patient story would be enhanced if such telephone messages could be recorded directly into RiO notes.

As one telephone contact was not recorded on RiO. The importance of entering information on to RiO, in a timely manner, should be re-enforced Trust wide.

Overall analysis

It seems clear from the above that the events in question were caused by a temporary psychotic episode. Extensive searches of agency records have revealed no history of domestic violence and no contacts outside of the NHS.

There is nothing to suggest that any actions could have been taken that may have led to a different course of events.

CONCLUSIONS AND RECOMMENDATIONS

In the professional opinion of the Chair, this case lacks the features of power and control which characterise domestic violence. As such, it was correctly identified as being most appropriately dealt with by means of a Mental Health Review.

It is regrettable that leave was refused to scale down this review. No additional lessons were learned to prevent future homicides. Service improvements required were fully known and implemented before the start of this DHR as a consequence of the Mental Health Review undertaken in 2011. As a result, this has been a disproportionate and costly exercise.

In addition, Mr Adult 2 has endured the indignity of being cleared of malice in a court of law yet still treated as an abuser by this process, an unkind experience for anyone, let alone someone with mental health issues.

As the recommended changes in practice identified under the Mental Health Review have been completed there are no further actions to be taken bar the following:

Both GPs should seek the support of NHS North Central London in developing an action plan around improving their record keeping. This is issue is being addressed by the Practitioner Performance Team at NHS NC London and will be concluded within six months of this report being published.