**BARNET COMMUNITY SAFETY PARTNERSHIP**

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DOMESTIC HOMICIDE REVIEW

into the death of

Songul in October 2013

**EXECUTIVE SUMMARY**

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**Report Completed: 6 March 2015**

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The Barnet Domestic Homicide Review Panel would like to express their sincere condolences to the family members affected by the sad events which have resulted in this Review. The death of a family member is never easy to come to terms with, and when it is the result of the actions of another family member the loss is undoubtedly particularly keenly felt.

The independent chair and author of the Review would also like to express her appreciation for the time, commitment, and valuable contributions of the Review Panel members and contributory report authors. This Review has been complex and the Panel has carefully considered many issues concerning the victim and the perpetrator in coming to its findings. We believe there is important learning on a national as well as local level from this Review, particularly with reference to vulnerable adults and their carers.

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BARNET DOMESTIC HOMICIDE REVIEW

**EXECUTIVE SUMMARY**

# The Review Process:

## This summary outlines the process undertaken by the Barnet Community Safety Partnership Domestic Homicide Review Panel in reviewing the death of a resident in the London Borough of Barnet.

## Following a Police investigation and criminal trial the victim’s son was found guilty of manslaughter on the grounds of diminished responsibility. He was sentenced on 23 July 2014 to a Section 37 Hospital Order and a Section 41 Restriction Order under the Mental Health Act 1983.

## The Review process began with a meeting called by the Chair of the Barnet Community Safety Partnership on 29 October 2013 where the decision was taken that the circumstances of the case met the requirements to undertake a Domestic Homicide Review. The Home Office was notified of this decision on 11 November 2013 as required by statute. The Review was concluded 6 March 2014. This is over the statutory guidance timescale for the completion of a Review due to the criminal proceedings; efforts to contact family members, and gathering information from agencies. The Review remained confidential until the Community Safety Partnership received approval for publication by the Home Office Quality Assurance Panel.

## A total of 18 agencies were contacted and 15 responded has having had involvement with the individuals involved in this Review; 3 had no contact. The victim’s solicitor declined to provide information due to the Solicitor’s Code on data sharing. Agencies participating in this Review and the method of their contributions are:

* Barnet Adults & Communities Department – chronology & Independent

Management Review (IMR)

* Barnet, Enfield & Haringey Mental Health NHS Trust – chronology, Root Cause

Analysis Investigation Report, & Board Level Panel Inquiry Report

* Barnet Hospitals NHS Trust – chronology & IMR
* Central London Community Healthcare NHS Trust – chronology & IMR
* London Ambulance Service NHS Trust – chronology & IMR
* Royal Free Hospital NHS Trust – chronology & IMR
* Metropolitan Police – chronology & Report
* Longrove Practice – chronology & IMR
* Vale Drive Medical Practice – chronology & information
* Victim Support – chronology & IMR
* Barnet & Southgate College – chronology & IMR
* Farsophone Association – information
* Home Office Immigration Service Evidence & Enquiry Unit – information
* NHS Direct archives - information

## In line with statutory guidance pseudonyms have been used for the victim and perpetrator throughout the Review to protect their identity and those of their family members. The pseudonyms used are:

The victim: Songul. At the time of her death Songul was 69 years old.

The perpetrator: Damon was the victim’s son. At the time of the homicide Damon was 42 years old.

Songul and Damon were of Iranian ethnicity. Songul was of insecure immigration status having been refused leave to remain in the United Kingdom. This decision had been appealed a number of times and was in the process of a further appeal. Damon was naturalised as a British citizen.

## **Purpose and Terms of Reference for the Review:**

## The purpose of the Review is to:

* 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;
* 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;
* Apply these lessons to service responses including changes to policies and procedures as appropriate; and
* Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.
* To seek to establish whether the events leading to the homicide could have been predicted or prevented.

This Domestic Homicide Review is not an inquiry into how the victim died or who is culpable. That is a matter for the coroner and the criminal court.

**Specific Terms of Reference for the Review:**

1. To review the events and associated actions that occurred which relate to the victim and the alleged perpetrator between October 2011 and 5 October 2013 the date of the victim Songul’s death. Agencies with knowledge of the victim or alleged perpetrator in the years preceding the timescale for detailed review are to provide a brief summary of that involvement.

2. The agencies which had involvement with the victim and the alleged perpetrator to assess whether the services provided offered appropriate support, resources, and interventions, and that procedures were followed. This to include any interaction with family members or friends which have relevance to the scope of this review as identified within agencies’ records, Individual Management Reviews (IMR) or other information sources as deemed appropriate.

3. To assess whether agencies have sufficient and robust relevant policies and procedures in place, and whether these are up to date and fit for purpose in assisting staff to practice effectively where domestic abuse is suspected or present.

4. To examine the knowledge and training of staff involved in relation to safeguarding of vulnerable adults, the identification of indicators of domestic abuse, the application and use of appropriate risk assessment tools and safety planning including:

* The CAADA DASH[[1]](#footnote-1) risk indicator checklist and referral mechanism to MARAC[[2]](#footnote-2).
* Agencies own specialist risk assessment tools to assess risk posed by a

perpetrator and/or risk posed to victim and follow up processes;

* + Knowledge and use of appropriate specialist domestic abuse services.

5. Examine the effectiveness of single and inter-agency communication and information sharing, both verbal and written.

6. Explore what issues if any prevented the perpetrator accepting the services offered to support him.

7. To consider what impact the victim’s immigration status had on how agencies responded to her needs.

## The Overview report author was responsible for contacting family to invite their contribution to the Review. .

## **Agency Contact and Information from the Review Process:**

## Songul, the victim, was of Iranian ethnicity. She had four adult children two of whom lived in Iran and two in the United Kingdom. She came to the United Kingdom in 1988, but could not settle and she returned to Iran for prolonged periods, however Immigration Service records show that she visited the UK frequently for the lengths of time permitted by her visa from 2000. In 1997 Songul suffered a Cerebrovascular Accident (CVA - stroke) which affected her mobility; as time passed she needed to use a walking frame and Damon’s support when in the home, and a wheelchair when outside. Songul also suffered from depression and anxiety with and without episodes of psychosis for which she was prescribed medication, and in addition to minor ailments she had type 2 diabetes which was controlled by tablets. Contributors to the Review report that at first Songul was not too debilitated by her stroke, but she appeared to ‘give up’ in recent years. Songul is first known to an agency in the UK when she registered with her GP on 11 March 2003. Her need to be cared for appeared to coincide with the onset of depressive illness in 2006; prior to this she managed to look after herself and Damon. Although never assessed as such Songul fulfilled many of the criteria for a ‘vulnerable adult’ as defined by the Department of Health (2000) guidance ‘No Secrets’. She would also have been likely to be defined as an ‘adult at risk’[[3]](#footnote-3) which has superseded the term ‘vulnerable adult.

## Songul resided in Barnet in the home of her son Damon on an ongoing basis in recent years and he was her main carer. She separated from her husband approximately 35 years ago, but he continued to support her and Damon financially. Applications for Songul to be granted leave to remain in the UK were made and refused four times between 2008 and December 2009 when the application was refused with no right of appeal. No removal order was made with this refusal. At the time of her death a fifth appeal was being made. Songul’s insecure immigration status was a barrier to her accessing support services for a number of years until Adult Social Care sought legal advice in 2013 and the barrier community care support was found to be unfounded.

## Damon was known to work in various jobs and to attend short college courses, but there were periods of time where his caring role prevented this. From when he was young he was said to act without consideration for the consequences. He was prone to outburst of anger and quick to lose his temper, but contributors had never known him to be violent to Songul. Contributors suggest his propensity to be quick tempered frequently lost him his job, with the consequence that Damon felt rejected. He is also said to have difficulty backing down from arguments or in letting issues go; this behaviour was evident when he came into contact with agencies and did not agree with their actions or decisions. He also had arguments with his family concerning his mother’s care and his manner intimidated them and alienated him from them.

## Damon did all aspects of care for his mother including personal care. Those who know Damon say that he loved his mother and was very caring towards her, but there is a sense that as her mental and physical health deteriorated he found caring for her more challenging, and at times he became frustrated by her ability to do things for professionals that she would not do for him, for example physiotherapy exercises. Songul’s various health problems meant many GP and hospital appointments. Between 2011 and the time of her death Songul had 95 contacts with her GP practice for routine treatments and diagnostic appointments. She was also referred to the local hospital for outpatient care and had many physiotherapy appointments to improve her mobility. Damon was often anxious that his mother was having another stroke and he would call the Ambulance Service or out of hours GP service whenever he saw symptoms which he thought indicated this. Songul had limited English and so Damon acted as his mother’s interpreter at all GP and hospital appointments.

