Domestic Homicide Review Executive Summary

'Kathleen'

Died: March 2019

Paul Johnston – Independent Domestic Homicide Review Chair and overview report Author

February 2023
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1. INTRODUCTION

1.1 This summary outlines the process undertaken by the Middlesbrough Community Safety Partnership (CSP) domestic homicide review (DHR) panel in reviewing the manslaughter of a mother by her adult son. They are referred to by the pseudonyms Kathleen and Trevor respectively in keeping with Home Office guidance.

1.2 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. He was later charged with Kathleen's murder and was remanded in custody under Section 48/49 Mental Health Act 1983.

1.3 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 said he 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 reappear just as he had done. During the court proceedings, the Judge said, "*… I cannot see [Trevor] being released from hospital for the foreseeable future…[Trevor] has had a long history of mental illness…There was violence to his mother…when he admitted to stabbing her and sucking her blood…His mother had a number of her own demons including drug and alcohol addiction, as did the defendant…In light of this he has committed few convictions, the last one was in 2004 when he served a short time in prison.*"

1.4 The DHR revealed that Trevor had been living in the community without incident for over ten-years and during that time there had been no evidence of instability in his mental state, including psychotic symptoms, or any known problems with his medication concordance. He was consistently assessed as posing a low level of risk to himself and to others.

1.5 The DHR also felt that to some extent Kathleen had almost become invisible to services. There had been no record of any contact between Community Mental Health Trust staff and Kathleen between 2009 and 2019 and although there is no suggestion that during that time that Trevor was abusing her, there were occasions when she

talked to her GP about historical domestic abuse involving an intimate partner. It appeared to the review panel that there may have been a lack of understanding of trauma within Kathleen's GP practice and how psychological and psychological symptoms of domestic abuse can be exhibited over a lengthy period. In addition, Kathleen was a woman who was not working and who appeared to be isolated, depressed, and anxious, but there was no mention in the GP records of any consideration around her being a vulnerable adult and whether she should be referred to adult social care or for trauma informed counselling.

2. SCOPE AND TERMS OF REFERENCE FOR THE REVIEW

2.1 The review examined agency involvement with Kathleen and Trevor between 1st January 2015 (when they independently moved to the Middlesbrough area) and the date of Kathleen's manslaughter in March 2019. The review panel also examined the mental health care received by Trevor dating back to 1st January 2001.

2.2 The Terms of Reference for the review were set to determine:

- *Whether the incident in which Kathleen died was an isolated event and whether there were any warning signs*
- *What knowledge each agency had that indicated Trevor might be a perpetrator of domestic abuse towards his mother*
- *Whether local agencies should have known more about the history of abuse between Trevor and Kathleen.*
- *Whether there were any barriers experienced by Kathleen or family/friends/colleagues in reporting any abuse in Middlesbrough or elsewhere, including whether they knew how to report domestic abuse should they have wanted to.*
- *What safeguarding concerns in respect of Kathleen were considered throughout Trevor's contact with services*
- *Whether, when Trevor was formally reviewed by community team members, there was evidence that they specifically explored or enquired about the issues of his unusual ideas about death/reincarnation, about possessing special powers, and about unusual ideas regarding his mother.*
- *When and how often did Kathleen contact the team to raise concerns about Trevor.*

- *Whether the most recent risk assessment included a complete list of Trevor's criminal offences and other assaultive behaviours*

- *If there were issues in relation to capacity or resources for agencies that impacted on their ability to provide services to Kathleen or Trevor, or their ability to work effectively with other agencies.*

- *Whether the learning in this review appear in other domestic homicide reviews commissioned by Middlesbrough Community Safety Partnership*

3. CONTRIBUTORS TO THE REVIEW

3.1 Paul Johnston was appointed Chair and overview report Author for the review. He is an independent practitioner who has chaired and written numerous domestic homicide reviews, child serious case reviews, adult safeguarding reviews, and multi-agency public protection arrangement (MAPPA) serious case reviews. He has never worked for any agency in the Middlesborough area. He has a wealth of safeguarding and multi-agency working experience and has enhanced knowledge of domestic violence and abuse issues including so-called 'honour-based' violence, research, guidance, and legislation relating to adults and children. He is also a former chair of MAPPA. He has completed all the Home Office approved domestic homicide review training and he also delivers his own independent domestic abuse and homicide review training.

