Domestic Homicide Review

London Borough of Newham

‘AB’

Author: Mark Yexley

2016

Contents

Please note, the Executive Summary is a standalone document to this report.

1. Introduction 3

1.1 Details of the incident 3
1.2 Terms of Reference 4
1.3 Methodology 4
1.4 Composition of the DHR panel 4
1.5 Parallel Reviews 5

2. The Facts 7

2.1 The death of AB 7
2.2 AB's contact with the statutory sector and third sector 9
2.3 The perpetrator BB 10
2.4 Interview with the perpetrator 15

3. Analysis 17

3.11 Lessons learned in this review 19
3.12 Information sharing 19
3.13 Risk Assessment 20
3.14 Understanding of the existence of domestic violence 20
3.15 Police action 21
3.16 Mental Health 21
3.17 Housing 21
3.18 Support Services 21
3.19 A culture of questioning 21
3.20 Policies and processes 22
3.21 Family contact 23
3.22 Equality and diversity 24
3.23 Key themes identified in this review 25

4. Conclusions and Recommendations 27

4.1 The issue of preventability 27
4.2 General Recommendations 28

Appendix 1: Glossary of Acronyms 30

Appendix 2: Domestic Homicide Review Terms of Reference for AB 31

Appendix 3: Members of the Panel 35

Appendix 4: Action Plan 36

Appendix 5: Letter from Home Office Quality Assurance Panel 39

1. Introduction

1.1 Details of the incident

1.1.1 On the evening of 13 June 2013 the police were called to the Newham home of the sixty-seven-year-old victim AB by his son CB, aged thirty-four years. CB told the police operator that BB, his twenty-seven-year-old brother, had attacked their father with an axe to the head. Police attended and found the body of AB in the kitchen of the house: he had severe head injuries. Police medics, London Ambulance Service and London's Air Ambulance Service attended AB but he was found to be dead. BB was found upstairs in the premises covered in blood. Police arrested him. A homicide investigation was commenced by the Specialist Crime and Operations Department of the Metropolitan Police Service. BB was found to have a mental health condition and he was initially placed in Mental Health care. BB was later charged with the murder of his father. He pleaded guilty to manslaughter on the grounds of diminished responsibility, and was sentenced to a hospital order.

1.1.2 These events led to the commencement of this Domestic Homicide Review (DHR) at the instigation of the London Borough of Newham Community Safety Partnership (CSP). The initial meeting was held on 2 August 2013, and there have been two subsequent meetings of the DHR panel to consider the circumstances of this death.

1.1.3 The DHR was established under Section 9(3), Domestic Violence, Crime and Victims Act 2004.

1.1.4 The purpose of the review is to:

a. 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

b. 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

c. Apply those lessons to service responses including changes to policies and procedures as appropriate

d. Prevent domestic homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

1.1.5 This review process does not take the place of the criminal or coroner's courts proceedings, nor does it take the form of any disciplinary process.

1.2 Terms of Reference

1.2.1 The full terms of reference are included in **Appendix 2**. The essence of this review is to establish how well the agencies worked both independently and together and to examine what lessons can be learnt for the future.

1.3 Methodology

1.3.1 The approach adopted was to seek Individual Management Reviews (IMRs) from all organisations and agencies that had contact with AB or BB. It was also considered helpful to involve those agencies that could have had a bearing on the circumstances of this case, even if they had not been previously aware of the individuals involved. Details of the agencies providing IMRs or summaries of information held are outlined in the terms of reference.

1.3.2 Once the IMRs had been provided, panel members were invited to review them and debate the contents at subsequent panel meetings. This became an iterative process where further questions and issues were then explored. This report is the product of that process.

1.4 Composition of the DHR panel

1.4.1 The Panel consisted of representatives from the following agencies:

a. Aanchal Women's Aid – Chair of DV Forum

b. East London Foundation Trust (ELFT) – Mental Health Services

c. London Borough of Newham Domestic and Sexual Violence Commissioner

d. London Borough of Newham Safeguarding Adults

e. London Probation Trust Newham

f. Metropolitan Police Service (MPS) – Critical Incident Advisory Team (CIAT)

g. Metropolitan Police Service Newham Borough

h. Newham Action Against Domestic Violence (NAADV)

i. Newham Clinical Commissioning Group (NCCG)

j. Standing Together Against Domestic Violence (Independent Chair and minutes).

1.4.2. A full list of panel members is contained in **Appendix 3.**

1.4.3 To assist this review the chair made contact with the family of AB. The family was represented by the victim's wife and his eldest son. The family provided constructive insight into the relationships with statutory services and community groups. The panel took the view that steps should be taken to interview the perpetrator. This prolonged the DHR process as the perpetrator was not considered fit to be interviewed for some time after his detention in a secure mental health facility.

1.4.4. Throughout this report the identity of the family has been anonymised using initials that do not match those of the family members concerned. It is appreciated that in some reviews it is practice to use pseudonyms to replace the names of all parties concerned. In this case the chair has attempted to gain the views of the family on the use of pseudonyms but they have not advised on a preference. Consideration was given to the selection of appropriate pseudonyms by appropriate partners within the Newham domestic abuse partnership. The chair considered that this action would also allow the possibility of a pseudonym being chosen that would have some unforeseen impact on the family.

1.4.5. The independent chair of the DHR is Mark Yexley, a former Detective Chief Inspector in the Metropolitan Police Service and a lay chair for NHS Health Education Services in London, Kent, Surrey and Sussex. Mark represents Standing Together Against Domestic Violence, an organisation dedicated to developing and delivering a coordinated response to domestic violence through multi-agency partnerships. He has no connection with the London Borough of Newham, Metropolitan Police Teams or any of the agencies involved in this case.

1.5. Parallel reviews

1.5.1 A parallel review was conducted into this case by the East London Foundation Trust (ELFT). It was signed off by the trust board on 26 September 2013. The review findings were shared with the victim's family, NHS England and the chair of this DHR.

1.5.2 It was apparent that mental health was a key factor in this report and the chair expresses his thanks to panel members from ELFT and the Consultant Psychiatrist leading the Mental Health Review. The close liaison with the Mental Health Trust ensured that the chair was able to eventually interview BB. BB was not well enough to be interviewed at the time of the ELFT review. The content of the interview was shared with BB's current carers.

1.5.3 The Consultant Psychiatrist conducting the ELFT Serious Incident Review was also the DHR IMR author for ELFT. This consultant was not a member of the panel but the Chair was able to liaise directly with them on issues of mental health and facilitating interview with the perpetrator.

1.5.4 Since submission of the DHR overview report to the Home Office the chair has been informed that NHS England have commissioned a Mental Health Homicide review for this case. The investigation is being undertaken by Niche Patient Safety and they are liaising directly with Newham CSP.

2. The Facts

2.1 The death of AB

2.1.1 On 13 June 2013 the victim, AB, was killed by heavy blows to his head and neck in his family home. He was sixty-seven years old at the time of his death. The circumstances leading up to his death are as follows.