## Damon and Songul were registered at separate GP practices. A contributor to the Review has reported that Damon was once registered at his mother’s practice, but was asked to leave due to his behaviour. It has not been possible for the practice to verify this due to the amount of time that has passed. There was no communication between the two GP practices for reasons of patient confidentiality; therefore Songul’s GP was unaware that Damon had previously been referred to Mental Health Services between 2000 and 2002 suffering from depression although his attendance was sporadic. In August 2002 he was seen by a Mental Health Crisis Team in a Police Station and referred for an anger management course which he did not attend. His last contact with Mental Health Services was November 2003 when he was seen in Barnet hospital A & E Department with ‘general paranoia and inability to cope’. There is no reference in the GP chronology notes for 2003 concerning this A & E attendance. No further referral was made to Mental Health Services for Damon or contact made by him after this date. However, he was regularly treated for depression and anxiety by his GP in the following years including being prescribed anti-psychotic medication. On occasion Damon reported to Health professionals i.e. A & E staff that he had stopped taking his anti-depressants, but then he would include them in his list of medication to another practitioner. Damon’s GP was unaware that he was his mother’s sole carer, they thought a daughter or daughter-in-law were also carers, therefore Damon was not on their register of carers. The growing stress of his caring role being noted by Songul’s GP and others was not shared with Damon’s GP and his permission to do this was not sought.

## Information concerning Songul and Damon was primarily held by a variety of Health agencies particularly Songul’s GP practice where she was seen very regularly. Her chronic health problems resulted in many appointments both within her GP practice with doctors and practice nurses, and with a variety of hospital departments including the Older People’s Psychiatry Service, Physiotherapy, the Ambulance Service, and A & E. All Health agencies were aware that Damon was Songul’s main carer except his own GP. It was a fact that, whether or not practitioners were aware of this from a referral, Damon would frequently make reference, even on occasions when he was seen alone as a patient himself. For example during his own A & E visits for a variety of minor complaints outside GP surgery hours, he would tell staff he was his mother’s carer and would leave the department to return home to care for her if his treatment was not completed in time.

## Damon was seen to be anxious about his own health in addition to being concerned about his mother. He was diagnosed with anxiety and high blood pressure in early 2008 for which he received medication. In April Songul was seen due to a fall, and on 7 November Damon took her to A & E as she was unable to walk for 2 days; a possible diagnosis given was catatonic depression. Songul had a number of appointments with Mental Health Services with the first contact being between 2008 and 2009. Her GP practice report finds only one communication is recorded on her notes for this period from Mental Health; a letter following a domiciliary visit dated 25 February 2009 which states that Songul was suffering from severe depression. It is of note that during November 2008 a number of important communications took place:

## Damon’s GP received a letter on 1 November 2008 asking that Damon be referred to a psychiatrist for ‘violent behaviour’; he had assaulted his father’s wife and they were concerned about his mental health. Damon refused a referral to Mental Health Services, and his mother and sister-in-law attended the GP with him accusing his step-family of trying to cause trouble.

## Barnet Hospital Social Work Team received a “Potential Adult Protection” fax from the hospital on 11 November 2008 and a follow up phone call from a doctor on 14 November. However, records do not show the detail or the actions taken, but it may relate to information in the hospital Individual Management Review which reports that on 7 November Songul was seen in A & E due to not being able to walk for 2 days and it was noted that she ‘sleeps in same bed as son’. Damon told the doctor this and maintained it was to comfort his mother.

## On 21 November 2008 GP3 in Songul’s practice received a message from her ex-husband’s wife stating that her son had assaulted her. This record is ambiguous and gives the impression that Songul was assaulted by Damon. However, information provided to the author confirms that it was Songul’s ex-husband’s wife who was assaulted by Damon. Nevertheless, given that Damon was a carer for a vulnerable adult any reports of assault by him should have triggered discussion and sharing information with the Barnet safeguarding adults lead. This did not happen; no considerations of a safeguarding alert or safeguarding actions were taken.

## Songul was referred by Mental Health Services for Social Services support for herself and Damon around this time and Adult Social Care records show a Community Care Assessment was required and a home visit took place on 27 November 2008, although the referrer is not evident from their notes. No carer’s assessment appears to have taken place and Songul was deemed ineligible for services due to her immigration status. Damon requested help for his mother from Social Care in January 2009, September 2011, and October 2012. A practice nurse was aware of his contact with Social Care in 2012 as Damon had requested that Social Care Direct contact the nurse which they did to advise that Songul was ineligible for services as she did not have access to public funds. Apart from this telephone call there is no information sharing between Social Care and Songul’s GP or Damon’s GP practice.

In addition to Health and Social Care, pre-2013 Damon had brief contacts with the Police none of which related to Songul, but some do give insight into his character:

* 2003 relating to a fight over a broken down car; no complaint made;
* 2005 due to an allegation of assault made against Damon who was a doorman at the time;
* 2009 following an argument between Damon and his brother when his mother changed her mind about visiting his brother;
* 2010 as an alleged offender after an altercation with his workplace manager when Damon refused to handle pork products. He later resigned.
* 2012 as a witness to an assault outside Barnet College;

None of these incidents resulted in or necessitated the sharing of information with other agencies at the time.

## On 31 January 2013 Damon was randomly hit on the back of the head by a fellow student who had mental health problems. Despite the student’s apology and the college’s attempts to mediate Damon appeared anxious and neurotic and refused to let the matter drop. He reported the incident to the Police, but as the college were mediating they took the report no further. The Police made a referral to Victim Support, but Damon told them he did not feel he needed their support at that time.

## Throughout 2013 Songul had contact with her GP, hospital or other Health agency on a monthly basis and sometimes several times within a month. In the early hours of 14 February 2013 Songul was admitted to Barnet hospital with community acquired pneumonia. She remained in hospital until the 19 February. Damon refused to leave his mother and stayed with her on the ward throughout her stay despite requests to leave the ward at night. This caused complaints from other women on the ward.

## During her admission Songul had an assessment of her mobility by physiotherapists on 18 February. Songul’s daughter was visiting from Iran and was also present. The physiotherapists noticed Damon was using unsafe handling techniques when helping Songul stand and on the stairs. They demonstrated correct methods to him. During the assessment the home facilities were discussed and Damon expressed his concern about how he would manager at home. The physiotherapist explained that they were happy with Songul’s mobility and they would refer her to an occupational therapist for her other needs. Damon walked off, but returned and questioned their decision and then left again. The physiotherapists decided that an interpreter was needed as Songul lacked sufficient English, and Damon was agitated and defensive. When Damon was informed of this he said “Why don’t you trust me? I will take my mother home if you do that. I look after her for 12 years, you will not take my mother away from me”.

## In the afternoon of 19 February an assessment took place on the ward. An occupation therapist, hospital social worker, physiotherapist and an independent interpreter and Damon were present. The occupational therapist had called to the Hospital Social Work Team that morning asking for a social worker and interpreter to attend the assessment. The reason for the call was recorded as ‘Safeguarding’; the call resulted in the case progressing to referral.

## Damon was asked to leave during the assessment but refused; he wanted to know what was said. He became agitated and said “he had had dealings with professionals in the past and that had been no help”. Damon’s inappropriate handling and lifting of his mother the previous day was discussed and alternatives to bathing suggested. Damon insisted there was no risk to his mother; he then explained he needed help from carers for his mother, and that he had asked for help before and was applying for his mother to stay in the UK. He stated that “no one can split me up from my mum”. When the occupational therapist began asking Songul questions through the interpreter Damon became very aggressive and would not allow this to take place; he began shouting and he threatened to call the Police. At this point the physiotherapist left the area. When the assessment continued Damon blocked the use of the interpreter and deflected many of the questions which were asked.