3.2 Dr John McKenna, a retired deputy medical director with expertise in community psychiatry and managing the care of difficult to engage service users with psychosis assisted the review. Dr McKenna also undertook a desk-top review of the internal investigation undertaken by Tees Esk and Wear Valley NHS Foundation Trust to ensure that key lines of enquiry were explored and to highlight areas requiring further examination.

3.3 After a scoping process, the following agencies confirmed they had been involved with Kathleen and Trevor. They submitted Individual Management Reviews detailing their involvement:

- Tees, Esk and Wear Valleys NHS Foundation Trust
- South Tees Hospitals NHS Foundation Trust
- Cleveland Police
- NHS South Tees Clinical Commissioning Group (changed to NHS Tees Valley Clinical Commissioning Group in April 2020) for both Kathleen's and Trevor's GP Practices

- Thirteen Housing Group Limited
- Harbour Support Service

3.4 Apart from Trevor, Kathleen had only two known relatives. One did not reply to a letter of invitation to participate in the review and the other could not be traced. A close friend of Trevor's did not respond to a similar invitation. No other friends or neighbours who could have assisted the review were identified. Trevor was interviewed by the review Chair within a secure mental health establishment. He is still mentally unwell and much of what he said did not add to the richness of the review, but where he was able to provide insight or provide clarity this was included within the overview report.

3.5 During the review, the following agency representatives participated in panel meetings and other discussions. They were all independent in that they had not previously been involved with Kathleen or Trevor.

Claire Moore	Domestic Abuse and Sexual Violence Lead	Middlesbrough Council
Lisa McGovern	Service manager	My Sisters Place
Alistair Russell	Lead Officer	Middlesbrough Council
Helen Smithies	Assistant Director of Nursing (Safeguarding)	South Tees Hospitals NHS Foundation Trust
Karen Agar	Associate Director of Nursing (Safeguarding)	Tees Esk and Wear Valleys NHS Foundation Trust
Gordon Bentley	Senior Adult Safeguarding Officer	NHS Tees Valley Clinical Commissioning Group
Alison Peevor	Head of Quality and Safeguarding	NHS Tees Valley Clinical Commissioning Group
Patricia Fenby	Detective Inspector	Cleveland Police
Janice McNay	Head of governance and compliance	Thirteen Housing Group Limited
Danielle Chadwick	Service manager	Harbour Support Services
Mandy Cockfield	Interim Principal Social Worker	Redcar and Cleveland Council
Rachel Burns	Advance Public Health Practitioner – Substance Misuse	South Tees Public Health
Gemma Swan	Operations Manager	Substance Misuse Service Middlesbrough Council

4. SUMMARY OF AGENCY INVOLVEMENT WITH KATHLEEN AND TREVOR

4.1

2000 to 2004	Aged sixteen, Trevor told professionals that he had stabbed his mother and had then sucked her blood and that he had attacked his mother's partner. Trevor was cautioned for an attempted sexual assault on a female psychiatrist. Trevor was diagnosed with paranoid schizophrenia.
2005	Trevor was assessed as posing a 'high-risk' of causing serious harm to others and was referred into MAPPA.
2006 to 2009	Trevor was detained under Section 3 Mental Health Act 1983
2008	A doctor and a social worker recorded an intention to visit Kathleen to ask about Trevor's violence and to tell her that he may pose a risk to her in the future. (There was no record of the visit ever taking place) Trevor was transferred to medium secure conditions, and he was prescribed Clozapine.
2009	MAPPA determined that Trevor could be managed by a single agency and recommended the Care Programme Approach Trevor began community care (August 2009 to March 2019)
2010	A care coordinator recorded an intention to determine the relationship dynamics between Trevor and Kathleen. (There was no record of it ever happening)
2014	A risk assessment identified 'Staff, public and parent' as potentially at risk of harm from Trevor. Kathleen presented as homeless.
2015	Kathleen was referred into MARAC (Intimate partner domestic abuse). Kathleen's GP recorded that she had disclosed she had been punched by her former partner.
2016	Kathleen disclosed to her GP historic abuse by an intimate partner. A referral was discussed by a Multi-Disciplinary Access team which agreed she would benefit from Talking Therapies Kathleen was arrested for possessing a knife. Kathleen told her GP she was anxious and that she was addicted to codeine.
2017	Mental health and medication reviews concluded that Trevor was doing well.

