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SAFER CROYDON PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

EXECUTIVE SUMMARY

Report into the Death of Adult D

October 2016

Independent Chair and Author of Report: Mark Yexley

Associate, Standing Together Against Domestic Violence

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1. Executive Summary

1.1 The Review Process

1.1.1 This summary outlines the process undertaken by Safer Croydon Partnership domestic homicide review panel in reviewing the homicide of Adult D who was a resident in their area.

1.1.2 The following pseudonyms have been in used in this review for the victim and perpetrator (and other parties as appropriate) to protect their identities and those of their family members:

The victim: Adult D - Aged 77 at time of death, South Indian ethnic origin

The perpetrator and daughter: Adult E - Aged 55 at time of homicide, South Indian ethnic origin

The perpetrator's husband: Adult F, South Indian ethnic origin

1.1.3 Criminal proceedings were completed in the summer of 2017 and the perpetrator pleaded guilty to the manslaughter of her mother on the grounds of diminished responsibility. She was detained under a Hospital Order with a Restriction Order under Section 41 Mental Health Act 1983

1.1.4 The process began with an initial meeting of the Community Safety Partnership when the decision to hold a domestic homicide review was agreed. The Home Office were informed of the decision on 13 April 2017. All agencies that potentially had contact with (victim/perpetrator) prior to the point of death were contacted and asked to confirm whether they had involvement with them.

1.2 Contributors to the Review

1.2.1 This Review has followed the statutory guidance for Domestic Homicide Reviews 2016 issued following the implementation of Section 9 of the Domestic Violence Crime and Victims Act 2004. On notification of the homicide agencies were asked to check for their involvement with any of the parties concerned and secure their records. A total of 13 agencies were contacted to check for involvement with the parties concerned with this Review. Nine agencies returned a nil contact. Three agencies submitted Independent Management Reviews (IMRs) and chronologies, and one agency a report and chronology only due to the brevity of their involvement. The chronologies were combined and a narrative chronology written by the Overview Report Writer.

1.2.2 The following agencies and their contributions to this Review are:

Agency	Contribution
Croydon Health Services (CHS)	IMR and chronology

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Croydon Clinical Commissioning Group (CCG) (for the General Practice)	IMR and chronology
Metropolitan Police Service (MPS)	Report and Chronology
South London and Maudsley NHS Foundation Trust (SLaM)	IMR and chronology

1.2.3 *Independence and Quality of IMRs*: The IMRs were written by authors independent of case management or delivery of the service concerned. Three agencies had involvement with the victim of sufficient duration which required IMRs to be submitted. All IMRs received were comprehensive and enabled the panel to analyse the contact with Adult D and Adult E and to produce the learning for this review. Where necessary further questions were sent to agencies and responses were received.

1.3 The Review Panel Members

1.3.1 The review panel members were:

Panel Member	**Job Title**	**Organisation**
Shade Alu	Director of Safeguarding	Croydon Health Services (CHS) NHS Trust
Caroline Birkett	Head of Service	Victim Support
Rachel Blaney	Lead Nurse for Safeguarding Adults at Risk	Croydon Clinical Commissioning Group (CCG)
Andrew Brown	Chief Executive	Croydon BME Forum
Nicky Brownjohn	Head of Quality and Regional Safeguarding Lead	NHS England
Brian Calvert	Safeguarding Lead	Age UK

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Helen Kelsall	Deputy Director of Quality for the Directorate of Psychological Medicine and Older Adults	South London and Maudsley (SLaM) NHS Foundation Trust
Alison Kennedy	Operations Manager	Croydon Family Justice Centre
Estelene Klaasen	Designated Nurse for Adult Safeguarding	Croydon Clinical Commissioning Group (CCG)
Yvonne Murray	Head of Tenancy and Caretaking	London Borough of Croydon - Housing
Tim Oldham	Group Coordinator	Hear Us
Sean Olivier	Safeguarding Coordinator	London Borough of Croydon – Adult Social Care
Carl Parker	Partnership & Analyst Officer	London Borough of Croydon – Safer Croydon Partnership
Russell Pearson	Review Officer	MPS – Serious Crime Review Group (SCRG)
Tony Reseigh	Detective Inspector	Metropolitan Police Service (MPS) – Croydon Borough Community Safety Unit (CSU)
Charmaine Wiggins	Independent Chair Safeguarding	London Borough of Croydon - Adult Social Care
Mark Yexley	Independent Chair	Standing Together Against Domestic Violence

1.3.2 *Independence and expertise*: Agency representatives were at the appropriate level for the Review Panel and demonstrated expertise in their own areas of practice and strategy, and were independent of the case.

1.3.3 The Review Panel met a total of three times, with the first meeting of the Review Panel in August 2017. There were subsequent meetings in November 2017, and October 2018.