2.1.2 The victim was born in Sri Lanka in 1946. He married his wife DB in 1977 and they had two sons: CB was born in 1979 and BB was born in 1986. The following year, AB moved to the United Kingdom as a political refugee. His wife and children joined him in 1990. They moved into the family home, a terraced house in the London Borough of Newham, which they later purchased. The family later gained British citizenship. The victim lived with his wife and sons at the home up until the time of his death. The family were practicing Catholics and worshipped at the local church.

2.1.3 AB studied in the UK and gained qualifications at MSc and PhD level. He also worked as an interpreter for public services. In 2007, AB opened a restaurant with his wife, and his sons would often help run the business. The eldest son, CB, studied to degree level and works as a driving instructor. CB lives at the family home.

2.1.4 The youngest son, BB, left home to study for a degree in business management. It was during this period that there were first recorded concerns regarding his mental health. In 2008, whilst BB was away at university, his family lost contact with him and later discovered that he had been admitted to hospital with mental health problems. BB had three months of hospital treatment and he was then discharged into his family's care. The responsibility for BB's medical needs was passed to ELFT.

2.1.5 BB was referred to the Newham Early Intervention in Psychosis Team in June 2009 with a diagnosis of paranoid schizophrenia. The team considered him to be well engaged and he was compliant with his regime of taking oral medication. AB took an active part in his son's care and regularly attended medical appointments with him.

2.1.6 BB and his family were involved in the local Catholic church. In January 2011, he reported to ELFT that he had attended regular exorcism sessions at his church. He

said that the sessions helped him and he reduced his oral medication at that time, although his parish priest had advised him to continue with his medication. Whilst under the care of ELFT there were a number of times when BB wanted to reduce his medication. BB continued to receive medical treatment and psychological support, attending a number of support sessions and classes. He did report motivational problems and some issues with gambling. In March 2013 BB's psychology sessions ended and he was reported to show little evidence of psychotic symptoms.

2.1.7 On 31 May 2013 BB contacted ELFT and asked for his medication to be increased, stating that his father thought he might be relapsing. He stated he would increase some of his medication himself. It was around this time that BB's family feared that he was not taking his medication. Although BB had never shown any signs of violence towards his family, his behaviour was deteriorating. He had become concerned over his mother's personal safety whilst out of the house. BB became very concerned when the gate was removed from outside the family home. AB was becoming concerned about his son's agitated state. BB missed his ELFT group meeting on 4 June 2013. At the time, BB's extended family suggested that he visit a pastor in South London for further exorcism.

2.1.8 On 9 June 2013 BB attended a service with a pastor in South London where he received exorcism. CB stated that BB was told that he had two demons in him, one was removed and another remained. CB maintains that his brother had never mentioned 'demons' before the exorcism service.

2.1.9 On 11 June 2013 BB attended his ELFT group. He appeared well and calm during his meeting and did not report any concerns. On the afternoon of 12 June 2013 BB's psychologist received a text message from BB's mobile phone. The message requested the psychologist did not to talk to BB again and mentioned regret over giving a present. This was reported to BB's care coordinator. The ELFT care coordinator contacted BB by phone on 12 June 2013. BB apologised for his text message and said that he had developed an 'addictive personality' with the psychologist. It is not clear whether this terminology was BB's. BB confirmed that he was taking his medication, was not relapsing and was fine. It was agreed that BB should meet with his care coordinator on 19 June 2013. BB was due to be discussed at an ELFT team meeting on 14 June 2013.

2.1.10 On 13 June 2013 CB was away from the family home when his phone registered a call from his father's phone; CB was unable to take the call. CB later called his father's phone and it was answered by his brother. BB told his brother that he had

killed their father using an axe and asked CB to come home. CB went home after informing his family. Initially BB refused to let his brother into the house. When CB was eventually allowed into the home, he found his father in a pool of blood. Police and emergency medical services were called to the home at 19.38 hours. Police officers immediately rendered medical attention to AB, being joined by London Ambulance and Air Ambulance Teams. After all efforts had been made to revive AB, he was pronounced dead after half an hour. An axe was found at the premises; this was one previously used by the family for chopping trees in the garden. Police also recovered a blood-stained knife.

2.1.11 BB was arrested by police and taken into custody. A homicide investigation was commenced by the Homicide and Serious Crime department of the Metropolitan Police Service. After his arrest BB was assessed by a forensic psychiatrist and admitted to a forensic medium secure unit. He was considered too ill to be interviewed.

2.1.12 A post mortem examination was conducted and AB was found to have died due to head and neck injuries consistent with blows from an axe. On 19 June 2013 a coroner's hearing was opened into the death of AB and adjourned.

2.1.13 On 12 March 2014 BB appeared at the Central Criminal Court. He pleaded guilty to the manslaughter of his father on the grounds of diminished responsibility. He was sentenced to a hospital order under Section 37 Mental Health Act 1983.

2.2 AB's contact with the statutory sector and third sector

2.2.1 The contact that AB had with statutory sector services is primarily recorded in a supportive role to his son BB. He was registered with the same General Practitioner (GP) as his son. He was seen by his GP for routine health interventions. There was no evidence of any recorded concerns of abuse or potential threat towards AB.

2.2.2 The DHR process has not revealed any contact between AB and any support or criminal justice agency. There are no records of any reported incidents or concern of a domestic or criminal nature.

2.2.3 AB was considered by health services to be acting in a supportive and caring role to his son, BB. From the outset of his referral to ELFT, BB had consented to his father being present at all Care Programme Approach (CPA) meetings. AB did not attend some meetings, but would always provide his own feedback on BB through

the care coordinator. AB did not report any concerns to ELFT on his safety or potential physical risks presented by his son.

2.3 The perpetrator BB

2.3.1 The DHR process has not revealed any prior contact between BB and any statutory or voluntary agencies before the emergence of his mental health problems in 2008.

2.3.2 The main area of contact between BB and statutory services came through his involvement as a patient after having an acute psychotic episode when he was aged twenty-one at a Home Counties University in 2008. Whilst he was studying for his final exams, BB reported that he had started to have paranoid feelings towards friends he was living with at the time. He lost control and slammed his finger in a door causing a fracture. BB also reported that he feared that people were trying to harm him. He was admitted to hospital under a mental health order. He was given a diagnosis of paranoid schizophrenia. BB expressed his wishes to return to his parents in Newham. He was prescribed regular depot injection intramuscular medication and a course of oral medication, and was referred to the Newham Early Intervention Service (EIS) under ELFT on 9 June 2009.

2.3.3 BB was first seen by ELFT staff in July 2009. He was not found to have any psychotic symptoms. He reported that he had low self-esteem. He was also found to have post schizophrenic depression. He was prescribed appropriate medication and his original regular depot injection drugs continued. BB was seen regularly by medical staff. Towards the end of 2009 BB reported that he had some psychotic symptoms and these included shaking of his shoulders or hips. These were symptomatic of him receiving messages from an unknown person that would result in him involuntarily nodding or shaking his head.