Monthly – between January 2018 and March 2019	Trevor attended the Clozapine clinics – No issues noted. Variously said he was drinking moderate amounts of lager per week and was not using illicit drugs.
April 2018	Kathleen was referred to Thirteen Housing Group for help with utility bills.
May 2018	Kathleen told her GP she was anxious, and she mentioned domestic abuse 'over a year ago.'
September 2018	Kathleen told her GP that she had been the victim of domestic abuse 'until five-years ago.' She was to see a physiotherapist and was given the contact details for My Sisters Place
October 2018	Trevor told a psychiatrist that he was doing well because of the Clozapine. Well kept and well-presented with no evidence of mood, thought or perceptual abnormality.
March 2019	Kathleen was killed by Trevor.
July 2019	Trevor was convicted of Kathleen's manslaughter and was sentenced to a hospital order.

5. SUMMARY OF DR MCKENNA'S FINDINGS

5.1 Dr McKenna's findings are summarised as follows:

5.2 Trevor was first diagnosed with paranoid schizophrenia in July 2004 which was consistently and exclusively also made throughout the following nearly fifteen years. There was no evidence incompatible with that diagnosis.

5.3 Kathleen's potential vulnerability fell into three broad groups:

- General vulnerability (longstanding substance misuse and being a victim of domestic abuse by an intimate partner)
- Vulnerability relating to Trevor (the previous assaults)
- Trevor's bizarre thoughts about assaulting his mother and delusional beliefs regarding reincarnation and attaining special powers. (During the period 2006 to 2007, it was noted that Kathleen featured in many of Trevor's delusions, such as that killing her would be followed by her rebirth and him obtaining special powers, and that he blamed her for (what he considered) to be his facial deformity.

5.4 There was no record of a 2008 planned meeting ever taking place between Trevor's care team and Kathleen to ask her about Trevor's violence and to tell her that he may pose a risk to her in the future.

5.5 The records suggest that Trevor had increasing unproblematic and positive contact with Kathleen and that there was nothing to indicate he posed a risk of violence to her if his mental health remained stable.

5.6 There was no evidence that an intention expressed in 2010 that a care coordinator should determine the relationship dynamics between Trevor and Kathleen ever materialized.

5.7 There was no record of any contact between Community Mental Health Trust staff and Kathleen between 2009 and 2019 and there was no record of whether the issue of contact with Kathleen was discussed with Trevor nor any record of discussion within the team about Kathleen's potential vulnerability.

5.8 Internal working and communication between Trust teams and services was good.

5.9 During the entire period of community supervision up until Kathleen's death, there was no evidence of instability in Trevor's mental state, including psychotic symptoms, or any known problems with his medication concordance. The assessment that Trevor posed a low level of risk was the correct one. Risk assessment documents were regularly updated with the 'triggers' identified as substance misuse, disengagement from services and medication non-concordance.

5.10 Trevor reliably attended monthly Clozapine clinics, the last being nine-days before he killed Kathleen. No untoward changes in his mental health were noted at any of those meetings.

5.11 The Trust should revise its internal policies and procedures relating to the functioning of 'Clozapine clinics' so that it can be satisfied that any function relating to formal assessment of attendees' mental health status is clearly described and supported.

