# BARNET COMMUNITY SAFETY PARTNERSHIP

SAFER COMMUNITIES PARTNERSHIP

Keeping Barnet Safe

# DOMESTIC HOMICIDE REVIEW

into the death of
Songul in October 2013

# OVERVIEW REPORT


Report Author

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# DOMESTIC HOMICIDE REVIEW

## Preface

The Barnet Domestic Homicide Review Panel would like to express their sincere condolences to the family members affected by the sad events which have resulted in this Review. The death of a family member is never easy to come to terms with, and when it is the result of the actions of another family member the loss is undoubtedly particularly keenly felt.

The independent chair and author of the Review would also like to express her appreciation for the time, commitment, and valuable contributions of the Review Panel members and contributory report authors. This Review has been complex and the Panel has carefully considered many issues concerning the victim and the perpetrator in coming to its findings. We believe there is important learning on a national as well as local level from this Review, particularly with reference to vulnerable adults and their carers.

This report of a domestic homicide review examines agency responses and support given to the victim, a resident of London Borough of Barnet prior to the point of her death in October 2013. The Review will consider agencies contact and involvement with the victim, and with the perpetrator, from October 2011 up to the date of the fatal incident.

The key purpose for undertaking a Domestic Homicide Review (DHR) is to enable lessons to be learned from homicides where a person is killed as a result of domestic violence. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future. The victim's death met the criteria for conducting a domestic homicide review under Section 9 (3)(a) of the Domestic Violence, Crime, and Victims Act 2004, namely the homicide appeared to be by a person to whom the victim was related, or with whom they had, or had been in an intimate relationship. The Home Office defines domestic violence as:

> *Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse: psychological, physical, sexual, financial, and emotional.*
>
> *Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour. Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim*

The term domestic abuse will be used throughout this Review as it reflects the range of behaviours encapsulated within the above definition, and avoids the inclination to view domestic abuse in terms of physical assault only.

# 1. Introduction

1.1 The circumstances leading to this Review are the result of a phone call to the London Ambulance Service in the early hours of 5 October 2013 by a concerned relative requesting their attendance at the home of the victim and her son. Due to the concerns raised by the relative the Ambulance Service requested Police attendance. There was no response to knocks on the door and a forced entry had to be made to the property. The victim's body was found in the living room with her son lying down close to her. Her son was arrested at the scene and later charged with his mother's murder.

### Timescales

1.2 The Barnet Community Safety Partnership held a meeting on 29 October 2013 following notification by the Police of the death on 10 October. The Home Office was informed of the Partnership's decision to undertake a Domestic Homicide Review (DHR) on 11 November 2013. It was not possible to complete the Review within six months of commencement as required by statutory guidance due to the timescale of the criminal proceedings which concluded on 23 July 2014 after which the Review recommenced.

### Confidentiality

1.3 The findings of this review are confidential. Information is available only to participating officers/professionals and their line managers until the Review is approved by the Home Office Quality Assurance Panel for publication.

1.4 Statutory Guidance requires that this report is anonymised to protect the identity of the victim, the perpetrator, and their families. To fulfil this duty the following pseudonyms have been used throughout this report:

The victim: Songul. At the time of her death Songul was 69 years old.
The perpetrator: Damon was the victim's son. At the time of the homicide Damon was 42 years old.

1.5 Songul was of Iranian ethnicity. She was of insecure immigration status having been refused leave to remain in the United Kingdom. She had appealed this decision a number of times and was in the process of a further appeal.

1.6 Damon is of also of Iranian ethnicity. He is a naturalised British citizen (see 3.3).

### Dissemination

1.7 The following will receive copies of this report.

Chair and Board members Barnet Safer Community Partnership Board
Chief Executive, Royal Free Hospital NHS Trust (formerly Barnet & Chase Farm Hospital NHS Trust)
Commissioner (Chief Constable), Metropolitan Police
Borough Commander for Barnet, Metropolitan Police
Deputy Mayor for London Policing & Crime
Chief Executive of the London Borough of Barnet
Director of Adults & Communities, London Borough of Barnet
Chief Executive, Barnet, Enfield & Haringey Mental Health Trust
The Chair of Barnet Clinical Commissioning Group

The Chief Officer of Barnet Clinical Commissioning Group
Board Chair of Central London Community Healthcare Trust
Chief Nurse, Central London Community Healthcare Trust
Chief Executive of Central London Community Healthcare NHS Trust
Chief Executive, London Ambulance Service NHS Trust
The Chair, Safeguarding Board for Adults & Children, London Borough of Barnet
Medical Director, NHS England,
Chief Executive, Victim Support
Senior Partner Longrove Practice
Senior Partner Vale Drive Medical Practice

## Terms of reference of the review

1.8 Statutory Guidance states the purpose of the Review is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;
- Apply these lessons to service responses including changes to policies and procedures as appropriate; and
- Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.
- To seek to establish whether the events leading to the homicide could have been predicted or prevented.

This Domestic Homicide Review is not an inquiry into how the victim died or who is culpable. That is a matter for coroners and criminal courts.

1.9 Terms of Reference for this Review:

1. To review the events and associated actions that occurred which relate to the victim and the alleged perpetrator between October 2011 and 5 October 2013 the date of the victim Songul's death. Agencies with knowledge of the victim or alleged perpetrator in the years preceding the timescale for detailed review are to provide a brief summary of that involvement.

2. The agencies which had involvement with the victim and the alleged perpetrator to assess whether the services provided offered appropriate support, resources, and interventions, and that procedures were followed. This to include any interaction with family members or friends which have relevance to the scope of this review as identified within agencies' records, Individual Management Reviews (IMR) or other information sources as deemed appropriate.

3. To assess whether agencies have sufficient and robust relevant policies and procedures in place, and whether these are up to date and fit for purpose in assisting staff to practice effectively where domestic abuse is suspected or present.

4. To examine the knowledge and training of staff involved in relation to safeguarding of vulnerable adults, the identification of indicators of domestic abuse, the application and use of appropriate risk assessment tools and safety planning including:

- The CAADA DASH[1] risk indicator checklist and referral mechanism to MARAC[2].
- Agencies own specialist risk assessment tools to assess risk posed by a perpetrator and/or risk posed to victim and follow up processes;
- Knowledge and use of appropriate specialist domestic abuse services.

5. Examine the effectiveness of single and inter-agency communication and information sharing, both verbal and written.

6. Explore what issues if any prevented the perpetrator accepting the services offered to support him.

7. To consider what impact the victim's immigration status had on how agencies responded to her needs.

### Methodology

1.9 Following enquiries of agencies to ascertain which had contact with the family agencies were ask to secure their files and chronological information was gathered and submitted. The information formed the source of the chronology of this Review. This provided the initial picture of what had taken place and a basis for further enquiry via the submission of Individual Management Review (IMR) by agencies. The IMRs were discussed and quality assured by the DHR Panel. A number of IMRs had gaps or required additional information to meet the terms of reference and this was requested from their authors.

1.10 Agencies undertook a review of their electronic systems and records and in some cases paper records where these pre-dated the introduction of electronic records. Mental Health and Adults & Communities also reviewed meeting minutes and relevant email communication. Interviews were held with appropriate staff within the hospital including physiotherapy. The Ambulance Service was unable to interview staff due to the number of call-outs over the time period and the shift patterns worked by those involved. Practitioners in the Old Age Psychiatry Team were interviewed as part of the Mental Health Board Level Enquiry. The victim's GP IMR stated that there were discussions with the practice GPs in two separate groups, but no individual interviews took place. This IMR does not summarise the outcome of these discussions. Staff involved within Adults & Communities from whom social work and social care services were delivered were interviewed, however one key member of staff had left the organisation and one was on maternity leave therefore contributions from these staff members could not be obtained. The Farsophone Association which provides a range of support services to the Iranian community as well as working towards mutual cultural appreciation between Iranian and UK residents

[1] The CAADA (Co-ordinated Action Against Domestic Abuse) DASH (Domestic Abuse Stalking & Harassment) is a risk assessment checklist consisting of 24 questions to ascertain the level of risk a victim faces. The questions are formed from an evidence base of known behaviours or experiences shown to lead to a serious risk of harm or homicide.

[2] Multi-Agency Risk Assessment Conference (MARAC) A multi-agency meeting at which information is shared, risk assessed and safety plans are made to protect high risk victims of domestic abuse.

has provided information, although their information was limited as their attempts to contact the family were not successful. Barnet College reviewed their electronic records and staff that had contact with the perpetrator were interviewed for their IMR. The victim's solicitor who was acting on her behalf to appeal the Immigration Service rejection of her application for leave to remain declined to take part in the Review due to the Solicitor's Code of Ethics on client confidentiality.

1.11 All bar one of the IMR authors were independent of case involvement and/or the line management of practitioners who had contact with the family. Statutory agencies IMRs were undertaken by authors holding a strategic role i.e. safeguarding leads, director of nursing or by an officer in a dedicated Review unit as was the case with the Police and Ambulance Service. The victim's GP practice IMR was undertaken by one of the GPs who is a partner in the practice who had not seen the victim or perpetrator. The Victim Support IMR was undertaken by a senior service delivery manager, who declared that they had line management responsibilities for those who had telephone contact, but they had not personally had contact with the perpetrator. This IMR was signed off by a divisional manager. The DHR chair and author is satisfied that the Victim Support IMR has looked openly and critically at their practice in this case.

1.12 The Review was hampered during its process by the inability to achieve an IMR or adequate report from the perpetrator's GP. The practice helpfully provided brief dateline information for the chronology and answered a number of specific questions via email and an attendance at a Panel, but a Review conducted from within the practice's own resources was not appropriate as it is a very small practice and the GPs are related. The Panel was informed that resourcing an independent IMR was not possible for the practice and other means of achieving resources from a variety of sources proved unsuccessful. Communication with NHS England and the Clinical Commissioning Group has been unable to resolve this matter. The Panel believes this is an issue for the Department of Health to investigate and resolve as soon as possible and a recommendation has been made to this effect.

1.13 Unfortunately, it was not possible to combine the Mental Health enquiry process with the DHR. The short timescale for the commencement of the Root Cause Analysis Enquiry meant this was completed before the DHR terms of reference were agreed, and although the DHR chair attempted to combine the terms of reference into the Board Level Enquiry which followed this did not happen for administrative reasons. Additional information was therefore requested to supplement the Board Level Inquiry to meet the DHR terms of reference.

1.14 Agencies were asked to examine their policies and assess whether these were appropriate and were followed in practice. Policies reviewed were:

- Mental Health Safeguarding Adults at Risk Policy (2010 reviewed July 2013
- Carers Strategy (2006 reviewed November 2011)
- Sharing Information Policy
- Health and Adults & Communities Section 75 Agreement
- Mental Capacity Act 2005
- Protecting adults at risk: London multi-agency policy and procedures to safeguard adults from abuse (January 2011)

1.15 Information was also requested from NHS England regarding safeguarding and information sharing policies for the NHS 111 Service, however this was not received by the time the DHR was concluded.

1.16 NHS Direct archives department provided information regarding calls to their service before it was disbanded.

1.17 The author was given access to psychiatric reports used at Damon's trial, and on application to one of the authors was granted permission to cite passages from their report. The author is grateful to Dr Phillip Joseph, consultant forensic psychiatrist for his assistance. The author is mindful of patient confidentiality and the passages have been used sparingly. They have been selected because they provide helpful insight and learning for practitioners.

1.18 The DHR Panel has had advice to assist in their understanding of Iranian cultural life and customs from the Iranian, Kurdish Women's Rights Organsiation (IKWRO). The chief executive of Barnet Mind was also invited onto the Panel to provide a non-statutory perspective and constructive challenge with regard to the mental health aspects of this Review, and they were able to attend one Panel.

1.19 The author sought the medical opinion of the consultant responsible for Damon's care in hospital concerning the possibility of interviewing him for this Review, but was advised that he was not well enough to take part. It was also not possible to gain his consent to access his information on health grounds; therefore it was obtained in the public interest and under Section 115 of the Crime and Disorder Act 1998 which allows relevant authorities to share information where necessary and relevant for the purpose of the Act, namely the prevention of crime. In addition, Section 29 of the Data Protection Act 1998 enables data to be transferred if it is necessary for the purpose of the prevention or detection of crime, or the apprehension and prosecution of offenders. The purpose of this Domestic Homicide Review is to prevent other similar crimes.

1.20 After liaising with the Family Liaison Officer for the family letters were sent to close family members at the beginning of the DHR process outlining the areas to be covered by the Review's terms of reference. The author was informed that the family spoke English, and although the letters were written in English a copy of the Home Office DHR leaflet in Farsi was included to assist their understanding of the process and purpose of a DHR. Prior to the trial it was thought that members of the family would be called as witnesses, therefore further contact was made by letter and telephone calls after the trial was completed. There was only one response to these further communications therefore the author has had to respect some family member's choice not to contribute.

1.21 Contributions from those who knew the victim and perpetrator have been given to the author via interview and they were informed of the learning and recommendations of the DHR. They expressed a wish to receive a copy of the Executive Summary only of the report and this will be provided following clearance for publication. The contributors wish to maintain their anonymity and in respect of this the author will not identify how they know the parties involved. The author is most grateful for their contributions.

### Contributors to the Review

1.22 Under Section 2(4) of statutory guidance[3] for the conduct of DHRs it is the duty of any person or body participating in a Review to have regard for the guidance. However, it must be noted that whilst a person or organisational body can be directed to participate, the chair and DHR Panel do not have the power or legal sanction to compel their cooperation or attend Panel for interview.

Agencies and the nature of their contributions to the Review are:

- Barnet Adults & Communities Department – chronology & Independent Management Review (IMR)
- Barnet, Enfield & Haringey Mental Health NHS Trust – chronology, Root Cause Analysis Investigation Report, & Board Level Panel Inquiry Report
- Barnet Hospitals NHS Trust – chronology & IMR
- Central London Community Healthcare NHS Trust – chronology & IMR
- London Ambulance Service NHS Trust – chronology & IMR
- Royal Free Hospital NHS Trust – chronology & IMR
- Metropolitan Police – chronology & Report
- Longrove Practice – chronology & IMR
- Vale Drive Medical Practice - chronology
- Victim Support – chronology & IMR
- Barnet & Southgate College – chronology & IMR
- Farsophone Association – information
- Home Office Immigration Service Evidence & Enquiry Unit – information
- NHS Direct archives - information

Review Panel Members:

1.23 Due to organisational changes taking place during the period of the Review Panel membership changed over time. The following were members of the Review Panel throughout or were members in the concluding stages and contributed to the deliberations and conclusions of the final Overview Report:

Manju Lukhman, Domestic Violence Coordinator, London Borough of Barnet
Karen Jackson, Assistant Director, Adult Social Care London Borough of Barnet
Christine Dyson, Interim Head of Safeguarding People, Barnet, Enfield & Haringey Mental Health NHS Trust
Kiran Vagarwal, Head of Service for Community Safety, London Borough of Barnet
Nazira Mehmari, Advice Coordinator, Iranian, Kurdish Women's Rights Organisation (IKWRO)
Heather Wilson, Adult Safeguarding Lead, Barnet Clinical Commissioning Group
Kate Bushell, Adult Safeguarding Lead, Central London Community Healthcare NHS Trust
Liz Royal Head of Safeguarding, Central London Community Healthcare Trust
Kate Aston, Adult Safeguarding Lead, Central London Health Care Trust
DS Angie Barton, Critical Incident Advisory Team, Metropolitan Police
Caroline Birkett, Divisional Manager North London Victim Support
Deirdre Blaikie, Safeguarding Adult Lead, Royal Free Hospital NHS Trust
Gaynor Mears, Independent Chair & Report Author

Other Occasional Contributors were:
Dr Ritata, Safeguarding GP, Barnet Clinical Commissioning Group

[3] Home Office (2013) *Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews - Revised*

Christina Meacham, Chief Executive, Barnet MIND
DS Marc Jones, Senior Investigating Officer, Metropolitan Police
Prof Mary Sexton, Executive Director of Nursing Quality & Governance, Barnet, Enfield & Haringey Mental Health NHS Trust
DI Kay Wise, Barnet Borough, Metropolitan Police.

### Author of the Review:

1.24 The author of this DHR Overview Report is independent consultant Gaynor Mears OBE. The author holds a Masters Degree in Professional Child Care Practice (Child Protection) and an Advanced Award in Social Work in addition to a Diploma in Social Work qualification. The author has extensive experience of working in the domestic violence field both in practice and strategically, including roles at county and regional levels. Gaynor Mears has undertaken previous Domestic Homicide Reviews, and research and evaluations into domestic violence services and best practice. She has experience of working in crime reduction, with Community Safety Partnerships, and across a wide variety of agencies and partnerships. Gaynor Mears is independent of, and has no connection with, any agencies in Barnet in the past or currently.

### Parallel Reviews:

1.25 A coroner's inquest was opened and adjourned. As the victim was a current patient of Mental Health Services for Older People at the time of her death a Root Cause Analysis Investigation Report commenced soon after the homicide became known and this concluded on 10 December 2013. It was followed by a Board Level Panel Enquiry which concluded on 2 June 2014. On 29 October 2013 a discussion took place between senior executives within the London Borough of Barnet Adults and Communities department and the chair of the Community Safety Partnership where consideration was given to the holding of a Safeguarding Adults investigation or a DHR. The decision was taken to hold the DHR.

## 2. The Facts

2.1 Songul, the victim, lived in Barnet in the home of her third child her son Damon. Songul separated from her husband approximately 35 years ago; she came to the United Kingdom in 1988, but could not settle and she returned to Iran for prolonged periods, however she visited the UK frequently for the lengths of time permitted by her visa. In 1997 Songul suffered a Cerebrovascular Accident (CVA - stroke) which resulted in right side weakness, this and further suspected CVAs and Transient Ischaemic Attacks left her with poor mobility; she also suffered from diabetes which was controlled by tablets. Songul resided in Barnet in the home of her son Damon on an ongoing basis in recent years. He was her main carer. Applications for Songul to be granted leave to remain in the UK were made and rejected. At the time of her death a local firm of solicitors was acting on her behalf to appeal the decision. Damon was known to work in various jobs, but there were periods of time where his caring role prevented this.

2.2 Songul and Damon received financial support from her ex-husband, and until recent years her ex-husband and another adult child also supported them with Songul having short stays with her other child and ex-husband's family. Family conflict, notably Damon's aggression towards his sibling, and an assault on his

father's wife, reduced this contact and in the year leading up to Songul's death contact significantly reduced or was telephone contact only. Damon told various practitioners that his family member's were afraid that direct meetings with him would lead to altercations, and contributors to the Review confirm this was the case. There was also telephone contact with Songul's adult children in Iran and occasional visits by them to the UK.

2.3 Songul's death was discovered following a phone call to the Ambulance Service by a relative who was concerned about her and the apparent upsetting nature of their phone call to her son Damon. The relative requested that an ambulance be sent to the family home and this was dispatched in the early hours of the 5 October 2013. Due to the concerns raised in the call the London Ambulance Service asked the Police to attend. Police arrived at the family address within 10 minutes of the call being made and met with the Ambulance Service. As there was no reply to repeated knocking at the front and rear doors of the premises entry had to be forced. A large amount of blood was seen on the kitchen floor. Damon was found in the living room lying with his mother's body. He was immediately removed and handcuffed. Songul had extensive injuries around her head and face. She was believed to have been severely beaten. She was pronounced deceased by the Ambulance staff at 02:10hrs.