2.3.4 During 2010 BB continued to be seen by ELFT. In his sessions he still reported receiving messages. It was also noted that he had problems with gambling. When BB was seen by his consultant in September 2010, he reported the shaking or tapping of his body linked to 'communications' he was receiving. The communications did not involve high risk to him or others and were associated with coming from an unknown friend or God. BB's medication was increased and he was noted to be taking up martial arts and dancing classes. His medication was reviewed on a regular basis and it was considered that he had a good relationship with his care coordinator.

2.3.5 In January 2011 BB was seen by a doctor and his care coordinator. He reported that he had stopped taking anti-depressants and was going to church daily, finding this helpful. He was still taking his depot medication. BB also said that he was undergoing monthly exorcism rituals at his church and he found this beneficial. He felt normal after exorcism and he did not feel like that after taking medication. He refused to take anti-depressants from that time.

2.3.6 In a Care Programme Approach (CPA) meeting in March 2011 BB discussed his exorcisms with the EIS consultant psychiatrist. He said that he had sessions at the local church until the evil spirits left him. The psychiatrist suggested that the priest should attend the next meeting with BB's father. BB was prescribed anti-depressants again.

2.3.7 In July 2011 BB had a medical review with his psychiatrist and his father was present. BB stated that he had occasional episodes of his legs shaking when he received messages. He did not report hearing voices and there were no other psychotic symptoms. AB said that he thought his son was doing well. There was no mention in this meeting of the exorcism sessions. During this meeting, AB informed the doctor that he was a pharmacist and he supported his son continuing with his medication. There was no mention of the exorcism or the priest being invited to the meetings.

2.3.8 In August 2011 BB attended a medical review with a higher trainee doctor and his care coordinator. He discussed his anti-depressant medication and declined to increase it. He reported attending church regularly but there was no mention of medical staff seeing the priest or exorcisms. BB was referred to the psychology team.

2.3.9 At the CPA meeting in January 2012, BB was accompanied by his father. BB had been attending a number of courses. He said that prayers at church were also helping. The priest was not present for the meeting. There were concerns over an abscess that had developed at the site of the depot injection of an antipsychotic drug. BB was anxious about this and wanted to take oral medication. His father's experience in pharmacy was noted, he agreed to help support his son in taking oral antipsychotic medication, and BB started on a new drug. BB was reviewed in March 2012. His father was present.

2.3.10 In April 2012 there was an urgent medical review as BB had stopped taking one of his drugs, although he was still taking his oral antipsychotic drug. BB wanted to

reduce his antipsychotic medication, however he was requested to take all medication as prescribed. He was further reviewed in June 2012.

2.3.11 In August 2012 BB requested a further medical review of his medication. He represented that he had been relatively stable for two years, he was not depressed and he was not having psychotic episodes. He was offered an alternative antipsychotic drug; however, BB did not want this. As BB wanted to reduce his medication and his father supported the request, the psychiatrist agreed to reduce dosage of antipsychotic drugs with the stipulation that BB was monitored and supported by his care coordinator in the community. BB was considered to have capacity to make decisions and told that he would require maintenance medication indefinitely. In the months following BB attended psychology sessions and attended a number of courses.

2.3.12 In January 2013, a key worker in the Mental Health Team requested funds from Adult Social Care of £1,813 for BB to attend martial arts and cookery classes to help improve his confidence. Later that month, BB told his psychologist that he had started gambling on his computer, losing money and then winning it back. He reflected that this may have been to find excitement as he was often bored. BB was reminded of previous plans to keep more active. He was informed that as he had been with EIS for four years, meetings would now be held to discuss his discharge over the next year.

2.3.13 During February 2013 BB attended six appointments with ELFT including 'Tree of Life' Group sessions. Tree of Life is a therapeutic group that enables patients to set goals and talk about aspirations for the future. BB was also provided with support from an occupational therapist (OT). In his meetings BB appeared well-presented, made good eye contact and was to be supported in his motivation to change and goal setting. He was supported by his psychologist in setting goals and group work. BB's psychologist invited him to involve his family in his relapse prevention plan, however he refused. In meetings with the OT, issues on lifestyle and job applications were discussed as well as recent gambling.

2.3.14 On 13 March 2013 BB attended his final psychology session. His relapse prevention plan was discussed and a follow up appointment was made for three months' time.

2.3.15 On 25 March 2013 BB met with his care coordinator and said that he had had a bad week. He said that he had been feeling anxious, low and that he had been gambling online, losing over £3000. He said that he had discussed things with his

father and was feeling better now. He reported that his mood had improved and that he had no negative or suicidal thoughts. On the same day he met with his OT and a constructive plan was made for BB's future activities.

2.3.16 Around April 2013 a friend of BB died. His mother remembers that he was worried and sad about the loss of his friend. He appeared to be getting more anxious. When a gate went missing from outside the family home, BB started to worry about his family's safety. As BB's family became more concerned for his welfare they were referred by an uncle to a 'pastor' or healer who operated from a church in South London. He was prayed for by the healer and during these sessions BB would faint and fall to the ground.

2.3.17 On 10 April 2013 BB met with his care coordinator and reported that he was ok and that he had no problems with his mood and medication. Other issues including family relationships, finance and spiritual goals were discussed with no mention of exorcism sessions or recent gambling problems.

2.3.18 During the rest of April 2013 BB attended group activities at EIS. On 24 April BB did not attend his appointment with the care coordinator. He was telephoned and a new appointment was made for 29 April 2013.

2.3.19 On 26 April 2013 Adult Social Care sent a letter to BB requesting proof of expenditure of the £1,813 authorised for the cookery and martial arts classes.

2.3.20 On 29 April 2013 BB did not attend the rearranged appointment with the care coordinator. He was telephoned and a further appointment was made for 1 May 2013. On 30 April 2013, BB did not attend his group work at EIS.

2.3.21 On 1 May 2013 BB met with his care coordinator and reported that he was doing well. He stated that he had enquired about cookery classes and attending a gym. He planned to get a job in the long term. He talked about gambling but said that he had not had any craving. He displayed no concerns on his mental health. He talked about his request for spiritual care but said that this was no longer an issue for him and he would inform his care coordinator if it was.

2.3.22 BB was joined by his father for his CPA meeting on 8 May 2013 with his psychiatrist and care coordinator. He was considered to be doing relatively well with "little evidence of positive psychotic symptoms". He still described thinking of a voice as he tapped his knee. BB said that he was helping out in his father's restaurant but could not maintain interest in courses, voluntary work and other activities. BB was not keen to change his medication. He was given a care plan

with instructions to his GP for prescribing and to attend a further CPA review in six months' time.

2.3.23 On 15 May 2013 BB failed to attend his appointment with his care coordinator. The meeting was rescheduled for 22 May 2013.

2.3.24 On 21 May 2013 BB attended his EIS Group activity. He attended the appointment with his care coordinator the next day. He was calm, stable and comfortable with his current medication. He mentioned his leg shaking and hand tapping, however felt able to control this

2.3.25 On 22 May 2013 Adult Social Care contacted BB by telephone as they had not received receipts for his cookery and martial arts classes. It was established that BB had not signed up for martial arts classes and his cookery classes were due to start in September 2013.