5.12 The Trust had already identified the need to conduct an audit to ensure there is no evidence of *'copy and pasting'* of entries in clinical records by Clozapine clinic staff.

6. KEY ISSUES ARISING FROM THE REVIEW

6.1 There was no evidence arising from the review of any negative or positive bias on the delivery of services to either Kathleen or Trevor in respect of any of the protected characteristics set out in Section 4 of the Equality Act 2010.

6.2 Child-to-parent abuse is one of the most under-reported and under-researched subject areas in the field of domestic abuse. What research there is tends to focus upon adolescent aggression, but Trevor was in his mid-thirties when he killed his mother, although he had been extremely violent towards her when he was in his teens.

6.3 Trevor had an extensive psychiatric and forensic history that included details of the time he had stabbed Kathleen and had sucked her blood around 2002 – and the fact that in 2008 Trevor had told mental health professionals that since an early age, he had harbored thoughts of killing her. However, there was no information held by any agency (other than mental health and GP services) in Middlesbrough or elsewhere that Trevor posed any sort of risk to Kathleen. Indeed, since his initial diagnosis of paranoid schizophrenia in July 2004, Trevor had remained mentally well. The team caring for him were aware of his history and that the triggers for increased risk would be his dis-engaging from the service, non-concordance with medication and illicit substance misuse. There was no suggestion of any untoward behaviour by Trevor towards Kathleen, and no evidence of concerning beliefs. The level of risk he posed therefore had been assessed by professionals as being low, as was the risk of relapse.

6.4 Notwithstanding there was no indication of the triggers to a relapse being present, it remained the view of the review panel that the issue of the potential risk to Kathleen was not addressed at any point after Trevor's hospital admission. The potential risk to her was not regarded as an active issue and 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.

7. CONCLUSIONS

7.1 Although agencies had no reason to think that Kathleen may have been at risk of harm from Trevor, there were indications that she had previously been the victim of domestic abuse by an intimate partner. In 2016, Kathleen's GP referred her to the Mental Health Access Team with a history of anxiety and depression after she described 'past events regarding an abusive relationship'. The most recent disclosure of domestic abuse was in May 2018, when she reported chronic rib-pain resulting from domestic abuse that took place 'Over a year ago' and then again in September 2018 when she told a GP that she had been the victim of domestic abuse 'For years, until five years ago'. (According to Trevor, Kathleen did not have another intimate partner

after she and her long-term partner separated towards the end of 2014).

7.2 As mentioned previously, it appeared to the review panel that there may have been a lack of understanding of trauma within Kathleen's GP practice and how psychological and psychological symptoms of domestic abuse can be exhibited over a lengthy period. Kathleen was a woman who was not working and who was, in the panel's view isolated, depressed, and anxious. There is no mention in Kathleen's GP records of any consideration around her being a vulnerable adult and whether she should have been referred to adult social care for assessment or referred for trauma informed counselling. Kathleen requested counselling on more than one occasion, and she was provided with the contact details to enable her to self-refer into Talking Therapies, but the panel considered if a direct referral into the service by the GP may have been more appropriate.

8. LESSONS LEARNED

8.1 The Middlesbrough Domestic Homicide Scrutiny Panel will monitor the implementation of the DHR-5 action plan on behalf of the Middlesbrough CSP, who will remain accountable for the implementation of the learning from it. A copy of the final overview report and updates regarding progress in relation to actions will also be shared periodically with the Middlesbrough Domestic Abuse Strategic Partnership and the Tees-wide Adult Safeguarding Board.

8.2 An area of learning for the Tees, Esk and Wear Valleys NHS Foundation Trust was that Trevor's care plan did not accurately reflect how often he would be reviewed by the lead professional or the frequency of intended reviews. On one occasion an entry within the clinical records (which described Trevor's presentation) had been 'copied and pasted' by a Clozapine clinic clinician from one appointment (14th January 2018) to another (11th February 2018). This was bad practice and was identified as an area of learning for the clinic staff.