2.4 A Post Mortem was carried out at Northwick Park Hospital on Sunday 6 October 2013 by Pathologist Dr Nathan Cary. Cause of death was recorded as blunt trauma head injury. A Coroner's inquest was opened and adjourned.

2.5 Damon was arrested on suspicion of the murder of his mother and charged on 6 October 2013. He was remanded in custody, but later transferred to a secure hospital. Following psychiatric assessments it was agreed that at the time of the attack on his mother Damon was clearly in a disturbed state of mind. During assessment he said that he felt energy came out of him and he maintained that 'jinn' (evil spirits) had possessed his mother and himself and the attack was carried out to 'get evil spirits out of his mother'. He also heard voices coming from items of household equipment. On the day of the incident Damon had taken amphetamines and cannabis reportedly to help the back pain from which he was suffering. Although the two assessing psychiatrists were not unanimous on a precise diagnosis, opinion was that his mental health appeared to have been deteriorating since March 2013 and by the October he was severely psychotic with paranoid delusions and may have been suffering from late onset schizoid psychosis.

2.6 Damon did however, accept some responsibility for what happened. His plea of guilty to manslaughter on the grounds of diminished responsibility was accepted by the court and Damon was sentenced to a Hospital Order under Section 37 of the Mental Health Act 1983 on 23 July 2014. In summing up the judge accepted that the role of sole carer for his mother would not have been easy and he was a caring son. Damon's family had confirmed that he was close to his mother, but he had accepted responsibility for the "terrible attack leading to her death". However, the judge accepted the explanation of paranoid psychosis at the time, and said that whilst it was easy to judge in hindsight, Damon had not been given appropriate care 4 days before the incident. Damon was assessed as having "a chronic and enduring condition"; he would be at risk of relapse, and his condition would be exacerbated by the use of cannabis or drugs. Taking into account events leading up to the death of his mother Damon was assessed as posing a risk to the public. To reinforce this view the judge also made a Section 41 Restriction Order.

2.6 Songul had not been assessed as a 'vulnerable adult' as defined by Department of Health 'No Secrets' guidance. Under this guidance a 'vulnerable adult' is:

> *"An adult (a person aged 18 years or over) who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or serious exploitation." No Secrets, Department of Health 2000*

The term 'vulnerable adult' has now been replaced by the term 'Adult at Risk' which is similarly defined as:

> *"adults who need community care services because of mental or other disability, age or illness and who are, or may be unable, to take care of themselves against significant harm or exploitation'.*
>
> *An adult at risk may therefore be someone who is:*
>
> - *is elderly and frail due to ill health, physical disability or cognitive impairment*
> - *has a learning disability*
> - *has a physical disability and/or a sensory impairment*
> - *has mental health needs including dementia or a personality disorder*
> - *has a long-term illness/condition*
> - *misuses substances or alcohol*
> - *is a carer such as a family member/friend who provides personal assistance and care to adults and is subject to abuse*
> - *is unable to demonstrate the capacity to make a decision and is in need of care and support*
> - *(This list is not exhaustive.)*
>
> Social Care Institute for Excellence (2011) *Protecting adults at risk: London multi-agency policy and procedures to safeguard adults from abuse' (page 4).*Adults' Services SCIE Report 39

2.7 Although never defined as such in any of her assessments, it is clear from the information gained during the course of this Review that Songul did meet a number of these criteria.

## 3. Chronology

### 3.1 Background Information Prior to 2011

3.2 Songul was born in Iran in 1944. She was married at the age of 19 years and she and her ex-husband had four children. Damon's father came to the UK from Iran for religious reasons. Songul left Iran with her children in 1984 as the family did not want their children conscripted into the Iranian army to fight in the Iran Iraq war (1980-88). Damon was 6 or 7 years old at the time. They spent some time in Turkey before moving to England. Songul's ex-husband remarried and he and his wife live in the same area as Songul. Two of Songul's adult children live in Iran and two in England. Songul was first known to an

agency when she registered with a Barnet GP practice on 11 March 2003. The GP records note that this was the date on which she entered the UK from Iran, although during an assessment Songul told a social worker that she had been coming and going from 1975 until 1997; between March 2003 and 1 October 2011 Songul lived for prolonged periods in Iran where she also received medical treatment. In the UK she stayed periodically with her ex-husband and his family, until Damon's father assisted him to buy his own home, after which Songul stayed with Damon. He was her third child. Both were of the Muslim faith.

3.3 Damon was naturalised as a British citizen on 20 July 1995. Between August 2000 and November 2002 Damon was an out-patient of Mental Health Services in Barnet. He was diagnosed as suffering from depression and experiencing unresolved grief reaction after the deaths of 2 relatives in Iran. His attendance was sporadic and he frequently failed to keep appointments. In August 2002 he was seen by a Mental Health Crisis Team in a Police station where he had been detained after becoming angry with a friend and his then girlfriend. He was referred for an anger management course, but he did not attend and was discharged. His last contact with specialist Mental Health Services was in November 2003 when he was seen in Barnet Hospital A & E Department with 'general paranoia and inability to cope'. He was not judged to be suicidal and was advised to see his GP for medication review and to make an appointment with the A & E liaison nurse if needed in future.

3.4 Songul applied to the embassy in Tehran for a visa to visit the UK and was granted a visa for a maximum of 180 days between 24 April 2007 and 24 April 2009. This probably explains her prolonged visits to Iran. From 27 December 2007 until 2 October 2009 Songul made five applications seeking leave to remain in the UK. Each application was refused, the last time being 14 December 2009. This meant that she was an illegal over-stayer from this point. It is understood that a local firm of solicitors were acting on her behalf to try and change this position. Her immigration status had implications for her access to services for some years.

3.4 Songul suffered a stroke in 1997 which resulted in right-side weakness. Following the stroke she experienced severe depression and from 2006 medical records show that Songul suffered from a number of episodes of depression, with and without psychosis; she was also treated for a psychotic episode in Iran. She had Type 2 diabetes which was well monitored and controlled by tablets, and Vitamin B12 deficiency for which she had regular injections. Due to the impact of the stroke Songul's mobility became gradually more impaired; she had significant walking and balance problems and used a frame to move around the house and a wheel chair outside the home. Contributors to the Review who knew her report that the effects of the stroke were not so debilitating at first, but she appeared to 'give up' in recent years. She needed assistance in most areas of her daily living activities including her personal care. Her son Damon at the age of 36 years old took on a great deal of her personal care including help with dressing and bathing. Her need to be cared for appears to coincide with the onset of her depressive illness in 2006; prior to this she looked after her herself and son Damon in his home.

3.5 When his mother first came to live with him Damon was working full time. In 2005 he is known to be working as a doorman, for on 27 January the Metropolitan Police investigated an allegation of assault by Damon on a victim who had been barred from a pub. There were no injuries to the complainant, no corroborating evidence and no further action was taken. Prior to this Damon's

only contact with the Police concerned an altercation in the street with another man; neither made any allegations and the matter was closed.

3.6 Damon himself appears to have been anxious about his health. He reported that family members had health problems which may have increased his anxiety about his own health. In April 2000 he consulted his GP due to depression and feelings of difficulty coping. He was prescribed anti-depressants, but he declined a referral for counselling, and in July 2000 he was seen by the Mental Health Team who changed his medication. In October 2002 he appears to still be in contact with the Mental Health Team when he saw his GP for a repeat prescription 'as advised' by the Team. Visits to his GP frequently resulted in referrals for further investigations at hospital clinics, or he would visit the local Accident & Emergency (A & E) department sometimes for very minor matters. During an appointment in November 2007 Damon stated that he had started smoking 'due to the stress of his ailing mother.'

3.7 On 1 November 2008 Damon's GP received a letter from a step-relative asking that he be referred to a psychiatrist 'for his violent behaviour'. The GP sought guidance from the Medical Protection Society and was advised that consent was needed by the patient if he had capacity. Damon was deemed to have capacity and he declined a referral to Mental Health Services. Contributors to the Review confirm that the letter to the GP was prompted by an assault by Damon on his father's wife in which she was grabbed around the throat resulting in marks and bruising. The matter was reported to the Police, but it was decided not to pursue a complaint. Instead on Police advice Damon was told he could no longer visit his father's house. This incident was not found by the Metropolitan Police IMR author. It would appear that Damon was made aware of the letter sent to his GP as contributors report that he in turn wrote a long letter of complaint to the Medical Protection Society.

3.8 Damon suffered from anxiety and high blood pressure in early 2008, a year in which Songul was seen due to a fall on 3 April, and on 7 November 2008 she was seen in the Accident and Emergency Department (A & E) at Barnet Hospital with a history of not being able to walk for 2 days; her history of depression was noted. The possible diagnosis was thought to be a further CVA (Cerebro-vascular Accident - stroke) or Catatonic depression. During the consultation the doctor recorded 'lives with son in a house, sleeps in same bed as son'. It is not clear what the outcome of this presentation was, but on 11 November 2008 a faxed Section 2 notification[4] was received from Barnet Hospital by the Barnet Hospital Social Work Team. This notification was received by Social Services from an acute hospital to inform them of the need for social services input for a patient under the Community Care (Delayed Discharges) Act 2003. The team's electronic record shows a notification was received from Barnet Hospital and a referral was passed to social worker 3 that day and then on to assessment and enablement officer 3[5] on 12 November 2008. An electronic entry for the 14 November 2008 records a telephone call from a Barnet Hospital doctor was received by social worker 1. Details indicate "potential Adult Protection" and "message passed to senior social worker 1". The outcome of the contact was 'No Further Action – information/advice offered'. No further details were recorded nor what action was taken as a response, or if social worker 1 acted upon the information.

[4] This notification is received by Social Services from an acute hospital to inform them of the need for social services input for a patient under the Community Care (Delayed Discharges) Act 2003.
[5] An assessment and enablement officer is an 'unqualified social work post. This post does not hold responsibility for safeguarding and cannot take the role of investigating officer.

3.9 On 21 November 2008 GP3 at Songul's GPs practice received a message from her ex-husband's wife stating that Songul's son had assaulted his mother. The GP notes that he 'may not be capable of looking after her and may need more Social Services input'. This appears to have been incorrectly recorded as the Review author is informed that it was Damon's father's wife who was the victim of his assault; she is a patient at the same practice and had contacted her GP about her injury.

3.10 On 26 November 2008 a case note in electronic records by social worker 2 in the Edgware Hospital records the arrangement of a home visit to complete a community care assessment. The visit took place on 27 November 2008 when social worker 2 'advised that the client did not meet the eligibility criteria for services as she has no recourse to public funds due to her immigration status'. Advice was given to seek help from Citizens Advice Bureau. Contributors to the Review recall that they were told that Songul could go and live with Damon, although they were concerned about his volatile behaviour. Contributors report that an arrangement for sharing the care of Songul between family members was suggested, but this was declined by Songul and Damon.

3.11 The events of November were followed by a visit to Damon's GP practice on 1 December 2008 by Damon, his mother and sister-in-law. They explained that they had problems with their step-family and they thought the step relative who wrote the letter to the GP was trying to get him into trouble. The Police were said to be involved and a case reference number was given to the GP, however the Police have been unable to find a record of this. The GP chronology note records 'not appeared violent and no action taken'.

3.12 By 2009 Damon had given up full time work and was working part time to enable him to care for his mother. There is reference in an assessment that Damon's father provided financial support to assist Damon to care for his mother, and a contributor confirms this to be the case. Damon's younger sibling would take their mother to their home once a week, and Songul's ex-husband and his wife were also involved at times. Her ex- husband visited regularly and accompanied her to a GP appointment in January 2007 when she was going through a period of experiencing paranoid ideas i.e. Songul thought all food was rotten, claimed to be wearing no clothes when fully dressed, not sleeping and screaming. He also attended a home psychiatric assessment for Songul with Damon on 23 January 2009 when Songul had moved back in after the house had undergone adaptations for her. She was presenting with anxious behaviours particularly when Damon went out. It was recorded in the assessment that Songul had "always been a worrier, now unbearable". Songul was said to need constant encouragement, and she was 'unsmiling and unresponsive' to affection, but she was communicating better and eating well when previously she had angrily rejected food. The diagnosis from this home assessment was of a severe depressive episode with psychotic features, in partial remission. A care plan was devised recommending an increase in her prescription of Citalopram which she had been taking since November 2008, advice that Songul should begin doing more for herself to avoid requiring in-patient rehabilitation, and a letter was to be written to the Home Office regarding a permanent visa. It was noted that Damon reassured his mother that he would always want her to live with him, even when he was to get married. A carer's assessment was offered, but does not appear to have been accepted. However, Damon did write to Edgware Hospital Social Work Team on 29 January 2009 stating that he would like help for his mother as she was unable to manage her care needs. Social Worker 2 discussed the request with

Team Manager 1 who was of the opinion that care would not be able to be provided until Songul's immigration status changed.

3.13 Songul was taken to A & E by ambulance on the 2 May 2009 when she was feeling unwell and had suffered an episode of dizziness. She was discharged home with medication. Four months later on 12 September 2009 the Police were involved when an argument ensued between Damon and his younger sibling because his mother changed her mind about visiting the younger sibling's home. No action by the Police resulted from this event. A contributor informs the Review author that this was a violent argument in which Damon was aggressive and due to his size and strength he was very intimidating at such times. In a statement to the Police Damon's sibling reported that they had a 'love hate relationship' with him. It would appear that this incident was a precursor to a lessening of contact between family members.

3.14 On 10 June 2010 Damon was treated in A & E for a fractured wrist following a fall from a ladder, and five days later he returned to A & E as he was worried about the plaster on his wrist. He was observed to be very anxious; he was reassured and booked for follow up at the fracture clinic. On 3 August 2010 Damon attended A & E for a burnt finger sustained whilst working as a chef. He attended again on 6 August 2010 for the wound to be redressed and was discharged to the care of his GP. It was in this role that Damon had another contact with the Police. He was spoken to by his manager about his refusal to cook pork products in the work place. Damon picked up a large kitchen knife and waved it around. No threats were made by him and he later resigned. No further action was taken. Damon appears to have difficulty in sustaining long term employment; he is reported as frequently losing his job due to disputes or through outbursts of temper.

### Chronology from 2011

3.15 During 2011 Damon saw his GP for minor ailments on 4 occasions. On 5 September 2011 Damon telephoned Social Care Direct concerning his mother. The reason given was 'problems with daily independent living' with medical conditions stated as: 'suffers from CVA (Cerebro-Vascular Accident - stroke), wheelchair user; walks with a frame; diabetic; depression. Difficulty with stairs'. A Self Assessment form was sent. The outcome of this is not recorded. Songul was seen at her practice on 4 occasions during 2011 for diabetic review, vitamin B12 injection and flu vaccination.

3.16 Songul was a frequent attender at her GP practice. Between 2011 and the time of her death there were 95 patient contacts with GPs, Practice Nurses, or Health Care Assistants; Damon took her to the practice for appointments. As Songul's English was not considered good he acted as her interpreter. As appointments were so numerous and included routine diabetic and diabetic eye screening appointments details will only be given in this chronology concerning appointments which were not routine or which resulted in an onward referral or significant event.

3.17 Songul had 31 contacts with GP practice staff, and hospital appointments during 2012, plus contact with the out of hours Barndoc service. On 27 June 2012 a telephone consultation took place with a nurse practitioner as Songul felt off balance when she went into the garden, although this was resolved after 15 minutes. It was recorded that Damon thought his mother did not want to go into the garden. Songul's lack of activity and motivation had been noted before in an assessment in 2009.

3.18 When Songul attended with Damon for her diabetic review on 10 July 2012 with practice nurse 1, screening for depression revealed that she felt low and unmotivated. She was displaying signs of paranoia, thinking everyone was after her. Damon was struggling as carer as well as working part time in a variety of jobs. He was worried about his mother's lack of mobility; she was reluctant to walk at times. Songul was referred to GP1 for an appointment and this took place on 20 July. It was recorded that her anti-depressant (Citalopram) had stopped the previous year and her mood had deteriorated since then. Citalopram was prescribed with a review planned in a month's time. Damon attended with Songul for the review on 22 August 2012. Songul was reluctant to take the Citalopram and it was recorded that she would like counselling with a Farsi speaking counsellor. A referral was sent on 24 August 2012 to Farsophone, a voluntary sector agency who provide Farsi speaking counselling. The referral letter included her history; she was not motivated to get better, was constantly depressed and had become paranoid, and her son had recommended seeking help with a Farsi speaking counsellor. On 4 September a letter from Farsophone stated they were unable to accept new clients due to a back-log of referrals, but they hoped to re-open their waiting list in a few months time.

3.19 On 4 September 2012 Damon had a telephone consultation with practice nurse 1. He was worried about swelling in his mother's abdomen. Two days later on 6 September Damon and his mother saw nurse practitioner 1 at the practice when the abdominal swelling was diagnosed as divarication of rectus (a separation of the rectus abdominal muscle). Reassurance was given, and the nurse practitioner discussed Songul's condition with GP1. It was recorded that Damon was concerned that his mother may have post-traumatic stress disorder (PTSD), however, there is no record of any discussion about this and why Damon thought his mother may be suffering from PTSD.

3.20 On 1 October 2012 Damon had a counselling assessment at Barnet College where he was undertaking part time courses. He attended Barnet College for a variety of courses between 2009 and 2013. These ranged from literacy and numeracy, IT, Food Hygiene, maths and GCSE English. The counselling assessment identified Damon's presenting problems as depression and anger. He had 17 sessions of counselling booked up to 18 March 2013. He attended 14 sessions in all, ceasing attendance in January 2013. He gave no reason for not attending the remaining appointments.

3.21 Damon telephoned Social Care Direct on 25 October 2012 requesting an assessment. The record shows that Damon identified his mother's needs and gave Songul's health history as diabetes, depression and mobility problems due to a stroke for which she used a walking frame. Damon made a request for a carer to come for 2 hours a week to check on his mother as she was lonely and to confirm 'son knows he is feeding her properly'. It is recorded that 'Son becomes tearful on the phone as he is having difficulty managing both work and being a carer'. Damon was advised that the service does not provide a befriending service, and that as his mother has no recourse to public funds this could be an issue. Damon requested that the call taker contact a named nurse at his mother's GP practice. A phone call was made by Social Care Direct to the nurse on 26 October, but the nurse was not available. On 29 October contact was made with the nurse who was advised that as their patient had no recourse to public fund she was not eligible for a service. The nurse said they would let Damon know.

3.22 The following day, 30 October 2012, Damon and his mother attended her practice and saw GP1. Songul had muscle weakness in the legs. She was referred to physiotherapy. She was also prescribed 10mg Citalopram. In the referral letter sent to physiotherapy it noted that she was extremely depressed, and her son was concerned as he was her only carer and had to look after her and take care of her personal issues. The same day Damon saw his GP and presented with depression; he was not deemed to be suicidal or having thoughts of self harm, but he was worried about physical symptoms he was experiencing; sore throat and abdominal pain, and possible links to a family history of serious illness. He was given reassurance and 'Citalopram restarted'. There is no previous reference to Citalopram being prescribed in the GP chronology notes.

3.23 In a telephone consultation between Damon and GP2 at his mother's practice on 27 November 2012 it appears that the Citalopram was helping Songul's depression. Damon was advised to bring his mother in for review in 8 weeks time at the end of the current treatment prescription.

