DOMESTIC HOMICIDE REVIEW – RDCNH/19

LEARNING BRIEF – 'MRS D'

ONE CALL CHANGES LIVES

THE REVIEW

The Safer Derbyshire Community Safety Partnership conducted a Domestic Homicide Review (DHR) regarding the sad death of Mrs D,[1] a resident of Derbyshire who died in 2019.

The key purpose of undertaking DHRs is to enable lessons to be learned from homicides where a person is killed as a result of domestic violence and abuse. The DHR report was authored by an independent reviewer, supported by a panel of senior representatives of all agencies who knew the victim and perpetrator. The Partnership is grateful for the contribution of Mrs D's family. Their perspectives on Mrs D and her grandson David, greatly added to the learning.

BACKGROUND

Mrs D was a woman of white British ethnicity who was in her seventies when she was killed by her grandson David. David killed his grandfather's dog and then killed his grandmother by stabbing her. David was experiencing a serious psychotic illness at the time. He held a delusional belief that Mrs D was a witch posing as his grandmother and that by killing her, he could protect himself and his family from harm.

David was in his twenties and living with his grandparents at the time of the fatal incident. He was a troubled young man having had a difficult childhood and poor relationship with his mother. He began using illicit substances and alcohol in his early teens. The family tried to get support for him, but alcohol and cannabis continued to dominate his life.

Mrs D was a key figure in her grandson's life and they were very close to each other. David had lived with his grandparents since he was sixteen. Mrs D had very little involvement from services in her own right. The family described Mrs D as a very caring person, but she would not identify herself as a carer; she simply saw supporting her family as being a mother and grandmother.

Mrs D supported David to attend his GP for help with anxiety, depression and problematic substance use. The GP provided appropriate treatment and referred on to mental health services. Services viewed his grandparents as a protective factor in supporting David's mental health. At no time was David assessed as being a risk of harm to others.

In the year leading up to Mrs D's death, various members of his family had noted David periodically appearing very frightened with strange behaviours and voicing paranoid beliefs.

Agencies were not aware of this. His grandmother was worried about him but was not sure how best to help him. Sadly, the true nature of David's paranoid beliefs about his grandmother were not known by anyone.

FINDINGS

It is important that reviews do not base findings on hindsight knowledge. Given the information that was known to agencies at the time, the death of Mrs D by her grandson was not predictable or preventable.

Agencies took reasonable steps to try and engage with David and to manage his mental health needs. Risk assessments that were carried out, did not identify him as being a risk to others. These were reasonable findings based on the information known at that time. Nonetheless, the review identified important learning.

[1] **Pseudonyms have been used, as agreed with family**

Derbyshire Domestic Abuse Helpline

08000 198 668

DERBYSHIRE County Council

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LESSONS TO BE LEARNT

ONE CALL CHANGES LIVES

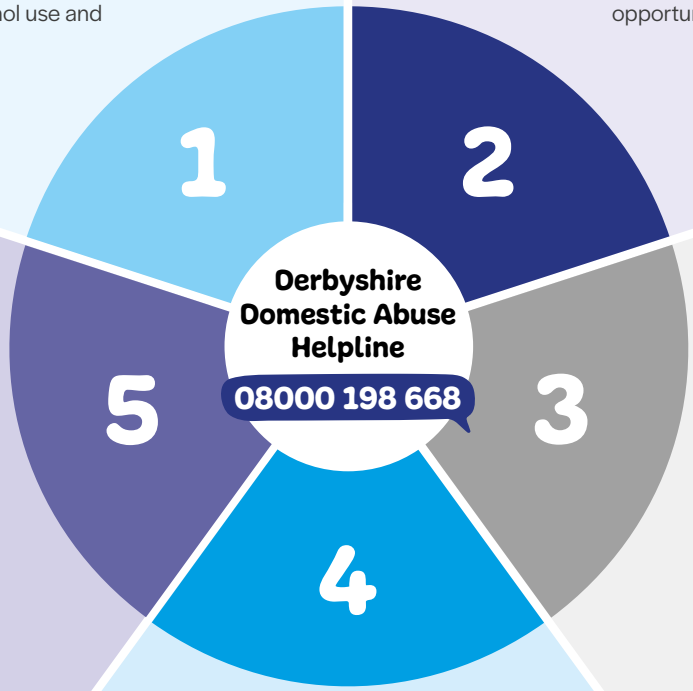
LEARNING FOR AGENCIES

EARLY INTERVENTION

Early intervention in young people's mental health needs to be a priority to reduce the likelihood of problematic substances and alcohol use and long-term mental health problems.

BRIEF INTERVENTIONS

Where substance or alcohol misuse is known, health professionals need to use every opportunity for brief motivational approaches based around harm minimisation.



ROLE OF GPS

GPs play a critical role in identifying risks associated with domestic violence and abuse. Their use of professional curiosity is essential in this task.

RECOGNISING CARERS

Carers play a key role in the individual's care. However, people providing care will not always identify themselves as carers. They may not be aware of how they can contribute information nor of what support they can receive. Agencies need to 'Think Family' and be attuned to identifying hidden carers. Services need to reach out to support and involve carers in the individual's care.

'DID NOT ATTEND' POLICIES

Agencies need to avoid blanket policies of ending services where the person does not attend and consider individual circumstances and risks. The needs of carers and family should also be considered within 'Did Not Attend' policies.

MESSAGES TO COMMUNITIES

1. Families and carers have unique knowledge about the person they are caring for. This information can be important to share with agencies in order for them to have a fuller understanding of the person and the best way to help. Agencies do have duties to protect a person's confidential information, however, information may be shared with others such as carers, with the person's consent. Agencies can also receive information from families and carers without breaching the person's confidentiality.

2. Caring for a family member with problematic substance or alcohol use or mental health needs can be a challenging and stressful role. Services are available to support carers and this is available, even where the cared for person is not in contact with services.

3. Research has highlighted a causal link between heavy cannabis use and psychotic disorders. Regular use of high-potency cannabis is highly hazardous to mental health.

POSITIVE PRACTICE

There was effective joint working between agencies in relation to David's care. David's GP was responsive to him, meeting expected treatment standards for anxiety and depression; providing good continuity of care and a holistic approach.