## Damon reported that he did all domestic tasks in the house and all person care for his mother, including washing and dressing her. He also explained that he slept with her at night as she needed to be cuddled throughout the night. When asked via the interpreter if she minded sleeping with her son Songul replied ‘no’. She also answered no when asked if she minded him washing and dressing her. However, it was not possible to interview her without Damon present, and so whether this was genuinely her view cannot be guaranteed. When staff questioned the sleeping arrangements Damon stated that it was normal in his culture and he became angry. He moved closer to the occupational therapist and asked if they were accusing him of sexual acts with his mother. The occupational therapist said they were not. Damon then started to act provocatively including touching Songul across the breast, stomach and groin area and said “this isn’t sexual”. He continued to ask “is this sexual” as he kissed his mother. The occupational therapist explained to Damon that Songul would need certain equipment in the house, but he would have to pay for these as she did not have leave to remain in the UK. At this point Damon became verbally aggressive, rolled up his sleeves and pointed at scars on his arms. The occupational therapist then left the ward and made a plan that Songul was not to be discharged due to safeguarding concerns, and if Damon tried to remove her Police should be called.

## The social worker explained to Damon that they would need to check if Songul was entitled to services and this was done in the coming days via legal advice and checks with the Immigration Service. Songul stated that Damon was her legal guardian and had power of attorney, and Damon said that his mother was happy for him to look after her. It was not possible to interview Songul alone and so again it was unclear whether this was accurate and no power of attorney documentation was seen. Throughout the interview Damon was seen as challenging and dominant and he did not let professionals conduct a proper assessment. The record states that it was not known if Songul had the mental capacity to make decisions; it was not possible to do a formal assessment as Damon did not want her to be seen alone. The capacity assessment was limited to asking Songul via the interpreter if she knew where she was; Songul knew she was in Barnet hospital and the reasons for her admission.

## At 16:33hrs on the 19 February the Hospital Social Work Team received a safeguarding alert. This was raised by a physiotherapist and an occupational therapist in the hospital. The alert identified general concerns about Songul’s well-being and set up at home; the way Damon manually handled his mother and his defensive and aggressive response on more than one occasion; the inappropriate way that Damon touched his mother, and the fact that Damon shared a bed every night with his mother and cuddles her all night. Hospital records show that the medical team was informed of the safeguarding concerns and of the priority for an assessment with an interpreter present.

## At 18:13hrs a registrar recorded on Songul’s notes that a consultant had spoken to Damon and suggested a further meeting with an interpreter and Damon had agreed to stay out of the meeting. Damon was advised that Songul could not be discharged that day. However, at 22:30hrs Damon approached a nurse and said he was taking his mother home. When she said that could not happen yet Damon appeared to use his mobile to call the Police. No call was recorded by the Police. At 23:05hrs a doctor asked to see Damon, another son and daughter-in-law as they wanted to take Songul home. They stated that the safeguarding concerns were unfounded and Songul was being kept against her will. The doctor advised against taking her home, but the family left with Songul at 23:20hrs. The hospital contacted the Emergency Duty Social Work Team to report the incident and was told the matter would be discussed with the caseworker the next morning.

## Damon followed this incident with a number of written complaints to the hospital and a visit in person to the physiotherapy department where he complained about the safeguarding alert having been made. At several points in this visit he was aggressive and tried to intimidate staff. Damon also telephoned the hospital social worker and said that he had taken his mother home and he reported that Police were called due to the safeguarding alert in place but advised that they could not stop him discharging his mother. No record of a call to the Police was found. Damon also attended the Patient Advice Liaison Office several times and was aggressive to staff and he had to be removed by security. This information was passed to the hospital social worker.

## During the process of gathering information for the hospital Individual Management Review it came to light that while Damon was in the hospital with his mother he had harassed a member of the nursing staff several times to go out with him. When she told him she was not interested his tone changed; he was angry and he called her a derogatory name.

## A multi-disciplinary meeting was held at 14:00hrs on 20 February 2013 between the hospital social worker, the occupational therapist and physiotherapy lead. It was agreed that the safeguarding alert was warranted. They stated that they had met with Damon and he was angry towards them. He wanted the safeguarding alert rescinded and an apology from the physiotherapist who raised the alert. The occupational therapist and physiotherapy lead planned to meet with Damon and his sister to discuss the referral. As Songul had returned home the case was transferred to the Complex North Locality Team under Safeguarding.

## A meeting took place on 21 February between senior nurses and therapists and Songul, Damon, and his sister. During the meeting Damon attempted to lift Songul’s clothing to demonstrate how he washed her breasts; she appeared unhappy with this and he stopped, but staff were very concerned for Songul’s dignity during the meeting; Damon was loud and aggressive towards staff and they called security; the Police were thought to be called by Damon, however, there is no Police record of such a call. Also on 21 February a Safeguarding Strategy Discussion took place between the hospital social worker, the team manager and the Farsi speaking social worker allocated to the case in the North Locality Team; the strategy document was entered onto the social work database The Action Plan section of the strategy discussion document was not completed. Risk assessment on the safeguarding strategy discussion document notes: *'Damon is still the main carer and providing personal care to his mother, risk still remains. Risk could not have been managed as lack of sufficient evidence of abuse. Carer refused to engage with Social services.'* No interim protection plan was recorded and Safeguarding procedures were not fully followed.

## Although the reasons for concerns arose from Damon’s manual handling and inappropriate touching of his mother in front of staff, the Police were not contacted to discuss the alert or to check if they had any relevant information, and no initial strategy meeting took place between professionals which would have facilitated information sharing and risk assessment. This was not in line with Multi-Agency Safeguarding Adults policy and procedures

## A further meeting on 25 February 2013 took place where it was established that Songul did have mental capacity. This was followed by a Safeguarding meeting on 27 February at which hospital staff raised concerns about the manual handling of Songul, what was seen as inappropriate touching of Songul, and aggression shown towards staff by Damon. A plan was made for any future hospital admissions. The findings from the meeting were that allegations of “sexual molesting is unsubstantiated” following interview with Songul and her daughter. The risks identified were “risk of family dynamic, risk of care breakdown, risk of mistrust to the health professionals”. The action from the meeting was to carry out a community care assessment and a carer’s assessment. It had been established that Songul’s immigration status did not exclude her from community care services.

## At no time during the safeguarding alert process was Songul’s GP contacted for information or alerted to the safeguarding concerns, nor was Damon’s GP approached for information to inform a risk assessment. The notes in Songul’s GP IMR chronology from the hospital discharge make no reference to a safeguarding alert, leaving the practice ignorant of events. The IMR from the Central London Community Healthcare NHS Trust also highlighted that their database does not currently enable them to flag safeguarding alerts for vulnerable adults in their Walk-In Centres and urgent care centre. Both Damon and Songul had used the Walk-In Centre.

## On the 14 March 2013 an assessment and Personal Budget Questionnaire was completed. The overview assessment, carer’s assessment and support plan were submitted by the social worker to their team manager. Damon requested 1 hour assistance with personal care via a direct payment, but Songul was reluctant to accept help from others. A carer’s contingency plan was discussed with Damon and he expressed the wish for a culturally appropriate residential home or for his mother to move to her other son with a support care package, but he said respite care was not needed currently. There is no evidence that the direct payment was ever used by Damon, nor was respite care used. There was no case recording as to how the assessment was carried, whether Songul’s views informed the assessment, or that the social worker was a Farsi speaker. A request was made by the social worker for an urgent occupational therapy appointment on 19 March as they had “witnessed how the son is supporting his mother with her personal care... It presents very unsafe both for Songul as well as her son”. The occupational therapy visit took place with the social worker on 8 April 2013 and unsafe handling was witnessed. Advice was given and equipment recommended to help Songul was ordered.

## Whilst issues around the care of his mother were going on at this time Damon contacted Victim Support on 8 March. He said he had received a letter from the college asking if he would accept an apology from the student who assaulted him at the end of January 2013. He now wanted support and to ‘re-evaluate his live’ and he said he wanted to be diagnosed as to what it was about him that created these problems. This was outside the remit of the Service and he was recommended to seek counselling from the college counsellor he said he was seeing at the time. However, Damon’s counselling had ceased at this time, and he had not attended his last few counselling session with the college counsellor.

## The routine of GP and hospital appointments continued in the coming months for Songul. On 30 May 2013 Damon saw his GP as he had ‘mood variations and the same symptoms like before’. Olanzepine (an anti-psychotic medication) was ‘started again as it helped him in the past’. The first reference to this medication is a repeat prescription in October 2002 as prescribed by the Mental Health Team. This is the first reference to the medication since then in the GP chronology.