3.24 On 27 December 2012 a 999 call was received from Damon's address at 17:14hrs. A Fast Response Unit was dispatched arriving at the address at 17:25hrs followed by an ambulance 17:37hrs. It was reported that a 68 year old female was possibly having a stroke and that her smile was not equal. It was documented that the caller was very distraught. On arrival of the Fast Responder Songul was standing in the bathroom, washing herself. Damon explained that he heard his mother cry out and found her in the chair in a collapsed state; Songul was gazing at him vacantly. A FAST (Face, Arms, Speech Test) was undertaken and found to be negative. Songul was taken to A & E by ambulance arriving at 18:07hrs. It is documented that ambulance staff had no safeguarding concerns. The following day on 28 December Damon called the out of hour's service Barndoc concerned that his mother's blood pressure was low following the sickness and diarrhoea.

3.25 In addition to consultations with his GP on 3 occasions for minor ailments in 2012 Damon had 6 attendances at A & E and contacted the out of hours Barndoc service. During one of his consultations with his GP on 13 March 2012 Damon said that he had a difficult past and 'interfering thoughts' were coming to mind. It was noted 'needs help'. Damon was referred to a counsellor. There is no information as to whether this counselling happened and to whom the referral was made. His A & E attendances were all out of practice hours except for Monday 14 May 2012 at 15:13hrs when he returned with pain in his wrist following an injury 3 weeks before due to a fall. Other A & E attendances were for minor issues such as a cut finger and GP prescribed antibiotics which had run out.

3.26 There are a great many appointments during 2013 and given the importance of this time period, and the opportunities for future learning which arise from it, a month by month review of contacts and events will be given.

### January 2013:

3.27 On the 2 January Songul was seen by a physiotherapist following the referral by her GP on 31 October 2012. An assessment was made regarding her mobility and general weakness. It was recorded that she was low in mood due to family disputes and possible childhood depression, and has had care from her GP and psychiatrist. Songul was observed to be very dependent on Damon and that he was unable to work due to his caring commitments. Damon was keen for a

home exercise programme, but Songul did not appear to want to be there. On the 7 January Songul attended her practice for her B12 injection.

3.28 At 12:39hrs on Sunday 20 January 2013 Damon attended Barnet Hospital A & E with pain to his right ankle following a fall. He was seen and discharged home to be followed up by his GP. The following day Damon went to his practice on crutches. He reported that he fell down during exercise, had been to A & E and was given crutches. No fracture was evident. Damon was noted to be no longer feeling depressed and he had stopped taking the anti-depressants prescribed previously.

3.29 On Tuesday 22 January 2013 at 13:29hrs Damon visited the Walk-In Centre at Finchley Memorial Hospital and was seen by a nurse at 16:40hrs. He was unaccompanied and was complaining of abdominal discomfort. He said he was a carer for his mother and gave a family history of a particular cancer. He gave a past medical history of depression, hypertension, and sprained ankle (he was still using crutches) and listed his current medication as Citalopram, Bisoprolol, Simvastatin, Lansoprazole and Naproxen. After examination no acute symptoms were apparent and Damon was advised to see his own GP as he may need a referral to a gastroenterologist.

3.30 Songul saw the physiotherapist with Damon for review on 30 January 2013. No problems were reported since the last appointment and she was encouraged to continue with the programme and return in a month's time.

3.31 On 31 January 2013 whilst in a class at Barnet College Damon was randomly hit on the back of the head in an unprovoked attack by a fellow student who had mental health problems. The student was apologetic and embarrassed by what had happened. The college curriculum manager tried to facilitate reconciliation between Damon and his fellow student, but Damon refused to participate and became agitated. The college IMR recalls that Damon 'found it hard to let the incident drop and came across as anxious and neurotic and made the point that he could have retaliated but he didn't'. In the end Damon was advised that it would be up to him to report the incident to the Police. The Police were briefly involved, but as the college was mediating no further action was taken.

### February 2013:

3.32 As a result of the assault at college Victim Support received a referral from the Police and contact was made with Damon on 5 February 2013. He confirmed that he had been hit on the back of the head, but he was physically fit, however he was just a bit confused as to why the suspect had hit him. He was concerned about what might happen if the suspect came back to college as he would prefer the Police dealt with it. Damon said he did not want to have to fight back unless his life was threatened. He reported that he had support at college and would like the Victim Support number just in case he needed support in future; no support was required at the time.

3.33 On Saturday 9 February 2013 at 06:24 Damon presented at Barnet Hospital A & E with a one day history of a cough and sore throat. It was noted that he had a history of depression and that he lived with his mother. A chest x-ray was performed and Damon was discharged.

3.34 At 10:34hrs on Wednesday 13 February 2013 a 999 call was received to attend Barnet Law Service. It was reported that a 68 year old female was

possibly having a stroke; she had slurred speech and was experiencing difficulty in breathing. Damon had received some bad news and Songul had become upset about this. On examination Songul was fully alert, was not experiencing chest pain or difficulty in breathing. A FAST test was undertaken and found to be negative. Songul was able to walk to the ambulance with assistance and the ambulance arrived at A & E at 11:46hrs. It was noted there that she had been having a heated discussion with a solicitor and had lost consciousness briefly. It was recorded that she lived with her son. A & E notes show 'Situation resolved. Discharged from A & E'. On the same day there was a home visit by the out of hours GP. Damon was concerned. He had been told in A & E that Songul may have had a Transient Ischemic Attack[6] (TIA). Advice was given. Songul's GP received notification of the A & E attendance and she was referred to the TIA clinic.

3.35 The following day, 14 February 2013 Damon called the out of hours service Barndoc. He was concerned that Songul was breathless. An ambulance was called via a 999 call from Barndoc at 01.34hrs. At 01.45hrs a further 999 call was made by Damon enquiring when the ambulance would arrive. He stated that he did not know if there was any change to his mother's condition, but explained that she was breathing abnormally and was very unwell. The ambulance arrived at 01.49hrs where the crew found Songul sitting on the side of the bed, alert and orientated. Damon explained that Songul had not been herself that day, feeling lethargic and unwell, that she had been taken ill with a possible TIA that morning whilst out and had been taken by ambulance to Barnet Hospital (this refers to the incident where she was taken ill at the Law Centre). At the hospital Songul was found to have a high temperature and cough. She was diagnosed with a lower respiratory tract infection, later described as community acquired pneumonia, given treatment in A & E, and admitted to a ward at 07:30hrs. She was accompanied by Damon and it was observed that he was reluctant to leave her side. Later that day Songul was transferred to another ward and again Damon refused to leave the ward. The site manager and security discussed this with him and he was permitted to stay overnight with his mother during her admission.

### Events leading up to a Safeguarding Alert:

3.36 Between 14 February and 19 February 2013 Songul remained in Barnet General Hospital with Damon assisting with her personal care. On 18 February Songul was assessed by two hospital physiotherapists. Songul's daughter, who was visiting from Iran, and Damon were present during the assessment. It was observed that Damon was using unsafe handling techniques when assisting Songul to stand and when assisting her on the stairs. Correct methods were demonstrated to him. The physiotherapists asked Damon how his mother washed herself at home. He explained that he helped her in and out of the bath. Damon expressed his concerns to the physiotherapists about how he would look after his mother in the future; they explained that they were happy with the situation regarding Songul's mobility, and they would refer her to an occupational therapist for her other needs. After this conversation Damon walked off, returned after a few minutes, questioned their decision and then left once more. The physiotherapists decided that an interpreter was required for the occupational therapy assessment due to Songul's lack of English and what was seen as Damon's agitated and defensive state. One of the

[6] A transient ischaemic attack (TIA) or 'mini stroke' is caused by a temporary disruption in the blood supply to part of the brain. (www.nhs.uk/conditions/Transient-ischaemic-attack)

physiotherapists approached Damon and informed him of the plan to get an interpreter and Damon said “why don’t you trust me, I will take my mother home if you do that. I look after her for 12 years you will not take my mother away from me”. A plan was made for an occupational therapy assessment the following day with an independent interpreter present.

3.37 Songul’s discharge summary noted that she spoke very little English and communicated mostly via her son. During this admission a social worker from the Hospital Social Work team visited the ward on the afternoon of 19 February 2013. This was at the request of an occupational therapist (OT) who had phoned the team at 11:00hrs that morning asking for a social worker to attend an assessment on the ward along with an interpreter. The reason for the call was recorded as ‘Safeguarding’. The call resulted in the case progressing to referral.

3.38 The assessment on the ward at 14:00hrs on the 19 February 2013 was undertaken with an occupational therapist, physiotherapist, social worker 5, and an independent Trust interpreter and Damon present. Notes from the OT/physiotherapy and social work records of the assessment are as follows:

Damon was present during the assessment. The team explained that they wanted to ask some routine questions regarding what equipment they had at home and how Songul was managing etc. Damon was asked to leave whilst they did this. He refused to leave; he stated that he wanted to know what was said. Damon became agitated in his manner and said 'he had had dealings with professionals in the past and that had been no help'. The occupational therapist asked some questions and Damon explained that he helps his mother with bathing. The occupational therapist suggested Songul strip wash, but Damon said she had a skin infection under her breasts. The team explained that they were concerned about some of the unsafe techniques that they witnessed the previous day, Damon lifts his mother in and out of bed; the risks of lifting were explained to Damon, but he stated that there was no risk to his mother. He then explained that he needed help from carers with his mother; Songul mobilised using a zimmer frame, but needed assistance on the stairs. He explained that he had asked for help in the past and that he was applying for his mother to have the right to remain in the UK. He stated "no one can split me and my mum up". The occupational therapist then began asking Songul direct questions via the interpreter. Damon became very aggressive and would not allow this to take place; he began shouting and he threatened to call the Police. At this point the physiotherapist left the area.

The assessment continued. Damon blocked the use of the interpreter and deflected many of the questions that were asked. He was annoyed regarding the discussion that took place around safe manual handling. Damon reported that he undertook all the domestic tasks in the house and personal care for his mother. This included washing and dressing her. Damon also explained that he slept in a double bed with her at night as she needed to be cuddled throughout the night. He reported that if he were to leave the bed during the night Songul would call out. Songul was asked via the interpreter if she minded her son sleeping in the same bed and being cuddled, Songul replied 'no'. Damon is recorded as saying that his mother liked him to cuddle her and said it was normal in his culture; he only stayed with her until she was asleep. As it was not possible to interview Songul on her own with the interpreter as Damon did not want this, it is unclear whether this was an accurate picture. Via the interpreter the occupational therapist asked Songul if she understood why she was in hospital and what the physiotherapist had done with her, Songul

answered appropriately. Again via the interpreter the occupational therapist asked Songul if she minded her son washing and dressing her. Songul responded that she did not mind. At this point Damon became angry and moved closer to the occupational therapist and asked if they were accusing him of sexual acts with his mother. The occupational therapist explained that they were not. Damon then started thrusting his pelvis and said "this is sexual, I'm not doing that". He then proceeded to touch Songul across the breast, stomach and groin area and said "this isn't sexual, I'm not having sexual intercourse with my mother." He continued to say "is this sexual" followed by kissing his mother on the lips. Damon grabbed his mother's head to kiss her forehead then turned his cheek to prompt her to kiss it, then went again to kiss her face and lips. The occupational therapist then explained to Damon that Songul needed certain equipment in the house, but as Songul did not have leave to remain in the UK he would need to buy these. He would also have to pay for private carers for her. At this point Damon became verbally aggressive, rolled his sleeves up and pointed at scars on his arms. The occupational therapist then left the area. The occupational therapist made a plan that Songul was not to be discharged at that time due to safeguarding concerns and if Damon tried to do this then security or Police should be called.

3.39 Social worker 5 explained to Damon that they would need to check if Songul was entitled to services. Songul stated that Damon was her legal guardian and had power of attorney, and Damon said that his mother was happy for him to look after her. It was not possible to interview Songul alone and so again it was unclear whether this was an accurate and no power of attorney documentation was seen. Throughout the interview Damon was seen as challenging and dominant and did not let professionals conduct a proper assessment. The record states that it was not known if Songul had the mental capacity to make decisions; it was not possible to do a formal assessment as Damon did not want her to be seen alone. The capacity assessment was limited to asking Songul via the interpreter if she knew where she was; Songul knew she was in Barnet hospital and the reasons for her admission.

3.40 Social worker 5 spoke to team leader 2, who advised that paperwork to ascertain on what basis Songul was in the country should be completed, to establish capacity, and to see if she can be seen alone with an interpreter. The social worker emailed their legal department to obtain advice as to whether a client is entitled to services if they have no recourse to public funds

3.41 At 16:00hrs that afternoon social worker 5 met Damon on the ward and he requested that the social worker liaise with the Home Office regarding his mother's right to remain. He said he wanted to take his mother home that evening. The social worker sought advice regarding this from team leader 2 and was advised that if Damon wished to take his mother home he could not be prevented; he would have to speak to social workers in the community. The social worker spoke to Damon who then said he would not take his mother home. Social worker 5 then had a discussion with a registrar who advised that a meeting should be arranged on the ward with an interpreter and doctors to discuss the situation. The registrar did not feel there were any safeguarding issues and wanted to discharge Songul the following day. Social worker 5 agreed to set up meeting if an interpreter was available.

3.42 At 16:33hrs 19 February 2013 the Hospital Social Work Team received a safeguarding alert. This was raised by a physiotherapist and an occupational therapist in the hospital. The alert identified general concerns about Songul's well-being and set up at home. Therapists had concerns about the way Damon

manually handled his mother and when they raised this with him he became defensive and aggressive on more than one occasion. During an assessment with therapists and an interpreter they viewed the way that Damon touched his mother as being in an inappropriate manner. Damon had also reported that he shared a bed every night with his mother and cuddles her all night. Hospital records show that the medical team was informed of the safeguarding concerns and of the priority for an assessment with an interpreter present.

3.43 Songul's hospital notes recorded by a registrar at 18:13hrs noted that the consultant had spoken to Damon and suggested another meeting with an interpreter present and Damon agreed to stay out of the meeting. Damon was advised that Songul could not be discharged that day. At 22:30hrs Damon approached a nurse and said he was taking his mother home. The nurse explained that this could not happen yet. Damon then used his mobile telephone to call the Police. The nurse did not speak on the phone and was not sure if the Police had actually been called. Hospital notes record that at 23:05hrs the doctor asked to see the family (Damon, his sibling and another family member) as they want to take Songul home. They stated that the safeguarding concerns were unfounded and Songul was being kept against her will. The doctor explained to the family that it would be better if Songul stayed in the hospital until the next day, however they insisted on taking her home and Songul accompanied by her family members left at 23:20hrs. The hospital contacted Barnet's Emergency Duty Social Work Team at 23:35hrs to report the incident and was told that the matter would be discussed with the caseworker the next morning.

3.44 Next day, at 10:50hrs on 20 February 2013 Damon collected discharge paperwork from the hospital and said he wanted to make a complaint. He also went to the Physiotherapy department regarding the concerns raised by the occupational therapist and at 12:30hrs Damon and his sister met with the Therapy Service lead and an advanced clinical practitioner. During the meeting Damon explained that he was very unhappy that an alert had been raised and at several points appeared aggressive and tried to intimidate staff by shouting, standing over them and clapping his hands. The manager agreed to find out more information and meet Damon again on the 21 February. Records by the Social Work Team this day show that an occupational therapist phoned social worker 5 to advise them that Songul was discharged from the hospital by Damon and a Barnet Hospital Safeguarding Alert form was loaded onto the Wisdom database record showing:

*'General concerns about patient's wellbeing and set up at home. Lives in her son's property with son who is main carer. Therapists had concerns about the way son manually handles patient and raised this with son. Son became aggressive and defensive on more than one occasion. Son initially said he needs help caring for his mum, then when we said this would involve assessments, son said he didn't want help. Son reports he is applying for leave for his mum to remain in the country, but this has not been granted yet. During an assessment with therapists and an interpreter present son touched patient in an inappropriate manner. Son also reports he shares a bed every night with patient and cuddles her.'*

3.45 At 13:00hrs the same day Damon telephoned the hospital social worker and said that he had taken his mother home the previous day. He reported that Police were called due to the safeguarding alert in place but advised that they could not stop him discharging his mother. No record of a call to or from the Police on the evening of 19 February has been found. Damon wanted to know

who had made the safeguarding alert. The social worker advised Damon about the safeguarding process and that social workers in the community would be in contact with him. He was very upset and stated that he would not let social workers through his front door.

3.46 During his mother's stay in hospital it transpired that Damon tried to persuade a member of staff to go out with him. He was very persistent and she eventually gave him her mobile phone number. Having obtained this he sent her numerous texts which she ignored, until finally she texted him that she was not interested. Damon's tone immediately changed and he responded with an abusive text. This information only came to light during the DHR.

3.47 A multi-disciplinary meeting was held at 14:00hrs on 20 February 2013 between hospital social worker 5, the occupational therapist and physiotherapy lead. It was agreed that the safeguarding alert was warranted. They stated that they had met with Damon and he was angry towards them. He wanted the safeguarding alert rescinded and an apology from the physiotherapist who raised the alert. The occupational therapist and physiotherapy lead planned to meet with Damon and his sister to discuss the referral. The carer's hospital discharge co-ordinator agreed to look into any carers support available. Following the meeting social worker 5 emailed a local authority solicitor in the legal department to request advice as to whether Songul was entitled to services if she had no recourse to public funds. The case was then referred via fax to the Complex North Locality Team under Safeguarding and the transfer completed and loaded onto the Wisdom database[7]. The transfer form identified 'concerns about son's relationship with mother i.e. son admitted to cuddling mother in bed, observations of son 'inappropriate touching' mother. Son's hostile behaviour and son would not allow staff access to speak to mother alone'. Social worker 5 also included information on concerns that Damon had discharged his mother from hospital. Team manager 3 in the North Locality Team immediately allocated the case to social worker 6, a locum social work practitioner who spoke Farsi, to be managed under safeguarding adult procedures.

3.48 On the morning of 21 February the second meeting took place between senior nurses and therapists. Damon, his sister and Songul were present. During the meeting Damon attempted to lift Songuls clothing to demonstrate how he washes her breasts; she appeared unhappy with this and he stopped, but staff were very concerned for Songul's dignity during the meeting; Damon was loud and aggressive towards staff and they called security; the Police were believed to be called by Damon, however, there is no Police record of such a call. Also on 21 February a Safeguarding Strategy Discussion took place between the hospital social worker 5, team manager 3 and social worker 6 in the North Locality Team; the strategy document was entered onto the Wisdom database. The record states that a meeting was planned for 25 February where Songul's mental capacity was to be established. Advice was again to be sought regarding access to community care services if a client has no access to public funds. The Action Plan section of the strategy discussion document was not completed. Risk assessment on the safeguarding strategy discussion document notes: *'Damon is still the main carer and providing personal care to his mother, risk still remains. Risk could not have been managed as lack of sufficient evidence of abuse. Carer refused to engage with Social services.'* It must be noted that no interim protection plan was recorded. Damon made

[7] The Wisdom database used by Social Care records case notes, transfers and documents used by the service.

counter-allegations about the way in which he was treated and what he perceived as a lack of cultural understanding by the occupational therapist at the hospital. According to records Damon appeared outraged, not wanting to engage in the safeguarding process, but he agreed to continue under the care management process. Damon's demands that there was to be no meeting alone with his mother, were not challenged even though his protective manner was noted. Songul, the adult at risk, was never interviewed alone with an independent interpreter. On 21 February social worker 6 sent an email to senior manager 1 seeking advice about Songul's immigration status and community care funding.

