DOMESTIC HOMICIDE REVIEW

Safer Ealing Partnership

Case of Barbara

Restricted

Independent Chair Laura Croom, for Standing Together

August 2014

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Introduction

Details of incident

1.1 On 28 December 2012, William, the brother of Nipper (aged 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 William and his son+ 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 (aged 67), Nipper's partner for thirty-nine 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.

1.6 **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.

1.7 The cause of death for Nipper was provisionally recorded as death by hanging as there were no defensive or offensive injuries.

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

The review

1.9 These circumstances led to the commencement of this domestic homicide review (DHR) at the instigation of Ealing Community Safety Partnership on 8 October 2013. The initial meeting was held on 13 December 2013 to consider the circumstances leading up to these deaths.

1.10 The process for initiating a DHR was informal at the time and, as a result, this DHR was very slow to get started.

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1.11 This problem has been addressed. The Safer Ealing Partnership recognise the delay in approving this review. The partnership have reviewed their processes and have agreed that in the future they will delegate the decision-making function to the Chair to approve a review. This will significantly reduce the time it takes after we receive notification of a homicide to establishing a review process. Should circumstances require the Chair to consult with colleagues, this will be facilitated via e-mail for a decision within five working days.

1.12 The DHR was established under Section 9(3), Domestic Violence, Crime and Victims Act 2004 and was conducted in accordance with Home Office revised guidance.

1.13 The purpose of these reviews is to:

1.13.1 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.

1.13.2 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.

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

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

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

1.14 This review process does not take the place of the criminal or coroners courts nor does it take the form of a disciplinary process.

Terms of Reference

1.15 The full Terms of Reference are included in Appendix 1. The purpose of this review is to establish how well the agencies worked both independently and together and to examine what lessons can be learnt for the future.

1.16 The timeframe for this review 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

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information was requested from the West London Mental Health Trust (WLMHT) on Barbara's mental health problems.

1.17 Nipper referred to previous mental health problems in discussion with some professionals. As a result, further information was also requested from WLMHT and Maggie's Cancer Care on any mental health problems that pre-dated 1 January 2010 for Nipper.

1.18 In the course of this review, it became clear through both correspondence and conversations with family members that there were no apparent issues of coercive control between Barbara and Nipper apart from the final act, that they had been loving partners for many years. In these circumstances, 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 any longer in light of his own deteriorating mental health. Nipper's despair appears to have triggered his killing of Barbara and himself.

Parallel and related processes

1.19 **Mental Health Review (MH Review).** Following notification from the police of the death of Nipper, the West London Mental Health Trust (WLMHT) initially set up a panel to conduct a Grade 1 incident review on the understanding that Nipper had had no history of contact with mental health services, the justice system or a history of domestic violence. In the course of a 'desk top review' of the papers, it became apparent that Nipper and Barbara were registered at the same general practice and were both treated there for mental health problems. Having also found that Barbara was a former patient of the Trust and Nipper had received about a week's contact with services at the end of November 2012, a Grade 2 Homicide Incident Review was begun and completed in September 2013. A Grade 2 Incident Review is one that involves significant harm or loss. It is the highest grade review conducted within a trust. Its findings and recommendations are noted within this report.

1.20 **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, if the family agree, a recommendation be made that further investigation would not be likely to add learning to this tragic case. The families of Barbara and Nipper have read a draft of this report and are satisfied that it addresses any concerns they have and agree that a further investigation by NHS England is unlikely to add to the learning gained here.

Panel membership

1.21 Agencies and services represented:

- Ealing Safer Communities, Joyce Parker and Uzma Butt

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- Ealing Clinical Commissioning Groups, Nicky Brownjohn
- NHS England, London Region, Nicola Clark and Karen Sobey-Hudson
- Adult Social Care, Stephen Day
- Housing for Women – as domestic violence specialists, Hina Patel
- Metropolitan Police Service, Helen Flanagan
- West London Mental Health Trust (WLMHT), Jeremy Mulcaire
- Victim Support, Liz Gaffney and Aiman Elal
- Maggie's Cancer Care, Bernie Byrne

1.22 As Probation and Housing had no records of involvement with either Barbara or Nipper, they were not required to attend panel meetings with an understanding that they would re-engage if information came to light that was within their expertise to comment on. Victim Support searched their records and found no contacts but remained on the Panel. Ealing Regeneration and Housing found that they had had no contact with Barbara or Nipper and so were not required to attend the panel.

1.23 Housing for Women were invited as domestic violence specialists, though they had no prior knowledge of Barbara. Maggie's Cancer Care is an independent charity that had contact with the perpetrator and a passing acquaintance with Barbara. The time and professionalism of both organisations was greatly appreciated by the Chair.

1.24 The Panel thanks everyone who contributed their time, patience and cooperation.

Independence

1.25 Following Ealing Community Safety Partnership's decision on 8 October 2013 to undertake a Domestic Homicide Review into the death of Barbara, the Ealing CSP appointed Laura Croom, an Associate of Standing Together Against Domestic Violence as the independent chair. Standing Together is an organisation dedicated to developing and delivering a coordinated response to domestic abuse through multi-agency partnerships. Laura has conducted domestic abuse partnership reviews for the Home Office as part of the Standing Together team that created the Home Office guidance on DV partnerships, 'In Search of Excellence'. She undertook the Home Office accredited training for DHR Chairs and has worked in domestic abuse for over ten years. She has no connection with the Ealing Community Safety Partnership or the agencies involved in this review.

Methodology

1.26 The Panel sought to obtain all relevant information and contacted the agencies that had had contact with either Barbara or Nipper in the previous two years and requested Individual Management Reviews (IMRs) from them. When it became known that Barbara's

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mental health difficulties began several decades ago, further information was sought from the WLMHT.

1.27 IMRs were provided by:

- WLMHT (Claybrook Centre in Hammersmith and Fullham and the Ealing Assessment Team)
- The GP practice
- Imperial College Healthcare NHS Trust (Charing Cross Hospital is part of this trust)
- A private consultant psychiatrist for Barbara (including his letter to the coroner)
- Maggie's Cancer Care

1.28 The IMRs were undertaken by agency members not directly involved with the perpetrator, victim or family members and who did not have line responsibility for those who did, with the exception of Maggie's Cancer Care.

1.29 The facts of this case were reviewed by Maggie's Cancer Care's Consultant and Lead Psychologist for Scotland who is external to the local centre and advises the local Programme Director on psychological issues. The psychologist involved took it to her clinical supervision with the Lead Psychologist for England and Wales. The IMR for this DHR was drawn from these reviews of the case. Maggie's Cancer Care is a small organisation and the manager there noted that she had briefly met Nipper and Barbara and was line manager for some of the staff who spoke to Nipper.

1.30 The GP surgery that both Nipper and Barbara attended did not engage at first with this process and there were a number of conversations and email exchanges before the surgery understood their role in this exercise. The third meeting of the Panel was delayed by a month to allow more time for them to complete their reports. They then provided IMRs for both Barbara and Nipper, and attended Panel meetings to talk the Panel through them. Following that meeting, the partners of the GP practice provided further information for the Panel as they did not feel that the Panel understood the context of their work and the GPs' role.

1.31 WLMHT drew on their Grade 2 Incident review to provide an IMR for this DHR. As such, it provided information on the other health services as well as WLMHT. The IMR referred to information that was not provided to this review, but was useful in providing some early analysis of the interaction of the health services involved. Where it was material, further clarification was sought when the information did not match up. Where it was not material, the discrepancies are noted.

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1.32 Barbara's consultant psychiatrist referred her to a psychotherapist. The Chair spoke to the psychotherapist, who had had three sessions with Barbara, and found that those sessions contained nothing beyond the information provided by the IMRs that the Panel had already reviewed. She was therefore not asked to provide an IMR.

1.33 The police provided a letter detailing their involvement which consisted of responding to William's call to the murder scene and provided information that was disclosed as part of the homicide investigation.

1.34 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.

Contact with family and friends

1.35 The Family Liaison Officers (FLOs) for Barbara's and Nipper's families put the Chair in touch with their families. The Chair interviewed Nipper's brother (William) and his sister-in-law (Pat) who live in the South East.

1.36 Barbara's family live in Yorkshire and Lancashire. The Chair contacted the niece of Barbara, who had asked that she be the single point of contact for her family, via email with information about the process. She spoke to the Chair by phone and her mother, Barbara's sister, followed this with an email. They did not wish to be interviewed further and the niece said, 'We are looking forward to having the matter closed so that we can remember both of them peacefully and together as they should be.'

1.37 The families saw a draft of this report and their further views are incorporated here.

Equalities

1.38 Barbara and Nipper were in their sixties, heterosexual, and white. They had lived together for many years but had not married. Barbara had suffered with debilitating mental health problems for many years and Nipper had suffered periods of depression. Neither were active with a faith-based organization. The issues of pregnancy and gender reassignment were not relevant here. The Panel considered these characteristics (age, sex, race, married, disability, religion) and determined that there was no requirement for further action or additions to the Panel to address these characteristics.

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The Facts

Key facts and events

2.1 Barbara (d.o.b. 6.11.45) and Nipper (d.o.b. 6.7.50) were both retired civil servants. They had been partners for thirty-nine years and lived in Ealing. They had no children.

2.2 Barbara had suffered with depression for many years. The earliest period of depression documented for this review was a period of almost ten years beginning in 1990 with a brief respite in 1994. She continued on anti-depressants and had several further periods of severe depression. Nipper looked after her. He had suffered several bouts of depression in his life too, but in the months leading up to his death told the psychologist at Maggie's Cancer Care that he had been depressed for five years.

2.3 In October 2012, Nipper was diagnosed with prostate cancer. He was told that it was treatable and had begun treatment. Over the months between his diagnosis and his and Barbara's deaths, Nipper had many health appointments during which he said that he was finding home life increasingly difficult and he felt desperate.

2.4 Barbara had had two sessions with a new consultant psychiatrist in November and December 2012 and had had three sessions with a psychotherapist. She had booked further meetings with both in January 2013.

The deaths of Barbara and Nipper

2.5 On 28 December 2012, William, the brother of Nipper (aged 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.

2.6 When William and his son received no reply at the door, they forced entry to the property.

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

2.8 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.

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

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2.10 **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. Toxicology analysis revealed evidence that she had taken anti-depressant medication consistent with therapeutic use. It also revealed that she had possibly taken an anti-psychotic drug prior to her death.

2.11 The cause of death for Nipper was provisionally recorded as death by hanging as there were no defensive or offensive injuries.

2.12 **Coroner**. Following inquests into the deaths, the coroner reported on 17 September 2013 that Barbara had been unlawfully killed by Nipper, who later committed suicide. The verdict was given as unlawful killing and suicide.

Barbara – background

2.13 Barbara was 67 at the time of her death. She is described by Nipper's family as very bright, speaking six or seven languages, and working for the civil service until she had a breakdown. The information she provided to the consultant psychiatrist suggests this was in 1995 (she would have been 50) and she retired the following year.

2.14 Barbara's family describe her as a dynamic individual. She was widely-travelled, well-read and she and Nipper were film buffs, passing on their interests to her niece and nephew. She organised holidays for her family, was very active in the allotment and interested in organic gardening. She was significant in the lives of her niece and nephew, taking care in choosing appropriate books for them and, later, their children, and taking an active interest in their lives. Barbara's family were in touch regularly and shared holidays both here and abroad and visited each other's homes. Barbara's nephew lived with Barbara and Nipper for about eighteen months in the mid-eighties.

2.15 Barbara's family say that Barbara was practically disabled by her depression. They say that Nipper supported her for many years.