2.3.26 On 31 May 2013 BB telephoned his care coordinator requesting to increase his antipsychotic medication. He said that his leg was shaking and although he thought it was natural, he stated that his father believed he may be relapsing. It was explained to BB that he would need to be reviewed by a doctor. BB said that he would increase his dosage and contact the doctor if symptoms remained. On 4 June 2013, BB sent a text to inform EIS that he would not attend his group session that day.

2.3.27 BB's brother stated that on Sunday 9 June 2013 the family took him to the healer in South London. BB had been informed by the healer that he had two demons inside him. BB's brother expressed that he felt that when BB was having a schizophrenic episode, BB would focus on the demon being inside him. BB's mother felt that BB's condition deteriorated over the four days that followed.

2.3.28 BB attended his group activity the next Tuesday, 11 June 2013. He was seen to be calm and engaged in conversation, with encouragement. He spent time talking to the OT and made plans to go to the gym. He said that he intended to attend the group meeting the following week. At this stage BB did not want AB involved in his meetings.

2.3.29 On 12 June 2013 BB's psychologist received a text message from BB's mobile phone. The message asked the psychologist not to talk to him again and expressed regret at giving her a present. This was reported to the care coordinator. The care coordinator telephoned BB. He discussed the text message. BB said that he had developed an addictive relationship with the psychologist and apologised

for sending the text. BB was asked if he was relapsing, he said he was not. He said that he had not increased his medication and would contact the care coordinator if he showed symptoms or felt unwell. Due to the contact that was made by BB to his therapist, the therapist felt it necessary to raise his risk from green to amber and he was scheduled to be discussed at a team meeting on 14 June 2013. An amber level of risk indicated that concern had been raised, but not to a critical level. An appointment was made for BB to attend the EIS office the following week on 19 June 2013.

2.3.30 It is believed by BB's family that he did not take his medication on 13 June 2013. On that day AB was killed.

2.3.31 On 14 June 2013 ELFT was contacted by police informing them that BB was in custody in relation to the murder of his father. The team arranged for a consultant psychiatrist to assess BB. After the assessment BB was taken to a medium secure unit. ELFT contacted the family's GP practice to inform them of the incident to check on the welfare of the family.

2.4 Interview with the perpetrator

2.4.1 After BB was sentenced, it was decided by the panel that the independent chair should assess whether it would be possible to interview him. BB was not deemed fit to be interviewed on his initial detention and it took some time until his carers considered him well enough. Even after BB had consented to be interviewed, he cancelled an interview because he did not feel well enough. When BB was eventually interviewed, his account provided information that was not previously known to the panel and was a valuable part of the process.

2.4.2 BB described how he first had a mental health issue when he was at university and after that his care was transferred to ELFT. He had a single person responsible for his care at ELFT and he would attend appointments every week or two. He had been visited at home by his ELFT key worker on one occasion to give him a depot injection of risperidone. BB said that his father joined him at all CPA meetings with his doctor.

2.4.3 BB said that he was doing fine on his medication, however he made an independent decision to reduce his dosage by fifty per cent and did not tell anyone about that. He reduced the dosage about three weeks before his father's death. His family were not aware that he had stopped taking his full amount of prescribed medication. He said that he took responsibility for his own drugs and kept them in

his room. He said that he had asked ELFT to reduce his medication however they refused to do this.

2.4.4 He confirmed that he had a relapse plan for when he developed paranoid thoughts, but he did not recognise that he was relapsing. He said 'the way of the illness was different this time, it manifested differently and I could not predict it and no one else could'. He said that his illness manifested itself through spiritual voices and he thought he was changing for good.

2.4.5 He said he had been exorcised about a year or two before the incident by a priest at his Catholic church, and given an 'exorcism' book of prayers to read on his own. He confirmed that he had told his ELFT team about the exorcisms. BB said that he went to his Catholic church on a daily basis towards his relapse.

2.4.6 He was asked about his visits to a South London pastor. He said that the pastor was mentioned by his uncle. He went for the exorcism where evangelists put hands on him and exorcised demons. He was told that he would feel agitated for a week after the event. He experienced two exorcisms. When asked if they had any effect on him, he said that he was more inclined to believe that the level of his medication had an effect on him.

2.4.7 It was confirmed that BB had a relapse prevention plan, but this was only known to him and his father. He said leading up the incident he could hold a normal conversation and it was highly unlikely that someone could have prevented what happened to his father. He felt that there was a stigma around the mention of mental health and this could have prevented his father from discussing his condition with other family members. He said that he felt supported and liked talking to ELFT staff. He said that he was warned against coming off his medication. He said he was competent and reducing his dose was his responsibility. He felt supported by his close family, who visit him on a weekly basis.

3. Analysis

3.1 The following analysis examines the lives of the victim of this homicide and the perpetrator.

3.2 There is very limited information about the victim held by any agency and the information gleaned comes from the health records of the perpetrator, police investigation and subsequent interviews with the family.

3.3 AB was a businessman with strong links to the local community. He was respected and considered to be a caring person. He had never reported any incidents of threats or violence towards himself and his family were not aware of any. He had not reported any undue stress or other concerns. It is apparent that AB was concerned for the health and welfare of his son, BB, and took an active part in meetings with mental health professionals and his son.

3.4 The panel considered that there were changes in the behaviour demonstrated by BB that were known to responsible agencies. From the information available to ELFT, it could not have been anticipated that BB was presenting a significant risk to his family.

3.5 There were also changes in BB's behaviour at home and it is not clear from the victim's family that they had an established line of communication to express concerns with healthcare professionals. BB states that his relapse plan was known to his father. It should be noted that the family never considered themselves to be at risk of harm from BB and were concerned that any hospital admission could cause BB distress.

3.6 It is apparent to BB's brother that the exorcisms in 2013 had an effect on his behaviour. The fact that the exorcisms were not reported to the mental health team is of concern. It is appreciated that the family may have wanted to keep this private. In 2011, the initial report was made to ELFT of the involvement in exorcisms. There was an invitation for the family's priest to come to the next review meeting. The priest did not attend the meeting and there is no record of the issue of exorcisms being discussed again in any meeting thereafter. Enquires with the priest have established that he was never invited to the ELFT meetings. ELFT maintain that there is a distinct separation between the notification of exorcisms in 2011 and the undisclosed exorcisms in 2013. BB has revealed that he was still referring to exorcism prayer books issued to him by his Catholic church after he attended the 2013 exorcisms. It is considered that there

were many opportunities to discuss what other spiritual healing was being offered to BB and if it was thought appropriate to invite the priest to a clinical meeting then this should have been followed up. This could have established an open dialogue with the family and they may have felt able to discuss alternative healing in the future.

