



STATUTORY DOMESTIC HOMICIDE OVERVIEW REPORT INTO THE DEATH OF MRS A

1. Introduction

- 1.1 This is the statutory overview report into the death of Mrs A which occurred on Monday 2nd February 2015. It is submitted in accordance with the statutory guidance issued under section 9(3) of the Domestic Violence, Crime and Victims Act, 2004.
- 1.1.1 Such reviews take place when a person over 16 years of age is killed, or appears to have been killed, as a result of violence, abuse or neglect by a person with whom the victim has been in an intimate relationship and/or where the victim is a member of the same household as the alleged perpetrator.
- 1.1.2 In this case, it appears from the available evidence that Mrs A was killed by her husband, Mr A, at the family home in Merton which the couple had occupied together since June 1980.
- 1.1.3 Mr A was arrested and charged with the murder of his wife but subsequently committed suicide in Wandsworth Prison in the early hours of Monday 8th June 2015 while still on remand awaiting trial.
- 1.2 The main purpose of a Domestic Homicide Review (DHR) is to examine the responses of the relevant agencies to the victim prior to the point of his/her death and to assess the adequacy or otherwise of the support offered by those agencies.
- 1.3 This review considers agency contact and involvement with Mr and Mrs A in the years prior to Mrs A's death in February 2015 and seeks to identify any significant learning points or lessons learned which may help to improve future policy and practice in relevant agencies at either national and/or local levels. Such reviews should be seen as learning exercises rather than a means of apportioning blame and this is the approach that has been adopted throughout this review process.
- 1.4 All relevant agencies have been approached and appropriate reports submitted for the review panel's consideration. In some cases, agencies reported that they had had no previous contact with either the victim or the alleged perpetrator.
- 1.4.1 The following agencies submitted written contributions:
- London Borough of Merton;
 - Metropolitan Police Service;
 - St Charles Hospital Mental Health Centre;
 - South West London NHS Mental Health Trust
 - St George's NHS Mental Health Trust.
 - Mr A's General Practitioner

The panel also reviewed diary entries compiled by Mrs A from 1st January 2015 up to the day of her death.

2. The facts of the case

2.1 On the afternoon of Monday 9th February 2015, Mr A dialled the 999 emergency number asking for the attendance of the police and the ambulance service to his home address which he had shared with his wife, Mrs A, since June 1980. He told the operator that he had a history of blackouts, that he had tried to kill himself through a drugs overdose and that he had actually killed his wife a week earlier on 2nd February 2015. The police attended and were let into the property by Mr A. The lifeless body of Mrs A was discovered slumped in a seated position on the kitchen floor. Mrs A was examined by ambulance staff at the scene and her life was pronounced as extinct at 13.37. She had sustained extensive head and neck injuries.

2.2 Mr A was arrested and cautioned at his home before being taken to Kingston Hospital for a medical assessment.

2.3 Subsequent to the medical assessment Mr A was taken to Sutton Police Station where forensic samples were taken and a Mental Health Assessment undertaken. At interview, he made no comment to all the questions put to him and was subsequently charged with murder and remanded into custody. He claimed to suffer from chronic anxiety for which he had apparently been prescribed medication.

2.3 According to police information, neither Mr nor Mrs A were known to the police and there was no evidence on file of any history of domestic violence within their relationship. That said, it was clear that their relationship was not a happy one and this was well illustrated by the sombre and unhappy contents of the diary entries made by Mrs A prior to her death. However, the diaries at no point suggested that Mrs A felt under any personal physical threat from her husband. The couple had married in October 1975 but they did not have any children together. Under a surface of apparent domesticity, the couple's relationship was a strained one with each adult sleeping in separate rooms and frequent irascible exchanges between them. On occasions, Mr A communicated with his wife by leaving her written notes to which she unsurprisingly often took exception. From the contents of her diaries, Mrs A presents as a dutiful if long-suffering wife. Their lives were to a large extent quite self-contained, often only coming together for purposes of eating meals, watching television or discussing routine domestic matters. In general terms, however, both appeared to be quite solitary figures with few outside interests or friends and family connections apart from Mrs A's elderly mother and a former school friend of Mr A.