2.16 Both families reported that Barbara had had mental health problems for many years. William reported that towards the end her moods would be up and then down, that she had periods where she was well enough to go out and do things and at other times she would sit for long periods and do and say nothing. They say that Barbara's 'up' times came less and less. Towards the end, they report that she was very detached and would sit and watch television and interact very little with people around her.

2.17 Nipper's family understood that Barbara had support from mental health professionals over the years and had been prescribed drugs for many years for her depression.

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2.18 Barbara's sister spoke to her several times on the phone in the last week of her life. Barbara told her sister that Nipper was struggling, but her family did not know how difficult it had become for him. Being so far away, they were not aware of Nipper's desperation.

2.19 Barbara's family would have liked Barbara to have been asked about her own situation, to have a voice not just about her medical needs, but about her need for care and their situation as a couple. Having read this report in draft, they think these conversations about the care that Barbara and Nipper were receiving and providing might have been part of a carer's assessment. They would recommend that such an assessment should consider the engagement of the wider family; they would have liked to have been involved by health professionals working with the couple.

2.20 Barbara's niece said that they were not surprised to learn of their deaths – they expected that they would die together – though they were surprised at the way they died.

Nipper – background

2.21 Nipper was 62 at the time of his death. He was one of two sons and had been close to his mother who had died about several years before. He had been a civil servant until his retirement in about 1997.

2.22 Nipper is described by his family as gregarious. He and Barbara were keen gardeners and Nipper was Chairman of the Allotment Association. He was on a darts team and a cricket team. He and Barbara were lifelong supporters of Fulham Football Club.

2.23 Nipper's brother felt that Nipper compartmentalised his life – that he separated his home life from the rest of his life and that he was active outside the home as it gave him some relief from his caring responsibilities for Barbara in the later years.

2.24 William and Pat report that Nipper had been very close to their mother. They think that Nipper confided in his mother and that this may have helped him cope.

2.25 William and Pat say that Nipper was very upset when he found that he had prostate cancer. He was so depressed that on a particular day – probably in late November – his brother feared for him, and he and his family tried to track down someone who could come and assess Nipper as they felt he needed immediate psychiatric help.

2.26 The family say that the only help they could find – they think it was on a Sunday – was Maggie's Cancer Care. Someone there spoke to them at length. They advised that Nipper come talk to them. He had already been to the cancer charity, but their confidentiality policy prevented them from sharing this with William. On reading this report, William said he would have liked to have known that Nipper had been talking to someone. As it was, he

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continued to ring and finally stopped as he felt he was becoming a nuisance. But his worry remained.

2.27 Contrary to what they expected, William and Pat said that Nipper was very low when he was told that his cancer was treatable. Nipper told them that he ‘couldn’t go on like this.’ He said that he had spoken to the Samaritans and had felt suicidal.

2.28 Barbara’s family say that they knew that Nipper was very frightened of cancer and that news he had ‘advanced cancer’ might overwhelm him.

Barbara and Nipper’s relationship

2.29 The information from the two families differs on several issues: how long Barbara had been ill, whether their retirement(s) were planned or were in response to Barbara’s depressive illness, and when they went on their long around-the-world trip. However, they agree that Barbara had been ill for many years, that Nipper was her carer and that it was after a long trip abroad that Barbara suffered a serious breakdown.

2.30 Information from Barbara’s family

2.30.1 Barbara’s family described Barbara’s & Nipper’s relationship as loving and affectionate. Her sister says that their son stayed with the couple in the 1980s and that he was always aware of their gentle affection for each other. They had many shared interests and spent most of their free time together.

2.30.2 Barbara’s family understood that Barbara’s and Nipper’s retirements had been planned rather than being the result of Barbara’s depression. They understood that Barbara and Nipper had decided to retire around the same time.

2.30.3 Barbara’s family say that Nipper and Barbara loved travelling and were specialists in travelling light.

2.30.4 Nipper was close to his mother and the two of them supported her and took her out when they could.

2.30.5 Barbara’s family say that Nipper was always ‘most solicitous and supportive’ of Barbara during her years of illness and that he was protective of her. After their deaths, they found notes he’d left for her saying, for example, that he’d gone to the shops and that he loved her.

2.30.6 The family understood that Nipper was assessed as not being a suicide risk because, though he’d considered suicide, he would not leave Barbara.

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2.30.7 Barbara's sister says, though, that she understood that Barbara and Nipper had agreed not to leave the other, even in death.

2.30.8 Barbara's family feel strongly that 'domestic abuse' does not describe this relationship, and indeed had not wanted to be involved with this process because of this. Her niece said that if anyone were a victim, it was Nipper as he supported and cared for Barbara over quite a long period of time.

2.30.9 Barbara's niece said that Nipper taking Barbara with him was a 'last loving gesture', and Barbara's sister said that Barbara was not so much a victim of domestic violence 'but rather a sharer of (Nipper's) suicide'.

2.31 Information from Nipper's family

2.31.1 Barbara and Nipper met and became a couple in their twenties. They took leave of their jobs and went backpacking around the world. William and Pat think this was in the early to mid 1970s. William and Pat characterised Barbara's and Nipper's relationship as very happy in their early years together.

2.31.2 In the later years, as Barbara's mental health deteriorated, they did less and less. William and Pat thought that Barbara's mental health difficulties began fifteen to twenty years before their deaths.

2.31.3 Nipper arranged a number of holidays for the two of them but when the day came, Barbara would not go.

2.31.4 Barbara retired in 1996 at the age of 51 and Nipper retired a year later to look after her.[1]

2.31.5 Nipper and Barbara went to a café near their house every day for coffee but the café owners told William and Pat that Barbara did not speak when they were there.

2.31.6 After their deaths, William and Pat found an occasional diary that Nipper kept. There were a few entries, undated. One said that it had taken two and a half hours to get Barbara out of bed and then listed the drugs that Barbara was taking. The diary describes having to coax Barbara to have a shower and to get her to leave the house.

2.31.7 Towards the end of their lives, Nipper and Barbara did not talk, but they would sit on the sofa and hug each other.

[1] According to the WLMHT IMR.

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2.31.8 William reported that when he went to his brother's house in response to the phone call that prompted them to seek emergency psychiatric help, Nipper was very upset and was sobbing. William says that Barbara stayed in the same room, not far from them, watching television and did not appear to acknowledge Nipper's distress.

2.31.9 William and Pat said that they understood that friends had brought food for Nipper and Barbara from time to time. William said that there was no food in the house when they died.

2.31.10 William did not think that Barbara had ever acknowledged that Nipper had cancer.

2.31.11 William and Pat thought that Nipper had reached a point where he could not go on and that, perhaps, he thought that the cancer was his way out. When he was told his cancer was treatable, he may have seen no way out of their present situation and therefore decided that he had to end it.

2.31.12 There was a joint wake for the couple. William talked to many people and found that Nipper and Barbara had not invited friends to their house. Many of Nipper's friends told them at the wake that they did not know Barbara well.

2.31.13 William said that, given the circumstances of Barbara's death, he was surprised that when they spoke to Barbara's family, there was 'no edge' to the conversation. Her family told him that they had known and loved Nipper for years.

2.31.14 On the day that William and his son went to the house and found that Nipper had hanged himself, they left the house to wait outside for the police and emergency services. A neighbour asked what had happened and when she was told that Nipper was dead, said that Barbara would be dead too as Nipper would not go without her. William and Pat feel that that observation captures the truth of the events and their relationship.

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West London Mental Health Trust – Barbara

2.32 Barbara presented to psychiatric services in 1990 at the age of 46 with her first major depressive episode. This occurred after a return to work following a year's sabbatical where she had journeyed abroad with Nipper.

2.33 Barbara was diagnosed with dysthymia[2] and recurrent depressive episodes. The symptoms recorded with some periods of relative remission were of anxiety, depression,

[2] Oxford Reference Dictionary: a mild but chronic depressive mood state, not severe enough to lead to a diagnosis of depression or dysthymic disorder.

lack of motivation and a pervasive sense of disappointment in herself and what she had not done with her life.

2.34 Over the following decade there appeared to be a resistant pattern of depression. A wide range of anti-depressants was prescribed over time. In 1997, a trial of Lithium was begun and ended in 1999 as Barbara did not feel that it had really helped her significantly. She was also diagnosed as being mildly hypothyroid and was started on thyroxin replacement therapy.

2.35 Barbara reported severe anxiety and mild depressive symptoms, some panic attacks and had low mood and low self-esteem. Throughout these years, Barbara's partner's support is noted as is his role in instigating activities with her.

2.36 A clinic letter during this time noted Barbara 'being better particularly when away from home'.

2.37 Barbara's notes say that she took early retirement in 1996.

2.38 On occasion Nipper attended the mental health clinic with Barbara. At the time of his planned retirement in 1997, Barbara was concerned that the true level of her mental disability might be more apparent to him. She had tried to protect the relationship and mask the depth of her experienced disorder.

2.39 In 2000, Barbara appeared to have made a recovery and all medication was stopped and she was discharged from psychiatric outpatients.

2.40 In September 2003, at the age of 57, Barbara was referred back with a further episode of depression. Again, a variety of medications were tried.

2.41 Barbara was referred for psychodynamic psychotherapy on 6 September 2004. When advised that she would have to wait six to nine months to be seen, she chose to find a private psychotherapist whom she started to see in November 2004.

2.42 In December 2004, Barbara reported feeling 'pretty terrible' with on-going problems with social anxiety and her feelings of dependence on her partner.

2.43 Barbara was experiencing a degree of low mood and anxiety but continued to function with the help of her partner. Barbara was socialising at times and was involved in various activities that her partner initiated.

2.44 During this time Barbara tried cognitive behavioural therapy (CBT) to challenge her negative thoughts but gave it up after a year as she did not feel it helped. She then had twelve sessions of counselling but felt that she did not benefit from that either. Despite

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this, she contacted services for further counselling. She reported feeling worthless but denied any intent to harm or kill herself or others.

2.45 She was on anti-depressants for a long time but they had limited effect. She spoke of suicidal thoughts, but did not ever act on these and denied any intention to do so.

2.46 In March 2009, Barbara was reviewed at the Lammas Centre, a mental health outpatient surgery, and noted that she was still feeling low, but went out with her partner daily. She had no thoughts of self-harm and viewed Nipper as a protective factor.

2.47 Barbara last attended the Lammas Centre on in the summer of 2009. She reported at this session that she was eating and sleeping well, but she had stopped yoga and voluntary work. She had occasional social activities with friends and her husband (sic) and was doing the cooking and housework. She attended the Ealing Abbey Counselling Service on a weekly basis and reported being happy with her current medication.

2.48 She denied suicidal ideation, intent or plan to harm or kill herself or others. She had no history of deliberate self-harm, suicidal attempt or violent behaviour.

2.49 Her care plan on discharge was

2.49.1 to continue with her medications,

2.49.2 continue her daily living activities, social integration and weekly sessions at Ealing Abbey Counselling Services

2.49.3 discharge back to the care of her GP as she did not require further input from the service.

2.50 It is not noted when she stopped attending the counselling services. Throughout Barbara's care for her mental health problems, she did not disclose any domestic abuse though it is not noted whether she was asked.

West London Mental Health Trust – Nipper

2.51 At the time of Nipper's use of the Trust's community services, they were organised on a service-type/borough basis. This meant that for each of the three boroughs the Trust covered (Ealing, Hammersmith & Fulham, and Hounslow) there were a number of community based services:

2.51.1 An assessment team – the point of entry to services providing support for new patients and people who need short-term care in addition to that provided by general practice. The assessment team for Hammersmith and Fulham also provides a walk-in service – here it is the Claybrook Centre which is mentioned

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below. This allows people to go directly to the service without an appointment and for those referred by a GP to have an emergency assessment. It also cares for people who are referred from the A&E Department, either during normal working hours or out of hours

2.51.2 Recovery teams, which support patients with more complex needs and in the longer term

2.51.3 An assertive outreach team, which supports patients who have a severe mental illness

2.51.4 An Improving Access to Psychological Therapies Service (IAPTS) which provides treatment and support for people who have common mental health problems like depression and anxiety

2.51.5 A crisis and home treatment team which cares for people at home so that they do not have to be admitted to hospital

2.51.6 A team which cares for people who are experiencing a serious mental illness for the first time

2.51.7 A psychiatry liaison team, which works with local emergency departments to care for people who go to there and need the support of specialist mental health services.