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1.3.4 The Chair of the Review wishes to thank everyone who contributed their time, patience and cooperation to this review.

1.4 Chair of the DHR and Author of the Overview Report

1.4.1 The Chair and author of the review is Mark Yexley, an Associate DHR chair with Standing Together. Mark has received Domestic Homicide Review Chair's training from Standing Together and has chaired and authored eleven DHRs. Mark is a former Detective Chief Inspector with 34 years' experience of dealing with domestic abuse and was the head of service-wide strategic and tactical intelligence units combating domestic violence offenders, head of cold case rape investigation unit and partnership head for sexual violence in London. Mark was also a member of the Metropolitan Police Authority Domestic and Sexual Violence Board and Mayor for London Violence Against Women Group. Since retiring from the police service he has been employed as a lay chair for NHS Health Education Services in London, Kent, Surrey, and Sussex. This work involves independent reviews of NHS services for foundation doctors, specialty grades and pharmacy services. He currently lectures at Middlesex University on the Forensic Psychology MSc course.

1.4.1 Standing Together Against Domestic Violence (STADV) is a UK charity bringing communities together to end domestic abuse. We aim to see every area in the UK adopt the Coordinated Community Response (CCR). The CCR is based on the principle that no single agency or professional has a complete picture of the life of a domestic abuse survivor, but many will have insights that are crucial to their safety. It is paramount that agencies work together effectively and systematically to increase survivors' safety, hold perpetrators to account and ultimately prevent domestic homicides.

1.4.2 STADV has been involved in the Domestic Homicide Review process from its inception, chairing over 60 reviews.

1.4.3 *Independence:* The chair retired from the police in 2011. He has no current connection with the London Borough of Croydon or other agencies mentioned in the report. Whilst serving in the police, he was never posted to Croydon Borough.

1.5 Terms of Reference for the Review

1.5.1 At the first meeting, the DHR panel shared brief information about agency contact with the individuals involved, and as a result, established that the time period to be reviewed would be from October 2014 to the date of the homicide. This date was chosen as it covered the period of Adult

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D's and Adult E's most significant contact with agencies. There had been no other safeguarding concerns raised before this two year period and agencies were asked to summarise any contact before this time.

1.5.2 *Key Lines of Inquiry:* DHR Panel considered both the 'generic issues' as set out in the 2016 Guidance and identified and considered the following case specific lines of inquiry:

- Analyse the communication, procedures and discussions, which took place within and between agencies.
- Analyse the co-operation between different agencies involved with Adult D / Adult E and wider family.
- Analyse the opportunity for agencies to identify and assess domestic abuse risk.
- Analyse agency responses to any identification of domestic abuse issues.
- Analyse organisations' access to specialist domestic abuse agencies.
- Analyse the policies, procedures and training available to the agencies involved on domestic abuse issues.

1.5.3 Analyse how the particular of the victim being cared for at home, age, undiagnosed mental health conditions, disability, gender and ethnicity would affect the response of services as individual or combined factors.

1.5.4 The DHR Panel felt that the membership would cover many of the areas, but not all. It was decided that further expertise was required to help understanding on the issues of age, ethnicity and mental health within the local community. The independent chair sought the expertise of AgeUK, Croydon BME Forum and Hear Us. These agencies contributed to the review from the second meeting onwards, supporting the IMR review and overview report.

1.6 Summary of Chronology

1.6.1 At the time of her death Adult D was 77 years old and living with her daughter, Adult E and son-in-law Adult F. Adult D was born in India and her first language was Malayalam. She was reliant on Adult E for day to day care. Adult D was an insulin dependent diabetic and had mobility problems. Adult D was known to be suffering from dementia and it appears that Adult D was reliant on Adult E for her caring needs. Shortly before her death, Adult D was diagnosed with cancer. Adult E was not formally recorded as a carer for her mother.

1.6.2 Adult E was second eldest of Adult D's seven children. She was born in Singapore, and then lived in India. She moved with her family to the UK when she was 19. She later married Adult F and her mother moved into the family home with them. Adult E was an insulin dependent diabetic and had

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experienced mental ill health in the 1990s and that resulted in her attempting suicide. She had not been seen by any healthcare agencies concerning her mental ill health since the 1990s.

1.6.3 In October 2016 Adult E telephoned the police and informed them that she had killed her mother by giving her an overdose of insulin and smothering her. The police and ambulance attended the house and found Adult E with the body of her mother. Adult D was taken by ambulance to hospital, but was pronounced dead on arrival. As a result, Adult E was arrested and upon arrest it was apparent to the Police that she had been subject to a psychotic episode. Adult E was charged with Adult D's murder and was later made the subject of a mental health order after she admitted Adult D's manslaughter.