## On 20 June 2013 Damon phoned his mother’s GP reporting concerns about her mental health and saying that she was very stressed. A referral had been made to the voluntary organisation Farsophone for Farsi speaking counselling, but Damon and Songul had not responded to letters offering her an appointment. This was not followed up. Instead a referral was made to a psycho-geriatrician. Damon complained that his mother acted more disable than she actually was. Damon also called the out of hours service on 22 June stating that his mother was raising her blood pressure deliberately and she was “creating problems. She thinks I am going to leave her”. It was noted that son is main carer and “struggling”. On 24 June Damon phoned Songul’s surgery once more requesting something to relax his mother. He was advised to await the outcome of the appointment with the psycho-geriatrician.

## Damon contacted Victim Support again at the end of June and the beginning of July stating that he was now ready for support. He was offered an outreach appointment. When he was informed that the organisation was a listening service and did not offer counselling he became agitated. During the call Damon went through issues which were on his mind:

* His mother and her health needs and that he is not getting support. He wanted guidance on “rules and regulations” so that issues did not keep coming up. (By this time he and Songul had received an assessment and access to community care)
* Damon mentioned misunderstandings with the chemist.
* He reported that he had received Cognitive Behavioural Therapy counselling through his college.
* He said he had asked his doctor for help, but felt he and his mother are being pushed towards psychology.
* Damon said he had been encouraged to call NHS Direct. He had done this on 30 June 2013 and they assessed him as being suicidal. He disagreed with this. (NHS direct have no record of a call on this date)
* Damon said he wanted to get on with his life and to understand how to not have these different situations occur.
* He asked if the Samaritans were a good place for listening – he had called them before just to talk.
* Damon appeared to still be concerned about why he was assaulted at college and said it was difficult to get information from the college.

## The Victim Support staff member explained to Damon that Victim Support’s role was to support victims of crime. It was suggested that some of the issues he raised were beyond their expertise and that he should contact his GP. It was also suggested that he contact the mental health charity Mind for support and counselling and their telephone number was given. Damon cancelled the outreach appointment.

## Damon made a call to Social Care Direct on 10 July 2013 requested that the social worker in the Locality Team phone him urgently. In the email message sent to the social worker, key worker, and managers Damon was reported to sound distressed, but he did not disclose what he was calling about. His call was not returned.

## On the 17 July 2013 the Police were called to the family address by an anonymous and concerned neighbour who reporting hearing shouting and they feared Damon might be harming his mother. Officers recorded that Damon was initially agitated to see the Police. Songul was very nervous and did not like being separated from Damon. Songul was spoken to alone using the interpreting service Language Line and she was adamant that she was alright and her son looked after her very well. Her son who was visiting from Iran told officers that their mother could be “very difficult at times due to her conditions and it can be a lot to take on by yourself”. Officers completed an ‘Adult Came to Notice’ report for a vulnerable adult incident. This was printed off for faxing to Adult Social Care, however there is no evidence that that it was received and it is thought likely that it was not sent.

## On the 14 August 2013 the first assessment home visit took place to Songul by a consultant psychiatrist, psychiatric nurse, and a social worker from the Older Adults Mental Health Team. An interpreter had been arranged, but the visit had been changed from the hospital to a home visit at Damon’s request and the interpreting service had not informed the interpreter, therefore Damon interpreted. During the visit Damon talked about the safeguarding alert and denied any sexually inappropriate intentions or behaviour towards his mother. He understood that it was not seen as acceptable for him to be involved in his mother’s personal hygiene, but he was still sharing a bed with her and he justified this as being culturally appropriate. The psychiatrist advised Damon that this was not appropriate in Western culture, and on subsequent visits the team were shown separate beds and believed Damon was no longer sleeping with his mother. The psychiatrist observed that Songul saw Damon as a “good boy” and she appeared to adore being in his presence and wanted him with her all the time. Damon felt he could not leave her because she became distressed. He also saw caring for Songul as his responsibility as part of his strong Islamic faith. During this and further visits Damon talked a great deal and did not like to be interrupted. He talked of wanting to have a wife and family of his own, his previous failed relationships, and that no one wanted to live with him and his mother which was a precondition of any relationship. Damon’s descriptions of previous relationships were sometimes overtly sexual in tone. A decision was made for staff to make visits in pairs, not through fear of physical aggression, but due to those present feeling uncomfortable by the sexual tone of his conversation. Damon is described as having ‘high expressed emotions’. He stated that he wanted to continue caring for his mother and did not want practical support from Social Services as he thought this would affect his mother’s application for leave to remain in the UK. It is not clear where he gained this impression and the validity of this was not explored to placate him.

## Songul presented as physically disabled and subdued, withdrawn, and low in mood. She did nothing with her time; she did not listen to music or read, or have any interest in leaving the house. Songul had not engaged in social activity for a very long time. The only time she left the house was for medical appointments with Damon. Songul denied any problem with her mood or that she was anxious or depressed. She was judged to have no insight into her presentation. The psychiatrist felt it was not possible to undertake the mini-mental health examination to assess her cognitive ability as it did not lend itself to translation into Farsi. The psychiatrist and community psychiatric nurse made a second visit on the 29 August with an interpreter and Songul was seen on her own and with Damon. In his absence she appeared anxious for his return; there was no indication that she was afraid of him and she seemed more comfortable in his presence. No social worker attended as the CMHT social worker thought the case was open to the Locality Team and the records showed that Damon had been offered support; their involvement would have been duplication, but the Locality social worker had in fact closed the case 2 days previously. From the two visits Songul was assessed as having a difficult and complicated life history and past experiences had undoubtedly compromised her emotional wellbeing resulting in anxiety, low mood, and panic over the decades. This was made worse by physical ill health. There was the possibility of cognitive impairment due to the stroke. Her mood disturbances were debilitating. Her management plan included an increase in her anti-depressants and starting medication to reduce her anxiety.

## The Community Mental Health Team (CMHT) achieved a good level of information from Songul’s GP referral and during their assessment of Songul’s mental health, however they were not fully cognisant of the safeguarding alert and the detail behind it other than that related to them by Damon. At the time of their first visit on 14 August they were unaware that a Borough social worker was already assigned to Songul as the CMHT social worker located in the team had not checked their Borough social work Swift database beforehand. The usual practice of the social work principle practitioner checking the database for Borough involvement and the one for safeguarding had not taken place as the request for a joint visit with a social worker came direct from the CMHT consultant. Songul’s GP had suggested that social care input may be required (Songul’s GP was unaware of Borough social work involvement). The social work and health IT information systems require separate entries and recording cannot be sent from one system to another. There was full feedback of assessments to Songul’s GP by the CMHT consultant psychiatrist.

## On 21 August Damon called 999 requesting an ambulance; he was unable bear weight on his ankle which he said was frozen; it had happened whilst doing jujitsu. The call was disconnect and twice he was called back and the call disconnected again. He was called back a third time and said he would make his own way to A & E. He was recorded as taking mood stabilising medication. He was x-rayed and discharged home with pain killers. Damon was also being seen at the hospital for appointments related to abdominal pain at this time.

## A third visit by the Older People’s Mental Health Team took place on 24 September 2013 accompanied by an interpreter. There was no improvement in Songul’s presentation and it was observed that Damon’s ‘carer stress remains immense’. In addition he was in extreme pain due to sciatica, but Songul failed to acknowledge his difficulties; she had high expectations of him and believed he had a duty of care towards her twenty-four/seven. She was anxious when he was not there and Damon admitted to being infuriated by her, especially as she worked well with the community physiotherapist, but expected him to do everything for her. Damon said he felt let down by his family, but admitted that they were scared of a physical altercation erupting and so did not come near him. A contributor to the Review confirms this was the case. Songul’s management plan was changed to increase her anxiety reducing medication and a visit by an occupational therapist was to be arranged to assess Songul for a chair which would aid her sitting/standing transfer to protect Damon’s back. A further visit was planned for 17 October, but efforts were to be made before that date to see if they could arrange day care once a week for Songul. The psychiatrist concluded that Songul’s difficulties were entrenched and they were ‘not optimistic about her convalescence and recovery with respect to her emotional well-being’. There was hope that ’we can try and see whether we can effect some improvement in mood, but more importantly put in some practical supports to give Damon a bit of a break’.