2.52 The Trust introduced this way of organising services in April 2012 after several months' planning. It is keeping the arrangements under review so that it can be sure it provides the most effective and efficient service possible.

2.53 20 November 2012: Nipper was escorted to the Claybrook Centre by the research nurse from Charing Cross Hospital. He completed a client form where in answer to the question 'Briefly explain your current problem/crisis', he wrote 'Live at home with partner who suffers from depression . . . Home life is now desperate. Am having to cope with my depression and hers. Finding it very difficult. Having suicidal thoughts.'

2.54 Nipper was seen by a mental health nurse and a social worker who was an approved mental health practitioner. The mental health nurse spoke with the duty doctor before completing the assessment. The doctor noted that Nipper was seeing his GP the next day and that any change [in medication] should be for the GP to decide on. They recorded their assessment and plan for Nipper's care and referred Nipper to the Ealing assessment team for follow-up care. They gave him information about who to contact in an emergency and sent a letter to Nipper's GP for his appointment the next day.

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2.55 After the deaths, both practitioners reported that nothing in their assessment of Nipper gave any indication that such a thing might happen.

2.56 21 November 2012: The Ealing assessment team picked up Nipper's referral and the duty team discussed it. They decided to contact Nipper's GP to find out about the consultation he was due to have that day, if the GP planned or had undertaken any interventions regarding his mental health issues, and then decide what to do next.

2.57 22 November 2012: A member of the Ealing assessment team spoke to Nipper's GP. GP reported that Nipper was being treated for depression, appeared stable mentally and would be followed up a week later.

2.58 The team member then spoke to Nipper. He reported feeling low because of Barbara's mental health, but felt calmer than previously. He said he did not feel suicidal. They arranged an appointment for 26 November 2012.

2.59 The usual practice would have been to send Nipper a routine appointment with a member of the assessment team. The assessment team manager said that at the time patients were waiting for up to three weeks for this sort of assessment. As the Hammersmith and Fulham team (Claybrook Centre) had referred Nipper, they thought they should see him with the least delay in order to assess whether he needed longer term care. (At the time of writing this report, the waiting time has been reduced to two weeks through the transfer of longer-term work to the Recovery Teams.)

2.60 26 November 2012: Nipper saw a mental health nurse at the Ealing assessment centre. The nurse did not see the form that Nipper had filled out on the 20th and she was allocated the case that morning. Nipper told the nurse about the situation at home and that Barbara was sometimes very unwell but better at other times.

2.61 They discussed the implications of his cancer diagnosis, and the nurse noted that Nipper said that he and Barbara had agreed not to act on any thoughts of suicide. Nipper said that he was not brave enough to harm himself. They discussed the support Nipper had from his GP and, potentially, from Maggie's Cancer Care.

2.62 If, at this meeting, the mental health nurse had assessed that Nipper needed longer-term care, an appointment would have been made for Nipper to be assessed further by a multi-disciplinary team.

2.63 The mental health nurse did not think this was needed and discharged Nipper to the care of his GP. She gave him information about the walk-in service and out of hours contact numbers in case he needed them. This decision was discussed at the end of the day with the duty team (composed of community mental health nurses, social workers and duty

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team leader) and they agreed with her assessment and decision to discharge Nipper to the care of his GP.

2.64 The assessment team manager acknowledged to the Mental Health Review Panel that the mental health nurse had not had much time to prepare for the meeting with Nipper, but she said that the nurse was experienced enough to make good use of the information available or to make further enquiries if necessary.

2.65 The Panel were told that questions about domestic violence are asked routinely by staff for the WLMHT, but this was not noted in the evidence provided.

2.66 There is no record of a carer's assessment being suggested for either Barbara or Nipper.

2.67 The MH Review noted that the records showed that the communications between the practice, the mental health trust, Charing Cross Hospital and Maggie's Cancer Care were received promptly and acted upon by GPs or practice staff. The Panel noted two occasions when care had been taken to coordinate health care:

2.67.1 The Hammersmith and Fulham Teams and the Ealing Assessment Teams exchanged information with the GP practice quickly so that consultations at Ealing and the practice were based on the most recent information

2.67.2 The clinical psychologist at the cancer charity checked to be sure that the record of her discussion with Nipper reached the practice the next day, when he was due to visit again.

Charing Cross Hospital – part of the Imperial College Healthcare NHS Trust

2.68 28 August 2012: Nipper was referred from the GP practice for urgent investigation of a raised PSA level and suspected cancer and was treated appropriately according to the Rapid PSA pathway.

2.69 28 September 2012: Biopsy performed after a delay due to Nipper having a urinary tract infection.

2.70 Nipper attended A&E as he had collapsed following the biopsy. He was seen by a doctor who 'had the impression it was a vasovagal attack[3]'. Basic health checks were done and the doctor provided reassurance and discharged Nipper.

[3] From NHS website: An external trigger, such as an unpleasant sight, heat or sudden pain, can temporarily cause the autonomic nervous system to stop working properly, resulting in a fall in blood pressure and fainting. It may also cause your heartbeat to slow down or pause for a few seconds, causing a temporary interruption to the brain's blood supply (vasovagal syncope).

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2.71 24 October 2012: Nipper was diagnosed with high grade non-metastic (that is, it had not spread) prostate cancer. Treatment options were then explained to Nipper: initially, Nipper was to have hormone therapy with the aim of putting his cancer into remission, and then radical radiotherapy as the hormone therapy's effect would not last – the mean time of response being a little less than two years. It was highlighted that the hormone therapy would need to begin as soon as possible. Hormone therapy was commenced which is standard treatment for this type of diagnosis. Nipper was informed that he would be eligible for a research trial and was provided with information about this by the research nurse. The details of the trial were not discussed at this time.

2.72 Nipper was 'greatly shocked' by the diagnosis and the doctor explained that with treatment it was hoped that Nipper would go into remission.

2.73 On 12 November, the hospital sent a letter to the GP about the appointment on 24 October, stating the diagnosis and prognosis, Nipper's response, and the trial suggested to him.

2.74 On 14 November 2012, Nipper was reviewed and expressed feelings of depression to the doctor. He was counselled about depression as a result of diagnosis, possible medication and treatment options.

2.75 20 November 2012: Nipper was again reviewed at Charing Cross Hospital.

2.76 Nipper was reviewed by the research nurse for a discussion of a trial and he consented to be part of the trial. He expressed suicidal feelings to the research nurse.

2.77 As a result, Nipper was immediately referred to the Claybrook Centre, a walk-in mental health assessment unit, at Charing Cross Hospital and was accompanied there by the research nurse for review that same day. The consultant urologist noted the need for specialist mental health care support in Nipper's case notes.

2.78 The consultant urologist noted to the Mental Health Review Panel that only very rarely did the oncology team's patients need this sort of care. He noted in the case notes that Nipper had an appointment with his GP the next day and gave him a note for his GP asking the practice to change Nipper's medication for cancer, asking them to prescribe a particular drug (a luteinising hormone-releasing hormone agonist). He did not mention the mental health concerns he and his staff had.

2.79 This medication, the standard treatment for prostate cancer, had a side-effect of depression. The consultant said that he always discusses this with patients and the fact that a patient might already be suffering from, and treated for, depression forms part of the discussion. A holistic assessment, including past medical history is taken when reviewing

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treatment options. However, with locally advanced disease, as was the case with Nipper, the priority is commencement of treatment and the patient's mood is monitored. When asked further about this in the course of this review, the consultant reported that, due to the time that has passed, he is unable to recall further specifics about this discussion with Nipper.

2.80 21 November 2012: the urologist sent a letter to Nipper's GP explaining the trial that Nipper is embarking on, his prognosis and the benefits of various treatments. It also notes that Nipper is feeling depressed but suggests that once the anti-androgen therapy starts to take effect, he may improve and feel better. He does not mention that Nipper was suicidal or that he was accompanied to the Claybrook Centre for assessment.

The GP practice

2.81 There were no flags against the files of Nipper or Barbara, but the practice knew that Nipper had been looking after Barbara for a number of years and this had been discussed among the GPs. (The GP practice follows common procedure of flagging files where there is a risk.)

GP practice – Barbara

2.82 Barbara registered at the GP practice on 19 October 1999. She had a long history of anxiety disorder, with a diagnosis of recurrent depressive disorder noted from 1990.

2.83 It is documented that she was supported at home by her partner.

2.84 Barbara came to the surgery regularly for reviews of her medications.

2.85 17 November 2012. Correspondence was received from the private consultant psychiatrist requesting prescriptions for Barbara. (This date does not match the psychiatrist's record that he saw Barbara on 19 November.)

2.86 20 November 2012. There was nothing irregular in her notes until she telephoned the surgery for an urgent appointment on this date. She said she'd seen a private psychiatrist and he had recommended a change of medication.

2.87 Barbara told the GP that she was feeling suicidal, the worst she had ever felt. She was given an urgent appointment. She told the doctor that her partner had been diagnosed with cancer and was also depressed. She said she had not made any plans to act on her suicidal feelings.

2.88 18 December 2012. Barbara saw a GP and said that she was finding it difficult at home. She was trying to support her partner who had recently been diagnosed with cancer and

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was depressed himself. She was not suicidal and said that she had found her partner supportive during previous spells of low mood. She said she spoke to her sister on the phone but had no local support. She was asked to return in a month for a review, but encouraged to make an earlier appointment if she felt she needed one. There is no record at the practice of any further contact with Barbara.

2.89 The GPs said that Barbara did not disclose domestic violence in any discussion and they did not suspect that Barbara was subject to domestic violence. There is no note that she was asked.

2.90 The GPs do not think that Barbara was a 'vulnerable adult', that is in need of community care services by reasons of mental or other disability, age or illness; and who is or may be unable to take care of himself or herself, or unable to protect him or herself against significant harm or exploitation.

The GP practice – Nipper

2.91 Nipper registered with the GP practice on 17 February 2000. His GP records note a brief treatment for depression before that in 1983. His usual GP was Dr A.

2.92 20 August 2012: Nipper attended with complaints that led to urine and blood tests.

2.93 28 August 2012: An urgent referral was sent by the GP practice to the Charing Cross Hospital for suspected cancer.

2.94 20 September 2012: Nipper visited the GP surgery as he was not sleeping well and was prescribed sleeping pills by a GP at the practice who had spoken to him previously about his sleeping problems.

2.95 17 October 2012: Nipper was diagnosed with anxiety and depression. He told Dr A that he was usually quite optimistic but had become more negative lately.

2.96 24 October 2012: Nipper was diagnosed with prostate cancer on 24 October 2012.

2.97 30 October 2012: Nipper told Dr A that he wakes in the morning and suddenly his mood drops and he feels anxious. He said he was 'up and down' and was considering entering a clinical trial. He was on medication for his cancer and for his mental health. His GP noted that 'it all sounds pretty optimistic'. He had difficulties with his mental health medication and telephoned the surgery for advice.

2.98 On 14 November he spoke on the telephone to a doctor and said he had no suicidal ideation.

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2.99 16 November 2012: Two days after previous phone call, Nipper saw Dr B at the practice and said that he had worsening anxiety and panic and wanted to stab himself, feeling much worse in the evenings. He stated at the consultation that his partner worried and that evenings are the worst time for anxiety. The GP discussed his ‘good and bad days’ and provided advice about sleeping tablets.

