# **Domestic Homicide Review (DHR) 5** Key Learning and Recommendations

**BACKGROUND** Middlesbrough Community Safety Partnership (CSP) commissioned DHR-5 in April 2019 following the death of women in March 2019 due to a domestic homicide incident. The female will be referred to as Kathleen. She was killed by her son, referred to as Trevor. The review examined agencies' contact and involvement with Kathleen and Trevor. Trevor is a paranoid schizophrenic. In March 2019, he went to his local police station and told officers that he had killed his mother by stabbing her with a kitchen knife. He was arrested and later charged with Kathleen's murder and was remanded in custody under Section 48/49 Mental Health Act 1983. After denying murder but admitting manslaughter, Trevor was sentenced to hospital and restriction orders under the Mental Health Act. The court was told that Trevor had stopped taking his prescribed medication up to six-days before killing Kathleen and that doing so had caused a significant decline in his mental health. Trevor had told professionals that the day before he attacked his mother, he had 'killed himself' by jumping off a bridge on to a train and that he had then come back to life to kill her. He said he had expected his mother to 'come back to life' just as he had done.

The DHR reviewed the period between Jan 2015 and March 2019

**THE PURPOSE OF A REVIEW** To understand if agencies are responding appropriately to victims of domestic abuse by offering and putting in place appropriate support mechanisms, procedures, resources, and interventions with the aim of avoiding future incidents of domestic homicide, violence, and abuse. It also considers if agencies have sufficient and robust procedures and protocols in place, and that they are understood and adhered to by their employees.

**WHAT WE LEARNT** The DHR panel identified that Kathleen was frequently not 'seen' by the services treating Trevor and by the professionals they both interacted with. The role she played in Trevor's life was not considered and her needs and any risks in relation to this understood. The panel recognised absence of information about the family and the relationship between Kathleen and her son in service records and acknowledged that services working with Trevor had made no effort to contact her. Kathleen, as a mother of a son experiencing long term mental ill health and with her own physical and mental health conditions was relegated 'to a position of acute social invisibility.' Mental health and misuse of substances were considered vulnerabilities for both Kathleen and Trevor

The DHR was led by Paul Johnston, who was commissioned as Independent Chair, he was supported by Dr John McKenna, a retired deputy medical director with expertise in community psychiatry who also undertook a desk-top review of the internal investigation undertaken by Tees, Esk and Wear Valleys NHS Foundation Trust.

The Review made both Middlesbrough Community Safety Partnership and Single agency recommendations.

## What were the identified recommendations for Middlesbrough Community Safety Partnership?

- Review the evaluation of the two-year pilot of IRISi in Middlesbrough and write to the NENC Integrated Care Board and Cleveland Violence Reduction Unit to make them aware of the benefits of the pilot, improved outcomes, and the risks in relation to sustainability of IRISi without collaborative commissioning, long term investment, or ownership of the initiative.
- Community Safety Partnership write to the Tees, Esk & Wear Valleys NHS Foundation Trust and request a written update and evidence that recommendations identified in this DHR have been addressed and that changes introduced in relation to policy and practice have been implemented.
- Identify partners and implement a communication plan on how learning and recommendations can be shared effectively across the partnership and monitor impact of this.

**The Published Executive Summary, DHR Overview and Action plan is available via the following link:** https://www.middlesbrough.gov.uk/dhr

**Kathleen** was 55 when she was killed. Sadly, very little was known about her life and circumstances. Other than Trevor Kathleen only had two living relatives. Attempts were not successful to establish contact with her aunt and sister so they could be involved in the review. Kathleen worked as a care home assistant until Trevor was born and since then she had been unemployed. Trevor said he could not remember a time when his mother was not a heavy user of alcohol and illicit drugs and for many years, she had the same partner who was alcohol dependent. Kathleen reported historical domestic abuse from her partner to GP and had spent time in refuge due to experiencing homelessness due to domestic abuse in 2014. Kathleen had moved from Redcar and Cleveland to Middlesbrough to be closer to Trevor in 2015.