8.3 Kathleen's GP Practice lacked professional curiosity in relation to whether she was at risk of further domestic abuse from intimate partners. Although there was evidence of appropriate referrals being made in respect of her long-term anxiety, there may have been further opportunities to explore the cause of it which in turn could have led to a more open discussion about her home circumstances and her relationship with intimate partners and about Trevor and his current mental health status. As mentioned above, there was no evidence of any consideration of whether Kathleen might have been regarded as

a vulnerable adult despite her longstanding mental health problems and the historical domestic abuse.

8.4 It was noted during the review that the GP Practice did not routinely display posters or provide domestic abuse related leaflets within public areas, nor did they provide information or links about domestic abuse on their website. In addition, there were no formal practice audits to monitor compliance with safeguarding activity such as record keeping and the identification of risk and appropriate referrals. The IRISi programme had recently been piloted within this practice, which should go a long way towards making sure that awareness raising of domestic abuse is given the priority it deserves.

8.5 Trevor's GP practice has mandatory safeguarding and domestic abuse training for its staff, but on reflection they felt an increase in the awareness of domestic abuse within the practice including reinforcing professional curiosity and increasing referrals through the IRISi programme would be beneficial.

8.6 Although the practice had no reason to suspect that Trevor posed an ongoing risk of violence towards his mother, they do feel that at a point of learning is that the historical violence that occurred in the early 2000s could have been referenced in their electronic medical records.

9. RECOMMENDATIONS

9.1 MIDDLESBROUGH COMMUNITY PARTNERSHIP

9.2

- Review the evaluation of the two-year pilot of IRISi in Middlesbrough and write to the Integrated Health 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.
- Write to the Tees Esk Wear Valley to request 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 in Community Safety Partnership and implement a communication plan on how learning and recommendations can be shared effectively across the partnership and monitor impact of this.

9.3 TEES, ESK AND WEAR VALLEYS NHS FOUNDATION TRUST

9.4

- A process should be put in place to ensure that potential victims of violence and abuse are provided with the means to communicate any concerns to professionals.
- Patient's care plans should accurately reflect the frequency of intended reviews and who is to conduct them.
- Written update and evidence provided to Community Safety Partnership that a previous recommendation that 'an audit be conducted to ensure there is no evidence of 'copy and pasting' of entries in clinical records by Clozapine clinic staff' has been adequately addressed.
- Assurance should be provided that a previous recommendation that 'The Trust must revise internal policies and procedures relating to the functioning of 'Clozapine clinics' in order to be satisfied that any function relating to formal assessment of attendees' mental health status is clearly described and supported' has been adequately addressed.

9.5 KATHLEEN'S GP PRACTICE

9.6

- Provision of domestic abuse help and support information should be available within the practice.
- Ensure staff are compliant with the Adult Safeguarding Roles and Competencies for Health Care Staff Intercollegiate Document and the Safeguarding Children, Young People and Adults at Risk in the NHS: Safeguarding accountability and Assurance Framework.
- Where Domestic Abuse markers are identified on patient records and/or concerns relating to potential domestic abuse are identified during consultations, appropriate enquires (for individuals aged sixteen and older) should be considered to ensure that safeguarding concerns are identified and that correct procedure is followed.
- The GP practice should monitor appropriate safeguarding activity and policy compliance through record keeping audits and referrals.

9.7 TREVOR'S GP PRACTICE

9.8

- Where Domestic Abuse markers are identified on patient records and/or concerns relating to potential domestic abuse are identified during consultations, appropriate enquires (for individuals aged 16 years and older) should be considered to ensure that safeguarding concerns are identified and that correct procedure is followed.
- Ensure staff are compliant with the Adult Safeguarding Roles and Competencies for Health Care Staff Intercollegiate Document and the Safeguarding Children, Young People and Adults at Risk in the NHS: Safeguarding accountability and Assurance Framework.