2.100 20 November 2012: the GP practice received a fax from WLMHT saying that Nipper’s life at home with his partner, who suffers from depression, is desperate. Nipper said that having to cope with his depression and hers was difficult and he was having suicidal thoughts.

2.101 The letter that followed this (received on 26 November) gave more information to the practice about the source of Nipper’s depression. It states that he was experiencing a deterioration of his social situation and his partner of thirty-nine years had had severe personality changes over the years and now had become socially withdrawn and isolated.

2.102 21 November 2012: Dr. B saw Nipper and noted the trigger for his stress was his partner’s deteriorating mental health problems. Dr B discussed his sleeping problems and medication with him. The notes document a plan to review him in one week and wean him off diazepam in two weeks.

2.103 27 November 2012: Nipper saw Dr A at the GP practice and discussed recent appointments with counsellors.

2.104 14 December 2012: Nipper saw Dr A and discussed his visit to Maggie’s Cancer Care. The GP had not seen the letter from the charity before the appointment but continued the consultation on the telephone that evening after she had read the letter. Nipper said that his depression stretched back about five years and suicidal ideation was explored.

2.105 21 December 2012: Nipper’s last meeting with his GP. Nipper said he was beginning to feel better and he even laughed which was unusual. He looked better and told the GP that he was being upset by the mess in his home. The GP asked another GP to add Nipper to her call list for 27th December to check that he was still happy with his antidepressant medication.

2.106 Dr A went on holiday for a few weeks and briefed two of the other GPs, Dr B and Dr C about Nipper’s situation. Nipper saw two GPs at the practice and had a telephone call with another.

2.107 27 December 2012: A GP rang Nipper to follow up his meeting on 21 December but there was no answer. The couple were found dead the day after this.

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2.108 The GPs do not think that Nipper was a ‘vulnerable adult’, that is in need of community care services by reasons of mental or other disability, age or illness; and who is or may be unable to take care of himself or herself, or unable to protect him or herself against significant harm or exploitation.

2.109 There appears to have been no assessment of how his mental health needs might be affecting his ability to care for Barbara.

Maggie’s Cancer Care

2.110 Some dates are approximate in this narrative as Maggie’s is a drop-in centre and does not hold cases, per se. Nipper’s meeting with the psychologist is documented.

2.111 Around 19 November 2012: Nipper came to Maggie’s following the recommendation of his oncology medical team. He was seen by the Deputy Centre head and a Cancer Support Specialist[4] who spent a long time talking to Nipper.

2.112 They explored his recent diagnosis and its impact on his increasingly low mood. Nipper said that it had no impact as he had been given a good prognosis. He said that his main concern was Barbara and her long history of depression. He described a home environment where there was very little communication. He reported that Barbara had been discharged from local mental health support as ‘there was nothing more they could do’. They were awaiting an appointment with a private psychiatrist.

2.113 They suggested that it might be useful for him to speak to the psychologist who was based there. He felt talking did not really help but said he would consider it. He was referred to the charity’s psychologist and consented to the psychologist contacting him. He was also offered the support of a stress management programme.

2.114 Later that week Nipper returned to the charity with a woman who was later identified as Barbara. Staff observed that Barbara had a very ‘flat affect’. Nipper told staff he was showing his partner around.

2.115 A few days later the brother of Nipper (later identified as such as the accounts provided suggested this) phoned the charity looking for support for his brother.

2.116 The Cancer Support Specialist followed this contact with a telephone call to Nipper and encouraged him to take up the offer to see the charity’s psychologist. Nipper told the Cancer Support Specialist that he had been referred to the Claybrook Centre. He said that

[4] From the charity’s website: Our Cancer Support Specialists are experienced professionals who offer high quality individual and group support to the people who visit our Centres. Through their initial conversations and ongoing support with each visitor they introduce people to the different types of support available, and help them to decide what they would like to get out of the cancer charity

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the charity's psychologist could contact him, though he said that talking about his situation made him feel worse.

2.117 In early December, the charity psychologist rang Nipper and made an appointment with him for 13 December 2012. Nipper confirmed that he had crisis contact numbers and could keep himself safe.

2.118 13 December 2012: In the course of this assessment, Nipper said that he had thought about suicide and this was happening more frequently but he had no plans to act on these thoughts, the protective factor being his partner. He felt he was able to keep himself safe.

2.119 Nipper said that he had been discharged by the Ealing mental health team and that no further support had been offered. He described feeling 'low' and 'awful' and that he lived an 'empty existence' with 'no purpose' and a 'bleak future'. He admitted to having suicidal thoughts that had been coming and going for six weeks. He talked about how he might kill himself though said he had made no attempt to act on these thoughts. He said he would feel guilty leaving Barbara.

2.120 He was asked if he had tried to commit suicide in the past and he said he had not.

2.121 Nipper said that his first episode of depression was twenty-three years before. He described a history of depression for the previous five years linked to difficulties coping with his mother's ill health leading to her death two and a half years before, and his partner's significant mental health difficulties.

2.122 When exploring the relationship between his cancer diagnosis and his worsening depression, Nipper said that the diagnosis was not the trigger for his depression and attributed it instead to the withdrawal of mental health support for his partner and her worsening mental state.

2.123 Nipper described his hopes for the future being that Barbara would get better and for them to be happy and walk together, travel and spend weekends away seeing family.

2.124 Nipper did not disclose any information that raised concerns about domestic abuse. Nipper said that he and Barbara loved each other but they were 'feeding off each other's depression'. He said they had stopped talking but would lie on the sofa cuddling for hours.

2.125 Nipper said that Barbara's depression had been precipitated by being made redundant in 1997[5] and that she was suicidal at that time. He said that she had been under the care of

[5] Different sources record different information. Some say that Barbara retired, here Nipper states that she was made redundant. Some sources record Barbara's retirement in 1996 and others in 1997.

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mental health services for many years but, again, said that there was nothing more they could do. He said that she'd recently started seeing a private psychiatrist.

2.126 Nipper reported that he and Barbara used to go walking. He used to go to his allotment, but now they had both withdrawn from friendships and social contacts. Nipper said that Barbara had become more withdrawn following their perceived withdrawal of support services.

2.127 As per NICE guidelines, an assessment was made, safety factors explored and his GP notified by fax on the same day, followed by a phone call to check that the assessment had been received and would be given to the GP immediately as the psychologist knew that Nipper had a meeting with his GP the next day, 14 December 2012. Nipper's GP was not available to speak to directly.

2.128 The charity psychologist recommended a re-referral to the mental health team or local IAPT as Nipper's concerns were not related to the cancer diagnosis but ongoing mental health. Nipper was encouraged to return and participate in aspects of the charity's programme that he might find beneficial. He was encouraged to bring Barbara.

2.129 The charity has a suicide policy that they report was followed in this situation.

Private Psychiatrist for Barbara

2.130 Barbara self-referred to this consultant psychiatrist.

2.131 19 November 2012: Barbara's first appointment. She said that she had first been depressed around 1990, after she had returned from a year's travelling. Her local mental health services started her on the antidepressant paroxetine, which she took for about two years and also undertook some anxiety management.

2.132 Barbara said that she became depressed again around 1995, following difficulties at work and went on to another antidepressant and was off sick from work for some time. She said she did not improve and retired from work in March 1996. Retrospectively, she thought she recovered from this depressive episode in about 1998.

2.133 In 2003, Barbara got depressed again with no particular triggers. She was seen by a local NHS psychiatrist and started on another antidepressant and a tranquilliser. She continued on both of these.

2.134 Barbara said that this treatment had been successful and she had been well until about October 2012. She said that Nipper had been diagnosed with prostate cancer and, since then, she had become much more morose with 'very low dark moods'.

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2.135 The consultant psychiatrist said that she did not present as significantly distressed, but described feelings of sadness, pessimism, failure, anhedonia[6], guilt, tearfulness, agitation, loss of interest and low energy levels. She said that she had some suicidal ideation, but was quite clear that she did not want to kill herself.

2.136 Using the Beck Depression Inventory, a self-report questionnaire on depression, the consultant diagnosed depressive illness.

2.137 The consultant psychiatrist advised her to stay on the antidepressant and add another one, steadily increasing the dosage. He advised her to stop taking the tranquilizer.

2.138 He also advised her to see a psychotherapist and recommended one to her.

2.139 The psychiatrist sent a letter to GP with requests for medications. (The GP reports that the letter they received was dated 18 November, but appears to refer to an appointment on 17 November with the psychiatrist. This difference in dates is not material to this review.)

2.140 17 December 2012: the psychiatrist reviewed Barbara again. She felt that her mood had improved slightly. She did not describe any suicidal ideation. She said the main stressor was her partner who, in addition to his physical problems, was depressed as well. The psychiatrist recommended a consultant psychiatrist at the Priory for Nipper and gave Barbara a number of names. The consultant has since learned that Nipper did not contact any of the psychiatrists at the Priory.

2.141 The psychiatrist advised an increase in the dose of one of the antidepressants and they agreed that she should stay on a low dose of the tranquilliser as she said she had become very agitated when she tried to stop it altogether.

2.142 Barbara said that she had had three sessions with the psychotherapist and had found them very helpful.

2.143 Another session with the psychiatrist was booked for Barbara on 14 January.

Psychotherapist

2.144 The Chair spoke briefly with the psychotherapist that Barbara saw. They had had three sessions in the month before Barbara's death. The psychotherapist reported that Barbara did not mention anything that made her think that Barbara was either a victim or perpetrator of domestic abuse. The psychotherapist said she had not asked the question directly. Barbara had booked another session in January.

[6] Defined in Collins English Dictionary: the inability to feel or experience pleasure.

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Analysis

Barbara's and Nipper's relationship and their mental health issues

3.1 Barbara and Nipper had been together for thirty-nine 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 affection for each other. They were both civil servants, but in 1989 they took a break from work and travelled around the world together.

3.2 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.

3.3 A year later Nipper retired to look after her. He later told Maggie's that Barbara was suicidal at this time. She continued on medications for her depression between bouts of severe depression, overseen by her GP.

3.4 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 Barbara.

3.5 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.

3.6 Nipper too had sought help for depression in 1983. He told the psychiatrist at the cancer charity that he had been depressed for a period in 1989 and for the last five years as his mother grew ill and then died two and a half years before. His brother noted that Nipper was close to his mother and that she may have provided important support for Nipper as he struggled to support Barbara. He had not sought help for his current depression until the events outlined here.

3.7 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.

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3.8 Then Nipper was diagnosed with prostate cancer on 24 October 2012. 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. The possibility of clinical trials was discussed with him.

3.9 Barbara dated the beginning of her last severe depression to Nipper's diagnosis of cancer. Nipper's mood appears to have dropped following his diagnosis, despite the good prognosis and immediate medical response.

Mental health and domestic abuse

3.10 This is a domestic homicide review and therefore the links between mental health and domestic violence are noted. The mental health effects from domestic violence have been extensively documented in the literature: for example, anxiety, depression, post-traumatic stress disorder (PTSD), low self-esteem and suicidal ideation.[7] Apart from the PTSD, all of these symptoms were reported by Barbara and some by Nipper. None of the health professionals involved with this couple noted asking either one of them questions to elicit information about any current abuse or historic abuse.

3.11 'Between 50% and 60% of women mental health service users have experienced domestic violence, and up to 20% will be experiencing current abuse.'[8] Though the Ealing assessment team report that asking this question is part of their assessment, it was not noted. The other professionals said that they did not ask but noted that there were no indicators. The NICE Guidance[9] that was published in February 2014, recommends that trained staff in mental health services, among others, routinely ask service users about domestic abuse, whether or not there are indicators of such abuse or violence. Neither Barbara nor Nipper was asked about domestic abuse.