3.49 Between 20 and 23 February Barnet Hospital received 8 letters of complaint from Damon. The letters made complaints about every member of staff involved in Songul's care and the fact that the safeguarding alert had been raised. A complaints procedure commenced. On 20 March Damon sent a letter retracting his complaints.

3.50 Meanwhile on 21 February 2013 Songul was seen in the TIA clinic with Damon in attendance to interpret. Songul's recent admission and safeguarding alert was noted by staff. Some health investigations were carried out and more were ordered. It was felt that Songul had experienced another TIA on top of the original stroke she had suffered previously. Changes to her medication were made and the plan was for a follow up appointment in 6 weeks time.

3.51 The following day, 22 February 2013, social worker 6 in the North Locality Team received an email from senior manager 1 informing them and their manager that services provided under community care legislation are not public funds. The social worker also received a telephone call from Damon when it was confirmed that there was to be a meeting on 25 February. Damon requested a letter in advance of the meeting stating its purpose. This was written and collected by Damon from the reception of the Locality Team office. The reason for the meeting was set out as firstly to give an opportunity to discuss the circumstances leading to the safeguarding alert. Secondly, to look at his mother's care needs and Damon's as a carer. Some time the same day Damon visited the London Borough of Barnet offices and was seen by social worker 7. The Safeguarding case note states the following were discussed: "(1) There was previously a Safeguarding Alert for the same purpose (this needs to be looked at). (2) The son is the main carer he does all personal care and has been caring for his mother for 12 years. (3) Client does not have indefinite leave to remain in the UK, client's son is appealing this, and would like to be supported as he is the main carer. (4) The son is willing to meet with social worker 6 on Monday to discuss the safeguarding, client's son would then like a letter detailing the safeguarding closure and investigation into the purpose of it".

3.52 Between the 20 and 23 February Damon visited the local Patient Advice and Liaison Service[8] (PALS) office several times. Each time he was very angry and aggressive towards staff and had to be removed by security. Due to his challenging and odd behaviour outside their offices this information was relayed to the hospital social worker by the PALS office. Damon had been challenging to other staff in the hospital on three occasions since he discharged

[8] The Patient Advice and Liaison Service (PALS) offers confidential advice, support and information on health-related matters for patients, their families and their carers. This includes help with health-related questions; help to resolve concerns or problems when you're using the NHS, information about the NHS complaints procedure, including how to get independent help if you want to make a complaint.

his mother. He was with his sister at the PALS office and she was reported as upset by his behaviour and apologised to staff.

3.53 On 25 February 2013 a meeting took place between the North Locality Team allocated social worker 6, Songul, Damon and his sister. There is no record on file regarding the content of this meeting. However, the Barnet Hospital IMR identifies from interviews and minutes that the meeting was also attended by senior medical, nursing, and therapy staff from the hospital and the staff expressed their concern regarding the inappropriate 'sexual' contact between Damon and Songul and the aggression he had shown towards staff. The hospital IMR reports records describing that the community social worker was of the opinion that the behaviour was cultural and the social worker provided reassurance that they had gained during a home visit. Social worker 5 at the hospital had an email from the local authority solicitor the same day advising that they needed to obtain an update on Songul's immigration status from the UK Border Agency and advised that the word of others should never accepted without checking. Social worker 5 was given the name of a UK Border Agency liaison officer for the Barnet area to contact to ascertain Songul's current immigration status, whether she has an 'extant' (existing) application and whether they had accepted that she is too ill to travel. The social worker was also advised to clarify Damon's immigration status. This information would inform what type of assessment a social worker needed to do. If the client was a failed asylum seeker it may be a Community Care Assessment (CCA), if they had never applied for asylum it would be a Human Rights Assessment. The liaison officer at the UK Border Agency was emailed that afternoon.

3.54 A Safeguarding meeting took place on 27 February 2013 at which Barnet Hospital was represented by staff from nursing, therapies, and physicians. Hospital staff raised concerns regarding the manual handling of Songul by Damon, the kissing and touching of Songul by her son which was felt to be inappropriate, and the aggression that Damon had displayed toward several hospital staff. A list of actions was produced regarding planning for any future admissions. References made in the Safeguarding Adults Investigators Report Summary of Findings which was completed and dated 27 February noted that:

- Allegation of "sexual molesting is unsubstantiated" following interview on 25 February 2013 with client and daughter.
- Risks identified:-"risk of family dynamic, risk of care breakdown, risk of mistrust to the health professionals."
- Actions resulting from the meeting: to carry out a community care assessment and carer's assessment to be completed by 6 March 2013.
- The report identified that: "client was alert and orientated to person, time and place. Slowed speed of information processing. Appears to have reduced concentration, needs at times the situation to be repeated. Songul was able to coherently express her needs and wishes".

3.55 A letter was written by the social worker to Damon on 27 February 2013 which informed him that following investigation there were no grounds to proceed further with a safeguarding inquiry and that this was closed as of that day. The letter also acknowledged that Damon had raised a complaint with Barnet Hospital regarding the Safeguarding alert. The letter reiterated a discussion between the social worker and Damon that services provided under the Community Care Act are not public funds, and that therefore they are entitled to a Community Care Assessment. The letter also stated that Damon had indicated that he did not require assistance with his mother's care needs at this stage, and that Songul wished to continue to receive care from her son. The

letter confirmed that Songul had agreed to an occupational therapy assessment and that the social worker had made the referral. The letter also confirmed that social worker 6 had given Damon information regarding a Carer's Self-Assessment as well as contact details for Barnet Carer's Centre. There is no record that a completed Carer's Self-Assessment was returned by Damon, or that he contacted the Carer's Centre.

3.56 On 27 February Songul's practice received a letter requesting a report for her solicitor regarding her visa appeal. The same day Damon had a telephone consultation with Nurse Practitioner 2 regarding Songul suffering from vomiting. A GP appointment was booked and GP4 carried out an examination and took blood tests; an ultra sound scan was requested. Songul also attended the Physiotherapy department on this day where she was seen with Damon for review. Little change in Songul's mobility was seen. At this appointment Damon again raised the issue of the safeguarding concerns that had been raised. The physiotherapist explained that this was a separate matter to the clinical physiotherapy session. A review was booked to take place in 3 weeks time.

March 2013:

3.57 On Saturday 2 March 2013 at 15:14hrs Songul was seen in A & E with blisters on her toes. Antibiotics were prescribed and she was discharged to the care of her GP. This was followed on the 4 March with a visit to practice nurse 1 where the blisters were dressed. Damon was advised to monitor for infection. It was thought that the blisters were caused by friction burns as Songul tended to rub her foot on the carpet. A further blood test was ordered by GP4 regarding anaemia.

3.58 On 4 March a referral was made to Occupational Therapy (OT) via Social Care Direct, requesting a joint visit. Information was given that 'son is requesting an OT assessment to establish if accommodation has been adapted in accordance with needs of client. Also that client is entitled to a community care assessment hence request for the joint visit'.

3.59 Songul was seen in Barnet Hospital TIA clinic on 4 March following referral from A & E when she was seen on the 13 February. Damon interpreted during the appointment. The examination, CT scan and blood tests that day were reassuring. Songul was to be followed up in 6 weeks time and a 24 hour ECG was planned. Her GP was asked to refer her to a psychiatrist or counselling with a Farsi interpreter concerning her depression.

3.60 On 6 March 2013 Songul's practice administration noted that their patient was requesting a report regarding her immigration visa. GP2 confirmed the report would be done. The report was written by GP1 the following day on 7 March. Songul also attended the practice on 6 March and saw Health Care Assistant 1 for a foot dressing.

3.61 An email was received on 6 March by hospital social worker 5 from the UK Border Agency liaison officer confirming that Songul did not have the right to remain in the UK.

3.62 On 8 March 2013 Songul saw GP4 for review of anaemia, TIA, ankle swelling and depression. She was to continue with her anti-depressant and stop Risperidone as she was now calm. A referral was made to gastroenterology concerning her vomiting and anaemia. Songul also saw practice nurse 3 for a

review of her foot blisters; she was accompanied to this appointment by Damon and her daughter.

3.63 At 12:30hrs on 8 March 2013 Damon telephoned the Barnet office of Victim Support and said he had been the victim of an assault on 31 January 2013. He went on to say that he had received a letter from the Police with the Victim Support logo on the bottom and he had spoken to someone in Supportline, although he was very upset as it took him a while to get their name. Damon said that the Police who were meant to be dealing with the matter had broken their promises and that Victim Support sounded better. He reported that he had felt so upset the previous night that he had cancelled his appointments with the Police to make a statement. However, that morning a letter had arrived from his college tutor asking if he would accept a written apology from his assailant. Damon said that this had made him feel he would like support now, and to re-evaluate his life. He asked how the service would support him. Damon appeared interested in meeting via the outreach service, however after he explained that he wanted to be diagnosed as to what it was about him that created these problems it was recommended that he see the counsellor he was already seeing (this refers to the counselling Damon had been receiving at Barnet College). Support was offered for these events and Damon said he would call if the apology from his assailant was not to his satisfaction.

3.64 On 12 March Songul had a further review by a physiotherapist at Barnet Hospital. There was little change in her condition. A plan was made to change to occupational therapy/physiotherapy visits to home.

3.65 On 14 March social worker 6 in the North Locality Team completed a FACE Overview Assessment[9] and Personal Budget Questionnaire. The overview assessment, carer's assessment and support plan were sent to team manager 3 on 18 March by social worker 6. The email advised that the social worker was unable to generate the assessment therefore the documents were not on the Wisdom database, but this was achieved later that day. The email indicated that Damon was requesting 1 hour of assistance with personal care via a direct payment, however Songul was reluctant to accept support from other people. A carer's contingency plan had been discussed with Damon, and he would like a culturally appropriate residential home or mother would move to her other son in another area with support of a care package. However, Damon had stated that respite was not needed at present. The social worker also outlined reasons for an occupational therapy assessment. There are no details of how the assessment was carried out as it is not clear from the recording notes, however information provided in the IMR shows that social worker 6 was a Farsi speaker and so an interpreter would not have been required. The Support Plan uploaded onto the Wisdom database that day included details of a 1 hour a week direct payment for home care support, 'to give son a break from his caring role', and respite care as and when needed. There is no evidence that the direct payment was ever drawn on by Damon for the home care support. Recording notes following the assessment visit state three important excepts:

1. "Songul reported that she valued the support which she received from her son and without his support she would have not been able to manage.

2. The son reported that following the recent safeguarding vulnerable adult alert he had been very upset and expressed his dislike on how he was treated

[9] The FACE Overview Assessment is a tool designed to be used as an holistic health and social care assessment for use with adults above the age of 18, who belong to the following groups: Those with learning disability; working age adults with a physical disability; mental health ill-health, and older people.

and he felt that the alert was inappropriately raised by the hospital occupational therapist. He felt a lack of cultural understanding.

3. Songul expressed that she was depending on her son and ex-husband for her financial support as she has no leave to remain in this country".

3.66 Social worker 6 emailed a request to Social Care Direct on 19 March for an urgent occupational therapy assessment for Songul. This was passed to a critical occupational therapist after discussion with the social worker who provided further information in an email which stated:

"The son is in desperate need of an OT assessment; I witnessed how the son was supporting his mother with her personal care....it presents very unsafe both for Songul as well as her son. He would benefit from moving and handling assessment and OT equipment."

3.67 On 20 March 2013 Songul's practice received a letter from Damon asking how her medical conditions were being treated: 1) triglycerides[10], 2) anaemia. (There is no indication as to why he asked for this when he attended all appointments with his mother and could be expected to know how she was being treated)

3.68 The allocation of an occupational therapist for Songul took place on 22 March 2013 and after liaising with her allocated social worker it was agreed that a home visit would take place on 8 April. 5 days later on 27 March Songul had a 24 hour ECG arranged by Barnet Chase Farm Hospital ECG department. The next day, 28 March Songul attended the GP practice with Damon and saw a locum GP regarding iron tablets.

3.69 Following the referral made by his GP for a gastroscopy Damon attended Barnet Hospital Outpatients department on 30 March 2013. He was diagnosed with a hiatus hernia and discharged back to the care of his GP.

April 2013:

3.70 On 8 April social worker 6 from the North Locality Team telephoned Damon to arrange a home visit with the occupational therapist. This visit took place on 11 April. Those present included Songul, Damon, Songul's daughter-in-law, social worker 6, and the occupational therapist (OT). The OT assessment showed that Songul demonstrated independence in sit to stand transfers, but mobilising on the stairs, the front access, and bath transfers were a problem. It was noted that her son Damon physically assisted her with stair mobility and getting Songul in and out of the bath. The OT observed bath transfer and noted that Damon was lifting her from between her legs to get her out of the bath. The OT explained that the practice constituted a risk to both client and son. The nature of the risk was not recorded. The OT recommended the use of the shower with shower board rather than bath and recommended equipment to make transfers safer. Damon expressed concern about the previous safeguarding investigation and was keen that the OT and social worker confirm that it would not happen again. Damon was informed that they were not raising a safeguarding alert, but if one was raised in the future it would need to be investigated. The next day equipment to aid Songul was ordered by the OT. A follow up letter was sent to Damon on 16 April outlining the outcome of the visit and this was uploaded

[10] Triglycerides are a type of fat found in the blood. Too much of this type of fat may raise the risk of coronary artery disease, especially in women.

onto the Adult Social Care Wisdom database which is used to download and store documents.

3.71 There are a number of routine check–up appointments for Songul during April which do not raise any significant issues, but which demonstrate the time commitment needed and the detailed nature of the monitoring which Damon undertook and the anxiety he had for his mother's health:

15 April 2013 telephone consultation with GP- Songul fainted and ambulance called; no hospital admission but her medication was changed by GP3.
15 April phone call to out of hours service to check that his mother's blood pressure was normal.
16 April hospital physiotherapy appointment – discussed changing physiotherapy sessions to home sessions.
18 April call to out of hours service details are not available.
18 April contact with practice nurse 1 reporting his mother was unsteady on her feet and he was monitoring her blood pressure; appointment booked.
23 April 2013 call to out of hours service – Damon worried about his mother's blood pressure.
23 April Songul seen in the stroke clinic at Barnet Hospital due to recurrent collapses; not considered suggestive of stroke disease.
29 April Songul was seen for review including blood pressure check by GP4 also seen at Barnet Hospital Out Patient's department, Elderly Medicine in view of her collapses; a plan was made for further tests.
30 April Songul was seen with Damon by GP2 regarding the blisters on her feet.

3.72 At 15:54hrs on the 23 April Damon attended Barnet Hospital A & E with abdominal pain. Observations were undertaken. At 17:30hrs he was treated with pain relief and antibiotics were started. At 19:00hrs Damon was seen to walk out of A & E and a student nurse reported that he left because he was worried about leaving his mother. He returned at 20:30hrs and his treatment continued, and he was transferred to the Clinical Decisions Unit at 21:15hrs. Damon reported that he wanted to go home as his mother was very agitated and distressed at home. A discussion was held regarding the possibility of his mother coming to the hospital to be with him; instead he was discharged home on antibiotics, with a CT scan arranged and a follow appointment.

3.73 On 25 April the occupational therapist received a letter from Damon dated 19th April 2013. The letter was in response to the occupational therapist's letter of 16 April. His letter clarified that Damon's surname was incorrect and was not the same as his mother's. The letter also recorded that he had received contact with Medequip and confirmed dates for delivery of equipment. Damon thanked the occupational therapist for their support. It is recorded on the notes that 'son refused the shower board, as previously advised to use for his mother by OT. Alternative equipment agreed upon'.

3.74 On 26 April 2013 Damon was seen in A & E. He was diagnosed with a kidney infection and prescribed antibiotics. On the 28 April he called the out of hours service regarding side effects from the medication and was advised to stop. No further action is recorded.

### May 2013:

3.75 On 2 May 2013 Songul's GP practice received a letter from the Farsi speaking counselling service Farsophone advising that they were able to offer her an appointment, but had been unable to contact her by phone and asking that she

get in touch. A Farsophone letter to Songul was not responded to. There was a change of coordinator within the organisation in the autumn and a further phone call was made on 3 December 2013 to try and establish contact, but unbeknown to them this was after the fatal incident which resulted in Songul's death. Songul's GP notes have an entry on 21 June 2013 stating that she had been assessed by a Farsi speaking counsellor, but no follow up had yet been arranged. However, Farsophone confirm that they did not manage to establish contact with Songul and she was never seen by them. It is possible that Songul's Farsi speaking social worker was mistakenly recorded or reported by Damon as a counsellor.

3.76 Songul attended the Finchley Memorial Walk-In Centre regarding a blister on her foot on 6 May 2013 at 19:10hrs. She was advised to attend by Barnet A & E for a dressing change. Songul presented with a blister that had been treated by the Barnet Hospital one month previously and she was requesting that it was redressed. On examination the wound condition indicated that a dressing was not needed. Records show that Songul was seen by a nurse accompanied by daughter/son.

3.77 On 8 May Songul was seen by Health Care Assistant 1 at her GP practice where she had a diabetic blood test. The following week on 15 May Songul had a review appointment at Barnet Hospital Physiotherapy department, and an improvement in her condition was observed; she was walking with the support of Damon's hand. Five days later on 20 May she was seen by practice nurse 1 at her practice for diabetic review.

3.78 On 23 May 2013 Songul was seen in the Out-patient's Department at Barnet Hospital Gastroenterology Clinic following the GP referral made on 8 March 2013 concerning episodes of vomiting. She attended with Damon who interpreted for her as usual. It was recorded that she experienced anxiety and panics when she left the house, and that she had had counselling in the past. No organic cause to the vomiting was found; it was felt to be related to her anxiety. She was discharged from the clinic for psychiatric follow up via her GP.

3.79 Damon was seen by his GP on 30 May 2013 when he complained of 'mood variations and the same symptoms like before'. Olanzepine (anti-psychotic medication) was 'started again as it helped him before'. Olanzepine was first prescribed for Damon by the Mental Health Team. The first reference to this medication is for a repeat prescription issued on 2 October 2002 as advised by the Mental Health Team. This 30 May date is the only reference to the medication being prescribed since then.

June 2013:

3.80 On 3 June 2013 the OT telephoned Damon and he confirmed that he had received a swivel bather and rails and they were happy with them. A bath step had not arrived and the OT said that this would be ordered.

3.81 Damon made a telephone call to Barnet Hospital Physiotherapy department on 10 June 2013 to inform them that he had been advised to go to A & E with his mother as her blood pressure was high. He expressed the opinion that she was doing less than she was capable of. Songul's physiotherapy appointment was rebooked.

3.82 On 12 June Songul did not attend an appointment at her GP practice. The reason for the appointment is not given.

3.83 On 17 June 2013 Physiotherapy department notes record that Damon reported that his friend had been helping him with manual handling and exercises to help his mum. Damon alleged that his mother was previously beaten by her husband and is therefore afraid of physical contact. A review was arranged for one week's time. There is no information as to whether the friend was male or female and whether the type of handling the friend helped with was appropriate. Also on Monday 17 June at 19:06hrs Damon attended A&E with a cut to the tip of his right little finger that happened 6 weeks previously. He was worried that it was not healing. Advice was given by a nurse. Damon left before being seen by a doctor. The next day on 18 June Damon saw his GP with a lesion on his finger for which he received treatment.