## On 27 September 2013 Damon had a review with his GP. He was noted as doing well and was exercising. He was commended and was to continue with his medication. 3 days later on 30 September Damon called 999 for an ambulance with what he suspected to be a trapped sciatic nerve. Ambulance staff found Damon balancing on his head with his legs outstretched which were held by Songul and a friend. He described pain going down his legs into his groin with shooting pains in his neck up to his temple and eyebrows. Damon was taken to hospital where the pain eased enough for him to be able to walk around. He was noted to be agitated and frustrated. Mental health issues were noted and his being known to Mental Health Services in the past. Damon told staff he was concerned about ‘trapped energy and he gets swollen around the groin and thighs, ease by massage and stretching.’ An initial assessment was undertaken by a registered nurse and a registered mental health nurse. Support from Mental Health was suggested to him, but Damon declined. Damon was reassured and discharged to the care of his GP for follow up. The discharge summary sent to Damon’s GP did not contain any detail as to the reason for his attendance nor did it mention any concerns about his mental health.

## On 1 October 2013 Damon visited his GP for follow-up concerning his back pain. He complained about his physical symptoms using a very unusual description of what he felt was happening to him. His GP noted soft tissue damage, and that Damon was very agitated, and ‘appears confused and paranoid’. His GP has clarified that this comment was made in connection with Damon’s description of his complaint. A referral to the Mental Health Team was discussed, but Damon did not agree with this being done; he promised to take his medication of Olanzepine which was prescribed on 17 September 2013. As Damon would not agree to a referral to Mental Health, and following his GP’s assessment at the consultation, his GP reports that he did not feel it necessary to call the Mental Health Crisis Team. According to his assessment Damon was neither suicidal nor at risk of self harm or harm to others. From past experience when Damon took his medication his GP’s observation was that he got better.

## On 5 October 2013 at 01:11hrs a 999 call was received from a concerned relative and an ambulance was dispatched to the family home. This was followed by a request for Police attendance. After forcing entry Songul’s body was found. Damon was lying next to her. Cause of death was recorded as blunt trauma head injury. Damon was arrested and taken to hospital where he was treated for swollen and cut hands after which he was taken into custody, but later transferred to a secure hospital. Following psychiatric assessments it was agreed that at the time of the attack on his mother Damon was in a disturbed state of mind. During assessment he said that he felt energy came out of him and he maintained that ‘jinn’ (evil spirits) had possessed his mother and himself and the attack was carried out to ‘get evil spirits out of his mother’. He also heard voices coming from household equipment. On the day of the incident Damon had taken amphetamines and cannabis reportedly to help the back pain from which he was suffering. During the psychiatric assessments Damon admitted to using these substances on a regular basis, he also admitted to slapping his mother on occasions. Although the two assessing psychiatrists were not unanimous on a precise diagnosis, opinion was that his mental health appeared to have been deteriorating since March 2013 and by the October he was severely psychotic with paranoid delusions and may have been suffering from late onset schizoid psychosis.

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## Damon pleaded guilty to manslaughter on the grounds of diminished responsibility which was accepted by the court. He was sentenced to a Hospital Order under Section 37 of the Mental Health Act 1983 on 23 July 2014. In summing up the judge accepted that the role of sole carer for his mother would not have been easy and he was a caring son. Damon’s family had confirmed that he was close to his mother, but he had accepted responsibility for the “terrible attack leading to her death”. However, the judge accepted the explanation of paranoid psychosis at the time, and said that whilst it was easy to judge in hindsight, Damon had not been given appropriate care 4 days before the incident. Damon was assessed as having “a chronic and enduring condition”; he would be at risk of relapse, and his condition would be exacerbated by the use of cannabis or drugs. Taking into account events leading up to the death of his mother Damon was assessed as posing a risk to the public. To reinforce this view the judge also made a Section 41 Restriction Order.

## Summing up the information known to agencies, particularly in the months of 2013 leading up to Songul’s death, it becomes apparent that her physical and mental wellbeing was deteriorating and at the same time what appears to be Damon’s anxiety and difficulty in coping is being observed by various Health organisations. Information appears to be shared between allied health practitioners involved in community services, such as between the Borough social worker and occupational therapist, but the key community based practitioner in constant contact with the family, Songul’s GP, appears to be completely out of the loop until the Mental Health Team assessment. Damon’s GP is equally outside the system of information sharing and seems to be oblivious to what is taking place. The lack of information gathering and sharing with GPs regarding the Safeguarding alert is particularly concerning.

# Key Issues Arising from the Review:

## **Lack of awareness of domestic abuse:**

## Despite the fact that the 2011 Pan London Safeguarding Adults policies and procedures highlight the fact that ‘Approximately one in five homicides in London are domestic related, with the murder of a parent by a son being prevalent’, no one saw the safeguarding alert in the context of domestic abuse. Therefore, it is important that all agencies are as robust in their interventions with interfamilial domestic violence as they are with intimate/ex-partner relationships, and appropriate support services are sought to meet the needs of the adult who is experiencing domestic violence’ (page 15). Songul’s homicide demonstrates why this statement is so relevant and needs to be emphasised across all services and within training programmes.

## The behaviour which generated the safeguarding alert; Damon’s control of the use of interpreters; always wishing to be present when Songul was seen by professionals, and his intimidation of practitioners, all demonstrate behaviours consistent within the definition of domestic abuse and coercive control. Their relationship as family members also defines this case as domestic abuse. Practitioners and managers need to suspend their disbelief that someone who outwardly cares for a close relative, such as a parent, can cause them harm. The growing older population means that greater awareness of domestic abuse in a family setting is needed, and this is particularly vital where a vulnerable adult/high risk carer dynamic exists and the imbalance of power in such relationships is heightened.

## The fact that this case was not seen through the lens of domestic abuse indicates a lack of knowledge of this subject. The majority of practitioners receive their domestic abuse awareness within safeguarding training, however this does not provide enough time for the in-depth knowledge and skills which need to be developed for two subjects which are important in their own right although clearly linked. Practitioners and their supervisors need in-depth domestic abuse training as a separate course.

## Given the many restructures which have taken place, and which continue to take place within public and voluntary sector services it is essential that organisations recognise the effects of staff turnover in this area of work. Not only is there a loss of staff who have received domestic abuse and safeguarding training, but a loss of organisational and team memory and of service users, a loss of inter-agency relationships, lessons learnt, and what works and what does not. The value of multi-agency domestic abuse training in such circumstances should not be underestimated, and that training needs to emphasise all aspects of domestic abuse and coercive control so that practitioners move away from thinking of domestic abuse as violent acts only.

## **Information sharing**:

## The failure to fully follow safeguarding procedures lead to a flawed process and inadequate gathering and sharing of information. Had the GPs been contacted and told about the safeguarding alert they would have felt at liberty to disclose information as part of that process. Nevertheless, there are also lessons from this case for GPs that where the welfare of a patient and their carer are at risk or under great strain every effort should be made to gain consent to share information between GPs where the patient and carer are registered with different practices to ensure that the best and most effective support can be given to both. If agreement for sharing information with a GP in another practice cannot be gained the risks to both patient and carer’s safety should be assessed and information sharing under safeguarding procedures considered. In this case there was no information sharing between GP practices concerning the stress on Damon and his mental health of caring for his mother for procedural reasons of patient confidentiality, and Damon’s GP’s lack of awareness that he was his mother’s sole carer and his mental ill health could be impacting on his ability to care safely. No consideration was given to seeking Damon’s permission to share information for the benefit of his health and that of his mother. Given the welfare issues for both carer and the cared for, consideration should have been given to this. Where information of concern comes from the person being, or suspected of being abused, great care must be taken to guard the source of the information to protect the individual from risk of further abuse and harm.

1. Information sharing between agencies was at times untimely or inadequate and sometimes nonexistent inadequate or not within a suitable timescale to be useful. Of particular concern is the lack of information sharing between Adult Social Care and GPs during the safeguarding alert process, the hospital A & E department and Damon’s GP after his last attendance, and within the Community Mental Health team regarding timely information from Adult Social Care.

1. There was no system for confirming the receipt of ‘Adult Comes to Notice’ alerts, therefore it was not recognised that the Notice generated by the Police to Adult Social Care for their call-out in July 2013 had not been received. It is essential that the new secure email method of sending generates a received and read receipt to ensure that this process can be audited. The fact that the ‘Adult Came to Notice’ report did not reach Adult Social Care from the Police may have been significant as it brought to light from another source the building stress in the household.