3.7 In relation to the gambling, there appears to have been no communication between the healthcare professionals and social care. Financial stresses caused by gambling can be a causal factor in domestic violence. BB reported that he had lost £3000 in gambling and there appears to have been no assessment on his ability to pay this. He was paid a sum of over £1800 in February 2013 for courses which he never attended. Adult Social Care were making direct contact with BB over his failure to provide proof of payment for the courses. On 26 April 2013 BB was sent a letter by Social Care concerning the funds. BB then failed to attend his next two appointments at ELFT. There is no recorded explanation for his failure to attend. On 22 May 2013, BB was contacted by Social Care again over the funds. BB did attend his next group session, however on 31 May 2013 he telephoned to request an increase in his medication. If there had been inter-agency communication, greater emphasis could have been given to the potential financial stress on BB. This is particularly pertinent given that ELFT had made the initial application to social care for the funding. On the facts provided a man who reported concerns with gambling had been provided with money from public funds that was unaccounted for. This could have caused stress to the individual and his family relationships. However, none of the surviving family members report gambling as a cause for concern.

3.8 The mother and brother of BB expressed that they were concerned about the deterioration in his behaviour in the weeks leading up AB's death. Whilst it is appreciated that BB was considered to have capacity to make all decisions in his life, ELFT also accept that AB was acting in the role of carer for his son. AB was invited to the review meetings, and he was provided with a relapse plan for his son. It is not clear that BB or AB shared any information with other family members. BB provided insight on this matter as he felt that the stigma associated with mental health would have stopped his father discussing matters with his family. BB's mother and brother were not aware of how to raise concerns and they did not know if AB had a means of emergency contact. There was a call to CB from his father's phone on the morning of his death, there is no record that he contacted ELFT. Although BB had refused to involve his wider family in his relapse prevention plan, consideration needs to be given to the duty of care to those sharing a house with a patient, balanced against the patient's rights to privacy. In this case it should be considered that the mental health

trust would not have seen the need to share information as there was nothing to show the family were at risk of harm.

3.9 The text messaging from BB to his psychologist and subsequent telephone conversation with his care coordinator resulted in the risk level being raised for BB. Consideration could have been given at this stage to contacting BB's carer. At this time the care coordinator would have been aware that BB said that his father was concerned about him relapsing less than two weeks before. Communication at this point may have revealed that BB had been undergoing the exorcisms during that period. It is appreciated that this is viewed with the benefit of hindsight. BB did not recognise himself to be relapsing and considered his agitation to be linked to the recent exorcism, rather than a dramatic reduction in antipsychotic medication.

3.10 With all the foregoing in mind, the issues raised within the panel meetings and which should lead to further consideration for the future are as follows.

3.11. Lessons Learned in this review

3.12. Information sharing

3.12.1. Information sharing is an essential element in the prevention and management of domestic violence. There was a lack of inter-agency information sharing.

3.12.2. There appears to have been no communication between Adult Social Care and ELFT over the expenditure of funds by BB and his gambling. Given that financial worries can raise stress it would have been beneficial for contact between the two agencies to explore what had happened to the funds provided to BB and whether there was any link to the gambling issues he had talked about in meetings with ELFT.

3.12.3. In relation to the information shared with carers, it is not apparent that a 'carers pack' or ELFT information leaflet had been provided to the carer. The surviving family were not aware of this and it is not mentioned in the ELFT IMR. It is the responsibility of ELFT to help carers with identifying signs of relapse and provide support that may help to prevent hospital admission. Carers should be considered as integral to the 'Triangle of Care' best practice of considering the role that carers play in the healthcare of patients.

3.12.4. There appears to be good information sharing between ELFT and the family GP. There are clearly documented updates to the GP on the health care of BB and prescribing. In the aftermath of AB's death staff from ELFT took immediate

steps to contact the GP to pass information and check on the welfare of his family.

3.13. Risk Assessment

3.13.1. Risk assessment should be considered as an on-going and dynamic process that can develop and gather further information essential for identifying and managing risk. Throughout this process ELFT made regular assessments on the risks to and presented by BB, but this was based on their own face-to-face dealings with BB. There is no record of ELFT staff visiting BB at home and assessing him in that environment.

3.13.2. On the day before the death of AB the assessment of BB's condition was based on a telephone assessment. If there had been liaison with the family at this point, then ELFT staff would have been in a better position to assess risk to all parties. It is appreciated that this is a two-way process and the family could have contacted ELFT. It was clear that BB did not wish to include his family in his relapse prevention plan, however confidentiality needs to be balanced against safety. Based on the facts known to ELFT the risk assessment level may have been appropriate; however, if information had been shared between more parties they would have been better informed. When BB's status was changed from 'green' to 'amber', consideration should have been given as to whether his family were made aware of this. However, based on the facts available to ELFT, and the family's own dealings with BB, it was not reasonable to anticipate that he presented a risk to others that would have required a breach in confidentiality.

3.14. Understanding of the existence of domestic violence

3.14.1. No agency involved in this DHR process was aware of any domestic violence being present between BB and AB before the homicide. The only time that BB had been known to conduct a violent act, this amounted to self-harm by fracturing his finger before he was admitted to hospital in 2008.

3.14.2. This is not a case where there had been any history of violence or threat to a family member. This incident falls within the definition of domestic violence, however there is no suggestion that there was ever any domestic abuse within the family. These are extremely tragic circumstances and it needs to be considered that any other person, including a healthcare professional or member of the public, could have been a victim of BB given the appropriate circumstances and his psychotic state.

3.15. Police action

3.15.1. There are no concerns over the initial response to the death of AB. The MPS staff were provided with clear evidence and adopted appropriate investigation procedures taking immediate steps to provide medical aid to AB and safely secure the arrest of BB, reducing the risk to the public.

3.16. Mental Health

3.16.1. The issue of mental health is at the centre of this DHR. BB was found to be suffering from a psychotic episode shortly after the attack on his father and was likely to have been in that state at the time of the attack. In considering the impact of mental health on families, BB voiced the opinion that there was a stigma around the issue that may have prevented his immediate family from seeking support from others.

3.16.2. Consideration needs to be given to whether circumstances such as these should be subject to a DHR or whether an NHS England Mental Health Homicide investigation is more appropriate. There needs to be consideration that there was no known history of domestic violence or incidents, reported or unreported before the incident. It is not known if there was a catalyst for the attack on AB. There could also be a likelihood that any other person could have been at risk from BB that day; this would also include self-harm.

3.17. Housing

3.17.1. There were no concerns raised on housing during this review. There were no records held by the local authority in relation to parties concerned. The family lived in a privately owned residence with both adult sons living at home.

3.18. Support Services

3.18.1. There are a number of agencies providing support for domestic violence victims in East London and the London Borough of Newham. There was representation on the DHR panel. This review has not revealed any incidence of domestic violence or threat of violence within the family home of AB and BB.

3.19. A culture of questioning

3.19.1. There were occasions when agencies came into contact with the family and the circumstances were such that questions should have been asked about the

domestic environment. The family felt that, as BB was being cared for in a community setting, it would have been helpful if he could have been seen in his home environment by healthcare professionals.