2.4 Mr A appears to have been a volatile, argumentative and controlling personality who had not worked for at least ten years. His childhood and adolescence had been quite turbulent and he had struggled with issues of low self-esteem and suicidal thoughts for much of his adult life. His relationship with his wife had initially been a good one but this deteriorated over the years at least in part as a result of Mr A's domineering and manipulative behaviour towards his wife. The couple had started to talk about separating after Mrs A had suggested that they should consider 'going their own separate ways' but Mr A was opposed to this idea. There was a suggestion that the couple were considering marriage guidance counselling at the time of the murder. Mr A also had a long-standing litigious streak which frequently brought him into conflict with others. It is perhaps significant to note that it was anger over an item of recently purchased technology that he was using which sparked Mr A's initial fury on the day that he apparently killed his wife.

2.5 Their shared occupancy of their home address may have presented a veneer of 'normality' to the outside world but it was clear that their day-to-day lives within the property were very different. Mr A seemed to occupy the bulk of the property and alternated at night time between the rear bedroom and the front room downstairs. He also used an upstairs box room as a study with a small desk and computer. In contrast, his wife (who had not worked since 2012) spent much of her time in the front bedroom upstairs watching television on her own or else downstairs in the kitchen preparing meals or attending to household chores. Her diaries describe in poignant detail the various meals that she often prepared for both of them. There is not much evidence of Mr A's active contribution to the running of their shared home although he was apparently often quick to criticise his wife's efforts in this regard. Their married life together was clearly not very fulfilling for either of them but equally they both appeared to have established some kind of pragmatic *modus vivendi* which allowed them to function on a day-to-day basis.

2.6 In terms of medical and mental health issues, Mr A had much the greater involvement with those services. Mrs A is recorded as visiting her local GP on five occasions since she registered with them in October 2013. Mr A however was well-known to the local medical services including his current and former GP practices, the Accident and Emergency unit at Kingston Hospital and the mental health services for the area. His case however was not open at the time of the tragic murder on 2nd February 2015 – his last contact with the Mental Health Trust having been a routine e-mail in December 2014. Over the years, Mr A had had frequent contact with medical professionals mostly over relatively minor physical ailments arising from cycling and road traffic accidents. He also reported enduring problems concerning stress, anxiety and sleeping difficulties which he felt related variously to his troubled upbringing, problems at work and his unhappy marriage. Although Mr A was referred to the Morden Community

Mental Health Team as far back as 2003/4, he was not diagnosed as clinically depressed even though he had occasionally taken anti-depressant medication to help manage his anxiety states.

2.7 Mr A was diagnosed as having an Emotionally Unstable Personality Disorder (EUPD) which would certainly not make him an easy person to live or work with but which did not suggest that he posed a serious risk either to himself or to other people around him. He had intermittent contact with local health services to help him to deal with his stress and anxiety including visits to group/art therapy sessions and cognitive behavioural therapy. In February 2007, he referred himself to Kingston Hospital's Accident and Emergency Unit following an apparent non-lethal overdose but his records state that he was only 'given advice and analgesia'. In the same year, he was assessed as having episodes of 'transient global amnesia' which may have caused his occasional temporary blackouts but no clear cause was found for this condition. Mr A appeared to recognise that he suffered from a personality disorder and showed some insight into how this affected his own behaviour and his ability to relate to other people. He was subsequently described as 'a man with somewhat fragile self-esteem and a strong inclination toward depressive self reproach'.

2.8 While there are no records of actual domestic violence towards Mrs A in either police or medical records, there were a few occasions when Mr A talked to medical staff about having suicidal feelings and/or wishing to do harm to his wife. He admitted that he 'accidentally' hit his wife on one occasion during his sleep and it is clear that he had some issues with anger management as evidenced by his destruction of his MP3 player on the day of his wife's death. His anger had a somewhat obsessive quality which prompted him to write frequent letters of complaint for alleged failures on the part of various organisations to meet what he felt were his legitimate rights and expectations. It was reported that around the year 2010 he did say he had violent feelings towards his wife as a result of their frequent rows but that these feelings had subsided after a while. He claimed at interview that the fatal attack on his wife on 2nd February 2015 was the first time he had ever deliberately tried to inflict physical harm on his wife – although he was unable to explain clearly what had prompted him to do so on that occasion.