## Damon himself did not share information about his use of illicit substances or non-prescribed drugs, therefore his GP and medical staff seeing him in A & E or in Walk-In services were unable to raise his awareness of the adverse effects of this use on his mental health when combined with his other medication.

## **Risk assessment**

## Assessment of risk at the time of the safeguarding alert was inadequate and no protection plan was put in place. Later risk assessment centred on the risk of relationship breakdown between Damon and professionals, or the offer of respite care to prevent the risk of Damon having difficulty in coping with his mother’s care. No checks were made with the Police at the time of the safeguarding alert to either inform them of the concerns or check for any relevant Police history to inform risk.

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## Risk assessment should be integral to any assessment, and not just confined to safeguarding. The areas considered need to be holistic, so that carers are always included, particularly were carer stress is high.

## **Professional Confidence and Assertive Practice**

## The service user should be the focus and should be interviewed or assessed without the presence of the person alleged to be causing them harm. Where a carer or family member is unwilling or obstructs this happening practitioners need to have the professional confidence to follow procedures. Management support should be sought and provided in pursuit of best practice in such circumstances. If necessary guidance and training should be developed to support this in practice.

## Damon’s GP appears to be the only person to identify that he was showing signs of paranoia at the beginning of October 2013, however, no referral for an emergency mental health assessment was made as Damon refused this and the GP believed he would improve with the use of medication as he had in the past. The hospital A & E department also suspected Damon was mentally unwell when he was seen on 30 September, but accepted his word that he was already receiving support. From this we can learn that practitioners need to take heed of their own assessment and be assertive in making referrals to Mental Health when their skills and instincts tell them all is not well. Whilst appreciating referral is patient driven if they are believed to have capacity, when their behaviour is seen as bizarre or unusual a more assertive approach may be necessary. When a patient is on medication for mental illness they should be reviewed by Mental Health services periodically to ensure that the prescription and the dose is appropriate for the current episode, especially when they have not been assessed by the specialist service for some significant time; taking this as a routine approach could be used with a patient who is reluctant to accept a referral.

## Staff need to have the confidence to constructively challenge decisions they disagree with and to be knowledgeable and supported in the policies and procedures to do so. This should be done whether it relates to challenging a safeguarding alert decision, or the ability to prevent a vulnerable adult from being removed from a place of safety such as a hospital.

## Staff intimidation can be very undermining to a practitioner’s confidence in their practice; in this case the intimidation was not adequately and explicitly challenged before it reached the stage of needing to call security. Such behaviour needs to be assertively and safely challenged when and wherever it takes place. Equipping staff to handle aggressive or intimadatory behaviour should be part of all practitioners training and they need management support and good supervision in dealing with such incidents. There is learning here too for staff in envisaging how the aggression and intimidation made them feel and how such behaviour will make the vulnerable person feel, both in their witnessing of the behaviour to staff, and the potential for this to be happening within their home to them.

## **Adequate and up to date recording and database access**

## Adequate and accurate recording is a cornerstone of effective communication. The information retrieval, recording and communication systems in the multi-disciplinary Community Mental Health Team appear particularly unwieldy, requiring double or triple entry of recording on different databases. Limited practitioner access to records hampered timely sharing of information to the detriment of assessments. The Walk-In health centres also have systems which do not coordinate with those used elsewhere in Health and do not show any safeguarding flags or markers.

## The reasons for the safeguarding alert were not clearly recorded; for example using terms such as ‘inappropriate touching’ without fully recording what this meant and what was witnessed. This vagueness resulted in a lack of appreciation later on of the behaviour and concerns which caused the alert. The use of specialist terms between disciplines which may be crucial to an assessment for example ‘high expressed emotions’ should have their meaning clearly described for those outside the specialism.

## **Assessment of Carers**

## There was inconsistency in undertaking a carer’s assessment and the depth and range of these assessments appears to be inadequate. A wider range of information needs to be gathered to provide an holistic assessment of a carer’s own health and wellbeing not just assessment of practical aids or respite. Such an assessment could also identify potential areas of tension and risk. The current Adults and Communities Carer’s Needs Assessment Form has one question headed ‘General health and wellbeing’ (question 2 page 3). It covers diagnosis and registered disability, whether the caring role interferes with sleep, affects the carer’s mood or how they feel, or causes any pain or strain. Whilst the form is probably designed to be simple to complete this section could be improved by enquiring separately into different aspects of health i.e. physical health, mental health and wellbeing with those sections broken down to ask more specific questions.

## **Inadequate Knowledge of Legislation**

## Practitioner’s had inadequate knowledge of legislation regarding the eligibility for community care in relation to a service user’s immigration status and the Human Rights Act. This had a significant impact on Songul and Damon’s access to support for many years. The Adult Social Care and Hospital IMRs also highlighted a lack of knowledge of the Mental Capacity Act and the related assessment guidance. Where relevant a service user’s immigration status needs to be clarified at the beginning of an assessment and their eligibility for services confirmed from the start.

## **The Use of Interpreters**

## The guidance for using interpreters was not always followed. Good practice in the use of interpreters needs to be reinforced and should be used for all relevant interviews and assessments, even when family members act as interpreters. The risks associated with family members or carers interpreting in safeguarding or domestic abuse cases needs to be reinforced as this gives additional opportunities to control and manipulate information available for assessments.

## **The Protection of Vulnerable Adults**

## Finally, this Review reinforces the case for adult protection to be on the same statutory footing as child protection as highlighted in Prevention in Adult Safeguarding: Adults’ Services Report 41[[4]](#footnote-4). This would place local authorities and others under a duty to share information and to cooperate in the protection of our vulnerable adults within the same statutory framework as the Children Act and Working Together.

