DOMESTIC HOMICIDE REPORT

Executive Summary

Safer Ealing Partnership

Barbara

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Laura Croom

Associate, Standing Together

August 2014

Executive Summary

Summary of the Incident

1. **The incident**

1.1. On 28 December 2012, William, the brother of Nipper (62), attended Nipper's address with his son. William was concerned as he had not heard from his brother for several days, despite several attempts to contact him by phone. William was particularly concerned because Nipper had recently been diagnosed with prostate cancer and William knew that he was very depressed.

1.2. When they received no reply at the door, they forced entry to the property.

1.3. William and his son found Nipper dead, apparently having hung himself. They called for Barbara (67), Nipper's partner for 39 years, but received no reply. William rang the police and waited outside.

1.4. Paramedics arrived and pronounced Nipper's life extinct at 11.20 am. Paramedics found Barbara on her bed, and her life was pronounced extinct at 11.30.

1.5. Police attended shortly afterwards and a murder investigation was initiated immediately.

2. **Post mortem**. The post mortem recorded that Barbara died as a result of ligature compression of the neck. There was evidence of bruising to her head, arm and a rib fracture consistent with a struggle.

3. **Coroner.** The coroner concluded that Barbara had been unlawfully killed by Nipper who later committed suicide.

The review process

4. **The purpose of the review is to:**

4.1. 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.

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4.2. 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.

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

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

5. **Process**

5.1. The Safer Ealing Partnership were not notified of this case until October 2013 when the polie review team asked if the partnership had decided to hold a domestic homicide review. The DHR was launched on 8 October 2013 and there was an initial meeting on 13 December 2013 of all agencies that potentially had contact with Barbara or Nipper prior to their deaths.

5.2. The Safer Ealing Partnership had no formal process in place to initiate a DHR at the time of this incident. To ensure that reviews are initiated promptly the partnership reviewed its processes and agreed a process and timeframe for future DHRs. This is detailed in the main report.

5.3. Safer Ealing Partnership appointed Laura Croom, an Associate of Standing Together Against Domestic Violence to chair the review. Standing Together is an organisation dedicated to developing and delivering a coordinated response to domestic abuse through multi-agency partnerships. The Associate has no connection with Safer Ealing Partnership or any of the agencies involved in this case.

5.4. The GP practice was contacted many times over the course of the first four months of this review but did not fully engage during that time. The third panel meeting was re-scheduled to allow the practice more time to prepare their IMR. When they did eventually engage, they were conscientious and self-analytical.

5.5. We have anonymised the names of the perpetrator and victim in consultation with the families.

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6. Terms of Reference

6.1. The full terms of reference for this review are included in Annex 1 of the main report.

6.2. The time frame agreed was 1 January 2010 to 28 December 2012. In the course of the review it became clear that Barbara's mental health problems began many years before this and that Nipper had cared for her for many years. As a result, further information was requested and supplied by the West London Mental Health Trust (WLMHT) on Barbara's mental health problems before 1 January 2010.

7. Parallel reviews

7.1. **Mental Health Review (MH Review).** Following notification from the police of the death of Nipper, the West London Mental Health Trust (WLMHT) conducted a Grade 2 Homicide Incident Review as both Barbara and Nipper were both registered at the same general practice and were both treated there for mental health problems. Barbara was a former patient of WLMHT and Nipper had received about a week's contact with services at the end of November 2013. The review was completed in September 2013. It's findings and recommendations are noted within the main report. They found that there were no care delivery problems that affected the care provided to Nipper or Barbara. They found 2 areas of service delivery that could be improved but determined that they did not affect the care of Nipper but could affect the care of others and so made a recommendation on this point.

7.2. **NHS England.** The Panel discussed the potential for further independent investigation by NHS England in relation to the care and treatment of Nipper and proposed that, with the families' agreement, a recommendation be made that further investigation would not be likely to add learning to this tragic case. The families of Barbara and Nipper read a draft of this report and agree that a further investigation by NHS England is unlikely to add to the learning gained here**.**

8. Notable aspect of this domestic homicide review

8.1. In the course of this review, the Panel found no evidence of coercive control or abusive behaviour by either party during their long life together. The

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families report that they had been loving partners for many years. Indeed, Barbara's family were loath to be involved in the process as they were concerned that their participation might endorse the view that Nipper was abusive. We have noted the link between mental health problems and domestic abuse but, in light of the evidence, the focus of the review moved to the support that Nipper and Barbara had and were offered to address their mounting concerns over their increasingly debilitating mental health and Nipper's expressed anxiety about his ability to care for Barbara in light of his own deteriorating mental health. His despair and sense of responsibility for Barbara appear to have triggered his killing of her and then himself.