3.19.2. It is appreciated that before the date of the homicide there was no suggestion of domestic violence. The family have confirmed this.

3.19.3. A factor in this case is the involvement in exorcisms. The matter was originally raised in 2011 referring to sessions taking place at the local church. It appears that this matter was never looked into again and the effect of the exorcisms on BB were not questioned after that initial contact. There were some conflicted views within the family on the effect of the exorcisms and better lines of communication could have supported the family to report their concerns to ELFT.

3.19.4. It is appreciated that questioning on domestic relationships could be considered intrusive, however the need to ensure that safe and healthy relationships exist must be considered as a priority. In this case BB's family wanted desperately to help their son and it may have helped the situation if the use of an exorcist had been discussed with ELFT. However ultimately the family were not aware that BB had stopped taking his medication.

3.20. Policies and processes

3.20.1. It appears that existing policies and processes are in place within agencies to support the identification and prevention of domestic violence.

3.20.2. There are no reported breaches of policies or processes in relation to the direct medical care of BB. It is important to note that AB was considered to be acting in the role of carer for his son. ELFT is committed to the principles of the 'Triangle of Care' best practice. The carers strategy for ELFT from 2013-2016 indicates that care coordinators should contact carers on a monthly basis and obtain a carer's input. There should also be information packs provided for the patient and carers on treatment and how to deal with emergencies. It is not apparent from the ELFT IMR that this process was implemented and in place before AB's death and it is not considered in any ELFT recommendations.

3.20.3. ELFT comment that the family did not contact the trust with concerns they had with BB's behaviour. The family state they had no written guidance or directions to support this contact. BB maintains that his father was aware of his relapse prevention plan.

3.21. Family contact

3.21.1. The guidance for DHRs recommends that families and friends should be a part of the DHR. The panel gave careful consideration on who would be the most appropriate person to involve. It was decided to contact the wife of the victim and her son, who lives in the family home. The DHR chair interviewed the family and provided them with a copy of terms of reference, the Home Office leaflet for families and a record of the interview. The contribution of the family is a valuable part of this review. AB was described as a very caring man who would go out of his way to help anyone. He was always there to support BB and would attend medical appointments with him.

3.21.2. They said that they first became aware of BB's mental health problems when they lost contact with him for a few weeks whilst he was at university. He was supported through this and completed his degree. They said that BB's father would generally check on him taking his medication and his brother would sometimes ask about it. They said that they had noticed that for about two weeks before the incident BB was not himself. They noted a change in his behaviour becoming very protective towards his mother; this was attributed to the front gate of the family home being stolen. They said that even when BB had not been taking his medication properly he was not violent towards family members.

3.21.3. One of BB's uncles had wanted to take him to be exorcised and they did not see that any harm would come of this. BB was seen by a pastor, of a denomination other than Roman Catholic, who told BB that he had two demons inside him. BB was seen to behave differently after he was told this. The family recounted a time when BB was angry and shouting and showed a 'demon like' face. They knew this was a schizophrenic episode, however he got caught up and distracted by the thoughts of the exorcism. The family wanted to do something to help BB but did not want him admitted to hospital, because they knew this would distress BB.

3.21.4. The family were aware of BB's gambling and they said that it did not cause any friction at home.

3.21.5. They said that BB got on well with all of the healthcare professionals and was very involved with group activities. AB would attend appointments with his son. BB's mother and brother did not have any emergency contact numbers to report any urgent concerns about his mental health and they were not aware of any information about this being provided.

3.21.6. The family felt that there should have been more regulation of BB's medication. They also felt that BB should have been visited in his home environment and that there should also have been documents telling the family about the medication, what to expect in side effects and signs of him not taking his medication.

3.21.7. They concluded by saying that both AB and BB were loving and caring people and the family felt this was an unfortunate accident.

3.21.8. The chair also spoke with the family's parish priest, who had provided support after the death of AB. He stated that he had been the parish priest for over four and a half years. He had known the family well and AB had been involved with the church. The priest stated that he had never been invited by the family to attend any meetings at ELFT. BB's parents were regular worshippers, but he had only spoken to BB on a few occasions. He said that he remembered seeing BB praying quietly in the church about a week before his father's death. He said that there had been no exorcisms practiced at his church in relation to BB. He said that he had been shocked that he heard that an exorcism had taken place. He said it was performed by someone he believed to be a Pentecostal minister. He had only heard of the exorcisms after he had been told of AB's death. It should be noted that this account is at odds with ELFT records where exorcisms at the Catholic church are mentioned. BB also makes reference to an exorcism book of prayers provided by his church.

3.22. Equality and diversity

3.22.1. The nine protected characteristics as defined by the Equality Act of 2010 have all been considered within this review. They are: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation. The issue of mental health would be considered as disability and this has been addressed in the body of the report. The other relevant characteristics are the age of the victim, the race and religion of the victim and perpetrator.

3.22.2. The victim was 67 years old at the time of his death. He was still in full time employment and playing an active part in the community. He was also fulfilling the role of carer for his son with mental illness. There were no concerns raised by the panel that the victim was in any way isolated or disadvantaged because of his age. It was not deemed necessary to include any age specific services on the review panel.

3.22.3. Both victim and perpetrator were of South Asian, Sri Lankan origin. There was nothing identified in this review that suggests that the race of the subjects was a significant factor in the relevant history or the incident. No specific services or skills were considered necessary to inform the review.

3.22.4. AB was a prominent member of the local Roman Catholic church; his sons were of the same faith but did not attend church as regularly as their father. The family priest has been contacted by the chair of the panel and informed of the DHR review. It was not deemed appropriate to include faith based services included on the panel. The chair spoke with the Catholic priest as he was mentioned as being a support to the family.

3.23. Key themes identified in this review

3.24. Mental Health

3.24.1. This case has centred on the management of care for a person with a mental illness within the community. It is now apparent that BB had not been taking his anti-psychotic medication for a period leading up to AB's death. Whilst there was an expression from the family that they should have been made more aware of the details of BB's care, there is also an expectation of confidentiality between BB and the Mental Health Trust.

3.25. Information sharing with families

3.25.1. There was an appreciation that there is a stigma that can be associated with mental health that does not always promote open discussion within families on this issue. This case has shown that there was some discussion with the extended family and as a result BB was subject to an exorcism in the period leading up to the homicide. This information on the exorcism was revealed to the Mental Health Trust by BB or his family. This case demonstrates the importance of the principles of the "Triangle of Care" between Mental Health Trusts, patients and carers.

3.26. Information sharing between agencies

3.26.1. The two key agencies in contact with BB were the Mental Health Trust and Adult Social Care. Whilst the Mental Health Trust was aware of the courses proposed for BB, there was no communication with Adult Social Care who were providing the funding and had concerns on use of money by BB. At the same time the Mental Health Trust had been informed that BB was gambling. This case demonstrates the need for improved communication and effective audit processes between agencies.

4. Conclusions and Recommendations

4.1. The issue of preventability

4.1.1. This case has allowed examination of current statutory systems and processes in relation to risk assessment, management and domestic violence. Although agencies have generally followed policies in relation to their internal working relationships, it has demonstrated that communication between some agencies and the family could have been better.

