Safer Cornwall

DHR Overview Report Executive Summary

DHR 4

Independent Chair and Author

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1. Introduction

In October 2013, Adult B physically attacked and caused fatal wounds to his wife Adult A and then took his own life.

This Domestic Homicide Review (DHR) examines the circumstances surrounding the death of Adult A. The DHR was commissioned by Cornwall Council on behalf of Safer Cornwall (Cornwall's Community Safety Partnership).

The DHR was commissioned in autumn 2014 and the panel met for the first time in December 2014.

The report and this Executive Summary uses Adult A to denote the victim in this case and Adult B to denote the perpetrator. The decision to adopt this approach was taken after discussion with Adult C and his advocate. It was taken to maintain confidentiality but also to be more personal to him rather than using random initials or other forms of anonymisation.

2. The DHR process

A DHR was recommended and commissioned by the Safer Cornwall in the autumn of 2014 in line with the expectations of the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews 2013. This guidance is issued as statutory guidance under section 9(3) of the Domestic Violence, Crime and Adults Act 2004.

A panel met for the first time in December 2014 following the appointment of an independent Chair, Dr. Jane Monckton Smith. In April 2015, Steve Appleton, Managing Director of Contact Consulting (Oxford) Ltd was appointed by NHS England South to provide additional mental health expertise and to assist the Chair in writing the Overview Report.

In October 2015, Dr. Monckton Smith withdrew as the Independent Chair and Steve Appleton took over the Chairing of the DHR and authoring of the overview report. Dr. Monckton Smith provided the review panel with a draft report of key findings which the panel has drawn upon in finalising this Overview Report.

The DHR Panel received and considered Individual Management Reviews (IMRs) from the following agencies:

- NHS England (Primary Care)
- Cornwall Partnership NHS Foundation Trust
- Outlook South West
- Education Welfare

3. Views of the family

In conducting this review the panel has sought the views of family members in order to inform its understanding of the incident and the events that led up to it. The chair has met with Adult C, step-son of Adult A and has had regular contact with his advocate from AAFDA. The overview report contains a statement from Adult C including areas where Adult C disagrees with the panel on specific aspects of the reports findings and the DHR process as a whole.

4. Conclusions

Having reviewed and analysed the information contained within the IMRs and having considered the chronology of events and the information provided by family members, the panel has reached the following conclusions:

Knowledge of domestic abuse and domestic abuse

Knowledge of domestic abuse and domestic violence, both in terms of the risks and the triggers was not of a sufficient depth and quality within the services that had contact with Adult B. The indicators of domestic abuse were not recognised and thus were not acted upon.

In addition those agencies in contact with Adult B did not use routine enquiry in relation to domestic abuse as an approach in their interactions with him. This meant that information about potential risks and triggers was not gathered.

Risk assessment

Risk assessment was variable and focused primarily on Adult B's risk to himself. Risk to others and in particular to Adult A was not adequately considered and explored. This meant that those risks that can now be identified as a result of this review were not known and thus not acted upon. There are wider questions about the adequacy of the risk assessments that were undertaken and these have been addressed within the IMRs.

The lack of an holistic view

The agencies in contact with Adult B saw him in isolation from both Adult A and the rest of his family. This meant that they did not have a wider or more holistic view of his circumstances, nor the validity or otherwise of his concerns about his relationship with Adult A. Although the Outlook South West (OSW) worker understood the nature of those anxieties and placed them in the context of what might be described as a delusion state, there was no wider understanding of the effect of this upon Adult A, and what was happening in the home environment.

Understanding of morbid jealousy

This case has highlighted the challenges in identifying and responding to the possible presentation of morbid jealousy and its part in domestic homicide. The research evidence suggests that domestic violence is a common result of jealousy, normal or morbid.[1] As the OSW IMR suggests, there remains a knowledge deficit in relation to morbid jealousy that is not confined to Cornwall as a locality.

Whether Adult B did present the symptomatology of morbid jealousy is not the remit of this DHR, but the information reviewed suggests that it may have been a part of his presentation. Its accurate and formal identification would have led to a different treatment methodology.

It is not possible to say with any certainty whether that would have had any impact on the likelihood of the incident occurring or not, it would certainly have assisted in the treatment of Adult B's anxiety about his relationship with Adult A.

Prescription of mirtazapine and GP follow-up

The matter of the appropriateness of the prescription of mirtazapine and the follow up by the GP after that prescription was the subject of additional independent expert review and advice.

The judgement of the independent experts was that the prescription of mirtazapine was not unusual. Adult B's symptoms and presentation indicated that treatment with an antidepressant would be beneficial, and as such mirtazapine represented a suitable option based on its pharmacology, known safety profile and the range of target symptoms.

[1] Aspects of morbid jealousy Kingham, Mu and Gordon, H. Advances in Psychiatric Treatment 2004

Any risks around increased anxiety, aggression or risk of suicide are low compared to the underlying illness and similar to other antidepressants. On a statistical basis, therefore, and when coupled with the pre-existence of symptoms which have subsequently been identified as morbid jealousy, it would seem highly unlikely that the subsequent violent acts were stimulated or accelerated by the use of mirtazapine.