9. **Agencies participating in this review**

9.1. There were twelve agencies and two private health practitioners involved in the review. There were ten agencies on the Panel. Nine agencies responded as having had no contact with either the victim or the suspect.

9.2. The Panel was composed of senior managers from the following agencies:

9.2.1. Ealing Safer Communities

9.2.2. Ealing Council

9.2.3. Ealing Clinical Commissioning Group

9.2.4. NHS England, London Region

9.2.5. Housing for Women

9.2.6. Metropolitan Police Service

9.2.7. West London Mental Health Trust

9.2.8. Adult Social Care – the representative for WLMHT also represented Adult Services

9.2.9. Victim Support

9.2.10. Maggie's Cancer Care

9.3. Agencies and professional individuals having contact:

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9.3.1. GP surgery – provided primary care for both Barbara and Nipper

9.3.2. Maggie's Cancer Care – provided some support to Nipper and provided a session with a psychologist

9.3.3. WLMHT – assessed Nipper and had provided care for Barbara in the past

9.3.4. Imperial College Healthcare NHS Trust – diagnosed and were treating Nipper's prostate cancer; staff accompanied Nipper to the mental health centre

9.3.5. A private psychiatrist – recently began working with Barbara

9.3.6. A private psychotherapist – recently began working with Barbar

9.4. Agencies who had no contact

9.4.1. Ealing Council

9.4.2. London Probation Trust

9.4.3. Metropolitan Police Service

9.4.4. Housing for Women

9.4.5. Southall Black Sisters

9.4.6. Victim Support

9.4.7. Children's Services – the couple had no children

9.4.8. Hestia Housing

9.4.9. Priory Group

9.5. Pseudonyms have been used for the couple who are the subject of this domestic homicide review and for their family members. The names of professionals have been anonymised.

10. **Individual Management Reviews**

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10.1. Agencies were asked to give chronological accounts of their contact with the victim prior to his death. Where there was no involvement or insignificant involvement, agencies advised accordingly. Each agency's report covers:

10.1.1. A chronology of interaction with the victim and/or their family

10.1.2. What was done or agreed

10.1.3. Whether internal procedures were followed and

10.1.4. Conclusions and recommendations from the agency's point of view

11. **Contact with family**

11.1. Barbara's family had agreed that her sister's daughter would be the contact for the police Family Liaison Officer (FLO). The information about the DHR was sent to the niece. Barbara's niece then rang the Chair with information and Barbara's sister sent an email with some further information. They did not wish to be interviewed further at that time.

11.2. Nipper's brother and his wife were interviewed by the Chair and the CEO of Standing Together. They saw and approved a written summary of that interview.

11.3. The Chair met members of both families to allow them to read and comment on the Draft Report. Their views are included in the main report.

Summary of the case

12. Barbara and Nipper had been together for 39 years, having met in their twenties. Her family describe their relationship as loving and affectionate. A nephew who lived with them in the 1980s noted only their gentle affection for each other. They were both civil servants, but in 1989 they took a break from work and travelled around the world together.

13. On returning from this trip, Barbara had her first severe depressive episode and suffered depressive disorder with marked severity for many years. From 1990 to 1994 she received clinical care, then again from 1995 to 2000. In the middle of this period, in 1996, Barbara stopped working, through retirement or having been made redundant.

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14. A year later Nipper retired and devoted himself to looking after Barbara. He later told the Maggie's Cancer Care that Barbara was suicidal at this time. She continued on medications for her depression between bouts of severe depression, overseen by her GP.

15. After retirement, Nipper continued to stay active – he was the chair of the Allotment Association and part of a darts club. But Barbara's situation was variable, suffering depression again in 2003 to 2004 and a briefer spell in 2009. Throughout this time, Nipper looked after her.

16. Barbara's medications were reviewed and changed regularly as clinicians searched for a more effective prescription. Some of this time she was under the care of mental health professionals, but at other times, Nipper and Barbara appeared to struggle on alone.

17. Nipper too had sought help for depression in 1983. He had been depressed for a period in 1989. He reported being depressed too for the last five years as his mother grew ill and then died two and a half years before. He had not sought help for his current depression until the events outlined here.

18. Their families report a devoted couple that undertook many activities together but note that Nipper was Barbara's carer for a great deal of the time and that Barbara's engagement with the world outside their home had reduced dramatically over the years.

19. Nipper was diagnosed with prostate cancer on 24 October. This was locally advanced cancer, but he was given a good prognosis in that it had not spread as evidenced through bone and CT scans. Treatment options were discussed and hormone therapy was begun immediately to put the cancer into remission. Nipper's mood appears to have dropped following his diagnosis, despite the good prognosis and immediate medical response.

20. In the course of the following 2 months, Nipper and Barbara had 28 conversations, either in meetings or on the telephone, with health professionals. Nipper had 22 of these conversations. These conversations were with his urologist and other Imperial staff, with his GP and others at the practice, with Maggie's Cancer Care and with mental health staff to whom he had been referred.