3.84 GP5 at Songul's practice received a telephone call from Damon on 20 June saying he had mental health concerns. His mother was very stressed. It is recorded that Damon said his mother 'acts more disabled than she actually is, he struggles to get her to be co-operative for example she will not let him floss her teeth'. Notes record that Damon was unclear about what he wanted; he threatened to leave rather than say he wanted a referral. Songul's records show 'question over history of abuse as a child/several marriages. Longstanding behavioural problems/withdrawn/depressed. Songul was last seen by psychiatry in 2007'. A referral was to be made to a psycho-geriatrician

3.85 On 22 June Damon telephoned Barndoc out of hours service stating that his mother was "raising her blood pressure deliberately, gets very tense when he takes her blood pressure, won't let him take her blood pressure", and "she is creating problems. She thinks I am going to leave her". It was noted that son was main carer and struggling. Damon was advised to ask his GP for a psycho-geriatrician referral. The GP had already said this would be done.

3.86 GP5 at Songul's practice had a telephone consultation with Damon on 24 June. He was requesting something to relax his mother; he was advised to await an opinion from the psycho-geriatrician. The practice also received a letter from Songul and Damon stating that GP5 had given them a copy of a referral letter to check if the information was correct. They wanted it noted that a very small fraction was false. They were advised to wait and discuss with the GP. The referral to the psycho-geriatrician was sent by GP3 at Songul's practice on 24 June.

3.87 Damon made his third telephone contact with Victim Support on 26 June at 14:19hrs. He reported that he was ready for support now following the assault at college in January. The service had offered him support nearer to the incident, but he had declined; now he felt he wanted counselling. The staff member explained that Victim Support does provide a listening service, but not counselling and Damon was fine with this. An appointment was made for 14:00hrs on 3 July at the Burnt Oak Library Outreach.

3.88 Songul and Damon attended a physiotherapy review appointment on 27 June 2013. It was recorded that Songul had had a fall that day, but she had not sustained any injury; Damon felt that she had thrown herself onto the floor. Physio treatment was carried out and a further review in one month was arranged. The following day on 28 June Songul was seen with Damon by GP5 at her practice. It was recorded that Songul had a 'fear of falling. Son helps her in bath. Can't do housework'. Denies anger/irritability. Balance and muscle power normal. Co-ordination slightly clumsy on left'. GP5 sent a further referral letter

to Old Age Psychiatry as Damon was angry that the first letter did not include details about ankle pain.

3.89 At 17:16hrs on 30 June Damon attended Barnet Hospital A & E with pain in his groin. He self-discharged at 18:00hrs as he was the sole carer for his mother and wanted to get home. The plan was for him to return if pain worsened.

### July 2013:

3.90 Damon made a fourth telephone contact with Victim Support on 1 July at 17:00hrs when he called and left a message asking when his "counselling" appointment was. The following day on 2 July at 14:10hrs, a member of staff telephoned Damon to explain that Victim Support does not offer counselling and sign-posted him, as they suspected that he had the wrong number. He said that he had rung Supportline who had directed him to Barnet Victim Support and he had phoned looking for support, but so far Victim Support had not been helpful. Damon was recorded as becoming agitated. When the member of staff looked up on their data system there were no notes. The staff member tried to explain to Damon that they would ask their manager, but he was still agitated. The staff member explained that they worked as part of a team and they needed to do this. Damon did not seem to understand what was being said; he said goodbye and hung up. At 14:24hrs the staff member telephoned Damon back and confirmed the appointment which had been made previously, however on 3 July at 14:00hrs Damon telephoned Victim Support to cancel the appointment. During the call Damon went through issues which were on his mind:

- His mother and her health needs and that he is not getting support. He wanted guidance on "rules and regulations" so that issues did not keep coming up.
- Damon mentioned misunderstandings with the chemist.
- He reported that he had received Cognitive Behavioural Therapy counselling through his college.
- He said he had asked his doctor for help, but feels he and his mother are being pushed towards psychology.
- Damon said he had been encouraged to call NHS Direct. He had done this on 30 June 2013 and they assessed him as being suicidal. He disagreed with this.
- Damon said he wanted to get on with his life and to understand how to not have these different situations occur.
- He asked if the Samaritans were a good place for listening – he had called them before just to talk.
- Damon appeared to still be concerned about why he was assaulted at college and said it was difficult to get information from the college.

The staff member explained to Damon that Victim Support's role was to support victims of crime. It was suggested that some of the issues he raised were beyond their expertise and that he should contact his GP. It was also suggested that he contact the mental health charity Mind for support and counselling and their telephone number was given. Damon was also given the telephone number of the Samaritans. The staff member discussed the assault at the college and told Damon that he had been given reasons for the assault i.e. the assailant was not taking his medication at the time and that they had been suspended by the college. The staff member assured Damon that it did not

sound as though he did anything to provoke the attack; it was due to the assailant not thinking rationally as they were not taking their medication. Damon was told he could call Victim Support again if anything else happened to do with crime.

3.91 On 2 July Mental Health Services for Older People record receiving the referrals from Songul's GP (referral letters dated 24 and 28 August). The referral letters stated that Songul had a longstanding, complex psychological history with depression and acting out behaviours and that her son was struggling to cope with providing care and was in need of support as a carer. Both letters referred to Damon expressing anger towards the GP. Songul was offered an outpatient appointment, but after a phone call from Damon this was changed to a home visit due to her mobility problems and the fact that she and Damon need reassurance that she would not be admitted to hospital. This change in arrangements meant that Songul could not be seen at home until 14 August. The appointment was also delayed as the psychiatrist felt that there might be a need for social work input and this had to be coordinated for the visit.

3.92 On 4 July Songul and Damon attended her practice and saw GP1. Damon was not happy with a letter written in support of her visa application. The following day Songul attended the practice for her vitamin B12 injection delivered by a locum nurse.

3.93 Social Care Direct sent an email to social worker 6 on 10 July 2013 to inform them that Damon phoned and requested that social worker 6 phone him urgently. He was reported to have sounded distressed, but did not disclose what it was about. There is no record of a follow up to this message, and the message is not recorded on the Wisdom database.

3.94 On 12 July 2013 Damon contacted the Police and alleged that he was getting nuisance text messages from a person unknown. Later he had the telephone number blocked.

3.95 Damon saw his GP for review on 15 July and was feeling better on the anti-psychotic medication Olanzepine and his mood was better. He was advised to continue with the medication.

3.96 On 17 July 2013 the Police were called to the family address by an anonymous and concerned neighbour after hearing shouting. They believed Damon may be harming his mother. Officers recorded Damon was initially agitated to see the Police, but that 'it was clear to see he was struggling to look after his mother's needs and becoming frustrated'. Songul was very nervous and did not like being separated from Damon and her other son who was visiting from Iran. When spoken to on her own using 'Language Line' Songul was adamant she was alright and her son looked after her very well. Her son from Iran told officers that their mother could be "very difficult at times due to her conditions and it can be a lot to take on by yourself". The family had apparently been in contact with Social Services and requested help, but had been told they were not eligible. The report (MERLIN Ref. No 13PAC102168) and its details were said to have been faxed to the Social Care department for what is called an 'Adult Came to Notice' on 19 July 2013 for their attention. This was a system introduced by the Police to deal with vulnerable adults. However, there is no reference in the Adult Social Care IMR to this fax and no evidence was found of its receipt. In August 2013 steps were taken to put in place a secure email for Police referrals to Adult Social Care for such notifications. Contributors to the

Review have described that it was not unusual for family interactions to be noisy and for arguments to take place, but these were usually over quickly.

3.97 On Monday 23 July Damon attended A & E with a finger injury. How this happened is not recorded. The following day on 24 July the London Ambulance Service attended the home address due to Songul suffering from diarrhoea and vomiting. She was not taken to hospital, but advice was given and she was referred on to GP3.

3.98 On 29 July Songul missed her physiotherapy appointment and the appointment was reorganised. This was probably due to illness as there was a telephone call to Barndoc out of hours service regarding dizziness, but the call was terminated by Damon as 999 had also been called. This was the second time in 6 days that an ambulance was called by Damon reporting that Songul was suffering from vomiting and diarrhoea. An ambulance was dispatched at 11:22hrs arriving at the address at 11:24hrs. On examination Songul was alert, hydrated, and had no respiratory distress. She did not wish to be taken to hospital. Advice was given and she was referred to her GP with a view to being prescribed follow-up rehydration and hygiene advice. GP3 records show there was telephone consultation with a paramedic on 29 July regarding Songul's illness. The matter was discussed with Damon and advice given about hydration. A call was also made to Barndoc out of hours service by Damon the next day regarding Songul's symptoms.

August 2013:

3.99 On 1 August 2013 a FACE Overview Assessment was loaded onto the social work Wisdom database by social worker 6 in the North Locality Team which had been undertaken on 14 March 2013.

3.100 Songul had her physiotherapy appointment on 5 August, and it was noted that she was booked in to see a psychologist. On 12 August Damon had a telephone consultation with GP4 at his mother's practice regarding the psycho-geriatrician home visit due to take place 2 days later.

3.101 A consultant psychiatrist, social worker, and a community psychiatric nurse (CPN) from the Older Adults Mental Health Team made their first home visit to Songul on 14 August. As usual Damon was present and he provided background information. An interpreter had been booked to attend the assessment, but failed to arrive. The change from outpatient to home visit had been relayed to the interpreting service, but had not been passed on to the interpreter, and although they did eventually arrive late, according to them no one answered the door when they knocked and so they left. Although Songul was noted as having a basic, but limited command of English, she was able to communicate well in her mother tongue with her son and an interpreter. An interpreter was needed to enable a full assessment to be completed therefore this took place on a second visit with an interpreter present on 29 August. The details below are from the two assessments.

During the assessments Songul was observed to be 'physically disabled and appeared subdued, withdrawn, and low in mood. She did not utter a word' on the first visit when she was seen eating breakfast in the kitchen. She was able to get up from the chair and to mobilise using a zimmer, but she had considerable difficulty in getting herself to the living room. Songul was seen to be entirely reliant on Damon. She did not do anything with her time; listen to music or read, or have an interest in going out of the house. Songul had not

engaged in social activity for a very long time. The only time she went out was to medical appointments which Damon took her to with some considerable difficulty. Songul denied any problem with her mood or that she felt anxious, depressed, panicky, homicidal or suicidal. She was judged to have no insight into her presentation. The consultant psychiatrist felt it was not possible to complete the mini–mental state examination (MMSE)[11] to assess her cognitive ability as it did not appear to lend itself to translation into Farsi.

Damon related that he ran the household, and his mother did nothing for herself. He assisted her with personal care and had equipment to help her bathe safely and he took steps to protect her modesty. He understood that it was not seen as acceptable for him to be involved in his mother's personal hygiene. His mother was able to dress herself, but he needed to put her clothes out for her, and he did all meal preparation. The only thing his mother was able to do was get herself a glass of milk from the fridge. When he went out shopping or urgent errands Damon said he could not leave his mother for long. During this time Songul would lie on her bed; the phone was next to her, and he said he would need to keep in contact with her in order to reassure her as she became overwhelmingly anxious and panicky when left alone. She could not bear it when he was not in her presence, and when he went outdoors he would return to find her literally shaking.

According to the Mental Health Investigation Report during this visit Damon talked about the earlier safeguarding investigation and he denied any sexually inappropriate intentions or behaviour towards his mother, but he was still sharing a bed with her at the time of the first visit. He justified this as being culturally appropriate, but seemed to take on board the consultant psychiatrist's comment when he was advised that it was not appropriate in Western culture. On subsequent visits the team believed they were using separate beds. The team noted that Damon appeared to be taking steps to preserve his mother's dignity and privacy when carrying out her personal care.

The consultant psychiatrist later related to the Mental Health Inquiry Panel that Songul adored being with Damon and saw her son as a "good boy". She was not afraid of him and loved being in his presence, wanted him with her all the time and could not bear for him to be out of her sight. In turn Damon felt he could not leave her alone because she became so distressed and this had lead to him giving up his job.

The Mental Health Panel Inquiry heard from those who met Damon that he talked a lot and did not like to be interrupted. He was keen to have a wife and family of his own; he had had a number of failed relationships, but no one wanted to live with him and his mother which was a precondition of any relationship with him. Damon did not exhibit any aggression during their visits.

A risk assessment and management plan was completed on 15 August. There was felt to be no evidence of abuse or exploitation at that time and the risk assessment score was 'low risk'.

3.102 On the 19 August Damon telephoned GP4 at Songul's practice and reported that he was planning care improvements for himself and his mother.

[11] MMSE is a brief 30-point questionnaire test used to screen for cognitive impairment. It is commonly used in medicine to screen for dementia. It is also used to estimate the severity of cognitive impairment and to follow the course of cognitive changes in an individual over time.

3.103 A 999 call was received at the Emergency Operations Centre at 20:47hrs on Wednesday 21 August from Damon requesting an ambulance. He reported that he was unable to weight bear on his ankle which had just frozen, he had been advised by a doctor to go to hospital. The call was disconnected by Damon and he then phoned back at 20:54hrs, this call also disconnected, he was phoned back at 20:59hrs. Damon duly cancelled the ambulance stating he was making his own way to hospital. At 21:37hrs Damon attended A & E at Barnet Hospital with an injury to his right foot which was said to have happened whilst he was doing jujitsu. He was recorded to be taking mood stabilising medication. He was x-rayed and discharged home with pain killers.

3.104 On 27 August a case closure summary was completed by the North Barnet Locality Team social worker. The reason for closure was that the safeguarding allegation of sexually inappropriate behaviour was not substantiated. A community care assessment had been carried out and occupational therapy referral made. 6 weeks of respite had been agreed by the team manager as an emergency service in the event that the main carer was not managing. The summary states that son is happy with his caring role, and would like to continue. Decision was for no further action to be taken.

3.105 Also on 27 August Songul had her second physiotherapy appointment of the month and was noted to be showing improvement. They were informed that she was due to see a psychologist on Thursday (29 August – second visit by psycho-geriatrician). A review was planned for 6 weeks time and a referral made for community physiotherapy.

3.106 Damon saw his GP on 28 August when he was recorded as being 'better, but looks anxious'. His prescription for Olanzepine was to continue. He also telephoned his mother's practice where he was noted 'to be anxious that he would be separated from his mother when the psycho-geriatrician visits tomorrow'. GP3 returned his call, but Damon answered and hung up.

3.107 At the second home visit of the Older People's Mental Health Team on 29 August the consultant psychiatrist and community psychiatric nurse were accompanied by an interpreter. The team social worker did not attend as following a check on the Swift social care database they had seen that Songul was already an open case to a social worker in the North Locality Team (although their involvement was closed 2 days before on 27 August). Details of the safeguarding alert were not known due to limited access to Social Care databases within the Community Mental Health Team. This will be explored later in this Review. The mental health social worker recollected that the database stated that Songul and Damon had been offered support, including respite vouchers, and that the case was to be reviewed and possibly closed. It was decided that the involvement of the mental health social worker would be duplication. During the first visit Damon had made it clear that he wanted to continue to care for his mother and did not want practical help from Social Services, but wanted help through treatment and medication for her. The reason Damon gave for not accepting help from Social Services was he thought it would jeopardise his mother's application for UK residency, and his sense of moral responsibility to care for her as part of his strong Islamic faith. On this second visit Songul was assessed on her own with the interpreter and with Damon present. In his absence she appeared anxious for his return; there was no indication that she was afraid of him, indeed she seemed more comfortable in his presence. She did not want day care and she did not wish to live apart from her son. There was no formal carer's assessment for Damon.

Following the findings of this and the previous home visit Songul was assessed as having a very difficult and complicated life history whose past experiences had undoubtedly compromised her emotional wellbeing resulting in anxiety, low mood, and panic over the decades, no doubt made worse by physical ill health due to stroke, vulnerability to falls, and limited mobility. There was a suggestion that there may be an element of cognitive impairment, possibly even a vascular dementia secondary to the stroke. She had mood disturbance which was debilitating. Songul's management plan included an increase in her anti-depressant and the commencement of a medication to reduce her anxiety. A further home visit was to take place on 24 September.

September 2013:

3.108 On 3 September Damon was seen at Barnet Hospital Urology clinic and a plan was made for further investigations.

3.109 A referral (dated 30 August) was received on 4 September by an Intermediate Care Services physiotherapist from a physiotherapist at Barnet General Hospital concerning Songul. The goal for the referral was to improve her confidence in walking as she was anxious when mobilising due to her fear of falling. As the reason for referral was not thought clear the Intermediate Care Team (ICT) tried to contact the referrer that day for more information. Contact could not be made and so a message was left. ICT also tried to make contact with the patient by telephone but the contact number given in the referral information was incorrect. A letter was sent to the patient asking her to contact the ICT by 24 September, however no reply was received and so the patient was discharged from care without having been seen.

3.110 On 19 September GP3 at Songul's practice wrote a report as requested by Damon for his mother's solicitor regarding her immigration visa.

3.111 A third home visit by the Older People's Mental Health Team took place on 24 September with an interpreter present. There had been no improvement in Songul's presentation and it was observed that Damon's 'carer strain remains immense'. In addition he had sciatica and was in considerable discomfort and pain, and Songul failed to acknowledge her son's difficulties. She was observed to have high and unrealistic expectations of him and believed he had a duty of care towards her twenty-four/seven. She was anxious when he was not nearby, and Damon admitted to being infuriated by her presentation. He was frustrated that when she worked with the community physiotherapist she mobilised very well indeed, but outside these times she expected him to assist her. She could get up from her chair, but more often than not she expected Damon to pull her out of the chair to the standing position. She was doing nothing for herself; she would not even switch on the kettle. Damon reported feeling let down by his family. He reported that his sibling had an injury and was not visiting and his father did not want to know his son's troubles; he acknowledged that they were scared of a physical altercation erupting therefore they did not want to be in his presence.

Damon reported that he had asked his mother to return to Iran, but she would not do this without him, and he would not go to Iran. In the view of the team there was an impasse between mother and son, and Damon was left feeling that it was his duty to care for his mother. However, he was saddened by the fact that he had been robbed of living his own life; he did not see that he had the free will to choose his own fate. He was felt to be enmeshed by his need to

look after his mother, which he attributed to the demands of his strong Islamic faith.

On examination Songul was sitting comfortably in bed. She was appropriately dressed and well groomed. Although she had a basic command of English it was found to be more helpful for her to be able to express herself though the interpreter. Her mood remained predominantly anxious and she looked low. Her thought content was limited as she did not have much to talk about; she did nothing day in day out. She had no insight into her presentation or her son's strain as her carer.

Songul's management plan was amended to increase her anxiety reducing medication further over time. She was to continue with her anti-depressants at the same level. A visit was to be arranged by an occupational therapist to see whether Songul would qualify for a chair which would aid her transfer from sitting to standing thereby protecting Damon's back, and whether she would benefit from an aid to support her to get out of bed independently. The visit report was copied in to the occupational therapist and they were asked to accept the report as a referral. A further visit was planned for the 17 October, but efforts were to be made before that date for staff to visit to see whether they could get Songul to day care at least once a week.

From this visit it was concluded that Songul's difficulties were entrenched and she was not 'psychologically minded' (lacks insight). Her social situation was seen as difficult and the team were 'not optimistic about her convalescence and recovery with respect to her emotional well-being'. There was a hope that 'we can try and see whether we can effect some improvement in mood, but more importantly put in some practical supports to give Damon a bit of a break'.