4.1.2. It is not considered that financial stresses would have impacted on this case. However, it is apparent that the perpetrator was reporting his problems with gambling to his mental health carers, whilst social care was enquiring into unaccounted for funds previously supplied to BB.

4.1.3. A key area in this case is the family's concern that they did not have a point of contact with mental health services, where they could share their concern. It is appreciated that the perpetrator's father, the victim, attended some meetings with his son. There was no awareness within the family of carers' information packs being provided and this was not mentioned in the mental health trust review.

4.1.4. Whilst there are issues on inter-agency and family communication they are not felt to be of sufficient gravity to indicate that AB's death could have been prevented. It is apparent that BB had drastically reduced his medication and he felt that others may not have been aware of this. From his family's point of view, they had concerns that making a referral to hospital could have caused distress to BB. This case demonstrates the importance of establishing the triangle of care between healthcare providers, patients and carers.

4.1.5. Whilst the victim of this case is the father of the perpetrator, consideration needs to be given to the fact that he was attacked by his son during a psychotic episode. There were no signs or indicators of domestic violence before this incident and consideration needs to be given to the fact that any other person could have been victim of attack by BB whilst he was in a psychotic state. This case could also have been subject to a Mental Health NHS England homicide investigation, however that process requires a conviction before a review can commence. The scope of an NHS England investigation was clearly covered

by the DHR process and this was deemed by the panel to be the most appropriate review process.

4.1.6. For these reasons it is important to test the performance of the agencies working individually and together to satisfy the partnership that practice has improved. The recommendations are designed to achieve this outcome and fall largely into the following areas:

a. Partnership effectiveness

b. Policies and processes

c. Training – dynamics and practice.

4.1.7. The information examined by the panel has not shown that this death was preventable. The family considers the event a tragic accident. This case has highlighted the fact that the potential for violence exists in the most loving and caring families, when there are the particular risks linked to the psychotic episode of a family member. The family demonstrates their care through regular weekly visits to BB in the secure mental health facility. This case does not reveal a failure to deal with long standing reported issues of domestic violence, it demonstrates the need to maintain a dynamic view of potential risks to all members of a family and the community, when managing mental health.

4.2. General recommendations

4.2.1. The recommendations below are, in the main, for the partnership as a whole but many organisations have internal recommendations that mirror these. It is suggested that the single agency action plans should be subject of review via the CSP action plan hence the first recommendation.

4.2.2. Recommendation 1: That all agencies report progress on their internal action plans to the relevant task and finish group of Newham CSP.

4.2.3. Recommendation 2: That the partnership conducts a review of its effectiveness to establish its strengths and weaknesses. This review, which should be completed by a task and finish sub-group of the Newham CSP, to include an examination of:

a. The effectiveness of support to carers supporting people with mental health concerns; and

b. The consideration of faith based abuse and the challenges presented when managing domestic violence and mental health.

4.2.4. Recommendation 3: That training strategy be reviewed, to ensure the following:

a. To allow frontline practitioners to understand the dynamics of domestic violence and good practice;
b. To support an increase in questioning about domestic violence and potential risk; and
c. To support an increase in awareness around the role of carers and links to the risk assessment process.

4.2.5. Recommendation 4: That ELFT examine its processes for information sharing with carers and families and effectively involve them in risk assessment. This should include provision of carers' packs and clear written guidelines for carers on the availability of a crisis line. Consideration should also be given to the potential risks to the wider family and community.

4.2.6. Recommendation 5: That there should be early joint consultation between Community Safety Partnerships and NHS England to discuss primacy for investigation between DHR and Mental Health Homicide Investigation.

Appendix 1: Glossary of Acronyms

ASC	Adult Social Care
CPA	Care Programme Approach
CPS	Crown Prosecution Service
CSP	Community Safety Partnership
DHR	Domestic Homicide Review
DV	Domestic violence
EIS	Early Intervention Service
ELFT	East London Foundation Trust
FLO	Family Liaison Officer
FME	Forensic Medical Examiner
GP	General Practitioner
IMR	Individual Management Review
MARAC	Multi-Agency Risk Assessment Conference
MHA	Mental Health Act
MPS	Metropolitan Police Service
NHS	National Health Service
OT	Occupational Therapist

Appendix 2: Domestic Homicide Review Terms of Reference for AB

This Domestic Homicide Review is being completed to consider agency involvement with *AB*, and his son, *BB*, following his death on 13.06.2013. The Domestic Homicide Review is being conducted in accordance with Section 9(3) of the Domestic Violence Crime and Victims Act 2004.

Purpose

1) Domestic Homicide Reviews (DHR) place a statutory responsibility on organisations to share information. Information shared for the purpose of the DHR will remain confidential to the panel, until the panel agree what information should be shared in the final report when published.
2) To review the involvement of each individual agency, statutory and non-statutory, with AB and BB during the relevant period of time: 01.01.2009 – 13.06.13.
3) To summarise agency involvement prior to June 2013.
4) To establish whether there are lessons to be learned from the case about the way in which local professionals and agencies work together to identify and respond to disclosures of domestic abuse.
5) To identify clearly what those lessons are, how they will be acted upon and what is expected to change as a result and as a consequence.
6) To improve inter-agency working and better safeguard adults experiencing domestic abuse and not to seek to apportion blame to individuals or agencies.
7) To commission a suitably experienced and independent person to:
    a) chair the Domestic Homicide Review Panel;
    b) co-ordinate the review process;
    c) quality assure the approach and challenge agencies where necessary; and
    d) produce the Overview Report and Executive Summary by critically analysing each agency involvement in the context of the established terms of reference.
8) To conduct the process as swiftly as possible, to comply with any disclosure requirements, and on completion, present the full report to the Newham CSP.

Membership

9) The following agencies are to be involved:

   a) Clinical Commissioning Groups (formerly known as Primary Care Trusts)
   b) Local domestic violence specialist service provider e.g. IDVA
   c) Education services
   d) Children's services
   e) Adult services
   f) Health Authorities
   g) Substance misuse services
   h) Local Authority
   i) Local Mental Health Trust
   j) Police
   k) Probation Service
   l) Victim Support.

10) Where the need for an independent expert arises, for example, a representative from a specialist BME women's organisation, the chair will liaise with and if appropriate ask the organisation to join the panel.

11) If there are other investigations or inquests into the death, the panel will agree to either:
   a) run the review in parallel to the other investigations, or
   b) conduct a coordinated or jointly commissioned review - where a separate investigation will result in duplication of activities.

Collating evidence

12) Each agency to search all their records outside the identified time periods to ensure no relevant information was omitted, and secure all relevant records.

13) Each agency must provide a chronology of their involvement with AB and BB during the relevant time period.

14) Each agency is to prepare an Individual Management Review (IMR), which:

   a) sets out the facts of their involvement with AB and/or BB
   b) critically analyses the service they provided in line with the specific terms of reference
   c) identifies any recommendations for practice or policy in relation to their agency
   d) considers issues of agency activity in other boroughs and reviews the impact in this specific case.