3.12 However there is no evidence or suggestion that Barbara and Nipper's relationship was abusive, or that asking about abuse would have elicited information that would have changed the course of events. Neither family nor professionals detected any behaviours that suggested that this was a controlling or abusive relationship. Neither Barbara nor Nipper disclosed any abusive behaviours to the professionals or to their families.

[7] Hastings and Kantor, 2004.

[8] Bowstead, Janet (2000) Mental health and domestic violence: Audit 1999 (Greenwich Multi-agency Domestic Violence Forum Mental Health Working Group); ReSisters (2002) Women speak out (Leeds: ReSisters); Department of Health (2003) op. cit.

[9] NICE Guidance on Domestic Violence and abuse: how health services, social care and the organisations they work with can respond effectively. February 2014.

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3.13 Barbara's family feel strongly that domestic abuse does not describe Barbara's and Nipper's relationship and were hesitant about being involved in this process as they felt they might be endorsing such a view. They note Nipper's supportive and protective care of Barbara over a very long period. Her family describe Nipper's taking Barbara's life as a 'last loving gesture' and that Barbara was 'a sharer of Nipper's suicide'.

3.14 Both Barbara and Nipper described their home life a good deal in their interviews with health professionals in the last months of their lives. There were a number of factors that might have encouraged a fuller conversation with Nipper or Barbara to assess their home situation: the strong links between mental health and domestic abuse (as noted above); the obvious struggles that Nipper was having with his role as carer and how that might link to abuse; that they had discussed suicide together and it was noted that they were protective factors for each other; and that Nipper had a life-threatening disease which could leave Barbara without her partner, carer and his influence as a protective factor against her suicide. Finally, Nipper's unexpected turn of mood at his last GP appointment might have raised a concern as in such situations, a point of marked improvement is always a risky time. When the mood of a depressed person suddenly lifts, it can be a moment of clarity, when they have agency to address their problems.

3.15 It appears Nipper felt so 'bleak' about his and Barbara's situation that he saw no alternative but to end both of their lives. As with Nipper, Barbara's lifted mood apparent at her last meeting with the GP may have reflected that she shared Nipper's view and they had agreed to a suicide pact. At the site of Barbara's death, there were signs of a struggle which may have been Barbara's instinctive response to Nipper's actions. Alternatively, it may suggest that this was not a suicide pact. At this distance we cannot know.

3.16 Despite Barbara's long history of depression, she had recently sought new sources of help from a private consultant psychiatrist and a psychotherapist. She was engaging in both processes – she had gone to the GP the day after seeing the psychiatrist to change her medication on his advice – and had booked appointments in the new year with both of them. Whether these initiatives would have made a significant change is uncertain and, given her history, perhaps unlikely, but whatever possibility for improvement there was, it was ended by Nipper's actions.

3.17 These deaths occurred when both Barbara and particularly Nipper were under the care of and accessing several health services that knew of their difficulties.

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Nipper's and Barbara's repeated efforts to get help

3.18 There are several aspects of this case that are mirrored in cases of domestic abuse: the increasing help-seeking that signals a building crisis, professionals judging the situation in front of them rather than looking at the pattern of events or symptoms, the need for a lead agency and a multi-agency meeting to gather information and develop a common approach and plan, and the complications introduced by a variety of compounding vulnerabilities in the clients.

3.19 Nipper's and Barbara's engagement with services in the autumn of 2012 may best be understood by tracking Nipper's and Barbara's progress through the different agencies. It is notable that Nipper and Barbara had twenty-eight conversations with health professionals over the course of their last three months. Nipper had twenty-two of these meetings and spoke of the deteriorating situation at home on many of these occasions. Barbara had six such meetings. Nipper's meetings are numbered below and Barbara's are lettered.

3.20 To understand the sense of desperation that may have existed, Barbara's and Nipper's history and their help-seeking in the months leading up to their murder-suicide is reviewed below in chronological order.

3.21 <u>20 – 28 September 2012</u>

3.21.1 Nipper saw his GP on 20 September (1) and was prescribed sleeping pills. He knew he had a high PSA count and was booked for a biopsy at Charing Cross Hospital on 28 September (2). He collapsed after the biopsy and was taken to A&E (3) where he was given reassurance and sent home.

3.22 <u>October 2012</u>

3.22.1 Nipper saw his GP on 17 October (4) and was diagnosed with anxiety and depression.

3.22.2 On 24 October (5) he was told that he had prostate cancer, that it was an advanced form and was provided with a full explanation and hormone therapy was started. Clinical trials were explained to him. It is noted that he was greatly shocked by this news. A letter was sent several weeks later – on 12 November – from the hospital to the GP practice detailing this meeting, the diagnosis and treatment options. It noted Nipper's depression and linked it to the diagnosis.

3.22.3 Barbara dated her recent mental health decline to this news.

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3.22.4 About a week later, Nipper saw his GP (6) and said his mood was up and down and they renewed his meds. She noted that 'it all sounds pretty optimistic' in reference to cancer treatment. He had medications for his cancer and medications for his mental health.

3.23 Early November

3.23.1 Nipper attended the GP surgery twice (7 & 8) and rang once (9) to discuss his medications for his mental health.

3.24 Mid to late November

3.24.1 On 14 November, Nipper had an appointment at Charing Cross Hospital (10). The depression as a result of his diagnosis was noted. He was counselled regarding the cancer treatments: possible medications and treatment options were discussed.

3.24.2 He spoke to his GP the next day (11) about his medication. It was noted that he was not suicidal. However, two days later he saw another GP at the practice (12) and described worsening anxiety and panic and that he wanted to stab himself. His medications were adjusted.

3.24.3 On 19 November, Barbara saw a private psychiatrist (A)[10] and reported that she had thought about suicide but had no ideation. He suggested that she change her meds and, after listening to her describe Nipper's situation, recommended that Nipper see a private psychiatrist and provided a list of contacts.

3.24.4 At his 20 November appointment at Charing Cross (13) about his cancer treatments, Nipper told the research nurse that he was depressed and suicidal and that his partner was depressed. Such was the concern of staff, that the research nurse escorted him to the Claybrook Centre (14) for immediate assessment. The urologist noted that very rarely was such care necessary for clients.

3.24.5 There was no formal referral from the oncology department to the Claybrook Centre on this occasion and the MH Review Panel noted this but found that the lack of formal communication between the teams did not affect Nipper's care. The Panel concluded, however, that it could affect the care of other patients and made a recommendation on this point: that the Trust reviews its protocols for co-ordinating care between Imperial College Healthcare NHS Trust (of which Charing

[10] Reminder: Barbara's health appointments are lettered. This is the first one noted here.

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Cross Hospital is a part) and the Trust so it can be satisfied that they are operating as intended.

3.24.6 The urologist gave a note to Nipper to pass to his GP when he saw her the next day, asking the GP to change Nipper's medications (for cancer) and ascribing his depression to the diagnosis. The information to the GP surgery does not mention that Nipper had been accompanied to the Claybrook. This would have been useful for the GP to know so that she could see the level of concern raised for Nipper's mental health by other professionals, particularly as the urologist knew Nipper was seeing his GP the following day. It also might have informed the GP's view of the situation, as a known side effect of the newly prescribed drug was depression.

3.24.7 At the Claybrook Centre, Nipper reported that his home life was now desperate and that he was finding it very difficult and was having suicidal thoughts. They faxed this information to the GP surgery and referred Nipper to his local Ealing mental health assessment team.

3.24.8 Both practitioners who saw Nipper were asked by the Mental Health Review Panel whether they considered contacting Barbara to add to the information about the home situation. They said that they did not consider it necessary at the time. With hindsight, the social worker said that she might have called Barbara with Nipper's permission. She was not sure that Nipper would have agreed or that she would have found out anything more than Nipper had told them. It appears that they did not think about Nipper's role as carer and they did not do a carer's assessment. This would have been good practice.

3.24.9 From the answers to this question, it appears that their purpose in ringing Barbara would have been to provide more evidence of Nipper's mental health rather than to gather contextual information to inform their assessment of Nipper's wider needs.

3.24.10 The date is unclear, but it is likely that this is also the day (20 November) that Nipper went to Maggie's Cancer Care (15) as he said that his medical team had advised him to come. He spoke to staff there and told them that he had a good prognosis for his cancer and that his main concern was his partner's deteriorating mental health. Nipper also reported that 'there was nothing more they could do' for Barbara. This is surprising in that Barbara had seen or was about to see (depending on dates) the private psychologist and was going to see a psychotherapist. The staff at Maggie's encouraged him to talk to their psychologist. Though he said that talking did not help (it may be that this was the

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third appointment in a day where he had explained his situation), he consented to being contacted.

3.24.11 Barbara called for an urgent appointment with her GP (B) on this day to review her meds, as advised by her new private psychiatrist. Barbara said she was feeling suicidal and the worst she had ever felt. The letter from the psychiatrist just spoke about the change in medication. A more informative letter from the psychiatrist would have added to the GP's understanding of the situation

3.24.12 Barbara had three (C, D & E) sessions with the psychologist suggested by the consultant psychiatrist between 19 November and her death just over a month later.

3.24.13 A few days later, William, Nipper's brother, contacted Maggie's Cancer Care to see if there was anything that they could do for Nipper as he was very worried about him.

3.24.14 On 21 November, Nipper saw a GP again (16), noting that Barbara's deteriorating mental health was a trigger for his own stress. The fax from the Claybrook Centre was available to the GP that day, but the fuller report only arrived at the GPs on 26 November.

3.24.15 The Ealing assessment team were in touch with Nipper on 22 November (17). He explained again that he was low because of Barbara's mental health. An appointment was made for 26 November. At that appointment (18), the mental health nurse did not have the information that Nipper had provided to the service on the 20th and she had little time to prepare for the meeting. She assessed Nipper and discharged him to his GP. This result was reviewed and agreed within the mental health assessment team at the end of the day.

3.24.16 The mental health nurse who made this second assessment was asked during the mental health review if she had considered contacting Barbara to check on the home situation. She said that she would contact a partner, with the patient's permission, only if she was concerned or thought that the patient was not telling her the full story. She said that Nipper, while low and despondent, was calm, rational and relaxed. Again, his caring responsibilities do not seem to have been addressed. This would have been good practice – the information that Nipper provided should have led to a carer's assessment.

3.24.17 As with the previous assessment, it appears that the health professionals here felt that a call to Barbara would only have been undertaken to provide corroborative or gather more information about Nipper's mental health needs.

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3.24.18 The MH Review recommended that the mental health assessment teams review the way they apply their policy which states, 'that all new assessments will be discussed with a senior member of the team (Senior Practitioner level or above)'. In this case the mental health nurse's decision was supported by the duty team at the end of the day, but was not discussed with a senior member of the team. The MH Review found that this had not affected the care of Nipper or Barbara.

3.24.19 The letter from the Claybrook Centre arrived at the GPs and gave the practice a good deal more information about Nipper's situation than they had had previously.

3.24.20 The next day, Nipper saw his GP again (19) and discussed his recent health appointments.

3.25 <u>December</u>

3.25.1 On 13 December (20), Nipper appeared for his appointment with Maggie's Cancer Care's psychologist and yet again reported his thoughts of suicide, that his partner was a protective factor. He described feeling 'low' and 'awful' and that he lived an 'empty existence' with 'no purpose' and a 'bleak future'. He admitted to having suicidal thoughts that had been coming and going for six weeks. Nipper talked about how he might kill himself though said he had made no attempt to act on these thoughts. He said he would feel guilty leaving Barbara.