The consultant psychiatrist reported to the Mental Health Inquiry Panel that Damon was in quite extreme pain from sciatica during this visit and he was getting frustrated as Songul had a community physiotherapist with whom she worked in a positive way, but with him she expected to be moved and lifted.

3.112 Information obtained during the Police investigation reveals a total of 4 calls to NHS 111 Urgent Medical Care Service in the lead up to the fatal incident. The first at 16:44hrs on Saturday 21 September 2013 when Damon made a call lasting almost 10 minutes to inform the operator that he had been suffering from back pain for the last 15 years. He answered all questions clearly for the operator's assessment and although he rambled on he did make sense.

3.113 On 24 September an addition was made to the Community Mental Health Team database RIO risk assessment document that Health Care professionals should do joint visits only. Interviews with staff for the Mental Health Investigation Report found this was due to staff feeling uncomfortable with the overtly sexual tone of some of Damon's conversation when he spoke in detail about previous sexual contacts and not because of concerns about physical aggression, although it is not clear from the records which do refer to Damon's 'high expressed emotions', and his statements that his family does not visit because they are concerned about a physical altercation. The following day on 25 September the team administrator at the Community Mental Health Team took a telephone call from Damon. The notes from this call were recorded on the RIO database by a community mental health nurse. Damon stated that he was ruminating about having said he wanted his mother to go back to Iran, but he wanted to make it clear that he would continue to look after her if the team can

help with her mood. According to the administrator he seemed upbeat and calm during the call.

3.114 At 15:47hrs on Wednesday 25 September Damon phoned NHS 111 for a second time. He confirmed his details and also his mother's, and this time said the call was about himself and his mother. The operator asked to speak to his mother and she could be heard on the line, but it appeared that she did not understand what she was being asked. Damon returned to the phone and stated that he was calling to give feedback on his previous call. He said his mother was fine and thanked the operator for their previous advice. He went on to talk about his depression, anxiety and anger issues and about family matters including no longer speaking to his father or having anything to do with his other family. He mentioned his mother needing a visa, and again his anxiety and paranoia, but confirmed he was not suffering that day. He again mentioned his back pain. The operator advised him to visit his GP. The call lasted just over 16 minutes.

3.115 Damon had a review with his GP on 27 September. He was noted as doing well and exercising. He was commended and he was to continue with his medication. The only reference to Damon suffering from back pain in GP records is an attendance at A & E on 1 November 2002 and the GP referred to an Orthopaedic Surgeon, however there is no record of the referral being taken up.

3.116 At 17:52hrs on Monday 30 September Damon made a third call to NHS 111. From the start of the call he sounded anxious and stressed, and he shouted at the operator before they could take his details or establish the reason for his call. He shouted about suffering pain everywhere, particularly his back and having swollen testicles. At one point he shouted at the operator "Are you stupid, don't you understand me". He went on to mention a trapped nerve and the operator asked him to hold the line because she could not get a word in. While on hold Damon could be heard breathing very heavily. A paramedic took over the call and tried to ask questions, but Damon continued shouting and mentioned that he was not mental. Eventually the paramedic was able to calm him down to ask some questions before advising Damon to seek medical advice if he felt he needed to. The call lasted 14 minutes 13 seconds.

3.117 Damon clearly felt he needed further medical help as about an hour later at 18:47hrs a 999 call was received from him reporting that he had trapped his sciatic nerve. At 19:07hrs Damon called 999 once more providing an update. He explained that his condition was deteriorating with worsening pain to his pelvis and legs, and he was prone on the floor due to the pain; he was also sweating heavily. An ambulance was dispatched at 19:13hrs arriving at Damon's address 2 minutes later. On arrival the crew found Damon was upside down balancing on his head, stretching his legs outwards with Songul and a friend present. It was explained that Damon had a 15 year history of sciatica; he described his sciatica as shooting pains down his legs, into his groin with shooting pains in his neck up to his temple and across his eyebrows. Damon explained he had been under a lot of stress being a carer for his mother and with a family that does not help. He further explained that he had a history of depression and that his doctor had not helped. Damon had last seen his doctor 3 days ago. There are no reports of sciatica present in Damon's GP notes supplied for the Review chronology. He stated it was ruining his life and affecting all aspects. On examination Damon appeared very tense, sticking his muscles out, he also had jerky movements. It is documented that he did not need any treatment; he was comforted by the ambulance staff. Following the

crew's examination Damon was conveyed to Barnet Hospital. Notes show he declined pain relief on admission; he was observed to be very tense. It was recorded that Damon was the main carer for his mother. His history of depression was documented and there was a question over whether a mental health referral was needed. Damon was seen by medical staff; the pain began resolving and he was able to walk around. He was noted to be agitated and frustrated. Mental health issues were noted and the fact that he was known to Mental Health services in the past. Damon explained that he was concerned about 'trapped energy and that he gets swollen around groin and thighs, eased by massage and stretching'. An initial assessment was undertaken by a registered nurse and a registered mental health nurse. Support from Mental Health was suggested to him, but Damon declined. Damon was reassured and discharged to the care of his GP for follow up. The discharge summary sent to Damon's GP did not contain any detail as to the reason for his attendance nor did it mention any concerns about his mental health.

3.118 On 1 October 2013 Damon visited his GP for an injury affecting his back sustained whilst he was exercising and he was advised to continue with medication. He complained about his physical symptoms using a very unusual description of what he felt was happening to him due to his exercise regime which had been advised by a physiotherapist in the past. His GP noted 'soft tissue damage. He is very agitated, appears confused and paranoid'. His GP has clarified that this comment was made in connection with Damon's description of his complaint. His GP discussed a referral to the Mental Health Team, but Damon did not agree with this being done; he promised to take his medication of Olanzepine which was prescribed on 17 September 2013. As Damon would not agree to a referral to Mental Health, and following his GP's assessment at the consultation, his GP reports that he did not feel it necessary to call the Mental Health Crisis Team. According to his assessment Damon was neither suicidal nor at risk of self harm or harm to others. From past experience when Damon took his medication his GP's observation was that he got better. His GP reported that they were aware that Damon lived with his mother, but were unaware that Damon was her only carer. They were under the impression that he had other family members. As a consequence Damon was not registered as a carer in the practice, although the practice does have such a register. Damon did not tell the practice that he was a carer, and as his mother was registered at another practice they were not aware of her needs.

3.119 Later the same day Damon called the out of hours Barndoc service regarding the same injury, and at 20:07hrs that evening he made his fourth call to NHS 111. He was calmer than his previous call and stated that he had seen an Asian doctor the previous day and mentioned that he was advised to see a psychiatrist; he had called to gain a second opinion. Damon also confirmed that he had seen his GP and been prescribed medication. The operator tried to start an assessment, but struggled to get a word in as Damon spoke for a long time about pain in his back, groin and buttocks; about his diet; drinking water; and taking things slow. Eventually the operator finished the assessment. The outcome of this is not known. The call lasted 26 minutes 49 seconds.

3.120 On 5 October a 999 call was received at EOC at 01:11hrs. An ambulance was dispatched at 01:13hrs arriving at the address at 01:32hrs, a second ambulance was dispatched at 02:00hrs and a senior officer was dispatched at 02:11hrs arriving at the address at 02:27hrs. It is documented on the 999 call log that the original caller was the son/brother of the occupants of the address who had commented "I don't know what he has done to her". Due to this information Police assistance was requested and once at the scene officers

forced entry to the property via the back window. The body of a woman was found lying inside the house; she had a 3-4 cm laceration on her left temple/left eye area radiating to cheek her with severe bruising and swelling to the left of her face. There were no vital signs and life extinct was documented at 02:10hrs. Damon was arrested by Police officers at the scene and taken to Barnet Hospital A & E where he was treated for swollen and cut hands. Schizophrenia was noted in his nursing notes. After treatment he was discharged accompanied by the Police.

# 4. Overview

### Summary of information known to agencies:

4.1 In summarising information known to agencies this section will briefly look at information known before 2013, and then look in detail at 2013 from when Songul was admitted to hospital in February that year and the months leading up to her death.

4.2 Information known pre-2013 gives helpful context and develops a picture of Songul's growing needs over time, particularly in regard to her mental wellbeing and her mobility problems. This information was primarily held by a variety of Health agencies particularly Songul's GP practice where she was seen very regularly. Her chronic health problems resulted in many appointments both within her GP practice with doctors and practice nurses, and with a variety of hospital departments including the Older People's Psychiatry Service, Physiotherapy, the Ambulance Service, and A & E. All Health agencies were aware that Damon was Songul's main carer except his own GP; it was a fact that, whether or not practitioners were aware of this from a referral, Damon would frequently make reference, even on occasions when he was seen alone, for example during his own A & E visits.

4.3 Songul had a number of appointments with Mental Health Services with the first contact being between 2008 and 2009. Her GP practice IMR finds only one communication is recorded on her notes for this period from Mental Health; a letter following a domiciliary visit dated 25 February 2009 which states that Songul was suffering from severe depression. It is of note that during November 2008 a number of important communications took place:

- Damon's GP received a letter on 1 November asking that he be referred to a psychiatrist for 'violent behaviour';
- Barnet Hospital Social Work Team received a "Potential Adult Protection" fax from the Hospital on 11 November and follow up phone call from a doctor on 14 November. However, records do not show the detail or the actions taken, but it may relate to information in the hospital IMR which indicates that on 7 November Songul was seen in A & E due to not having been able to walk for 2 days and it was noted that she 'sleeps in same bed as son'.
- Then on 21 November 2008 GP3 in Songul's practice received a message from her ex-husband's wife stating that her son had assaulted her. This record is ambiguous and gives the impression that Songul was assaulted by Damon. However, information provided to the author confirms that it was Songul's ex-husband's wife who was assaulted by Damon. Nevertheless, given that Damon was a carer for a vulnerable adult any reports of assault by him should have triggered discussion and sharing information with the Barnet safeguarding adults lead. This did not happen; no considerations of a safeguarding alert or safeguarding actions were taken.

4.4 Songul was referred by Mental Health services for Social Services support for herself and Damon around this time and Adult Social Care records do show a Community Care Assessment was required and a home visit took place on 27 November 2008, although the referrer is not evident from their notes. No carer's assessment appears to have taken place and Songul was deemed not to be eligible for services due to her immigration status. Damon requested help for his mother from Social Care in January 2009, September 2011, and October 2012. A practice nurse was aware of his contact in 2012 as Damon had requested that Social Care Direct contact the nurse which they did to advise that Songul was ineligible for services. Apart from this telephone call there is no information sharing between Social Care and Songul's GP or Damon's GP practice.

4.5 In addition to Health and Social Care, pre-2013 there were brief contacts with the Police by Damon in 2003 due to a fight; 2005 due to an allegation of assault made against Damon; following an argument between Damon and his brother in 2009 about his mother visiting; as a witness to an incident; as an alleged offender after an altercation with a workplace manager, and as a victim of a minor assault in college. None of these incidents resulted in or necessitated the sharing of information with other agencies at the time. In August 2002 Damon was detained in a different Police area after becoming angry with a friend and his then girlfriend, and due to his behaviour he was seen by a Mental Health Crisis Team at the Police station. Following this he was referred for an anger management course, which he did not attend. This information did not appear in the Police information to the Review as the record is no longer available due to the amount of time which has passed; it came to light via the Mental Health Board Inquiry. This Board Inquiry also revealed that Damon was seen in Barnet Hospital A & E department in November 2003 with 'general paranoia and inability to cope', following which he was advised to see his GP for a medication review. There is no reference in the GP chronology notes for 2003 concerning this A & E attendance. No further referral was made to Mental Health Services for Damon or contact made by him after this.

4.6 Information concerning the safeguarding alert referral by the occupational therapist and physiotherapist to the Hospital Social Work Team on 19 February 2013 appears to have been limited to the hospital staff concerned, the Hospital Social Work Team, and the following day when Damon had discharged his mother, the North Locality Team when the case was transferred to them. There was good communication between the Social Work Teams, with the one reservation being that details of the original safeguarding alert were lacking and ambiguous. It is of concern that when Damon was talking about discharging his mother and the social worker discussed this with the hospital registrar (paragraph 3.41), the registrar could see no reason for safeguarding concerns. This begs the question was the registrar informed of the reason for the alert and clear about the concerns, and was this entered onto Songul's hospital notes for staff to be made aware at shift changes?

4.7 At no time during the safeguarding alert process was Songul's GP contacted for information or alerted to the safeguarding concerns, nor was Damon's GP approached for information to inform a risk assessment. The notes in Songul's GP IMR chronology from the hospital discharge make no reference to a safeguarding alert, leaving the practice ignorant of events. The IMR from the Central London Community Healthcare NHS Trust also highlighted that their database does not currently enable them to flag safeguarding alerts for vulnerable adults in their Walk-In Centres and urgent care centre.

4.8 As mentioned above, there was a lack of detail recorded in the allegations which gave rise to the alert; the alerter was never asked to detail the allegations, whereas hospital occupational therapy and physiotherapy recording is detailed about events leading up to the safeguarding alert, Social Care recording contains little detail. The Safeguarding Alert form which was loaded onto the Wisdom database mentions 'general concerns'; Damon's manual handling of his mother and his aggressive and defensive behaviour; his application for his mother to remain in the UK, and ends that he touched his mother 'in an inappropriate manner' and 'shares a bed with her and cuddles her'. There was no description to explain what the 'inappropriate' touching was or expansion on the term 'cuddles' and no risk assessment recorded. This resulted in ambiguity later on when others, such as the social worker in the Community Mental Health Team, were unable to access the reasons for the alert to inform their approach and actions.

4.9 Although the reasons for concerns arose from Damon's manual handling and inappropriate touching of his mother in front of staff, no information was shared or discussed with Police, and no strategy meeting took place which would have facilitated information sharing and risk assessment. This was not in line with Multi-Agency Safeguarding Adults policy and procedures.

4.10 Information received from the Patient Liaison Service on 22 February 2013 by Adult Social Care that Damon had been at their office and was very challenging and 'displaying odd behaviour' resulting in him being removed by security, does not appear to have been transferred to inform any risk assessment. The closure of the safeguarding process due to findings from a meeting with Songul and her daughter that allegations of "sexual molesting is unsubstantiated" were not shared with the safeguarding alert agencies.

4.11 The North Locality Adult Social Care Team was informed on 25 February 2013 by the local authority solicitor that Songul was able to receive services despite having no recourse to public funds and this enabled an assessment to go ahead. During this assessment on 14 March 2013 unsafe manual handling of Songul by Damon was witnessed by social worker 6 and this information resulted in an emergency request to Occupational Therapy and a joint visit to try and remedy this. The Adult Social Care IMR highlights that the information clarifying Songul's eligibility for services could have been sought before, but over the years no previous request for support had resulted in this step being taken.

4.12 There are hints during June 2013 that Damon is finding his caring role more difficult. In June he informed Songul's GP that his mother acts more disabled than she actually is, and he struggled to get her to be co-operative. In a call to the out of hours service he reports that his mother is "raising her blood pressure deliberately… won't let him take her blood pressure", and "she is creating problems". It is commented upon in the following months by the out of hours service, GP, the Mental Health Team during assessments in August and September, and the Police attending the report of shouting and screaming at the home on 17 July 2013, that Damon was struggling as Songul's main carer. Unfortunately, the vulnerable adult referral completed by the Police following their visit which was thought to have been faxed appears not to have been received by Adult Social Care and a fax sent receipt cannot be found. The last call made by Damon to Social Care Direct on 10 July 2013 requested that social worker 6 phone him urgently. In the email message sent to social worker 6, key worker, and managers Damon was reported to sound distressed, but he

did not disclose what he was calling about. His call was not returned. Thus a variety of agencies knew Damon was under stress, but the information was not shared.

4.13 There is a considerable gap in information known to GPs. There was no information sharing between them or communication by other agencies with them. A contributor has informed the author that Damon was once registered at the same practice as his mother and the rest of the family, but he was asked to transfer to another practice which was thought to be because of his behaviour to staff, but due to the amount of time which has passed it has not been possible for the GP practice to confirm this. He registered with a different practice in September 1998; therefore Songul and Damon were patients at different GP practices. Songul's GP practice IMR points out that Damon's permission would have been needed for information to be shared with his GP, but there appears to have been no consideration that it may have been appropriate to seek his consent to do this. Therefore Damon's GP was unaware of the view of other professionals that he appeared to be struggling as his mother's carer. Equally Songul's GP was unaware of Damon's mental health problems following his consultation with his GP on 30 May 2013 due to 'mood variations and the same symptoms as before' when he was prescribed anti-psychotic medication Olanzepine. From the brief chronological notes from his GP practice it would appear that Damon remained on this medication, although from psychiatric reports to the court his consistency in taking his prescription cannot be relied upon. (*full details of this consultation are not known in the absence of his GP IMR)*.

4.14 Although the Community Mental Health Team (CMHT) achieved a good level of information from Songul's GP referral and during their assessment of Songul's mental health, they were not fully cognisant of the safeguarding alert and the detail behind it. At the time of their first visit on 14 August they were unaware that a Borough social worker was already assigned to Songul as the CMHT social worker located in the team had not checked their Borough social work Swift database beforehand. The usual practice of the social work principle practitioner checking the database for Borough involvement had not taken place as the request for a joint visit with a social worker came direct from the CMHT consultant. Songul's GP had suggested that social care input may be required (this reinforces the fact that Songul's GP was unaware of Borough social work involvement). The team learnt of the existing social work involvement and the safeguarding investigation from Damon at their first home visit. The restraining nature of IT systems on information sharing will be discussed in the analysis section of this Review. There was full feedback of assessments to Songul's GP by the CMHT consultant psychiatrist.

4.15 In addition to the main statutory agencies, Victim Support were contacted by Damon and they became aware that he appeared anxious and in need of further help which was outside their usual remit and it was suggested he seek counselling. They were informed by Damon that he had already been receiving counselling from Barnet College. The college counsellor was aware that Damon suffered from depression and managing anger issues which prompted the counselling which commenced on 1 October 2012 after which he received 14 sessions. He had appointments booked until 18 March 2013, but he stopped attending in the January without giving any reason. The college knew that Damon was caring for his mother, but he was seen to be coping with this. Damon's GP appears unaware that he was receiving this counselling.

4.16 Summing up the information known to agencies, particularly in the months of 2013 leading up to Songul's death, it becomes apparent that her physical and mental wellbeing was deteriorating and at the same time what appears to be Damon's anxiety and difficulty in coping is being observed by various Health organisations. Information appears to be shared between allied health practitioners involved in community services, such as between the Borough social worker and occupational therapist, but the key community based practitioner in constant contact with the family, Songul's GP, appears to be completely out of the loop until the Mental Health Team assessment. Damon's GP is equally outside the system of information sharing and seems to be oblivious to what is taking place. The lack of information gathering and sharing with GPs regarding the Safeguarding alert is particularly concerning.

4.17 Damon's GP appears to be aware that he was mentally unwell at his appointment on 1 October 2013, but there is no evidence that consideration was given to phoning the Barnet Triage Service to speak to a clinician to discuss his condition. The Triage Service is a resource whereby practitioners can receive advice or discuss a patient and where appropriate an assessment can be made with the involvement of the mental health Home Treatment Team. The assessment would inform the pathway into community or inpatient treatment.