3. Assessment and analysis of agency actions

3.1 It appears from the available information that the National Health Service, specifically its mental health services, medical staff at Kingston Hospital and two local GP practices were the main public services in regular contact with Mr A. Overwhelmingly, their contact related to Mr A's assorted physical and mental problems, most notably the management of the anxiety and stress issues

that derived from his personality disorder. Mr A did therefore have reasonable levels of contact with medical services over many years but Mrs A's apparent needs – and therefore the frequency of her contact – were much more modest. The couple resided in quite isolated lives with limited business or social contact with other people and agencies. Their family connections were very limited, contact with neighbours was intermittent at best and neither appeared to have a wider social circle on which they could rely and from which they could draw support. Prior to the 999 call made by Mr A on 9th February 2015, the only record of previous contact with the Metropolitan Police was three calls he made in 2010/11 to complain about anti-social behaviour issues in his neighbourhood. Mr A had no previous convictions for violence (or indeed any other offences) and no domestic violence incidents involving the couple were ever reported to or recorded by police or health authorities.

3.2 It is against this background that we need to judge the actions of the various agencies with whom Mr and Mrs A came into contact. Specifically, we need to ask four principal questions to determine what, if any, learning points there may be from this tragedy:

- Were all the relevant agencies who should have been involved with Mr and Mrs A actually involved in supporting them?
- Were Mr and Mrs A offered support by the relevant agencies that was appropriate, sufficient and timely?
- What was the quality of the interaction and communication between the agencies in this case?
- Could or should anything else have been done in retrospect to avoid or reduce the risk of this tragedy happening?

3.5 In considering our response to the above questions, the panel has been acutely aware of the need to recognise Mrs A's needs and entitlements. Her husband appears to have been a somewhat controlling personality, who had reasonably extensive contact with health services of various kinds whereas, apart from her own private diaries, Mrs A's voice does not appear prominently in most of the written submissions. The panel has been especially conscious that we need to 'hear' her voice during our discussions and to ensure that she is not once again 'overshadowed' by her husband. The panel was particularly aware of the need to ensure that we explored how the various agencies responded to her perceived needs.

3.6 The following paragraphs represent the panel's considered attempt to answer the four questions set out in paragraph 3.2 above.

Were all the relevant agencies who should have been involved with Mr and Mrs A actually involved in supporting them?

3.7 Mr A was a well-known user of health services in his part of London. He had fairly frequent contact with two GP practices, with Kingston Hospital's accident and emergency team and, most substantially, with staff at the South West London and St George's Mental Health NHS Trust. According to Mr A's medical records, the Community Mental Health Team (CMHT) in Morden had occasional contact with him from 1994 onwards as a result of his stress, anxiety and occasional suicidal feelings. He was further assessed in 2003 but judged to be 'low risk' and not to be suffering from biological depression. As a result, he was discharged back into the care of his GP. In subsequent years, he was referred to various therapeutic support groups as well as a service user led network (which he had been attending up to December 2014). The panel probed carefully the suggestion in the psychiatric report that Mr A had expressed thoughts of killing his wife around 2010. It also considered the material in his medical records which mentioned a referral initiated by the London Ambulance Service (LAS) in February 2013 after Mr A reported suicidal feelings.

Mrs A is reported to have told the LAS that her husband was depressed and had threatened to harm both him and herself. She also said that she had felt at risk on a few occasions and that this was why she slept in a separate bedroom. A telephone assessment was subsequently conducted by the Mental Health Trust's Adult Assessment Team (AAT) but by that time Mr A appeared to have stabilised and was able to reassure staff that he had no plans to harm himself or his wife. As a result, the patient was discharged back to the care of his GP.

There is no record that these apparently threatening thoughts were shared by any professional directly with Mrs A herself nor was she offered any advice or support in her own right about how she might ensure her own safety and well-being although the AAT did send some general information about the Merton Carers' Group and the support available locally to carers.