# Conclusions:

1. It has been interesting to observe that for the most part agency records predominantly contain descriptions of interactions with Damon and his characteristics, whilst a rounded picture of Songul as an individual feels lightly sketched. This is probably due to the fact that most communication with her took place through Damon or occasionally through an interpreter. However, when it came to assessments Songul’s needs predominated. Assessment of Damon as a carer, when it did take place, assessed his practical needs and not his mental wellbeing and the effects of the acknowledged stress he was experiencing, even though he was known to suffer from depression and anxiety. A word constantly used by a variety of agencies in describing Damon whenever he is under any pressure or things did not go his way is “agitated”, and yet his mental health was not questioned. Even when his GP noted that he appeared ‘paranoid’ during an appointment on 1 October 2013 just four days before he killed his mother, the seriousness of his mental state was not recognised.
2. Information was not shared which could have brought together a more holistic picture. Even during the safeguarding alert when one would hope a wider range of information would be gathered, procedures and processes were not all followed. It is to be hoped that by putting the safeguarding of adults on a statutory footing information sharing for safeguarding assessments will in future be achieved without difficulty. Communication methods of retrieving, recording, and sharing information were also hampered by uncoordinated IT systems, and at times the gaining of information was effectively prevented by Damon blocking the use of interpreters or subjecting staff to intimidation which was not adequately challenged or dealt with.
3. This has been a complex case to examine, and the Panel has wrestled with the analysis of the information which has emerged during the Review. The questions we have discussed are:
4. Could Damon’s position be seen as one where he was controlled and emotionally abuse by his mother, rather than Damon abusing and controlling her? She expected him to care for her; it was his duty. She refused care from anyone else and was reluctant to consider attending a day centre to give him a break, even when he was suffering severe sciatic pain she did not reduce her expectations of him. If he went out Songul would phone him anxious for his return. His brother, who was visiting in July 2013 when the Police were called out, reported to officers that their mother could be “very difficult due to her conditions and it can be a lot to take on by yourself.” Damon also told Mental Health staff and Songul’s GP that his mother was not always cooperative. There are frequent allusions to Songul doing less than she was capable of; she was reported to be more mobile for physiotherapists than she was for Damon, and she did nothing for herself apart from serve herself a glass of milk from the fridge. Did the pressure of caring for his mother under these conditions exacerbate his depression and anxiety levels and tip him into a more severe mental illness? Arguably it did.
5. Yes, Damon touched his mother in an intimate manner which was genuinely and rightly viewed as inappropriate, but as he had been providing her personal care for 12 years could he have become immune to the connotations of this? Is it because he was a man and performing personal care that his actions were suspect? Would the same perception of inappropriate touching have resulted if Songul’s daughter had acted in this way? Or in the situation of a close female relative caring for a man? It may have been construed as showing a lack of dignity for the person cared for, but would it have been viewed so seriously? Did Damon touch his mother’s body physically in the manner reported because he was in a healthcare setting where there is an expectation that professionals are used to seeing patient’s bodies? Was Damon, as he said, demonstrating to practitioners what was *not* appropriate and this was misunderstood? Or could his behaviour have been one of the first signs that his mental illness was emerging more visibly? With the benefit of hindsight his mental health assessment for the court surmises that his mental health appeared to have started to deteriorate from around March 2013. It may be that the pressure of the safeguarding alert and his aggressive combative behaviour around that time was the beginning of this deterioration.
6. Damon reported that he slept in the same bed as his mother to comfort her and that this was appropriate in his culture. This has been dismissed by our Panel adviser on Iranian culture and customs, and confirmed by other contributors. There is a sense that some practitioners felt unable to adequately challenge his assertion, apart from the consultant psychiatrist who did so during a home visit. Damon’s agitated, aggressive behaviour towards staff who challenged him verged on intimidation, notably during a ward meeting and when he sought out the physiotherapist who made the safeguarding alert. It is not therefore surprising given Damon’s tall stature and intimidatory behaviour that staff found this difficult to handle. Staff should always be protected in such situations and his behaviour should have been challenged more effectively by management and security. It would have been appropriate for him to be removed from hospital premises during some incidents, but this was not done.
7. References are made in agency records of Damon being a caring person who loved his mother and wished to do the best for her. There is evidence that Damon was frustrated at times that his life was not his own; he wanted a wife and family, but no one would meet his precondition that a prospective partner must live in his home with his mother. He had been caring for her for many years and he had seen his personal freedom and opportunities for a life outside the home diminished as Songul’s health deteriorated and her needs increased. Were his outbursts of anger with professionals borne out of frustration with services, or his increasing agitation a manifestation of emerging psychosis? It is clear from the chronology, and confirmed in the psychiatric assessment for the court that his stress levels were increasing from March 2013 and his mental health was becoming affected. In the Barnet College IMR Damon is described as ‘caring and responsible’ and at no time did he express anger towards his mother or resentment about looking after her; his anger was directed at others. This affected how he was assessed in terms of risk.
8. However avoiding hindsight, and from the information known to agencies at the time, Songul’s homicide was not predictable. Had different actions been taken at the end of September and beginning of October 2013 to refer Damon to Mental Health Services to secure a diagnosis and treatment for his deteriorating and ‘psychotic’ mental ill-health, a risk assessment may have predicted that he posed a risk to his mother or others at that time. Research shows that the risk of violence appears to be greatest in untreated individuals during a first episode of psychosis, and although matricide is fortunately infrequent it is considered to be committed by those with severe psychiatric disorders[[5]](#footnote-5). Research by Marleau et al agrees with other literature that a ‘majority of adult parricide offenders suffer from mental illness, specifically paranoid schizophrenia (56%). They also observed that all of the adult offenders were found insane at the time of the offence’[[6]](#footnote-6). A correlation has also been found between the age of the offender and parental victimization; those between 20 to 50 years of age were most likely to kill their mothers[[7]](#footnote-7). Damon was in this age group.
9. Although in the circumstances present at the time Songul’s death was not predictable, there are a number of reasons why her death could have been preventable:
10. Had Immigration Services followed up on their refusal to grant her leave to remain in the UK on 14 December 2009 (with no right of appeal) with a removal notice and she had been returned to Iran she would not have been in Damon’s care at the time.
11. Had the existence or severity of Damon’s mental ill-health been recognised and he had been immediately referred to Mental Health Services for treatment it is possible he may have been admitted to hospital, and with successful treatment it is most unlikely that he would have harmed his mother.
12. A more rigorous investigation at the time of the safeguarding alert which included a robust assessment of Damon, his ability to carry on caring for his mother, and the impact on his own mental wellbeing could have had the potential to identify the increasing instability in his mood and thus sources of risk. Including information from his GP would have revealed his history of mental ill health and opened the door for a more informed risk assessment and appropriate services for him as well as his mother.
13. A more thorough holistic carer’s assessment which included information from his GP would, or should, have raised concerns that his anxiety and behaviour were not just due to ‘carer stress’, but that he was mentally unwell and the stress of caring for his mother and the safeguarding alert had exacerbated his illness. Signs of mental illness were missed; the carer’s assessment appeared to concentrate on purely practical resolutions to the family situation.

**Recommendations:**

1. The recommendations below have been informed by those contained in agencies IMRs, from the lessons learnt from this Review, and by the Panel’s long deliberations. The author sought the views of College of Policing What Works Centre which is currently reviewing the DASH risk assessment tool regarding the suitable lead agency to which National recommendation 1 should be addressed. The author also canvassed the views of Professor Gene Feder via the Royal College of General Practitioners regarding National recommendation 5.

**National Level:**

**Recommendation 1:** Consideration should be given to amending the CAADA DASH risk assessmentto include a question asking whether the perpetrator is a carer for a vulnerable adult. This would reflect the additional power imbalance and vulnerability that can result from this relationship, and the inevitable increase in these roles due to the country’s growing older population. (*A question has now been added locally to the CAADA DASH assessment asking about being a carer*)

**Recommendation 2:** That the Department of Health and NHS England should provide clear and binding guidance and resources for the provision of DHR IMR reports from GP practices which are independently authored and which meet the terms of reference required for the Review.

**Recommendation 3:** NHS England should review the policies and procedures under which NHS 111 operate where a vulnerable patient may be at risk to themselves or others due to mental illness to ensure that their GP is informed as soon as possible and/or emergency services are called to assist the patient.

**Recommendation 4:** That the Government consider introducing new statutory processes to ensure a duty to protect vulnerable adults is in place similar to the duty and procedures in the Children Act and Working Together.

**Recommendation 5:** That GPs have a protocol setting out steps for sharing information with a carer's GP where that carer is not registered at their practice, and where there is concern about that carer which may impact on their patient who is cared for resulting in an increased risk of harm or threat to their wellbeing. Caution must be exercised if the information about the carer's health or behaviour comes directly from the patient, as disclosure of its source may increase risk of harm.

**Recommendation 6:** That the chair of the Community Safety Partnership write to the Solicitor's Regulatory Authority director of Regulatory Policy to request that amendments are made to the code of ethics, or that guidance is issued, which will enable solicitor's to assist with information for Domestic Homicide Reviews where their client's death has met the statutory requirement to undertake such a Review under Section 9 of the Domestic Violence, Crime and Victims Act 2004.

1. **Local Level:**

**Multi Agency:**

**Recommendation 1:** An electronic flag on agency systems to highlight when someone is a carer for a vulnerable adult should be implemented. This is both to alert practitioners to the vulnerability of the cared for adult, and to highlight the needs and stresses involved in being a carer of someone with significant additional needs.

**Recommendation 2:** Ensure there is best practice guidance on the use of interpreters in safeguarding and domestic abuse cases for practitioners and its use included in safeguarding training. This should include the risks associated with using family members as interpreters.

**Recommendation 3**: All agencies who had involvement with this Review to ensure that the full Overview Report, its findings, and learning is disseminated to decision makers, trainers, and the key staff involved by July 2015 or as soon as practicable following confirmation from the Home Office that the Review can be published

1. **Barnet, Enfield & Haringey Mental Health Trust Recommendations:**

**Recommendation 1:** That a formal protocol should be developed in Mental Health Services for Older People (MHSOP) to ensure that practitioners who are screening referrals for allocation will have a clear criteria to refer to when they are assessing risk, to support their professional judgement.

**Recommendation 2: (a)** Team Manager to ensure that the Team adhere to Trust Policies regarding information sharing and standards of record keeping and completion of carer’s assessments (CPA Policy), in regard to information obtained from SWIFT under section 75 agreement.

**(b)** Verbal conversations & information obtained from SWIFT to be documented in RIO so that all staff has access to this information. All reports or letters received by the team should be scanned and uploaded onto RIO. These should be audited by Team Manager.

**Recommendation 3:** The Trust to take action to ensure that staff are appropriately skilled to work with challenging behaviour when exhibited by carers, and are aware of their responsibilities towards carers. The Trust should make available training to develop practitioner’s skills to meet these requirements.

**Recommendation 4:** A comprehensive Review should be undertaken into the mechanisms and agreements by which the London Borough of Barnet and the Barnet & Enfield Mental Health Trust work together and share information with the aim of achieving a formal agreement for a more integrated way of working which results in timely information sharing and more coordinated systems between services for the benefit of service users.