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21. During his conversations, Nipper's deteriorating mental health and his worry about his ability to look after Barbara were constant themes. He spoke of suicide several times. Nipper's mental health was assessed and several times health professionals went out of their way to assist him in getting help for his depression.

22. On one particular day, probably in November, Nipper's brother was so alarmed by Nipper's state that he tried to find someone who could help him that day, but could find no one.

23. Barbara dated her recent mental health decline to the diagnosis of Nipper's prostate cancer. She started sessions with a private psychiatrist and the clinical psychotherapist that he recommended. At these sessions she said that she was worried about Nipper's mental health. She also told her sister this. But we have no other information about what Barbara might have wanted at this time.

Key issues arising from the review

24. Nipper's family could not find help for him when he was in crisis.

25. The health professionals involved with Barbara and Nipper addressed their medical needs but did not address Nipper's needs as a carer for Barbara.

26. Several of the health professionals involved with Nipper were very concerned about his mental state and went out of their way to get him more help. But their heightened concern was not reflected in the response that Nipper received from the next professional he spoke to.

27. The health professionals had different expectations of each other's role in situations like Nipper's where he did not meet the threshold for specialist support.

28. All the information known was not gathered and reviewed together to get a fuller picture of Barbara's and Nipper's situation. They did review the situation of the couple and treated each in isolation. The families would have liked to have been involved.

Conclusions and recommendations from the review

29. There was no pattern of coercive control identified by agencies working with Barbara and Nipper – indeed both Barbara and Nipper appeared and spoke as a

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loving couple. But Nipper's apparent desperation about his inability to cope with his own depression following his cancer diagnosis, and with Barbara's deteriorating mental health appear to have led to the decision to kill Barbara and then take his own life.

30. Nipper's role as a carer was not recognised and addressed, nor were the signs that the situation was escalating for him: the multiple presentations, the repeatedly expressed concern of health professionals, the co-morbidity of their problems, and the impact of these on Nipper's ability to care for Barbara. Their situation was not viewed holistically, but narrowly and medically.

31. Nipper's apparent decision that there was no future for them was tragic for him and deprived Barbara of the opportunity to try again to get on top of her depression and have that better life described by Nipper when he spoke to Maggie's.

32. We cannot know whether Nipper would have accepted practical help or whether Barbara's new mental health supports would have made a difference. But providing Nipper with help for his caring responsibilities may have made a difference.

33. **Recommendation 1: Ealing Borough Council, the Ealing Clinical Commissioning Group (Ealing CCG) and WLMHT review and improve the accessibility of emergency contacts for those needing urgent support for mental health problems and for their families and friends.**

34. **Recommendation 2: The Ealing CCG and WLMHT agree a clearer care pathway for those who present with mental health problems but who may not meet the threshold for secondary mental health services. This care pathway should be adequately resourced and worked through with local partners to ensure everyone understands their role and duty of care in this regard.** This would include information on the role of each agency, advice about referrals routes, address information sharing throughout the care pathway, and how and where to escalate concerns when needed.

35. **Recommendation 3: The Ealing CCG and Ealing Borough Council review provision for carers against the Triangle of Care and develop services to help identify and respond to carers of those with mental health problems, including carers' assessments.**

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36. **Recommendation 4: The South Central network of Ealing Clinical Commissioning Group to work with NHS England and the Local Medical Committee to review this case to improve integrated care planning for those with mental health problems.** This should be done at two levels: strategically, to understand how provision can be improved; and operationally with GP practices to learn from each other and ensure that each practice's systems reflect the learning here.

36.1. As part of this exercise, the operational session would look to strengthen the GP response to mental health concerns in the following ways:

36.1.1. documenting all in-house conversations and discussions about patients. *This has already been undertaken by the GP practice involved in this case.*

36.1.2. enquiring and recording more information about the social context of those with mental health problems to address risks posed by patients and carers as well as risks faced by them

36.1.3. reviewing this case internally and with others to identify triggers to bring in their mental health lead, or a practice-wide or multi-agency discussion of such cases, e.g. where the psychosocial situation is impacting negatively on a patient's health and the situation is escalating

37. **Recommendation 5: NHS England to provide guidance to GP surgeries on their engagement with domestic homicide reviews.** NHS England in the London Region has a working draft, *Principles and Process for the Management of DHRs*, in use now. A common approach across the whole of the NHS, drawing on this work, would greatly assist these processes.

38. **Recommendation 6: NHS England, during their next Appraisal and Revalidation of the GP practice involved here, reviews this practices' planned response to DHRs and the other changes that they have put in place as a result of this DHR.** This will provide reassurance and support for the practice as they respond to this review.

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