Shared learning bulletin

Domestic homicide by mental health service user Mr Y

Introduction

This document provides an overview of findings from a Domestic Homicide Review into the care and treatment of Mr Y, who committed the homicide of his wife, Ms Z.

Key themes: communication with families and medicine management

Agencies and teams who might benefit from this bulletin:

- Adult Social Care
- Mental Health provider services
- Improving Access to Psychological Therapy services (IAPT)
- Safeguarding partnerships and Domestic abuse organisations

Case background

Mr Y and Ms Z were Asian Pakistani and practiced a sect of Islam. They met several months prior to the incident and were married. They subsequently moved in together. Mr Y found Ms Z's family supportive towards him.

Mr Y had ongoing medical conditions which had caused him to leave his job. Ms Z was a housewife and was reportedly unhappy that he was not earning. Mr Y stated that this situation impacted their relationship, resulting in verbal arguments between them. He said that these disagreements were placing stress on him but he was reluctant to go to a doctor because he felt he would not be able to explain how he was feeling in terms of language or his understanding of how he was feeling.

Mr Y first accessed mental health services when Ms Z took him to the GP and stated that Mr Y was not feeling his normal self, had memory problems, was weak and felt stressed and tense. Mr Y was given medication but he was not fully compliant in taking it.

A month prior to the incident, Mr Y self-referred to the IAPT service and commenced sessions with a therapist. He reported unhappiness in his marriage. Mr Y later became irritable, depressed and experienced weakness in the body. Ms Z took responsibility for Mr Y's medication including sourcing homeopathic alternatives and would ensure that Mr Y took it, since he was not complying with his medication. Mr Y recalls taking whatever medication he was given.

Key findings

Care delivery

There were missed opportunities to gain collateral information about Mr Y, for example when Ms Z asked the team to speak to her brother. The Trust have identified the requirement for staff to be aware that they can speak to relatives even if the patient refuses to give consent.

No Carer's Assessment was offered, despite indications that it should have been.

Domestic abuse

It is unclear whether the marital tensions between Mr Y and Ms Z were fully explored by the mental health social worker, particularly in relation to any issues around Ms Z's personal safety. The lack of awareness of

the signs and 'red flags' regarding domestic abuse, in relation to Mr Y in particular, is apparent. The current training provided to staff should address this issue to enhance the awareness and understanding of mental health social workers about domestic abuse.

Service Delivery

The justification for a change in diagnosis was not documented in medical notes and there were mistakes in recording compliance with medication. Ms Z preferred her husband to take homeopathic medication, but it is unclear if this preference was ever shared with medical professionals or recorded.

There was a lack of coordination of care between the Trust and GP, and between primary and secondary mental health services. Both services were working with Mr Y at the same time, however there was no communication between these agencies.

Language Barriers

Mr Y did not speak English. In less than half of the visits an interpreter was provided, suggesting that there was room for misunderstanding and an inability for Mr Y to detail how he felt. Ms Z could speak rudimentary English but she may have had difficulty understanding medical terms. Ms Z's ability to access services for herself and for Mr Y was therefore diminished.

Key Learning Points

1. Trusts should develop a strategy which encapsulates the prevention, early intervention, partnership priorities and approaches to tackling domestic abuse when issues arise with service users.
2. Staff members should be fully trained in the medication monitoring regime. This should highlight the importance of not documenting a patient's compliance with medication until they have checked compliance or asked the patient if they have taken their medication on each visit, or clarified when further stock is due.
3. Interpretation services for patients should be easily accessible. The Commissioned Interpretation Services should be readily available to meet staff requirements in delivering a high quality service to patients and their families.
4. Trusts should enhance their engagement with BAME communities, older people and their support groups, to improve awareness of domestic abuse and how to access specialist support services.
5. Trusts should also work with faith communities to improve awareness of prevention and tackling domestic abuse, and to review the safeguarding approaches adopted by diverse faiths and places of worship.

Learning Quadrant

Individual/Team practice	Governance focused learning
• Have you considered the patient's cultural background and language and adjusted your approach accordingly, taking into account cultural norms and language difficulties when communicating with the patient? • How will compliance with medication be monitored? How do you manage non-compliance? • How well do you know the triggers and markers for non-violent forms of domestic abuse? • Are your electronic patient records accurate and up-to-date? • Does your risk assessment sufficiently consider risk of violence to others and include robust safeguarding interventions?	• How are you assured that all forms of potential domestic abuse and threats of harm are being considered? • Are there clear systems for working together, and the sharing of knowledge and skills? • Do you provide clear guidance to all staff on accessing interpretation services for patients?
Board assurance	**System learning points**
• How do your services recognise and respond to the risks of domestic abuse? • How are you assured that risk assessments are completed to the required standards? • Are there information sharing agreements and joint working practices with other key agencies? • How are you assured that NICE guidance is adequately adhered to within all local policies and procedures?	• Do you offer appropriate and up-to-date training to all staff on cultural sensitivity? • Do you provide specific training on all forms of domestic violence and abuse? • How are you supporting improved information management and sharing between agencies and services? • How are mental health services provided to people whose first language is not English? • How are you supporting improved communication between agencies and services, such as with local supportive faith organisations?