1.6.4 Clinical Commissioning Group (CCG): Adult D and Adult E were seen by their GP practice on a number of occasions between 2013 and 2015. This included contact with continence services for Adult D. There were regular contacts with Adult D and Adult E on diabetic care matters

1.6.5 Croydon Health Services (CHS): Adult D was seen by CHS on 20 occasions between 2014 and 2016. These contacts included routine diabetic appointments, visit to Emergency Department and diagnosis of cancer. Adult E was seen on 10 occasions for routine diabetic appointments and minor injury.

1.6.6 Metropolitan Police Service (MPS): There were no relevant incidents known to the police before Adult E telephoned them and admitted killing her mother.

1.6.7 South London and Maudsley NHS Foundation Trust (SLaM): SLaM's first significant contact with Adult D came in 2012 when she was referred to the Croydon memory service, when Unspecified Alzheimer's disease was confirmed. Adult D was seen again in 2013 by the Older Adults Community Health Team for assessment. There was no further contact between SLaM and the family until Adult E was admitted after she killed her mother.

1.7 Conclusions and Key issues arising from the review

1.7.1 It is clear in this case that Adult D was subject to domestic abuse from her daughter, Adult E, resulting in her death. That abuse is known to be through the act of giving a lethal overdose of insulin. In August 2016 Adult D was in a vulnerable position, with multiple serious health conditions. It is tragic that at the same time her daughter experienced a psychotic episode, whilst she was alone caring for Adult D. The availability of insulin, that was there to maintain Adult D's health, was utilised by her daughter who was experiencing mental ill health to cause Adult D's death.

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1.7.2 It is not the purpose of this review to attempt to predict whether Adult D's death was preventable given the information that was available at the time. This review seeks to learn lessons from Adult D and Adult E's contact with statutory agencies. Through this learning, the review aims to improve services and promote understanding of abuse with a view to preventing harm in the future.

1.7.3 This process has enabled the DHR panel to examine the policies and procedures for safeguarding adults within a number of agencies. The family had limited contact with statutory agencies and these have all been NHS services. The review has established some areas for improvement in safeguarding protocols and training within primary care. Consideration is given to these in the single agency recommendations.

1.7.4 A key issue for this review has been the recognition of the language and translation needs of a vulnerable patient. There was a great reliance on the family to act as interpreters when they accompanied Adult D to medical appointments. An interpreter was used in her initial memory assessment in 2012 and all NHS services record Adult D's language as Malayalam. In the following four years there was no recorded use of an interpreter to communicate with an adult at risk who was experiencing increasing health needs. This included practitioners assessing Adult D's capacity to consent to medical procedures or to inform her of terminal medical conditions. Whilst these matters raise serious internal concerns for the services involved in healthcare, there is a direct impact on the ability of those services to effectively safeguard a vulnerable person.

1.7.5 The ability of Adult D to understand the nature of any treatment and to be able to repeat back that information, to medical professionals, is a key element in determining her capacity to consent to treatment. It does not appear that an assessment was ever made of her capacity, despite having formal diagnosis of serious health conditions. The combination of her dementia and inability to express herself in English ensured that she effectively had no voice in her dealings with statutory agencies and was merely a body to be treated.

1.7.6 We do not know whether Adult D was a victim of domestic abuse from her daughter in the time leading up to her death. We do know that Adult D had no effective voice when she was seen by agencies outside her family. If she had wanted to tell others that her daughter, was behaving strangely, had mistreated her or that she was giving her the wrong doses of insulin, NHS staff would not have been able to hear those concerns. Adult Ds interaction with healthcare professionals was all managed by her family, and her primary carer was the daughter who would later kill her.

1.7.7 Another key factor in this case has been the perpetrator's undiagnosed mental illness. Adult E's husband had previous concerns about his wife's mental well-being but not enough to feel justified in referring her for support. Whilst Adult D's family had seen that Adult E occasionally behaved in

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an unpredictable manner, she was never known to have previously experienced a psychotic episode. Adult E spent every day with her mother Adult D, there is no evidence that Adult D told her son-in-law that she had concerns for her daughter. We do not know whether she disclosed any concerns to the wider family.

1.7.8 Adult E's husband had dealt with people with mental ill health in a professional context, but he did not consider that his wife's behaviour warranted any form of intervention. Her husband did know of his wife's previous mental ill health that required her admission to hospital, but this was over 20 years ago and he was not made aware of her diagnosis.

1.7.9 Whilst the public are encouraged to recognise the symptoms of serious physical illness, the same cannot be said for mental ill health. It must be considered that Adult E had a number of interactions with healthcare professionals as a patient and as Adult D's carer and there were never any signs of Adult E showing any behaviour that would cause concerns.