Ethnicity, Cultural & Equalities Issues:

4.18 Songul and Damon were of Iranian ethnicity. Both were of the Muslim faith. Songul had very limited English and Damon acted as her interpreter for all of her appointments. He was very reluctant to accept an independent interpreter for assessments stating in the hospital on 18 February 2013 "why don't you trust me, I will take my mother home if you do that, I look after her for 12 years, you will not take my mother away from me", and following the Safeguarding alert he perhaps not unsurprisingly appeared to have a deep mistrust of statutory agencies. It was good practice when Songul was in hospital for an interpreter to be used, but this was almost achieved under duress as Damon appears to have been very averse to anyone else interpreting for his mother. Although the Mental Health Team used interpreters for most assessments it was noted by the psychiatrist that the mini mental state examination to assess her cognitive ability did not appear to lend itself to translation into Farsi and adjustments had to be made. The Mental Health Board Level Inquiry confirmed that there was limited understanding of cultural 'norms' within the team, but felt that these issues would have been explored further as the therapeutic relationship with Songul was established.

4.19 It was good practice by the team manger and a significant advantage that locum social worker 6 in the North Locality Team who was a Farsi speaker, was assigned to the family in the community. However from the recordings seen by the IMR author this was not apparent in the notes and does not appear to have resulted in any strong engagement with Songul and Damon. Nor does it appear to have resulted in a referral to culturally appropriate services such as those provided for the Iranian community by the Farsophone Association, with the exception of the GP referral for counselling from this organisation at Damon's request. It is somewhat surprising that Damon appears to have asked for this referral, and yet he did not directly access any of the groups for older people for his mother run by Farsophone in the community. The invitation to contact Farsophone for Songul's counselling appointment was also not taken up.

4.20 Damon's rebuttal of the concerns about his sharing a bed with his mother was that it was acceptable in his culture. The DHR Panel was fortunate to have expert advice on Iranian culture from a representative of the Iranian, Kurdish Women's Rights Organisation, who confirmed that such a custom was not culturally acceptable in Iran. This has also been confirmed by other contributors with an intimate knowledge of Iranian culture and customs. It was good practice to see Damon's assertion that it was acceptable challenged by the psychiatrist who carried out the assessment in August 2013. Staff in the hospital appeared to have been less confident in outwardly challenging this.

4.21 During an assessment for the court proceedings Damon confirmed to consultant forensic psychiatrist Dr Phillip Joseph[12] that he 'used to share a bed with his mother' but said there was nothing sexual in this arrangement until shortly before her death when an *"unnatural"* thing started to happen. He explained that whilst in bed his mother pushed herself against him and he pulled away. It happened two or three times and it made the Damon think that his mother was interested in him sexually, but she told him that it was not her. He believed that she had been taken over by a 'Jinn' (evil spirit) to make sexual advances to him; his mother had no control over it.

4.22 Damon often stated his commitment to caring for Songul, and this appears to have deep seated roots in his religion and his culture. The psychiatrist assessing Songul noted that "He was felt to be enmeshed by his need to look after his mother which he attributes to the demands of his strong Islamic faith." Damon felt it was "his moral responsibility to care for her and that this is part of his culture and strong Islamic faith". In her paper on the elderly population in Iran Dr Maryam Noroozian[13] states the "Caregivers' burden is higher in Iran - and societies with the similar culture-as the strong emotional bonds between the family members and their elderly parents don't let them to leave their old parents in the institutional homes". There is a strong sense in the IMRs from agencies that had direct contact with him that Damon's sense of responsibility for his mother was both driven by a cultural and religious imperative as well as genuine care for her, although at times this appeared to cause him frustration, and sometimes periodic verbalisation of his resentment that his own life was affected to the extent that he did not have a life and a wife and family of his own. Songul herself appeared to expect Damon to care for her. During the assessment on 24 September with an interpreter present it was recorded that "she was observed to have high and unrealistic expectations of him and believed he had a duty of care towards her twenty-four/seven". Yet despite his occasional frustrations and outburst of aggression many practitioners and others contributing to this Review observed that Damon was a very caring man who genuinely loved his mother who was diligent in his care of her.

4.23 It is possible too that cultural difference could have affected Songul's interactions with the Police. When the Police went to investigate concerns about shouting and screaming coming from her address on 17 July 2013 they spoke to her on her own as is good practice, using the telephone translation

[12] Confidential Psychiatric Report 27 March 2014 – extracts cited with kind permission of Dr Philip Joseph, Consultant Forensic Psychiatrist

[13] Maryam Noroozian, MD '*The Elderly Population in Iran: An Ever Growing Concern in the Health System' in* Iran Journal of Psychiatry & Behavioural Science, Volume 6, Number2, Autumn / Winter 2012 (page 5)

service Language Line. Information from the report of the visit records that Songul did not like being separated from her sons (another son was visiting at the time), and she "seemed very nervous, but when spoken to alone was adamant that she was ok and that her son looks after her very well". Songul's nervousness and statement that she was 'ok' may have been due to a difference in perception of Police services in Iran compared to the UK, or she may have feared that she or Damon might be removed by the Police due to her immigration status leaving her without support both physically and verbally due to her lack of English.

4.24 Although the informant raising concerns with the Police in July 2013 reported that shouting and screaming had been coming from the address for the 'last couple of weeks and they believed the son may be harming his mother', Songul's vulnerability and communication difficulties heightened the likelihood that she would be unable to disclose abuse if it was taking place. The Panel's special advisor also suggests that older women from Songul's culture would be more likely to be accepting of male power and less able to challenge. Conversely, it is also probable that in a traditional Iranian family structure a mother would not feel comfortable with a male relative providing personal care, but in Songul's case her daughter lived in Iran and Damon was the only person available in the UK to care for her.

4.25 During assessment for court by Dr Joseph in March 2014[14] Damon confirmed that 'he found it increasingly difficult to cope with looking after his mother due to both his and her physical and mental problems'. He reported that he 'asked social services for help but they turned them down', and he admitted that 'His mother had different moods and sometimes he slapped her like a child when she would not listen to him. She would respond by asking him not to do it. His mother was never aggressive to Damon when he was looking after her, although he said she used to hit him when he was a child'. This information is very important, however, it must be treated as hindsight as it has been discovered after the event. Nevertheless, it highlights the difficulties practitioners face when undertaking assessments or inquiries to get to the truth of what is taking place in a family. Various skills and knowledge are needed to assess the level of stress a carer is under especially when mental health issues add complexity.

4.26 There is no evidence to suggest that Songul, or Damon, were discriminated against by any services under the Equality Act 2010. The "protected characteristics" of disability, age, and religious belief, which are relevant to Songul were mainly taken into consideration. However, during her stay in hospital in February 2013 a male social worker was allocated to undertake an assessment. Given her Muslim faith, and her cultural background it was insensitive to assign a male social worker, especially given the concern about possible sexual abuse behind the safeguarding alert which needed to be investigated. Her access to Community Care services was eventually resolved by advice from the Local Authority legal adviser with reference to the Human Rights Act 1998[15]. Under legislation agencies were required to consider

[14] Confidential Psychiatric Report 27 March 2014 – extracts cited with kind permission of Dr Philip Joseph, Consultant Forensic Psychiatrist

[15] Information provided confirmed: The Human Rights Act 1998 incorporates the European Convention on Human Rights (ECHR) into UK law. This Act has been in force since October 2000. There is a requirement that public bodies act in accordance with the ECHR. The Nationality Immigration and Asylum Act 2002 Schedule 3 sets out the classes of people who are excluded from different kinds of support, this includes support under s21 and s29 under the National Assistance

Songul and Damon's religious beliefs, and it is evident that his expressed conviction that his religious beliefs meant he must care for his mother were trying to be supported during interventions by agencies in 2013, however Damon appears to have been reluctant to accept some of these services.

### Other relevant facts or information.

4.27 Songul's insecure immigration status had significant relevance for her access to Community Care services, for whilst deemed to be ineligible for services as she had no recourse to public funds, Damon continued to care for his mother and appeared to be under increasing strain due to her diminishing mobility and increasing depression. However, by the time Social Care were advised that Songul could be assessed and receive Community Care services the relationship between Damon and Social Care had become one of distrust, and he feared that Social Care involvement would affect his mother's application to remain in the United Kingdom or that they would be separated. How this perception came about is not clear, but it appears to have contributed to his reluctance to accept support. Equally of consideration is that Damon would be Songul's sponsor for her application to remain in the country which would give him considerable power. Also Songul reported that she was dependant financially on her son and her ex-husband making her doubly dependent which could have affected her ability to express any unhappiness with the care she received from Damon. However, judging from the number of agencies Damon sought letters of support from for his mother's application to remain in the UK his wish for her to remain appears genuine.

### About Songul and Damon

4.28 Songul has been described by contributors as a happy woman prior to her stroke and increasing mobility problems, although soon after the stroke she appeared to get better, the last time she returned to the UK from Iran she was anxious and coping less well. Songul previously travelled regularly between Iran and the UK to see her children as she found it difficult to settle in England. She and Damon had also visited Iran together in the past when she had tried to find him a wife there, and at one time Damon had tried to set up a business in Iran. She is perceived as having 'given up' and become withdrawn in recent years.

4.29 Those who know Damon say that he loved his mother and was very caring towards her. From when he was young he was said to act without consideration for the consequences. He was prone to outburst of anger and quick to lose his temper, but they had never known him to be violent to Songul. Contributors suggest his propensity to be quick tempered frequently lost him his job, with the consequence that Damon felt rejected. He is also said to have difficulty backing down from arguments or in letting issues go; this is evident from his attitude to the assault in college, and his follow up letter to the Medical Protection Society after the letter to his GP requesting he had a psychiatric assessment. In the past family members offered to share caring for Songul, but she and Damon refused the arrangement. As well as being anxious about his own health Damon also appears to have been very concerned about his

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Act. However Schedule 3 also states that a person is excluded unless 'its exercise or performance is necessary for the purpose of avoiding a breach of—
(a) a person's Convention rights, or
(b) a person's rights under the EU[1] Treaties'
To establish whether or not a breach has taken place a Human Rights Assessment would have to be undertaken.

mother's health and the risk of a further stroke; this is evident from the large number of appointments and telephone calls to her GPs and other health professionals. He also cut short his own hospital appointments and refused to be admitted on one occasion to return home to avoid his mother becoming anxious.

4.30 Neither Songul nor Damon was in receipt of any benefits. Direct Payments had been offered to purchase a limited amount of care, but Damon did not draw on these funds.

4.31 Information from Dr Joseph's assessment[16] suggests that Damon's "mental state appears to have deteriorated significantly from around March 2013 onwards, and by the summer of 2013 he was noted to express paranoid ideas. He was prescribed antipsychotic medication by his general practitioner, although it is not clear whether he complied with the medication. He continued to abuse amphetamine which will have worsened his psychotic symptoms". (Damon admitted using cannabis and amphetamine on a regular basis for some years, but whether he disclosed this to his GP is not known). There was agreement between the consultant psychiatrists who assessed Damon for the court concerning his diagnosis. Dr Joseph's assessment encapsulates these views that "In the period leading up to and including the killing of his mother, the defendant was suffering from severe psychotic symptoms characterised by paranoid delusions…….. The most likely diagnosis is a paranoid psychosis, which could be part of a depressive or schizophrenic illness and which could have been triggered by amphetamine abuse. However I do not believe that he was suffering from a drug induced psychosis at the material time, as his symptoms have persisted for many months after the cessation of drug abuse. The defendant's paranoid psychosis is a recognised medical condition". In a direct quote from Dr Joseph's report Damon stated:

*"I was not trying to kill mum, I was trying to save her by getting rid of the Jinn. I did not think I was killing my mum, it was to get the Jinn out of her….. I was feeling so angry with the Jinn…. I thought by the power of God everything would be back to normal again. I did not think I was doing anything wrong to her. I love my mum and did not want harm to come to her".*

## 5. Analysis

5.1. This analysis will examine how and why events occurred, information that was shared, the decisions that were made, and the actions that were taken or not taken. The information informing this analysis comes from the IMRs provided for the Review and from those who knew Songul and Damon who have felt able to contribute. This will be done while addressing the terms of reference for the Review.

***1. To review the events and associated actions that occurred which relate to the victim and the alleged perpetrator between October 2011 and 5 October 2013 the date of the victim Songul's death. Agencies with knowledge of the victim or alleged perpetrator in the years preceding the timescale for detailed review are to provide a brief summary of that involvement***:

[16] Confidential Psychiatric Report 27 March 2014 – extracts cited with kind permission of Dr Philip Joseph, Consultant Forensic Psychiatrist

5.2. This item in the terms of reference has been achieved in the background information and chronology section of this Review. However, in reviewing the information between 2011 and 2013 it becomes evident that the dynamics within the family appear to have changed during 2013 and there is a greater involvement of agencies during this time. This suggests that greater scrutiny should be given to events in 2013 in this analysis. It is therefore helpful to recap on the key events of this year with one salient addition from 2012.

5.3. Key events were:

- 13 March 2012 Damon saw his GP and reports 'interfering thoughts coming to mind' and 'needs help'. Referred to counsellor – no information on this.

2013:

- 31 January: Damon assaulted whilst in class in college - assault was minor, no injury but Damon appears to have been angry and deeply affected. This is the last month that Damon attends counselling sessions at college.
- 13 February: it appears that Damon and Songul received bad news about her application to remain in the UK. Probably that she has no leave to remain – this confirmed by UK Border Agency to social worker on 6 March.
- 14 February: Songul's admission to hospital with community acquired pneumonia for 5 days during which there was the safeguarding alert due to concerns about Damon's handling and inappropriate touching of his mother. This resulted in Damon and two family members removing Songul from the hospital the night before she was due to be discharged. There were a number of incidence of Damon trying to obstruct Songul being seen alone with an interpreter and being defensive and aggressive to staff.
- From 20 February to 27 August Borough social worker and occupational therapist were involved with the family in addition to the already established involvement of physiotherapy and many hospital appointments, GP and practice nurse appointments.
- 8 March Damon made contact with Victim Support in follow up to the assault at college saying he felt let down by the Police and wondered by this (the assault) had happened to him.
- 30 May Damon went to his GP as he had 'mood variations' and he was prescribed anti-psychotic medication 'as before'.
- Damon called Victim Support again in June and the beginning of July and seemed to be under the impression that they offered counselling, when it was clarified that this was not the case he became agitated and hung up.
- 10 July Damon phoned Social Care Direct sounding distressed and asking for social worker to phone him urgently. Message to social worker and managers not followed up.
- On 17 July the Police visited in answer to concerns that shouting and screaming had been heard at the family address for a couple of weeks. Police were assured by Songul that she was ok and Damon's brother who was visiting reported that their mother 'could be difficult'. A vulnerable adult form was completed, but there is no confirmation that this was sent to Adult Social Care and they have no record of its receipt; no further action taken.
- In August the Community Mental Health Team became involved due to Songul's depression and anxiety; during their assessments observed the Damon was under acute carer stress.
- 28 August Damon saw his GP and was said to 'be better' but he 'looked anxious'. The same day he called Songul's GP practice when he was noted to be anxious that he might be separated from his mother when the psycho-

geriatrician visited the next day. When the GP returned his call Damon answered and then hung up.

- 24 September 3rd visit by the Mental Health Team. Damon reports he has asked his mother to return to Iran, but she will not without him, and he will not go. He feels he has been robbed of living his own life; he did not see that he had free will to choose due to his faith. Damon's carer stress is noted as 'immense'; he had sciatica and was in 'considerable discomfort and pain'. Songul was doing nothing for herself. Damon states 'his brother and father are frightened of him; they are scared of a physical altercation and do not want to be in his presence'.
- 25 September Damon called the Mental Health Team to say he did not want his mother to return to Iran and sounded more up-beat.
- 30 September Damon made a third call to NHS 111. From the start of the call he sounded anxious and stressed,
- 30 September Damon called 999 due to acute back pain as a result of sciatica – seen in A & E. Staff assess Mental Health support needed.
- 1 October Damon's GP notes record he is injured whilst exercising; to continue medication "appears paranoid".

*2. The agencies which had involvement with the victim and the alleged perpetrator to assess whether the services provided offered appropriate support, resources, and interventions, and that procedures were followed. This to include any interaction with family members or friends which have relevance to the scope of this review as identified within agencies' records, Individual Management Reviews (IMR) or other information sources as deemed appropriate.*

Adult Social Care:

5.4. It is true to say that early requests for support from Damon to Adult Social Care for Songul were affected by the focus on her immigration status and by the perception that this prevented her from receiving community care services. This was rectified by the hospital social worker who contacted the UK Border Agency to clarify her immigration status during Songul's admission in February 2013, followed by the local authority solicitor, who confirmed that she was eligible for services and this was passed to the North Locality social worker after case transfer. The Adult Social Care IMR confirms that this information could, and should have been gained before. It is possible that had services been offered in the years before the safeguarding alert, Damon and Songul may have been more disposed to accept outside help. Following the alert there is a distinct impression that Damon developed a deep distrust of Social Care, and Songul expressed a wish not to have outside help. Her insistence on Damon as her only carer inevitably increased the strain on him over time.

5.5. In considering the application of the safeguarding process the Adult Social Care IMR confirms that Pan London safeguarding policies and procedures were not followed in their entirety. Most notably there was no initial risk assessment to give a comprehensive understanding of the details of the alert and there was no multi-agency strategy meeting held prior to meeting with the family. This undoubtedly prevented open and candid discussion between practitioners about the substance of the concerns, especially given the sensitive nature of possible sexual abuse. Damon's confrontational behaviour verged on aggression and intimidation towards the staff that had raised the alert, and to go straight into a meeting with him could not have been easy. Admittedly allegations had not been substantiated at that stage, but in theory a meeting

with an alleged perpetrator present has the potential to put a victim at additional risk, and again was not in line with procedures.

5.6. At this stage Songul had not been interviewed on her own with an independent interpreter in a place where she might feel safe, nor been offered an alternative advocate to support her; Damon would not allow this to happen. However, it is unlikely that Songul would have disclosed any intimate information in interview even with an interpreter as the hospital social worker was male. Given her religion and cultural background, this was insensitive and should have been taken into consideration when the team manager allocated the case.

5.7. There was evidence from IMRs that a difference in perception of the situation with regard to the safeguarding alert and the inappropriate touching of Songul by Damon may have been at play between Health and Social Care practitioners. Health practitioners felt strongly that their views and concerns were overridden by the community social worker, who was said to be of the opinion that Damon's behaviour with his mother and aggression towards staff was 'cultural'. The community social worker also expressed reassurance about the situation following their home visit. Another social worker observed that they were 'not able to get a clear understanding of what the allegations were'. Such lack of clarity concerning the reason for a safeguarding alert is unacceptable and indicates procedures were not followed adequately. Practitioners need to bear in mind that recording in such circumstances needs to be timely and accurate, especially when there is the potential for any safeguarding issue to lead to criminal proceedings where accurate recording is essential. Damon had told them that he had been lying on the bed with his mother because she was distressed and he had touched his mother's breasts to show the professionals what '*in*appropriate' was and had been misunderstood. He had been very offended. Whilst there is no suggestion that Damon's English was limited, there was no independent interpreter present at the time; had there been communication might have been clearer and the situation defused.