15) Agencies that have had no contact should attempt to develop an understanding of why this is the case and how procedures could be changed within the partnership which could have brought AB or BB in contact with their agency.

Analysis of findings

16) In order to critically analyse the incident and the agencies' responses to the family, this review should specifically consider the following six points:

    a) Analyse the communication, procedures and discussions, which took place between agencies.

    b) Analyse the co-operation between different agencies involved with the victim, perpetrator, and wider family.

    c) Analyse the opportunity for agencies to identify and assess domestic abuse risk.

    d) Analyse agency responses to any identification of domestic abuse issues.

    e) Analyse organisations access to specialist domestic abuse agencies.

    f) Analyse the training available to the agencies involved on domestic abuse issues.

Liaison with the victim's and alleged perpetrator's family

17) Sensitively involve the family of AB in the review, if it is appropriate to do so in the context of on-going criminal proceedings. Also to explore the possibility of contact with any of the perpetrator's family who may be able to add value to this process. The chair will lead on family engagement with the support of the senior investigating officer and the family liaison officer.

18) Coordinate with any other review process concerned with the child/ren of the victim and/or perpetrator.

Development of an action plan

19) Establish a clear action plan for individual agency implementation as a consequence of any recommendations.

20) Establish a multi-agency action plan as a consequence of any issues arising out of the Overview Report.

Media handling

21) Any enquiries from the media and family should be forwarded to the chair who will liaise with the CSP. Panel members are asked not to comment if requested. The chair will make no comment apart from stating that a review is underway and will report in due course.

22) The CSP is responsible for the final publication of the report and for all feedback to staff, family members and the media.

Confidentiality

23) All information discussed is strictly confidential and must not be disclosed to third parties without the agreement of the responsible agency's representative. That is, no material that states or discusses activity relating to specific agencies can be disclosed without the prior consent of those agencies.

24) All agency representatives are personally responsible for the safe keeping of all documentation that they possess in relation to this DHR and for the secure retention and disposal of that information in a confidential manner.

25) It is recommended that all members of the Review Panel set up a secure email system, e.g. registering for criminal justice secure mail, nhs.net, gsi.gov.uk, pnn or GCSX. Confidential information must not be sent through any other email system. Documents can be password protected.

Copyright © 2016 Standing Together Against Domestic Violence. All rights reserved.

Appendix 3: Members of the Panel

Agency represented	Panel members
Aanchal Women's Aid – Chair of DV Forum	Su Bhuhi
East London Foundation Trust (ELFT) – Mental Health Services	Paul James
East London Foundation Trust (ELFT) – Mental Health Services	Janet Boorman
London Borough of Newham Domestic and Sexual Violence Commissioner	Kelly Simmons
London Borough of Newham Safeguarding Adults	Mandy Oliver
London Probation Trust Newham	Donna Vincent
Metropolitan Police Service (MPS) – Critical Incident Advisory Team (CIAT)	DI Paul Gardner DS Angie Barton
Metropolitan Police Service Newham Borough	DCI Dave Rock
Newham Action Against Domestic Violence (NAADV)	Jane Ishmael
Newham Clinical Commissioning Group (NCCG)	Anne Morgan Roger Cornish
Standing Together Against Domestic Violence (Independent Chair and minutes)	Mark Yexley Eliza Cardenas

Appendix 4: Action Plan (see combined DHR action plan)

RECOMMENDATION	ACTION What are we going to do?	BY WHOM Who is going to do it?	OUTCOME What do we intend to achieve?	MONITORING What has been achieved?	BY WHEN? What further action is needed?
That all agencies report progress on their internal action plans to the relevant task and finish group of Newham CSP.					
That the partnership conducts a review of its effectiveness to establish its strengths and weaknesses. This review, which should be completed by a task and finish sub-group of the Newham CSP, to include an examination of: a. The effectiveness of support to carers supporting people with mental health concerns b. The consideration of faith based abuse and the challenges presented when managing domestic violence and mental health					
That training strategy be reviewed, to ensure the following: a. To allow frontline practitioners to understand the dynamics of domestic					

violence and good practice b. To support an increase in questioning about domestic violence and potential risk c. To support an increase in awareness around the role of carers and links to the risk assessment process.					
That ELFT examine its processes for information sharing with carers and families and effectively involve them in risk assessment. This should include provision of carers' packs and clear written guidelines for carers on the availability of a crisis line. Consideration should also be given to the potential risks to the wider family and community.					
That there should be early joint consultation between Community Safety Partnerships and NHS England to discuss primacy for investigation between DHR and Mental Health Homicide Investigation.					

Appendix 5: Home Office Panel Letter

Home Office

Public Protection Unit
2 Marsham Street
London
SW1P 4DF

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

Kelly Simmons
London Borough of Newham
Newham Dockside
1000 Dockside Road
London E16 2QU

14 March 2016

Dear Ms Simmons,

Alison Buchanan, who I understand has moved on, submitted a Domestic Homicide Review report for Newham to the Home Office Quality Assurance Panel. The report was considered at the Quality Assurance (QA) Panel meeting on 27 January 2016.

The QA Panel would like to thank you for conducting this review and for providing them with the final report. The Panel found this to be a good review which engages the reader and where the family's views are well represented. The Panel noted that a parallel mental health investigation (MHI) was conducted which was concluded in September 2013 and shared with the family and the chair. The Panel concluded that mental health was a key factor in this homicide and it would be helpful if the DHR report could be refocused to bring this out more clearly and, if appropriate, linked more closely to the MHI.

In terms of review panel membership, the Panel believed that it may have been beneficial to have had the author/chair of the MHI on the review panel. Additionally, the Panel felt that, given the prominence of cultural and religious aspects of the case, the family priest and other relevant voluntary sector representatives may have provided useful insight into the dynamics of the family.

There were other aspects of the report which the Panel felt could be revised which you may wish to consider before you publish the final report:

- The Panel suggested pseudonyms would allow the reader to more easily follow the narrative;
- A section summarising the lessons learned would be helpful;
- The recommendations could be articulated more clearly and made SMART;

- The action plan at the end of the overview report (appendix 4) is blank and needs to be removed and replaced with the completed one that was submitted separately;
- There is a potential contradiction in the report regarding preventability: please revisit the statement in paragraph 4.1.4 and the one in paragraph 4.1.7;
- The Panel questioned the appropriateness of the final sentence in paragraph 3.1 and recommended its removal;
- The Panel felt that it would have been useful to cite relevant research into such homicides, which are not uncommon.
- Please proof read as there are a number of typing or other errors which you may wish to correct. For example, paragraph 3.14.1 "to" missing; paragraph 1.4.5 "review findings *were* shared…"; paragraph 3.18.4 "and" missing. Please also review paragraph numbering in the executive summary.

The Panel does not need to see 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.

Yours sincerely

Christian Papaleontiou
Chair of the Home Office DHR Quality Assurance Panel