1.7.10 Whilst Adult E was not formally recorded as a 'carer' by health services she was shown as her next of kin. All major decisions concerning Adult D's care were channelled through Adult E and other children of Adult D deferred to Adult E. Whilst Adult E appeared to be coping with the complex healthcare demands of her mother, she was never offered a Carer's Assessment and her own support networks were never assessed by her GP.

1.7.11 Healthcare services aim to work with a 'triangle of care' between healthcare provider, patient and carer. In a case where there should have been channels of communication between three parties. In this case healthcare agencies accepted that the patient's communication with the healthcare provider was managed by her carer. We have since discovered that the 'carer' part of that triangle, Adult E, had an undiagnosed serious mental illness. This review has demonstrated that agencies need to ensure that clear lines of communication between the agency, patients and carers are established. These need to be documented and checked regularly to maintain robust safeguarding for adults in all cases.

1.8 Lessons to be learned

1.8.1 **Lesson 1.** *Responding to the diverse language needs of patients to ensure clear communication with healthcare agencies. There is potential for abuse to be hidden from agencies with safeguarding responsibility.*

It is essential that the all patients have the opportunity to communicate effectively with those managing their healthcare and making critical decisions. It is known that domestic abuse can often be revealed or disclosed in healthcare settings. It is therefore important that patients with specific

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communication needs should have access to interpreting services that are independent from family and friends.

1.8.2 ***Lesson 2.*** *Focus on the needs of and capacity of vulnerable persons ensuring that their views are considered and safeguarding concerns can be voiced in privacy.*

Consideration needs to be given to the capacity of a person to consent to medical care at all times. When a person has mental ill health, it does automatically mean that they do not have mental capacity. This case has shown that a vulnerable patient's voice was not heard by those treating her. She was of an age, where it seemed acceptable for her children to speak on her behalf. Care should be person focussed and in this case it appears that Adult D was completely overlooked as a person with agency over her own body. Adult D was effectively a 'body' and did not provide any informed consent to medical procedures over many years.

1.8.3 ***Lesson 3.*** *Consider the welfare including physical and mental health of persons caring for vulnerable persons*

The role of a carer is an important asset to the NHS as well as the people that they care for. A person performing the role should be formally assessed and recognised. Carers should receive appropriate support and checks on their own welfare. There needs to be consideration of the stresses on the carer and how that may impact the person they are caring for.

1.9 Recommendations from the review

1.9.1 Recommendations from Agency IMRs

1.9.2 This Review expects that all Review Panel member agencies will share the learning internally with all levels of staff once the DHR is published.

1.9.3 Following each recommendation, in italics, is an update on progress.

1.9.4 **Croydon Clinical Commissioning Group (on behalf of the General Practice):**

The practice should review the recording and consideration of the compliance with the Mental Capacity Act (2005) and Best Interest Decisions

The practice must update their knowledge and understanding of adults at risk

The practice to review their utilisation of interpreters

The practice should update their knowledge on assessments of the needs of carers

The practice should review their safeguarding policy with the support from the CCG Safeguarding Team and incorporate Domestic Abuse including referral pathways.

The practice should identify a DASV Lead

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The practice must attend CCG Safeguarding Training, Updates and Workshops and other learning opportunities within the borough.

1.9.5 **Croydon Health Services:**

The Trust must ensure the application of the Mental Capacity Act is embedded in all practice appropriately including fully documenting mental capacity assessments and Best Interest Decisions.

The Trust must ensure that all staff use of interpreters/language line, when there is a language barrier, in line with Trust guidance.

1.9.6 **South London and Maudsley NHS Foundation Trust (SLaM):**

The MHOA&D Clinical Academic Group should ensure that staff are aware of the process for booking an interpreter and that all non-English speaking patients to be offered the opportunity to meet clinical staff with a trained interpreter.

The Community mental Health Teams have received additional training on identifying signs of domestic abuse and appropriate liaison with social services.

1.10 Overview Report Recommendations

1.10.1 The recommendations below should be acted on through the development of an action plan, with progress reported on to the Safer Croydon Partnership within six months of the review being approved by the partnership.

1.10.2 Recommendation 1: Croydon Clinical Commissioning Group and Croydon Health Services ensure that referral protocols between primary care, and specialist services include reference to the language needs of patients.

1.10.3 Recommendation 2: Safer Croydon Partnership work with statutory healthcare agencies and local NGOs to implement an initiative raising awareness of mental health and consider the role of carers when safeguarding adults. This will include the promotion of Non-Government Organisations supporting older adults and people with disabilities.

1.10.4 Recommendation 3: Croydon BME Women's Project work in partnership with local statutory healthcare providers and Non-Government organisations to support training for staff.

1.10.5 Recommendation 4: Croydon CCG, CHS and SLaM ensure that the learning from this case is disseminated to practitioners.

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