Shared learning bulletin

Homicide/matricide by a mental health service user George

This document provides an overview of the findings from a domestic homicide review into the care and treatment given to George, a mental health service user, who seriously assaulted his mother, in 2019, leading to injuries which resulted in her death. Agencies and teams who might benefit from this bulletin include the Police, housing providers, adult social care, safeguarding. As the range of lessons learned is quite wide, a separate bulletin has been provided for mental health providers.

Case background

George had intermittent, often fleeting, contact with the community mental health services over a period of over ten years, a significant history of serious drug misuse and for most of this period had a mental health key worker (an RMN) from the jointly run local substance misuse service. George had a very supportive family and his mother, who lived in independent living accommodation, saw him regularly. He was discharged from a mental health hospital admission two months before the homicide, but in subsequent weeks had become increasingly paranoid. He had called the police, ambulance and mental health services on numerous occasions during this period. His GP and family had also asked for help for him. George had previously been aggressive towards his mother and a few weeks before the homicide had locked her in his flat.

Key Findings

Lack of regard for the safety of George's mother and family

None of the agencies who came into direct contact with George and his mother considered the nature of their relationship beyond her being a supportive parent. No consideration was given to there being any element of coercive control in the relationship, nor how the relationship might have changed over the 20 years that the family was in contact with services as his mother aged, and her potential vulnerability increased. Housing provider was aware of these concerns when George's mother first moved into their property, but with changes in personnel, this intelligence became "lost" over time.

Safeguarding

After George's mother moved to independent living accommodation adult social care closed the case which related to his previous aggression to her. The domestic homicide review suggested that consideration should have been given to keeping her open to services for 3 to 6 months after this move, to determine if she was able to comply with the plan in place and maintain her own safety. It found that consideration should have been given to contacting the family before the closure of the safeguarding concern raised about the deterioration in George's mental health. This would have clarified the willingness and ability of the family to support George and allowed for consideration of any possible risks to the family. The police did not consider that George locking his mother in his flat a month before the homicide was false imprisonment, a safeguarding incident, nor a domestic abuse incident. This was a missed opportunity for the incident to be dealt with as either a criminal justice incident or mental health incident. None of the services involved in this incident made safeguarding referrals for George's mother. The police finalised the incident as being the result of George's substance misuse without considering the wider risks to George and his mother. George's symptoms were persistently considered by professionals to be as a result of his substance misuse; although there was evidence to suggest that in the month before the incident he was not using illicit substances and his mental health was still deteriorating.

Information sharing between health service and police force

There was no mechanism in place to facilitate information sharing between police and health services. Police officers/PCSOs who attended calls to George's address only had knowledge of George's mental health issues if they had attended previous incidents. Individual staff within the street triage team did not have independent access to both police and health service record keeping systems.

Critical Learning Points

1. Services need to recognise that, as carers age they become potentially more vulnerable.
2. The safety of carers/family members should always be considered when a service user is displaying coercive, controlling or violent behaviour. Safeguarding referrals should always be considered in such cases.
3. Domestic abuse training should consider issues around age and elderly carers.
4. The need to consider the safety of family members should be no different whether behaviour is seen to be driven by substance misuse or mental health issues.

Learning Quadrant

Individual practice

- All agencies - do I listen and take note of families concerns about a deterioration in their loved one's mental health/behaviour? Do I ensure that action is taken to keep all parties safe?
- All agencies - do I recognise how the needs and vulnerabilities of carers may change over time and take this into account with regard to risk assessment and safeguarding?
- Safeguarding - do I contact the family before closing a safeguarding referral which involved a threat to the safety of family members?
- Police - when I submit an adult care note/safeguarding referral do I ensure that consideration has been given to the potential vulnerabilities of all of the active participants in the incident?

Governance focused learning

- Police - how are we assured that our staff have timely access to information about a person's mental health when required?
- Police - how are we assured that our staff are trained and competent to identify vulnerabilities at incidents including identification of coercive and controlling behaviour especially within the context of adult familial violence?
- Safeguarding - how will the safeguarding partnership seek assurance that joint working arrangements work effectively the risk of silo working has been addressed?
- Ambulance – how are we assured that our ambulance crews consider safeguarding issues when responding to callers with mental health problems and elderly carers?

Board assurance

- Police - as a Board member how do I know that our service adequately considers the risk to, and safety of, vulnerable and elderly carers of people with mental health issues?
- Adult social care – as a Board member am I confident that our recording system can capture historical safeguarding relationships between alleged victims and perpetrators, to inform future safeguarding decisions?
- Housing providers – as a Board member how do I know that historical safeguarding and risk information is easily available to current staff?
- All - does domestic abuse training provided to our staff include information about how to take a longitudinal view of relationships, and how an individual's vulnerability increases with age, and their ability to maintain their safety decreases?

System learning points

- Is record sharing between the police and the NHS mental health trust effective in ensuring that all members of the street triage team have timely access to the information they require, and have an agreed approach on collaborative record keeping?
- Does the local domestic abuse strategy include appropriate focus on the impact of mental ill health, substance misuse and the risks faced by elderly, particularly female, carers?
- Does the local domestic abuse partnership board include adequate representation from mental health services?
- Have we recognised and responded to the need for system wide collaboration and learning in relation to serious incidents?