Turning to the matter of GP follow-up, if the national guidance had been strictly applied, this would suggest that follow up review of the treatment by the GP could have happened sooner after initiation of the medication. In clinical practice for someone considered to be at low risk of self-harm, an initial review period of 2-4 weeks might be appropriate, depending on how well the patient was known to the clinician and whether previous treatment courses had been successful.

Having noted that, the independent GP advice was that it would not be unusual or sub-standard professional practice for a patient not to be seen within three weeks of starting a new antidepressant medication. The judgment of the expert pharmacist is that arguably a follow up review of the treatment by the GP could have happened sooner after initiation, but that any adverse effect on the patient's behaviour or mental state in this time frame would have manifested itself and would have been picked up in either of the two subsequent contacts with other professionals.

Having considered the expert advice, the conclusions reached are that the prescribing of mirtazapine was appropriate, and that the medication itself is unlikely to have any direct effect or causal link with the subsequent violent incident.

In relation to the issue GP follow-up, it appears that the application of the NICE guidance for Generalised Anxiety Disorder was not fully adhered to. In saying this it is important to bear in mind that the guidance itself is not applicable to mirtazapine as part of a treatment plan for anxiety. Nevertheless, that guidance recommends seeing patients two weeks after the commencement of the medication and this did not happen.

Therefore, the DHR finds that there is no evidence to indicate that mirtazapine had any direct effect or causal link to incident. It also finds that although the follow-up did not take place within two weeks, this was not unusual and cannot be said to have had a direct effect on the eventual incident.

Predictability and preventability

The review has not identified any evidence that indicates that physical violence had been a factor in Adult B's relationship with Adult A. Indeed Adult C has stated that no such incidents took place that he was aware of.

Adult B had self-disclosed his anxieties and concerns about his relationship and these centred on his (misplaced) belief that Adult A was being unfaithful to him. He had also articulated thoughts about his life not being worth living without her and stating that he would kill her and/or himself if they were separated. The validity of these statements must be viewed in the context of his anxiety state, but even in that context this represents a real concern and escalation of risk.

The risk factors present and those identified in this review were not well recognised by the professionals in contact with Adult B. However, given the risk factors and the behaviours being exhibited by Adult B in the period prior to the incident, demonstrate that it was likely that Adult A would be a victim of domestic abuse.

Coming to a view about the predictability of the homicide is a complicated process and necessarily is a nuanced judgment. The panel has come to the conclusion that the probability of physical violence directed towards Adult A was highly likely and that it could have been predicted. When considering whether or not a homicide was predictable is harder to judge, but given the risk factors and the statements made by Adult B, our conclusion is that the homicide was predictable.

Turning to the matter of preventability, neither the police or health services received any information or calls around the time of Adult A's death alerting them to the fact that there was an immediate threat. It is on this basis that the panel has concluded that no professional or agency could have prevented Adult A's death.

5. DHR Recommendations

1. We recommend that there should be clear domestic abuse policies/policy written for all GP surgeries in the county. These policies should be regularly reviewed by practice managers and subject to audit at regular intervals. Such a policy should be distinct and separate from policies relating to safeguarding.

2. We recommend that a training needs analysis for GP's, mental health workers and others for example, NHS Kernow commissioned services such as psychological therapies should be conducted to identify which staff would benefit from training in recognising high risk markers for domestic abuse. Further work should be undertaken across local agencies to ensure the dissemination of regular training and information in relation to domestic abuse. In particular the use of a specialist package like IRIS to support GPs in their responses to domestic abuse should be used.

3. We recommend that direct enquiry into domestic abuse is used by all agencies in any assessment or risk assessment process. In addition we recommend that pastoral care in schools have issues relating to domestic abuse as part of their work plans and processes. Direct enquiry should be considered as part of the tool kit of skills and interventions to be utilised within the pastoral care process. There weren't indicators of abuse regarding concerns relating to the youngest Child (known as Child C in the Overview report). The consideration of domestic abuse in these circumstances should not be reliant on specific indicators, it should form part of routine enquiry when a child presents with anxiety issues.

4. We recommend that a programme of work be developed to raise public awareness of domestic abuse. It should include information about where members of the public can appropriately and safely share concerns or information about individuals they believe may be at risk of domestic abuse or at risk of perpetrating domestic violence.

5. We recommend that guidance relating to the identification and management of morbid jealousy by primary care workers and those working in primary care mental health services should be developed to

aid those workers in supporting individuals who may be exhibiting those symptoms.

6. We recommend that assessment and risk assessment processes in health and social services be reviewed to ensure clearer guidance about the need to consider and respond not only to the needs of the presenting individual, but to spouses, partners and children within the family unit.

7. We recommend that a focused themed review of previous DHRs in Cornwall be undertaken to identify common themes and issues, from which focused learning and practice development can take place with local organisations. We make this recommendation in the context of there having been three previous DHRs in Cornwall where the perpetrator has exhibited symptoms and risk assessed as risk to self as opposed to risk to others. This emerging theme around quality of risk assessment in the wider context of an individual and the effect this may have on understanding whether they pose a risk to others is an area of practice that should be considered for wider learning and practice development. There may be other commonalities and it would be of benefit to the local system to know and understand these so that a co-ordinated approach to learning and development can be undertaken in response to DHRs undertaken as a whole rather than seeing each in isolation.