Kathleen suffered with depression, which she disclosed to GP was due to the abuse from her ex -partner and had sought help from GP in relation to this several times but never accessed counselling or Talking Therapies which she was signposted to contact She had told GP she was addicted to codeine, and she sourced this from GP and illegal suppliers. She experienced financial issues and had asked for support for this from her social landlord. Trevor had told review Chair when he was interviewed that Kathleen had spent a large part of her income on alcohol and drugs. It was evident that she was vulnerable, isolated, and anxious but not engaged with any services who could have offered her support.

**Trevor** was 34 when he killed Kathleen. At the age of 16 he had disclosed to professionals he had stabbed his mother and had then sucked her blood and that he had attacked his mother's partner. Trevor was also cautioned for an attempted sexual assault on a female psychiatrist. During that period, he was first diagnosed with paranoid schizophrenia and was assessed as posing a 'high-risk' of causing serious harm to others and referred into MAPPA. He was Detained under Section 3 Mental Health Act 1983 (From September 2006 to August 2009) In 2009 MAPPA screening panel determined Trevor could be managed by a single agency and recommended the Care Programme Approach. Following his discharge from hospital in 2009, he remained under the care of the Psychosis Community Mental Health Team, remaining on 'enhanced CPA' until December 2016. Trevor had remained mentally well during this time until March 2019.

During the period of community supervision by Mental Health Team (2009 to 2019) there was no suggestion of any untoward behaviour by Trevor towards Kathleen, and no evidence of concerning beliefs. The level of risk posed by Trevor was justifiably assessed as being low as was the risk of relapse as there was nothing to indicate he posed a risk of violence to her as long as his mental health remained stable.

Mental health professionals acknowledged that Trevor had a diagnosis of schizophrenia worsened by a long history of poly-drug misuse, and a social history indicative of poverty and deprivation. He lacked insight and had a history of disengagement with services and non-adherence with prescribed medications.

**Key learning Agencies**

**TEWV** Trevor's care plan did not accurately reflect how often he would be reviewed by the lead professional or the frequency of intended reviews. During his period of community supervision by the Mental Health team the panel noted concern that there was a total reliance on Trevor to provide updates in relation to his mental health and substance use whatever evidence there may have been. There was no evidence that an intention expressed in 2010 that the care coordinator should determine the relationship dynamics between Trevor and Kathleen ever materialized. There is no record of any contact between the community mental health team and Kathleen at any point between 2009 and 2019. From 2012, Kathleen was only mentioned in the records in the context of being Trevor's nearest relative/next of kin.

**ICB** – GP surgeries working with both Kathleen and Trevor lacked professional curiosity in relation to Domestic Abuse and if she was at risk of ongoing abuse. Kathleen's GP surgery lacked understanding of trauma and how psychological and psychological symptoms of domestic abuse can be exhibited over a lengthy period. Although there was nothing to indicate concern records did not reference previous violence and risk in relation to Trevor towards his mother.

**Conclusion** After Trevor had been arrested for murdering Kathleen, Trevor told mental health professionals that he had stopped taking his Clozapine and that he had been using cannabis and cocaine. He presented as acutely psychotic. Trevor told the review Chair that he was fed-up with the side effects of the Clozapine, namely excessive salivation, so four-days after his final attendance at the Clozapine clinic, he decided to stop taking his medication, knowing it would make him poorly again. It is the view of the review panel the issue of the potential risk to Kathleen was not adequately addressed at any point after Trevor's hospital admission in 2009. In fact, it appears that the potential risk to her was not regarded as an active issue and that essentially, she failed to appear in Trevor's records (despite remaining an important person in his life). Staff did not ensure that Kathleen knew how to contact services in the event of a crisis - nor was there a record of any community team discussion about the relative merits of such an approach. Bearing in mind Trevor's history and known circumstances (and what was known about Kathleen), it is concerning that mental health staff did not at any point document a discussion with Trevor about the potential benefits of involving Kathleen in his care arrangements. Equally concerning, is that there was no apparent consideration given to Kathleen's continued vulnerability or whether the potential for her coming to further harm from Trevor should have been escalated into a safeguarding concern.