Domestic Homicide Review - John

What happened?

Prior to his death and for many years John Smith, a resident of Derbyshire, had been suffering from a rare, but debilitating, chronic pain condition caused by injury to a layer of the spinal cord. In 1972 John Smith had severe back pain and underwent investigations, involving an injection into the spine. He had a severe reaction to this, which he believed brought about a painful long-standing condition. From about 2008 his condition got progressively worse. The scoping period of the Review covered January 2014 to the date of John's death in autumn 2019 while John was living with his son, Stephen, and his elderly mother. There was very little contact with agencies.

In January 2018 the GP reviewed John's medication with his son and noted that John had not been seen face to face "for years", also that he was regularly experiencing pain and not taking any analgesic medication. In a typed note John described a number of unpleasant symptoms that restricted his daily life and that of his family, including: burning pain the full length of his spine, chronic lower back pain, bladder and bowel difficulties, pain down all four limbs, hypersensitive eyesight and hearing. In May 2018 Stephen attended the GP surgery on behalf of his father, and, a week later the GP carried out a home visit to see John, who was house-bound and bed-ridden, with pain and multiple symptoms. His mood was very low and hopeless. The GP's diagnosis was of complex issues including severe depression, and they referred him to palliative care team and the Community Mental Health Team. John was seen by a community psychiatric nurse, and he described suicidal thoughts but reported no active plan to end his life: he declined further input from mental health services, and said he was waiting for palliative care input. Stephen stated they did not need any support from social services. The next month the GP and a palliative care consultant visited John at home, but he could not tolerate assessment and did not attend a subsequent pain clinic appointment. A palliative care consultant phoned and offered a further follow-up appointment to explain what interventions could be offered to John - this was declined by Stephen on behalf of his father. An open-ended appointment was put in place however there was no further contact from John or Stephen and the GP, whom John trusted, went on long-term sick leave - John's care was not picked up by anyone else at the practice.

On a date in November 2019 Police were called to John's home address following a telephone call from Stephen, who stated that his father had taken his own life. John was found lying in bed and there was evidence that he had inhaled Argon gas. No note was found. Stephen identified his father's body and stated his father had talked about committing suicide in the past. The death was deemed non-suspicious and the attending officer completed the investigation. Later review led to further investigations and interviews with Stephen but possible charges were dropped and HM Coroner reached a conclusion of suicide.

What did it tell us?

- Reviews of John's medication were sometimes carried out by the GP with John's son and without seeing John himself
- John had a positive relationship with his GP who he felt understood his situation but when his GP went on long-term sick leave there was no mechanism in place to ensure that John's care was picked up
- The family became socially isolated
- Stephen's role as a carer was known to several agencies but there is no evidence that he was offered a carer's assessment and it is likely that the purpose of a carers assessment was not clearly explained to him
- The relationship between depression and pain was not understood by John who declined input from mental health services
- Offering out-patient appointments to someone who is bed-ridden was inappropriate
- On several occasions Stephen declined input on behalf of his father so his father was not involved in discussions about treatment options

What can we do now?

- When a member of the primary care team goes on long-term sick leave, procedures need to be in place to ensure that patients with long-term conditions are followed up
- Recognise the risk - where carers are isolated and witness the suffering of the person they care for over a long time and are repeatedly subjected to that person's belief that suicide may be/ is the only way out for them, they may understandably come to share that belief
- Review how carers assessments are explained to carers who know that the person they care for does not want service involvement
- Generate positive engagement with people like John by a proactive professionally-curious approach over time