3.25.2 Nipper said he had been discharged by the mental health services and that there was no more support for Barbara. He did note that she had started to see a private psychiatrist. The psychologist was concerned enough about Nipper's mental state that she faxed information to the GP surgery as she knew that Nipper had an appointment with his GP the following day. She noted that the depression was not linked to the cancer but to his home situation and suggested a re-referral of Nipper to mental health services.

3.25.3 On 14 December (21), Nipper saw his GP again. The GP had not seen the letter from the psychologist at Maggie's and the GP said that Nipper was distressed by this, which is unsurprising given the number of times he had explained his situation. At this meeting Nipper said that his depression had started five years before and they explored his suicidal ideation. They agreed to review his situation in a week. The GP followed this up with a phone call that evening after she had seen the information from the cancer charity.

3.25.4 On 17 December, Barbara attended a second appointment with the consultant psychiatrist (F), again describing Nipper's situation as the main stressor. Based

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on Barbara's information about Nipper, he suggested that Nipper would benefit from seeing someone at the Priory.

3.25.5 On 18 December, Barbara attended the GP surgery for a mental health review saying that she was finding it difficult at home trying to cope with her partner's depression as well as her own. She said she had no family close by, though talked to her sister on the phone. She said she was not suicidal.

3.25.6 On 21 December (22), Nipper again saw his GP. He said he was beginning to feel better and the GP noted that he looked better. He said it was the mess in his house that was upsetting him. His GP briefed colleagues on Nipper's case later that day as she was going on holiday.

3.25.7 The bodies of Nipper and Barbara were found on 28 December.

Nipper's and Barbara's help-seeking

3.26 Barbara mentioned to her clinical psychiatrist and her psychologist that she was worried about Nipper's mental health. The clinical psychiatrist suggested that Nipper talk to a psychiatrist too and provided names.

3.27 Nipper spoke of his depression and the burden of caring for Barbara with her deteriorating mental health to the oncology team, the Claybrook Centre, the Ealing mental health assessment team, his GP, staff at the cancer charity and the psychologist at Maggie's during twenty-two appointments over the course of three months. He reported this with varying degrees of desperation. Yet he did not find the help that he needed.

3.28 Nipper's family tried for many hours on a particular day (they are unsure of the date but think it was a weekend) to have Nipper seen by a psychiatrist as they could see that he was in a terrible state. They report that the only agency they could find to provide support was Maggie's.

What did Barbara and Nipper want and need to happen

3.29 We have no information about what Barbara wanted and little about her view of her situation. She told her sister that Nipper was struggling and she told the psychiatrist and the GP that she was worried about his mental health. The conversations with the medical professionals focussed on her medications. It may be that Barbara thought Nipper was getting some help in that he was seeing a variety of health professionals.

3.30 Nipper told professionals in all the health settings that he was desperate and that he was finding coping with Barbara's mental health problems very difficult. He noted that the

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Ealing early assessment centre had discharged him and offered no further help. He told several professionals that there was nothing more that could be done for Barbara.

3.31 He appears to have needed help in caring for Barbara. He described their situation as 'bleak' and 'an empty existence' with 'no purpose'. Nipper's brother thinks that Nipper was unlikely to accept help. These appointments and Nipper's repeatedly recounting his desperation suggest that he was looking for help for his role as carer for Barbara.

3.32 By the time Barbara's psychiatrist had provided a list of people that Nipper might see, Nipper had already had twenty-two consultations.

What might have helped?

3.33 Recognition of Nipper's role as carer. None of the agencies addressed the source of Nipper's concern – Barbara's deteriorating mental health and his inability to care for her because of his own depression. Nipper's role as carer for Barbara was not addressed through his mental health assessment at Claybrook Centre, by the GP practice or his consultations with them or the Ealing mental health assessment team. As part of this assessment, the wider context of this couple could have been explored and their families alerted and involved.

3.34 Nipper might have been assessed as needing longer-term mental health support. The mental health review concluded that 'there were no care delivery problems which affected the care provided to Nipper or Barbara. They were satisfied that the health care professionals carried out assessment which were of a good standard. They examined the risk of suicide and harm to others and came to the view that the care they agreed upon with Nipper and Barbara was appropriate in the circumstances. The evidence and their assessments supported these decisions.'

3.35 Nipper or Barbara might have been assessed as vulnerable adults in need of safeguarding. The GPs report that neither Nipper nor Barbara would have met the definition of vulnerable adult for these purposes, though they were not assessed at the time. The Panel discussed the likelihood of Barbara being assessed as being a vulnerable adult if Nipper were so ill that he could not care for her. The Panel thought that she would still have not reached the threshold for a safeguarding alert.

3.36 Nipper might have been helped by the medications. The GP surgery discussed Nipper's medications a number of times with him and had reviewed Barbara's meds regularly over a long period and adjusted them after her psychiatrist visit in November 2012. So this help was being provided.

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Why did Nipper not get the help he sought?

3.37 Family could not find help when he was in crisis. Nipper's family did not live in the same area as Nipper and Barbara and so would not have known the local services. They were distraught that they could not find help for him on the day they felt he was in extreme distress. They exhausted the routes they could think of to find help.

3.38 Nipper had been given contact numbers and the routes to help as a result of his assessment visits. But on the day his family were looking for help, a weekend as they recall, Nipper did not provide this information so they were unable to assist him. The family were from out of the area and did not know the local services. They contacted many agencies[11] and directory enquiries, but they could not find help for him.

3.39 Access to support and publicity for that support has improved since the autumn of 2012. If searching on-line for help and typing 'mental health Ealing', the top two hits are www.mhws.org and www.wlmht.nhs.uk, both of which provide crisis numbers for twenty-four hour support through a further two clearly-labelled clicks. In addition to specialist numbers, these sites suggest ringing 999 and attending the nearest A&E department.

3.40 William commented that the situation on that day was not one requiring the police or an ambulance in that no one had been hurt and Nipper was not threatening to harm himself or others, and therefore he did not ring 999.

3.41 In April 2013, health advisors were recruited to run a support telephone line that is now open to anyone to call (it used to be solely for those already accessing services) and small business cards showing the telephone number have been distributed to all boroughs to pass on to service users at outpatient appointments. Community mental health staff also give this number out as part of care plans. The Council has an emergency duty team that operates out of hours and at weekends but the route to this number would be through the patient themselves knowing they can contact this service and being willing to get help.

3.42 Professionals noted in their records that they had supplied Nipper with numbers to ring in a crisis. The person in crisis, though supplied with appropriate numbers, may not be in a position to seek help themselves. Nipper's family note that Nipper wanted help that day, but did not provide them with numbers to ring. They also note that carers and family members who take responsibility in such situations are often older people who might be more likely to use a telephone to summon help than go on-line.

[11] The Mental Health Act 2007 places a statutory duty on LAs to provide 24 hour access to an Approved Mental Health Professional (AMHP) (to enable assessments under the MHA). In practice, the way local authorities deliver this duty is subject to negotiation with their commissioners.

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3.43 Access to twenty-four hour emergency help should be easy to find via the web or telephone. Contact numbers should be clearly highlighted and, when sourced through the web, require few click-throughs. However, if accessing the Ealing Borough Council website directly and following click-throughs to urgent help for mental health, the seeker can find him or herself at the Mental Capacity Act which is unhelpful to someone seeking emergency help.

3.44 Directory enquiries should know where to direct callers who are seeking emergency help for someone with mental health problems.

3.45 Narrow response. The responses to Nipper and Barbara were primarily of assessment and reviewing medications. These are obviously important aspects in providing help, but Nipper also had caring responsibilities for Barbara that he was finding impossible to fulfil. The letter from Charing Cross Hospital to the GP surgery did not mention that Nipper was so distressed that they felt it urgent that he was seen for a mental health assessment. Responses to his efforts to get help were very narrowly focused on a medical response to him, on responding to his symptoms rather than what he said was the cause: his inability to cope with Barbara's needs. He was not offered a carers assessment by any of the professionals and there is no record of anyone asking Nipper what would help his situation.

3.46 The professionals engaged with Nipper also did not appear to consider that Nipper's deteriorating mental health meant that he might not have been able to make appropriate care decisions about Barbara and therefore her care needs required attention. There is no record of anyone asking Barbara what would have helped.

3.47 Barbara's family felt that they would have been able to help if they had understood how desperate the situation was. They suggested that, particularly in situations where patients may not meet the threshold for specialist support, that families are alerted, informed and invited to be involved in caring for their relatives. They think that a wider conversation with Nipper about who else might assist him could have led to their involvement.

3.48 Heightened concern not reflected in response. A number of professionals and Nipper's family were particularly worried and felt an urgency about getting help to Nipper: William and his family tried to find someone to assess Nipper on a particular day and could find no one to help; the research nurse walked Nipper to the Claybrook Centre when he disclosed his suicidal thoughts (though this information was not included in the letter sent to the GPs); and the psychologist at Maggie's who made an extra effort to send the information through so that the GP would have it for her meeting with Nipper on 14 December. This

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heightened concern and urgency were not reflected in the GP's response to Nipper's needs.

3.49 These concerns may have been balanced against the fact that Nipper had been assessed and was seen as not needing longer-term help, that he was accessing services, and that Barbara was a protective factor for him.

3.50 The information known was not reviewed and assessed together. Each professional appeared to assess the situation afresh every time Nipper presented himself rather than looking at the pattern of information and help-seeking, and using information supplied by others. Indeed, Nipper was upset when the GP did not have his notes from his meeting with the cancer charity psychologist – he had to repeat information yet again.

3.51 There were several breakdowns in communication. The information from the Claybrook Centre was not used by the Ealing mental health nurse when she assessed Nipper on 26 November. The urologist did not note in his letter to the GP that Nipper was so mentally unwell that the research nurse had walked him over to the Claybrook Centre. The psychiatrist only communicated with the GP about Barbara's medications and did not add any detail about the nature of her difficulties. As such situations are dynamic and changing all the time, the patterns and context need to be noted to be able to respond effectively. The GP practice was the only agency in a position to see the patterns and review all the information together.

3.52 The MH Review noted two occasions when professionals communicated well with each other. It is worth noting that on neither of those occasions was that information used in the next consultation with Nipper.

3.53 Most of the professionals passed their concerns on to someone they felt was better placed to respond: Charing Cross Hospital to Claybrook House, Claybrook House to the Ealing assessment team, Maggie's Cancer Care to the GP. They all informed and passed responsibility back to the GP for Nipper's mental health. The GP practice suggests that, having reviewed the file, the various assessments led to similar conclusions and that one professional having an overview and co-ordinating care might have been more supportive of Nipper. The other professionals appeared to think that this was the role of the GP.

3.54 This suggests that the various health agencies involved have different expectations of each other's role in situations like Nipper's where he did not meet the threshold for specialist support.

3.55 The GPs have reflected on their role as a result of this process. The practice noted that they have a high proportion of patients with mental health problems and, as a result, have regular training and support for this work, including the use of a consultant psychiatry 'hot-

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line' for case managing such risks, and the occasional attendance at clinical meetings of a consultant psychiatrist for support. They have an in-house GP lead on mental health. They work on a ten-minute consultation model, though additional time is readily offered to patients with greater needs. Patients with urgent problems or those that are vulnerable are always given priority.

3.56 The practice also says that risk assessment underpins the nature of their work, that they make risk assessments regularly and they are used to holding some of that risk as part of their normal daily responsibilities to patients, seeking external help only in the more serious cases and when they are no longer in their comfort zone. With experience, they say that this then becomes a finely balanced judgement call.

3.57 The local health partners need to have a common understanding of the care pathway for patients like Nipper, of each other's role, and how information might pass between them and be used by another agency. This would avoid patients being sent from agency to agency to get support and being assessed each time without reference to the information they have already provided.