We noted that this is a difficult area where some subtle professional and ethical judgements may be required but it is something we comment on further in our conclusions and recommendations below. Compared to her husband, Mrs A herself had a low profile with health and other services although there is a suggestion that she may have had some alcohol dependency issues (this was apparently an issue when she lost her job in 2012). With the exception of Mr A's contact with NHS staff, the couple therefore appear to have had little desire or need to contact local statutory or voluntary agencies apart from occasional calls by Mr A complaining to the police about anti-social behaviour issues.

Were Mr and Mrs A offered support by the relevant agencies that was appropriate, sufficient and timely?

3.8 Because of Mr A's frequent referrals (and self-referrals) to local health services, it is evident that he received quite considerable inputs from a range of medical professionals for two decades or more. His deep-rooted feelings of anxiety and stress meant that he routinely sought out assistance from mental health services and, due to the frequency of his physical complaints, he was also a regular visitor to his GPs and to Kingston Hospital for a variety of mostly fairly minor ailments. Indeed, it was suggested during our discussion that one of the reasons why he changed his GP in October 2013 was his persistent complaints about the support he was or was not receiving from his previous practice.

During the investigation it came to light that Mr A had previously raised a complaint with the Kingston health service. The health provider had investigated this and addressed via their internal complaints procedure.

Given the general medical view that Mr A was not a high risk depressive who posed a serious threat to himself or others, it could be argued that he still received a very considerable amount of support from medical personnel in his area.

With regard to Mrs A, there is nothing in the written documentation to suggest that she actively sought practical help or any kind of emotional support even though her relationship with her husband was a difficult and stressful one where some external input might have been helpful to her. Furthermore, despite their apparent emotional disengagement, Mrs A continued to act effectively as her husband's principal carer and domestic helper up to the very day of her death. Her diary entries do not suggest that she felt seriously threatened by her husband although she clearly found him a difficult and unrewarding housemate. The panel did discuss whether the limited number of agencies involved with the couple might have been more proactive in offering support to Mrs A and, as indicated above, we return to this issue later on in this report.

What was the quality of the interaction and communication between the agencies in this case?

3.9 The documentation does not suggest that there were major flaws or weaknesses in the various communications that took place between the agencies working with the household. Mr A's own medical records show frequent referrals and information sharing between the agencies about his physical and mental health concerns. Regular exchanges took place between his GP practices, hospital staff and specialist mental health services over a very prolonged period and a considerable investment of professional effort was devoted to trying to help Mr A to

cope better with his various conditions. Despite Mr A's occasional use of threatening language concerning his wife, he was mainly viewed as someone who was prone to dramatization and unlikely to follow through on such threats. As noted above, this is a complex and sensitive area as the mere voicing of violent thoughts may not in itself be an indicator of future violent intent – indeed, in some cases, it may well be a means of releasing the pressures or anxieties that provoke such thoughts in the first place. That said, all agencies must take such statements seriously and there is clearly a duty of care to ensure that potential victims are aware of any serious threats made and that they are enabled to take appropriate safeguarding measures. It is clear from the professional exchanges concerning Mr A that he was often seen as a self-absorbed loner or an 'oddball' who struggled to fit in – a view shared as recently as 2014 by staff at the service user group that Mr A attended. He was never categorized by health or other professionals as a potential homicide risk and so the communications between agencies inevitably reflected this low level of risk assessment. Although we now know that he was indeed capable of inflicting very serious harm, it is frankly difficult to see how any of the relevant professionals could form this view based on the information available to them at the time of their engagement with Mr A.

Could or should anything else have been done in retrospect to avoid or reduce the risk of this tragedy happening?

3.10 The panel has given careful consideration to this issue but we do not believe there were significant organisational failings in the support offered to Mr and Mrs A given the information available at the time to the professionals involved with the couple (but principally of course with Mr A). It is clear from her own diaries that Mrs A did not perceive herself to be at serious risk even though she recognised that her husband's behaviour could be both volatile and unreasonable. The couple appeared to have argued frequently over the years and it does appear that Mrs A had started to raise the issue of a possible future separation, something which Mr A opposed. However, this discussion did not seem to have reached a clear conclusion at the point at which Mrs A was fatally attacked by her husband. The tone of her diary entries was of someone who understandably found her husband's harsh and unappreciative behaviour difficult to accept but who, despite that, was not yet in a position where she felt able to move on and out of the home they had shared together for more than thirty years. Tragically, it appears that she may have been taken by surprise by her husband's brutal and violent behaviour on 2nd February 2015 in the same way that most agency professionals have been shocked and surprised when it was subsequently disclosed to them. The prevailing view in the submissions we have received is that these were two unhappy people in a seriously dysfunctional relationship but who had not been able either to resolve their difficulties amicably or to disengage from one another in pursuit of a new and better life apart.