1. **Adults & Communities:**

**Recommendation 1:** The Adult and Communities Carer’s Needs Assessment Form to be reviewed and consideration given to separating the questions on General health and wellbeing into ‘Physical Health’ and ‘Mental Health/Wellbeing’ to enable greater depth of information to be given in each section. Also consider prompt questions being added under each section to determine level of severity of health issue.

**Recommendation 2:** Ensure that all practitioners & locum practitioners have regular & updated mandatory training on the Mental Capacity Act (MCA) 2005. Focus to be on the application of the 2nd principle in relation to service users where there are communication barriers i.e. where first language is not English or who do not share a common language with their worker. The 2nd principle is: ‘*A person must be given all practicable help before anyone treats them as not being able to make their own decisions*.’ (MCA 2005). Training to include tools for use when assessing mental capacity e.g. use of interpreters, *Makaton, Talking Mats* & other non-verbal communication. Confirmation of training to be audited.

**Recommendation 3:** Best interest assessors (BIAs) and the Mental Capacity Act/Deprivation of Liberty Safeguards Lead to take a role in the education of the workforce on the ground in relation to the Mental Capacity Act (MCA) by providing practice advice and supervision to practitioners when they carry out mental capacity assessments. More staff should to be trained as BIAs to increase skills and competency levels in all cases where mental capacity is an issue.

**Recommendation 4:** The Mental Capacity Act quarterly practice fora should include as agenda items a focus on challenging case examples with a focus on applying the MCA. Any practice issues learnt from them should be shared widely among practitioners e.g. In team meetings. MCA case discussion to become a standing item to be added to the forward plan agenda of the MCA quarterly practice board by March 2015.

**Recommendation 5:** Safeguarding Adults training for all practitioners and Safeguarding Adults Managers to ensure that the principle of always hearing the voice of the adult at risk directly during investigations, and the need to meet with service user without the alleged abuser being present, is embedded in training. Training to include practical tools to enable appropriately assertive practice to manage conflict and aggression, family/carers preventing access to a vulnerable service user, and where family/friends may be intimidated into condoning the situation.

**Recommendation 6:** To support Recommendation 5 and to reinforce practice Adults and Communities to develop policy and practice guidance on working with carers under stress, with carers as alleged perpetrators of abuse, and for situations where the alleged carer/ perpetrator is preventing access to the adult at risk, and identify an appropriate risk assessment for these situations.

**Recommendation 7:** To assist practitioners and their supervisors in confirming the validity of practices, and challenging situations where alleged cultural practices may be causing harm, Barnet Borough Council to work in partnership with local agencies and groups to provide a directory of resources that are willing and able to assist with information clarifying the various cultures and customs within the Borough’s communities (ethnic and cultural).

**Recommendation 8:** Policy guidance to be developed and cascaded to practitioners on the eligibility for a care and support assessment for those with uncertain immigration status. This should include the need to establish a service user's immigration status and eligibility for community care services as soon as possible and methods of achieving this.

**Recommendation 9:** Adults and Communities should review its mechanisms for recruiting, supervising and performance monitoring of locum practitioners. This should include consideration of whether the Council has access to sufficient choice and quality of locum/agency workers through its agency worker system. Locum workers should be trained and briefed on local procedures and resources. Completion of this review and any changes made to existing processes December 2015.

**Recommendation 10:** Updated recording guidance & standards should be issued and all practitioners should have access to regular training & guidance in excellent recording. Recording issues should be addressed in supervision & clear, explicit, timely and pertinent recording of all case work should be an objective for all front line practitioners & supervisors, especially in safeguarding cases. Interviews conducted in a language other than English must be clearly stated in assessments and case notes whether this took place through an interpreter, or using the practitioner’s own skills if they are fluent in the language.

* 1. **Police and Adults and Communities:**

**Recommendation 1: (a)** An agreed secure system is put in place to ensure the safe and traceable receipt of vulnerable adults referrals on an ‘Adult Coming to Notice Merlin Report’ between the Police and Adults & Communities. The process should include a confirmation of email delivery, and read receipt to the sender. Both agencies should log the notifications. This process should aim to be in place by September 2015.

**b**) A ‘flag’ should be put in place within the IT system used by Adults & Communities practitioners to indicate a high priority MERLIN Report has been received on a service user and/ or carer.

* 1. **Royal Free London NHS Foundation Trust:**

**Recommendation 1:** The Trust to review the MCA policy and Capacity assessment tool and for this be included in training and disseminated through Trust briefings.

**Recommendation 2:** The Trust to review safeguarding training and offer bespoke training to staff on new policies and procedures including the escalation and information sharing process.

**Recommendation 3:** The process of discharge letters to be altered by the Trust to have a fail-safe device that unpopulated letters from the Emergency Dept cannot be sent. Specific patient information where a safeguarding alert has been raised should always be included in discharge letters.

* 1. **London Community Health Care:**

**Recommendation 1:** The flagging of the electronic records health care settings (Walk In Centre/ Urgent Care Centre) is extended to include vulnerable adult alerts.

**Recommendation 2:** Further development of bespoke training for adult services in relation to domestic abuse should be arranged to include recognition, routine enquiry, and sign posting of clients to appropriate services where domestic abuse is suspected.

* 1. **Barnet Clinical Commissioning Group:**

**Recommendation 1:** To monitor the implementation of the action plans for the Royal Free London Foundation NHS Trust, Central London Community Health Care Trust and the Barnet Enfield and Haringey Mental Health Trust.

**Recommendation 2:** To request that electronic patient records for Primary Care contain a flagging and tagging system for domestic abuse and MARAC.

* 1. **GP Practice:**

**Recommendation 1:** Practices should review use of family, friend, or carer to consistently interpret for patients. Whilst an interpreter at every appointment may not be possible, practices should aim to ensure that such patients are reviewed with a trained interpreter annually to ensure they can be seen alone & can communicate freely. To assist acceptance of the policy patient information should be available stating this is routine practice at the surgery and assurance of confidentiality given. A surgery leaflet & posters could be made available in waiting rooms explaining the system.

* 1. **Victim Support:**

**Recommendation 1:** Using the learning from this Review training to be provided to staff and volunteers by Senior Service Delivery Managers in each London Borough to increase staff and volunteers’ understanding of the wider support needs affecting service users other than issues arising from crime. This should include safeguarding, issues and onward referral to appropriate statutory and voluntary support agencies.

1. The CAADA (Co-ordinated Action Against Domestic Abuse) DASH (Domestic Abuse Stalking & Harassment) is a risk assessment checklist consisting of 24 questions to ascertain the level of risk a victim faces. The questions are formed from an evidence base of known behaviours or experiences shown to lead to a serious risk of harm or homicide. [↑](#footnote-ref-1)
2. Multi-Agency Risk Assessment Conference (MARAC) A multi-agency meeting at which information is shared, risk assessed and safety plans are made to protect high risk victims of domestic abuse. [↑](#footnote-ref-2)
3. Social Care Institute for Excellence (2011) *Protecting adults at risk: London multi-agency policy and procedures to safeguard adults from abuse’ (page 4).*Adults’ Services SCIE Report 39 [↑](#footnote-ref-3)
4. Prevention in adult safeguarding Adults’ Services Report 41. Published May 2011 (Review May 2014) <http://www.scie.org.uk/publications/reports/report41/files/report41.pdf> accessed 13.10.14 [↑](#footnote-ref-4)
5. Carabellese F et al (2013) ‘Mental illness, violence and delusional misidentification: The role of Capgras’ syndrome in matricide’ in *Journal of Forensic and Legal Medicine 21 (2014) 9-1.* [↑](#footnote-ref-5)
6. Marleau, J. D., Auclair, N., & Millaud, F. (2006). Comparison of factors associated with parricide in adults and adolescents. *Journal of Family Violence, 21,*321-325. in Rhona Mae Amorado1, Chia-Ying Lin, Hua-Fu Hsu (2008) Parricide: An Analysis of Offender Characteristics and Crime Scene Behaviors of Adult and Juvenile Offenders (page 6) [↑](#footnote-ref-6)
7. Heide, K. M. (1993a). Parents who get killed and the children who kill them. *Journal*

   *of Interpersonal Violence, 8,* 531-544.(page 4) In ibid above [↑](#footnote-ref-7)