3.58 There are a number of factors that might, when viewed together, have suggested that Nipper's and Barbara's situation needed to be reviewed at least within the GP clinical meeting and with their in-house mental health lead: the multiple presentations in health settings, the co-morbidity of his and Barbara's mental problems, Nipper's role as a carer and the impact of his depression on his ability to make appropriate care decisions for her and, at their last appointments, the marked improvements – which is a risk factor in those with depression as it may signify that a plan has been made.

3.59 Did not address the situation of the couple and Nipper's role as carer. The responses to Barbara and Nipper focused on their individual pathologies, on their own depression, rather than looking to practical ways to lessen the burden of two vulnerable and depressed people trying to care for each other. There was little professional curiosity about Nipper's home situation and the implications or risk to Barbara of Nipper's inability to cope. A home visit might have been revealing of their situation.

3.60 The GP practice had both Barbara and Nipper as their clients. Barbara had recently sought help from a new psychiatrist – an act that the GP practice viewed as a positive effort to get help. The GP practice reports that there were informal discussions within the practice about Nipper and Barbara, but not a formal discussion. The GP practice does have a weekly clinical meeting where they discuss patients and cases. They say that two patients of the practice experiencing mental health difficulties and influencing each other is the type of case that would prompt a discussion at this meeting, but this did not happen in this case. It is not clear why. They feel that if the doctors involved had discussed their

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patients they would have benefitted from a whole practice clinical dialogue, drawing on the expertise of the full doctor team. They think that this may have led to a fuller understanding of the situation and suggested an intervention.

3.61 This case would provide a good case study for the practice as a way of developing some triggers or criteria for cases that might benefit from review at the weekly clinical meeting. In addition to the recommendation below regarding the use of this case for discussion at the South Central Network of Ealing CCG, the practice might use it to think about other agencies that they might consult or involve in such situations to address social issues or relationships that might be impacting badly on a patient's health.

What impact might this sequence of events have had on Nipper and Barbara?

3.62 Nipper was upset when the GP did not have his notes from his visit to Maggie's on 13 December. It is no wonder, as he had explained his situation on so many occasions before that. As with victims of domestic abuse, people do not want to have to tell their story again and again to different workers and agencies. They need and want someone to be the point person in their care. When their story is about not being able to cope, it is likely to be more difficult and debilitating to retell time and time again.

3.63 The professionals listening to Nipper were taking pro-active steps to help him address his depression. Those who recognised an urgency in his situation – the research nurse at Charing Cross Hospital and the psychologist at Maggie's– acted swiftly and professionally to get help to Nipper, but nothing changed for Nipper as a result. No one acted to address the issue he kept raising – his caring responsibilities.

3.64 Nipper told several professionals that 'there was nothing more they could do' for Barbara. Yet Barbara had started with a new psychiatrist and had had several sessions with a new psychologist. It may be that Barbara's depression was so much worse than before – Nipper's brother was taken aback by Barbara's lack of emotional engagement when Nipper was distraught – that Nipper felt she could not get better. As he had seen Barbara through a number of cycles of depression, Nipper may have held no hope of improvement, or as he was so depressed himself, perhaps he could not see these new efforts by Barbara as steps towards a change.

3.65 An agency working with them both might have helped Nipper see his situation differently, could have addressed some of their immediate practical concerns and helped Nipper cope. They also might have involved a wider network of support, including their families.

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What needs to change?

3.66 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.

3.67 To help families and friends trying to help someone suffering a mental health crisis. This would include ensuring that Directory Enquiries can provide appropriate information.

3.68 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.

3.69 By creating a clearer care pathway for those with mental health needs that do not meet the threshold for longer-term care, patients will not be sent from agency to agency without getting the help they need. The roles of all the agencies should be clear and all partners (statutory and voluntary) should know how to escalate concerns effectively. Wider health partners should understand their role in this and ensure that they record and share psychosocial information and inform partner health agencies about the care of their mutual patients, e.g. the oncologist noting the mental health concerns about Nipper in his letter to the GP, and the consultant psychiatrist providing fuller information to the GP following his consultations with Barbara.

3.70 This care pathway will also make it clear to partners who are concerned about a particular patient how to escalate those concerns to ensure an effective intervention, e.g. through a conference call with other healthcare professionals.

3.71 Recommendation 3: The Ealing CCG and Ealing 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.

3.72 This case highlights the complications of working with those who have mental health difficulties and are also caring for others. It appears that Nipper's own mental health needs obscured his role as carer.

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3.73 The Triangle of Care Best Practice Guide[12] recognises the value of carers' involvement in the treatment and care of those with mental health problems. It suggests a range of carer support services that might be available to alleviate the stress of caring for someone with long-term needs. The guide particularly notes the reluctance of many carers to be assessed for their own needs and helpfully links a carers' assessment to the benefit to the mental health service user. It also recognises that there is more work to be done to develop family work in adult mental health services.

3.74 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.

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

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

3.75.2 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

3.75.3 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

3.76 GPs are used to assessing risk and carrying risk when working with those with mental health problems. They should be encouraged to use their in-house clinical meetings more often to discuss such patients and ensure that they consider the psychosocial situation of clients, especially when they know other members of the family, and involve a wider range of agencies when addressing a situation. The GP practice identified several ways that they might improve their practice in this regard and suggested recommendations to disseminate the learning wider.

[12] *The Triangle of Care, Carers Included: A Guide to Best Practice in Mental Health Care in England*

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3.77 The situation that Nipper and Barbara were in was not unique: two people with deteriorating mental health taking care of each other. Local partners and the GPs would benefit from reviewing this case together to develop more locally-derived approaches and responses.

3.78 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.

3.79 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 DHR was delayed by the GP practice not being familiar with this process and not understanding its importance. Support for GPs in how to engage with these processes is required so that they can participate fully and effectively. This recommendation will provide reassurance and support for the practice as they respond to this review.

Equalities

3.80 The Panel considered the protected characteristics: Barbara and Nipper were in their sixties, heterosexual, and white. They had lived together for many years but had not married. Barbara had suffered with debilitating mental health problems for many years and Nipper had suffered periods of depression. Neither were active with a faith-based organization. In reviewing the information provided, the Panel did not feel that their sex, age, disability, sexual orientation, race or their marital status had an impact on the care and service they received.

Good practice

3.81 There were a number of examples of good practice in this case which should be highlighted. A number of professionals recognised the urgency of Nipper's needs and acted immediately to address them:

3.81.1 The oncology team nurse walking Nipper to the mental health assessment centre.

3.81.2 Maggie's Cancer Care sending information through in time for Nipper's appointment with GP the next day.

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3.81.3 The cancer charity following up William's call with a call to Nipper to encourage him to talk to their psychiatrist.

3.82 Nipper's GP did not have the material faxed over from Maggie's when she saw Nipper, but she followed this up with a phone call when she had read the information. When the GP went on holiday, she discussed Nipper's situation with colleagues so that they had some background when they met with Nipper.

3.83 The healthcare professionals all provided Nipper with contact details in case he needed more help. For reasons that we cannot know now, these were not available to Nipper's family when they were searching for immediate help for him in late November, early December.

3.84 The WLMHT is committed to having 85% of its community teams, recovery teams and Ealing Assessment Teams trained on domestic violence by September 2015. The three managers have already received the training and will ensure that it is provided annually. Staff are reviewing the possibility of making this training mandatory for these mental health teams.

3.85 Barbara's family, while agreeing that Nipper's needs as a carer were not assessed and that the couple would have benefited from a broader, more holistic evaluation of their situation, wanted it noted that they were 'astonished' and grateful for the medical care provided and the efforts made on behalf of Nipper and Barbara.

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Conclusions and Recommendations

4.1 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 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 him to the decision to kill Barbara and then take his own life.

4.2 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.

4.3 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 with Nipper described by him when he spoke to Maggie's in December 2012.

Preventability

4.4 Barbara and Nipper had been together for thirty-nine years and had struggled through many periods of depression together, with Nipper providing support for Barbara over many years. With the advent of his cancer diagnosis, despite the positive prognosis with treatment, their situation appeared to deteriorate. Barbara had started with a new psychiatrist and psychotherapist as her mental health deteriorated, but Nipper still felt that the situation was hopeless. Nipper's brother thinks that Nipper would have found it hard to accept help, yet he sought help on many occasions and did not get the help that he sought that may have led to a different course of action. The agencies responded sympathetically and there was active engagement to find the right medications to help lift his mood, but practical help was not offered to help him cope with Barbara's depression or to assess their situation to see what might make enough difference to encourage Nipper to think positively about the future.

4.5 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. Barbara was not given the chance to see if she could be lifted out of her depression so that they could live the lives they wanted.

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4.6 The professionals around this couple all agree that this tragedy was unforeseeable. However, if there had been more pro-active engagement to address the issue that Nipper highlighted as his main concern – his caring responsibilities – it may have been avoided. Opportunities to help were missed that might have made a difference. This death cannot be described as clearly preventable but the recommendations below may allow a similar set of circumstances to be resolved differently.

The Mental Health Review findings and update

4.7 The MH Review into this situation completed in autumn 2013. That Panel's recommendations and progress to date are noted below.

4.8 The panel recommends the Trust review the way assessment teams apply their operational policies, and particularly the role of senior staff in decisions about assessment and discharge. It can then come to a view about whether it should amend or otherwise reinforce the policy. (This refers to the analysis in 3.24.18 above.) This action was completed at the end of October 2013 and a revised policy and guidance were circulated to assessment teams with responsibility for monitoring and reviewing its implementation assigned to the Local Services and Trust incident review groups.

4.9 The Trust reviews its protocols for co-ordinating care between Imperial College Healthcare NHS Trust (of which Charing Cross Hospital is a part) and the Trust so it can be satisfied that they are operating as intended. (This refers to the analysis in 3.24.5 above.) The implementation of this recommendation has been delayed as the Imperial lead on this has left that Trust. WLMHT is liaising with the new lead about this recommendation.

4.10 The panel recommends that the Trust reviews the support it offers staff when current or former patients are involved in homicides. It should be made sure that, as far as possible, staff are informed about such events quickly and offered appropriate opportunities for discussion and other support. This was completed at the end of December 2013 and a revised policy was sent to the team via email with responsibility for monitoring and reviewing its implementation assigned to the Local Services and Trust incident review groups.

GP findings

4.11 The GP practice has recommended and undertaken several improvements internally:

4.11.1 All clinicians and staff of the practice will be reminded and retrained in the practice's Significant Event Policy which sets out how the practice welcomes and learns from documented near misses and significant events, and this process leads to improved quality of service to patients.

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Action: The action is for the Practice Business Manager to complete by the end of April 2014

4.11.2 This domestic homicide is more than a Significant Event. The seriousness of the event was not appreciated within the managerial team of the GP practice. It required a different approach from a Significant Event. The Senior Partner and

Senior Partner and Manager to ensure that such extraordinary events are dealt with through the managerial team.

4.11.3 The GP practice notes that the final event occurred over the Christmas period, a time when there are fewer doctors and clinical staff at the surgery and therefore less formal clinical weekly meetings to discuss complex cases. The practice has undertaken that in the future, during times where the surgery is closed for a few days, they will review possible vulnerable patients and ensure they have crisis support information over the bank holidays and that routine reviews are in place.

4.12 The other recommendations of the GP surgery are included and in this DHR's overall recommendations.

4.12.1 Clinical meetings about patients: These meetings and discussions about patients should always be documented, even informal discussions outside the main meeting framework.

Action: This action is for the Senior Partner to oversee immediately.

4.12.2 Integrated Care Planning: The GP practice is a member of the South Central Network of Ealing Clinical Commissioning Group. Monthly meetings are held with representation from all practices in the network to discuss individual cases for integrated care planning. This case would be an ideal one to take to that multidisciplinary forum for discussion and dissemination of learning points.