In retrospect, there may have been some 'windows of opportunity' for a more active and supportive engagement with Mrs A but we do not feel that the actions taken by the agencies were inherently unreasonable or neglectful given the paucity of indications about Mr A's potential to commit this heinous crime.

Conclusions and recommendations

4.1 The group considered whether more could have been done by any of the agencies and their staff to help support and potentially safeguard Mrs A in the months and years prior to her tragic death at the hands of her husband. Throughout his contact with professionals, Mr A was generally seen as a vulnerable person who may experience strong anxiety states but these were mostly seen as manageable through medication, therapy of various sorts or by improved social interaction with others. While he clearly had considerable contact with the National Health Service, in particular with mental health professionals, he was mostly viewed as a relatively low risk in terms of self-harm or harm to others. The fact that there were no known reports of domestic violence between the couple may well have reinforced this view.

4.2 From the information available, it is clear that the focus of most professional discussion was Mr A himself and with his needs rather than those of his wife or the few other people in his wider social or community networks. While accepting that this focus was understandable, we do think that greater attention could have been given to the possible risks being posed to Mrs A by her husband's sometimes threatening words and/or that someone in the medical and social care professions who had heard Mr A voicing violent thoughts against his wife should have acted at the time to ensure Mrs A's active personal involvement in the discussion of the case and any implications it might have for her own well-being. It is apparent from the account of the referral to the LAS in February 2013 that Mrs A had reported some concern on that occasion about her own safety but this does not appear to have been actively followed up and, after the initial referral to the LAS, Mrs A does not appear to have played any role in the assessment of her husband's condition even though she was the person most directly affected by his behaviour. Of course, we can only speculate how Mrs A might have reacted when and if presented with an opportunity to be more actively involved but we feel that she should at least have been afforded the chance to contribute and to make a more informed judgement as to the seriousness of the threat and how she could best protect herself from any risk.

Equally, it does not appear that Mrs A's fears were shared with other agencies, most notably of course the Metropolitan Police, nor does it appear that police views were sought as part of the AAT assessment process.

4.3 It is good practice to ensure that adults considered at potential risk of abuse are helped to understand the nature of the threat facing them and also allowed a confidential opportunity to have a private conversation on neutral territory with a relevant professional adviser or counsellor. They should also be involved directly in any professional assessment process so that their perspective is fully taken into account. This does not appear to have happened in this instance and we feel on balance that it should have done.

4.4 As the Independent Chair of this review panel, I have considered whether any further action of any kind is needed with respect to either agencies or individuals but **I do not feel that any further action is warranted** given the facts of this particular case.

Dealing with people with personality disorders or mental health problems is a challenging area of work for all professionals and one which can place very heavy burdens of professional responsibility on those undertaking that work. In retrospect and with fuller information available from all the relevant agencies, it is possible, sometimes, to identify steps that might have been taken by those concerned but we need to acknowledge that such a comprehensive and well-documented picture is not always available at the time to professional staff working with multiple cases in often professionally pressurized environments.

Equally, we must never forget the human consequences of poor practice or missed opportunities and we must always ensure that our guidance and support to staff address the needs of both potential perpetrators and potential victims. Getting this balance right is never straightforward but it is one we should always strive to achieve.

5. Acknowledgement

5.1 I am grateful to all the people and agencies who have participated in this Domestic Homicide Review and to everyone who provided written submissions to assist the panel in its deliberations. Although the subject matter has of course been harrowing, the process has been conducted in a professional and efficient way and in conformance with the national guidelines covering such reviews. I am particularly grateful to the staff of Merton Council's Public Protection Team who have supported the entire review process including my own role as the independent chair of the review panel.

Gareth Daniel

Chair of Review Panel

14th October 2015