Action: This action is for all partners of the GP practice

Recommendations

4.13 **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.**

4.14 **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**

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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.

4.15 **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.**

4.16 **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.

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

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

4.17.2 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.

4.17.3 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.

4.18 **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.

4.19 **Recommendation 6: NHS England, during their next Appraisal and Revalidation of the GP practice involved here, reviews this practices' planned response to DHRs**

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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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Annex 1

Terms of Reference for

Domestic Homicide Review into the death of Barbara

This Domestic Homicide Review is being completed to consider agency involvement with **Barbara**, and her partner, **Nipper**, following her death on or before 28.12.12. The Domestic Homicide Review is being conducted in accordance with Section 9(3) of the Domestic Violence Crime and Victims Act 2004.

Purpose

1. Domestic Homicide Reviews (DHR) place a statutory responsibility on organisations to share information. Information shared for the purpose of the DHR will remain confidential to the panel, until the panel agree what information should be shared in the final report when published.

2. To review the involvement of each individual agency, statutory and non-statutory, with Barbara and Nipper during the relevant period of time: **1 January 2010 to 28 December 2012.**

3. To summarise agency involvement prior to**1 January 2010**.

4. To establish whether there are lessons to be learned from the case about the way in which local professionals and agencies work together to identify and respond to disclosures of domestic abuse.

5. To identify clearly what those lessons are, how they will be acted upon and what is expected to change as a result and as a consequence.

6. To improve inter-agency working and better safeguard adults experiencing domestic abuse and not to seek to apportion blame to individuals or agencies.

7. To commission a suitably experienced and independent person to:

   a) chair the Domestic Homicide Review Panel;
   b) co-ordinate the review process;
   c) quality assure the approach and challenge agencies where necessary; and

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d) produce the Overview Report and Executive Summary by critically analysing each agency involvement in the context of the established terms of reference.

8. To conduct the process as swiftly as possible, to comply with any disclosure requirements, and on completion, present the full report to Ealing Safer Communities.

Membership

9. The following agencies are to be involved:

   a) Ealing Safer Communities
   b) Ealing Council
   c) Ealing Clinical Commissioning Groups
   d) NHS England
   e) Adult Social Care
   f) Housing for Women
   g) Metropolitan Police Service
   h) West London Mental Health Trust
   i) Victim Support
   j) Maggie's Cancer Care

10. Where the need for an independent expert arises, for example, a representative from a specialist BME women's organisation, the chair will liaise with and if appropriate ask the organisation to join the panel.

11. If there are other investigations or inquests into the murder, the panel will agree to either:

   a) run the review in parallel to the other investigations, or
   b) conduct a coordinated or jointly commissioned review - where a separate investigations will result in duplication of activities.

Collating evidence

12. Each agency to search all their records outside the identified time periods to ensure no relevant information was omitted, and secure all relevant records.

13. Each agency must provide a chronology of their involvement with the Barbara and Nipper during the relevant time period.

14. Each agency is to prepare an Individual Management Review (IMR), which:

   a) sets out the facts of their involvement with Barbara and/or Nipper;
   b) critically analyses the service they provided in line with the specific terms of reference;

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c) identifies any recommendations for practice or policy in relation to their agency, and
d) considers issues of agency activity in other boroughs and reviews the impact in this specific case.

15. Agencies that have had no contact should attempt to develop an understanding of why this is the case and how procedures could be changed within the partnership that could have brought Barbara or Nipper into contact with their agency.

Analysis of findings

16. In order to critically analyse the incident and the agencies' responses to the family, this review should specifically consider the following six points:

a) Analyse the communication, procedures and discussions, which took place between agencies.
b) Analyse the co-operation between different agencies involved with the victim, alleged perpetrator, and wider family.
c) Analyse the opportunity for agencies to identify and assess domestic abuse risk.
d) Analyse agency responses to any identification of domestic abuse issues.
e) Analyse organisations access to specialist domestic abuse agencies.
f) Analyse the training available to the agencies involved on domestic abuse issues.

Liaison with the victim's and alleged perpetrator's family

17. To sensitively involve the family of Barbara in the review, if it is appropriate to do so in the context of on-going criminal proceedings. Also to explore the possibility of contact with any of the alleged perpetrator's family who may be able to add value to this process. The chair will lead on family engagement with the support of the senior investigating officer and the family liaison officer.

Development of an action plan

18. To establish a clear action plan for individual agency implementation as a consequence of any recommendations.

19. To establish a multi-agency action plan as a consequence of any issues arising out of the Overview Report.

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Media handling

20. Any enquiries from the media and family should be forwarded to the chair who will liaise with the CSP. The CSP is responsible for the final publication of the report and for all feedback to staff, family members and the media.

Confidentiality

21. All information discussed is strictly confidential and must not be disclosed to third parties without the agreement of the responsible agency's representative. That is, no material that states or discusses activity relating to specific agencies can be disclosed without the prior consent of those agencies.

All agency representatives are personally responsible for the safe keeping of all documentation that they possess in relation to this DHR and for the secure retention and disposal of that information in a confidential manner.

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Annex 2

Members of the Panel

NAME	POSITION	ORGANISATION
Laura Croom, Chair	Associate	Standing Together Against Domestic Violence
Joyce Parker	Safer Communities Team Leader	Ealing Safer Communities
Uzma Butt	Risk Coordinator	Ealing Safer Communities
Nicky Brownjohn	Associate Director for Safeguarding	Ealing Clinical Commissioning Groups
Nicola Clark Karen Sobey-Hudson	Patient Safety Lead for Mental Health	London Region, NHS England
Stephen Day	Director	Adult Social Care
Hina Patel	Refuge Manager	Housing for Women – as domestic violence specialists
Helen Flanagan	DS, Critical Incident Advisory Team	Metropolitan Police Service
Jeremy Mulcaire	Sector Manager	West London Mental Health Trust
Liz Gaffney/Aiman Elal	Senior Manager for Ealing	Victim Support
Bernie Byrne	Head	Maggie's Cancer Care

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Annex 3

Domestic Homicide Review (DHR) into the death of Barbara

Action Plan

The Panel is responsible for ensuring that all recommendations must be SMART (specific, measureable, achievable, realistic, time bound) and for the completion and implementation of the Action Plan.
The CSP will monitor the implementation and delivery of the Action Plan.

Recommendation	Scope of recommendation	Action to take	Lead	Key milestones achieved in enacting recommendation	Target Date	Date of completion and outcome
Theme 1 – accessibility to mental health services						
Recommendation 1: Ealing Borough Council, the Ealing Clinical Commissioning Group (Ealing CCG) and WLMHT review	Local	Communications Teams from partners to look at the information on web sites				

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Recommendation	Scope of recommendation	Action to take	Lead	Key milestones achieved in enacting recommendation	Target Date	Date of completion and outcome
and improve the accessibility of emergency contacts for those needing urgent support for mental health problems and for their families and friends.						
Theme 2 – Develop clear care pathway for those with mental health needs						
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	Local	Highlight to mental health transformation Team and present to Head of Commissioner at the CCG	Nicky Brownjoh n	Clearer pathways developed for GP's to refer to Mental Health Services	May 2015	

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Recommendation	Scope of recommendation	Action to take	Lead	Key milestones achieved in enacting recommendation	Target Date	Date of completion and outcome
worked through with local partners to ensure everyone understands their role and duty of care in this regard.						
Theme 3 – Develop response to carers, including carers' assessments						
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.	Local	Include this within the group from West London Mental Health Trust and Social Services addressing the implementation of the Care Act.				

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Recommendation	Scope of recommendation	Action to take	Lead	Key milestones achieved in enacting recommendation	Target Date	Date of completion and outcome
Theme 4 – Improve integrated care planning by use of this case						
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.	Local – strategic Local -- operational			Psychiatrist has provided training to all staff in the practice concerned. Within the practice all those patients with mental health issues and their carers have care plans put in place and the cases are brought for discussion to the mental health nurse whon works with the practice.		**completed**
Theme 5 – Guidance for GP surgeries on domestic homicide reviews						

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Recommendation	Scope of recommendation	Action to take	Lead	Key milestones achieved in enacting recommendation	Target Date	Date of completion and outcome
Recommendation 5: NHS England to provide guidance to GP surgeries on their engagement with domestic homicide reviews.	National	The NHS England Serious Incident Framework will highlight that the Domestic Violence, Crime and Victims Act requires provider organisations to respond to requests for individual management reports in a timely manner, reflecting on any learning which might be gained from the issues raised in the IMR	Vicky Aldred Head of Patient Safety NHS England London	The Serious Incident Framework has been drafted and is due to be published and disseminated to provider organisations (including primary care practices) by February 2015		
Recommendation 6: NHS England, during their next Appraisal	Local	NHS England London Practitioner	Andy Mitchell Regional	Process for checking the appraisal content	End March	

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Recommendation	Scope of recommendation	Action to take	Lead	Key milestones achieved in enacting recommendation	Target Date	Date of completion and outcome
and Revalidation of the GP practice involved here, review this practices' planned responses to DHRs and the other changes that they have put in place as a result of this DHR.		Performance Team will ensure the performers annual appraisal includes reflection on their responses to Domestic Homicide	medical Director	regarding DH reflection to be defined and implemented.	2015	

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Annex 4

Further information about services involved in this DHR

The GP surgery

The GP surgery has about 9,300 patients on its list. They are cared for by four partners and, during the period covered by this report, 2 salaried general practitioners. The GPs have clinical meetings twice a week when they discuss cases or issues of concern and meet regularly for educational activities. Their computer can flag the files of clients where a GP has a particular concern.

The GP practice reports that the practice has a higher than average prevalence of patients with mental health illness. The mental health lead organises regular in-house training and support for this work. A consultant psychiatrist has attended the practice's clinical meetings on several occasions in the past few years for supportive training and risk assessment in general practice has been specifically discussed. They have been involved in 'Shifting Settings of Care' and have undergone all relevant training to date. They report that they often contact the Consultant Psychiatry 'hot-line' for case management of risk.

Maggie's Cancer Care

Maggie's Cancer Care provides informational, practical, emotional and psychological support by a team of professionals for those people affected by cancer including family and friends. No appointment is required – people can drop-in to be met and assessed by one of the Cancer Support Specialists who work with people psychologically at level 2/3 and the charity offers a space and programme of support.

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Annex 5

Home Office

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Joyce Parker
Community Safety Team Leader
Safer Communities Team
Perceval House
14-16 Uxbridge Road
Ealing
W5 2HL

23 September 2015

Dear Ms Parker

Thank you for submitting the Domestic Homicide Review report for Ealing (Barbara) to the Home Office Quality Assurance (QA) Panel. The report was considered at the QA Panel meeting on 25 August 2015.

The QA Panel would like to thank you for conducting this review and for providing them with the final report. The Panel found the report to be honest, sensitive and probing, with a good set of conclusions and appropriate referencing to research.

There were some aspects of the report which the Panel felt could be revised, which you may wish to consider before you publish the final report:

- The Panel felt the report would benefit from further analysis on the burden of caring for someone with mental health issues, both from the perspective of the person cared for as well as the carer;
- The Panel noted the format of the report does not follow statutory guidance. For example the review panel is mentioned at the end of the report rather than at the beginning;
- The Panel felt that interviewing friends may have given a different perspective to the review;
- Unless there are reasons not to do so, the Panel suggested naming the "local cancer charity" mentioned in the report;
- The executive summary does not mention the cause of death;
- The Panel found the action plan to be inadequate as it only includes recommendations. The Panel recommended following the template in the statutory guidance.

The Panel does not need to see another version of the report, but I would be grateful if you could include our letter as an appendix to the report.

Yours sincerely

Christian Papaleontiou
Chair of the Home Office DHR QA Panel

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