5.8. The perception of another social worker was that some of the hospital staff may not have been used to dealing with agitated people and found it difficult to manage the situation with Damon. This seems a rather inappropriate view considering the various people and behaviours hospital staff encounter during their day to day work, and hospitals, in common with most public sector agencies i.e. local authorities, have policies in place explicitly to counter aggression and intimidation towards their staff. Although the Hospital IMR is clear that Damon was never seen to exhibit any physical violence towards his mother, it does beg the question that if Damon was not concerned about being aggressive in a public space like a hospital, what could his behaviour be like in the privacy of his own home if things did not go the way he wanted? There is certainly evidence of a difference in approach once Songul left hospital and there is a distinct contrast between the explicit and detailed recording of events and actions witnessed in hospital staff records to the vague and inexplicit records in those of Social Care.

5.9. Despite the nature of the concerns no checks were made with the Police concerning the safeguarding alert. Pan London Adult Safeguarding policies and procedures (2011) in place at the time state:

> *"There may be Safeguarding Adults referrals that involve sexual innuendo or remarks that will not result in a criminal investigation; however, all Safeguarding Adults referrals that indicate any form of*

*sexual abuse require a risk assessment, intelligence gathering and appropriate information sharing with relevant partners".( Page 11)*

Crucially no checks took place with the family GPs for background information or to see if they had any concerns. Nor were checks made with the Police to see if either party was known them, or whether there were any relevant previous convictions. These checks are routine in child safeguarding cases and need embedding in safeguarding vulnerable adults procedures.

5.10. The IMR identified that along with establishing Songul's immigration status the team leader advised social worker 1 to establish Songul's mental capacity. However, the assessment of her mental capacity appears rudimentary and confined to knowing where she was indicating a limited understanding of the Mental Capacity Act 2005. There was no recording of Songul's wishes and feelings or possible risks from Damon, indeed Songul's 'voice' was judged to be absent from recordings. Although Songul's daughter was visiting from Iran and was in the hospital at times she too was thought to be reluctant to confront Damon; she did not speak English and information from her is absent in the records.

5.11. The transfer of the case to the North Locality Team under safeguarding was carried out swiftly and efficiently and there was good communication between the teams even after the case was transferred. Good practice was noted in the IMR as the team leader allocated the case immediately to a Farsi speaking locum social worker. The concern with establishing mental capacity continued into the Locality Team, however no immediate protection plan regarding potential sexual abuse appeared to be considered. As the IMR put it 'The family's message to professionals was that the home situation was acceptable', and Damon's assertive and challenging manner seems to have gone unchallenged by practitioners; indeed at times he appeared to be 'calling the shots' for example in demanding a letter setting out the reasons for a meeting; demanding the alert was withdrawn and apology given. It is almost as though the safeguarding concerns took second place to mental capacity and immigration status issues. When a risk assessment was completed in the investigator's report it did not even address the original allegation, and no consideration is given to Damon's mental health.

5.12. When the FACE Overview Assessment and personal budget questionnaire was completed during a visit on 14 March 2013 it is not recorded how the assessment was carried out. The social worker was a Farsi speaker, but it is not known whether they saw Songul alone. A carer's assessment was also undertaken at the visit and assistance with personal care was proposed via direct payment, however there is no evidence that Damon took up these payments and Songul was reported to be unwilling to accept support from other people. In the assessment Songul reported that she valued her son's support, and she said she was depending on her son and ex-husband for financial support. There appears to be no consideration of the impact this financial dependency might have on Songul's ability to disclose abuse or any controlling behaviour being exerted over her if that had been the case, had she wished to do so. It is evident from interviews undertaken for the IMR that no consideration was given to aspect of the case which might indicate domestic abuse or coercive control and a possible referral to MARAC, not even the fact that Damon avidly tried to block Songul being seen alone with an interpreter, rang alarm bells and was framed as controlling behaviour.

**Barnet Hospital:**

5.13. Songul and Damon both had contact with the Barnet and Chase Farm Hospitals. Their contacts were:

- Doman's A & E attendances
- Songul's A & E attendances
- Songul's outpatient attendances including physiotherapy
- Songul's inpatient stay in February 2013
- Letters of complaint from the family and Damon's interactions with staff

5.14. Damon's attendances at A & E were for minor complaints and could reasonably have been treated by his GP. Only one occasion necessitated admission, but after a few hours Damon discharged himself to go home as he was the main carer for his mother. The hospital IMR observed that although Damon was a frequent attender this was not out of the ordinary for the hospital and there was no particular pattern or connection with his caring role for his mother. He always attended on his own. When he was noted to be on 'mood stabilisers' during an attendance for a foot injury on 21 August 2013 there were no concerns about his mental health. When he presented with sciatic pain on 30 September 2013 he was assessed by two registered nurses, one of whom was experienced in mental health, and his history of depression was noted. Damon presented as being very agitated and the nursing staff judged that he needed the support of Mental Health services. However Damon told them that this was already in place; staff were reassured and no further action was taken. It is possible that Damon did not want mental health involvement and this was an avoidance tactic, or equally he may not have been trying to deceive staff to avoid a referral, but he answered the question in the affirmative as his mother and he were receiving visits from the Old Age Community Mental Health Team at this time. With hindsight one might suggest that staff could have checked to see if Damon was known to a Mental Health Team (if that was possible from A & E), but in the context of someone suffering from acute sciatic pain his agitation could be reasonable given the level of pain associated with this condition. There were no concerns relating to Damon's behaviour in A & E or his one brief admission to hospital.

5.15. Songul had 17 out-patient and 4 A & E attendance during the period 2011-2013. She was accompanied by Damon consistently. She appeared frail, but well presented and well cared for. There are several references in notes to her low mood during appointments, but she was known to be in the care of her GP and a psychiatrist therefore referral on was not necessary. Staff at her out-patient appointments always felt that Damon was caring towards his mother. The IMR gives the example that 'he would ensure that she was compliant with care at home in terms of her mobility', and her mobility was viewed as improving with each session.

5.16. When Songul was admitted to the hospital on 14 February 2013 she was frail, but found to have been well cared for at home. Her treatment with antibiotics saw an improvement in her chest infection within a few days. Damon was insistent that he stay on the ward with Songul to interpret for her, and said she would get upset if he left. It was not usual practice for relatives to stay on an open ward with patients, especially a man staying in a women's only ward, but after discussion and escalating the decision up the management chain it was agreed he could stay, but he was to leave at night, however Damon would return to the ward ignoring the agreement. This was exceptional leeway given by staff to accommodate Damon's wishes in light of other patients' privacy considerations, or another example of his ability to intimidate until he got his

way. Some patients did complain verbally about his presence on the ward. Why this was allowed and what consideration was given to other patient's safety and privacy by management is unclear. There was no safety plan in place for the ward, and other patient's complaints were not dealt with to remove Damon from the ward.

5.17. The hospital IMR documents the concerns raised in Damon's physical handling of his mother when he was assisting her. Physiotherapy staff appropriately tried to guide him into safer ways of doing this, both for his sake and Songul's. However, Damon became very defensive and aggressive with nursing and therapy staff particularly when there were discussions about the home situation or there was an interpreter present. It was during a therapy session on the 19 February that Damon again became defensive and aggressive to staff and made sexual suggestions, and he touched his mother in a way that concerned staff (see paragraph 3.38). This incident triggered the safeguarding alert. This was an appropriate action given what was witnessed and the concerns of staff.

5.18. Nursing and medical staff did their best to prevent Damon from taking Songul home late in the evening of 19 February 2013. They acted appropriately in consulting the site manager and in contacting the duty social work team as there was a safeguarding alert. The Police were not called. Pan London Safeguarding policy (2.7.6.4 page 95) states that 'If there is any indication that such a removal is being planned, legal advice must be sought urgently. If removal does occur, legal guidance must still be sought'. There is no record that legal advice was sought by Health or social work staff and it was therefore believed that there were no legal grounds to keep Songul in hospital and no right to prevent her going home.

5.19. The senior nurses and therapists who met twice with Songul, Damon, and Songul's daughter on 20 and 21 February at which Damon was again aggressive to staff did their best to be open and informative with him, however consistent with his behaviour on similar occasions when he was not happy with an outcome his anger erupted and appropriately security were called by staff. It would have been justified to make a further safeguarding alert referral following this incident to reinforce the concerns raised in the alert of 19 February.

5.20. Although not connected with Songul and her care it is relevant for this Review to raise concerns about the supervision and support of nursing staff including students on placement within the hospital. The staff member harassed by Damon did not raise concerns with her supervisor at the time. Apparently she felt her actions in giving him her mobile phone number was unwise and she appeared to take some of the blame herself for her predicament, a not uncommon reaction in victims of such harassment. However, Damon was older and very persistent; he was on the ward constantly and difficult for her to avoid. This, and not wanting to appear unprofessional in her role, may have prevented her from taking the matter to her supervisor. This begs the question is guidance given to staff and students at the hospital during their induction covering such situations, and do staff and students feel they would be believed and supported if they report such behaviour from a patient or visitor?

Mental Health Services:

5.21. Songul's GP referrals to the Community Mental Health Team dated 24 and 28 June 2013 were received by the Intake Team on 3 July; both letters mention Damon expressing anger towards the GP. Songul was seen on the 14 August. The delay was due to an outpatient appointment having been offered, but

Damon requested a home visit, thus the appointment was rearranged. A further delay was caused by the consultant's wish to do a joint visit with a social worker from the team. Considering that Mental Health Services for Older People receive approximately 45 referrals per month and the consultant was trying to accommodate Songul and Damon's individual circumstances this timescale does not appear unreasonable.

5.22. The initial visit was undertaken by a consultant psychiatrist, a community psychiatric nurse, and a team social worker. An interpreter had also been booked to attend, but the company concerned failed to inform the interpreter of the change of venue. However, on subsequent visits staff were accompanied by an interpreter. From the Mental Health Board Level Inquiry report it would appear that the team took steps to try and build a trusting relationship between themselves and Songul and Damon. It was recognised that there was reluctance on their part to accept services, and they had needed reassurance that Songul was not going to be admitted to hospital. Damon had been open at the first visit about the safeguarding alert and Social Care's involvement, a fact that the visiting team did not know at that time due to the failure of the social worker to check their database beforehand. Prior knowledge of these facts would have been helpful in planning and undertaking the assessment, and the fact that the Borough social worker was a Farsi speaker could have resulted in a joint visit with someone already known to the family and saved the need to bring in an agency interpreter.

5.23. When discussing the safeguarding alert Damon denied any sexually inappropriate behaviour towards his mother, but he was still sharing a bed with her at that time. He justified this as being culturally appropriate, but when advised by consultant psychiatrist that it was not appropriate in Western culture he seemed to take it on board. On subsequent visits the team were shown that they were using separate beds, and therefore did not feel that a further safeguarding investigation was required.

5.24. By the second visit the social work database had been checked with varying degrees of success in terms of the level of detailed information obtained about the safeguarding alert, and due to the social worker believing that the Borough social worker was involved, they withdrew to avoid duplication. However, the case was closed by the Borough social worker on the 27 August thus leaving no social work involvement. The Mental Health Inquiry Panel felt more should have been done to gather information about the concerns which led to the safeguarding investigation to better inform assessments and this is a justifiable view.

5.25. A further area worth comment is the fact that Damon was identified by the team at their first visit as experiencing 'significant carer stress'. However, he did not want Social Care input, but wanted medication for his mother because she 'was not always cooperative'. This led the social worker to surmise that there was no role for Social Care; he had said he did not want their involvement and they were convinced that Damon would already have had a carer's assessment by the Borough social worker as this was a requirement for his respite vouchers. Relying on databases solely for information proved flawed; it is arguable that picking up the phone and checking with a colleague social worker within the same organisation could have provided an instant picture of current involvement and a chance to discuss the case. However, there was no evidence to suggest that anyone in the Mental Health Team offered Damon a carer's assessment during their contacts with him even though they were unaware at the first visit that he may have had one previously. Situations

change and regardless of an existing carer's assessment it would be good practice to review provision for a carer just as it would be for a service user.

5.26. Of note is the fact that Damon's uninhibited disclosure of previous sexual contacts went unchallenged. Practitioners decided to visit jointly because they felt uncomfortable, but there is no mention that the inappropriateness of his conversation was discussed with him, even though it probably also took place in front of his mother. There is the impression that staff are bending over backwards to keep Damon on board so that they do not alienate him.

5.27. The Community Mental Health Team appeared to have tried their best to engage with Songul and Damon and the level and resources put into their assessments was very good. They seemed to be succeeding in gaining acceptance from Songul and Damon; they were considering a local day centre and additional help from an occupational therapist, but events sadly overtook this. The importance of adequate attention to assessing carers themselves as well as service users needs stands out.

### GP Surgeries

5.28. Songul was a frequent attender at her GP practice. Between October 2011 and the time of her death she had 95 contacts. Damon attended all appointments with her and interpreted for her. Songul was never seen alone with an independent interpreter present.

5.29. Songul had chronic health conditions which required regular monitoring, including mental health conditions such as long term depression, anxiety, and diabetes. From her GP chronology and IMR it is evident that she was given timely and comprehensive care for these conditions and when necessary she was referred to specialist services in the local hospital or Mental Health Services.

5.30. Songul's practice staff were responsive to both her and Damon's anxieties about her health, and responded with both face-to-face appointments as well as telephone consultations. A GP also provided a report to Songul's solicitor in connection with her application for leave to remain in the UK.

5.31. Where practice was below what would be expected was when it was recorded in a message to one of the GPs in Songul's practice in November 2008 that Damon had assaulted his mother. The practice was aware that he was Songul's main carer and there is a comment in the notes that Damon 'may not be capable of looking after her and may need more Social Care input', and yet no safeguarding referral was made, nor were the Police contacted. The IMR cannot explain why. Contributions provided for the Review suggest that the message may actually have been incorrectly recorded, for it was Songul's ex-husbands wife who was assaulted by him. They are also registered with the same GP. Even if the assault was not of his mother, but his step-mother, this too would give rise to concerns, as violence towards another person should also raise questions about a carer's propensity for violence with others and at least trigger enquiries of the Police and other safeguarding adults agencies. The phrase 'may need more Social Care input' implies that the GP thought Songul was having some Social Care provision, but this was not the case. The allegation that Songul was assaulted by Damon (even if incorrectly recorded) comes in the same month that Songul was seen in A & E as she was unable to walk for 2 days, but no physical cause could be found. It was hypothesised that she was suffering from catatonic depression and she was seen by Mental

Health Services. Clearly there were stress factors in the family at this time which were not picked up. Damon admitted in interview with a psychiatrist for the court process that he had hit his mother on occasions, but as he interpreted for her this would not have been revealed to her GP.

5.32. From the limited information available to the Panel provided by the chronology and answers to questions put to them, Damon's GP practice was aware that he was a carer for his mother, but said they were not aware that he was her sole carer as they thought a female relative was also involved in her care. This meant he was not registered as a carer at their practice, and yet his GP described him as "an anxious man who always wanted to be in good health to care for his mum." If this was the case why was he not registered as a carer? Damon's GP practice report that there was no indication of domestic violence during their contact with him. However, they had received the letter in November 2008 reporting that Damon had been violent and requesting he had a psychiatric assessment, but following a visit from Damon, his sister-in-law and mother when they named the author of the letter as a 'trouble maker', no action was taken as Damon refused a referral. Damon's GP had no contact with Songul's GP practice, no contact from social workers, or Mental Health and was unaware of the safeguarding alert of February 2013.

5.33. From the 30 May 2013 Damon was prescribed anti-psychotic medication by his GP as he was experiencing 'mood variations and same symptoms as before'. The medication had previously been prescribed in 2002 by Mental Health Services. By 28 August 2013 Damon's GP observed that he was 'better, but looks anxious'. No referral to Mental Health Services appeared to be considered necessary, and at a review a month later Damon was recorded as doing well. Damon's last appointment with his GP was on 1 October 2013 and was a follow up to his A & E attendance with sciatic pain the previous evening. Arising from this consultation is the GP's comment "appears confused and paranoid," but his GP has stated that this observation was due to the way Damon described his symptoms, and their experience was that he had previously improved by taking the medication prescribed for him.

5.34. Damon's GP was not aware that the Mental Health Service for Older People was involved with the family around this time and was ignorant of the fact that the psychiatrist in that service viewed Damon as being under 'immense stress' as a carer. The GPs chronology reference 'appears paranoid' comes the day after the assessment by medical staff in A & E that Damon needed the support of Mental Health Services, indeed Damon told the out of hours Barndoc medical service later that evening that he had seen an Asian doctor who had recommended that he see a psychiatrist, whether this was his GP or in A & E is not clear. However, the hospital discharge notification to Damon's GP gave no detail whatsoever about the reason for his attendance or the advice that mental health involvement would be advisable, but which Damon declined.

5.35. The Barnet Triage Service exists to give GPs an easy access route into advice from a clinician at the end of the phone to discuss a patient who presents with a deteriorating mental state. This has the potential to lead to assessment by the Home Treatment Team and a pathway into inpatient or community treatment. All GPs are aware of this service and there are regular liaison meetings between the Trust and GPs plus referral guidance on a website. However, Damon's GP assessed that, based on previous experience, he was not sufficiently unwell to require this service and the Triage Team was not phoned for advice about Damon on 1 October 2013. Damon had also refused mental health intervention. Whether this approach was ultimately in Damon's best

interest is debatable. Could he have been persuaded to accept a mental health assessment on the grounds that he needed a medication review? Given that he was taking anti-psychotic medication which had first been prescribed so many years ago would have been a reasonable cause to refer him and perhaps gain his understanding and agreement for this to take place.

### Ambulance Service:

5.36. The Ambulance Service received many call outs to Songul and Damon's address. All calls were responded to very promptly and appropriate care and advice given, or when necessary transfers took place to A & E. The vast majority of calls were for Songul.

5.37. The number of call-outs indicates to some extent the level of Damon's concern and anxiety in managing his mother's care and medical conditions. He appeared to be undertaking regular blood pressure checks, and at the slightest change Damon would call for advice from the GP, the out of hours medical service, or Ambulance Service. It is also evident that some of his calls to the Ambulance Service on occasions were because he feared Songul was having another stroke.

5.38. The Service's IMR did not identify any safeguarding concerns arising from their attendances, nor was anything witnessed which would have given rise to thoughts of domestic abuse taking place.

### Central London Community Health Care NHS Trust

5.39. Songul and Damon had minimal contact with the Community Health Care with only one attendance each for minor ailments to their Walk-In Centre. Treatment was appropriate for the presenting problem and summaries of the attendances were sent to their GPs.

5.40. When the Trust's Intermediate Care Services received a referral for physiotherapy from Barnet Hospital on 4 September 2013 it was felt that the referral was not clear enough and an attempt was made to contact the referrer. This was not successful and a message was left. A call to Songul was also made, but the number supplied was incorrect and a letter was sent with a deadline for a response. No response was received. This emphasises the importance of clear and accurate communication whether written or verbal. It would have been preferable to follow up with the referrer for the correct details in this case, and it is remiss of the referrer not to return the phone call message. There is always the consideration that there could have been no response to a letter because the recipient's literacy skills prevented them from reading or understanding the letter.

### Victim Support:

5.41. Victim Support provides victims and witnesses of crime with practical and emotional support. Their clients are referred predominantly by the Police as Damon was following the assault by a fellow student at college in January 2013. However, it was not until 8 March that Damon phoned the service. This may be because he had other things on his mind in February due to his mother being in hospital and the safeguarding alert having been made. Between the initial call and 3 July Damon had 5 contacts with Victim Support.

5.42. Damon appears to have misconstrued the service available through Victim Support for records suggest he thought he would receive counselling, whereas the Service offers a listening service and referral on to other agencies if required. When Damon was informed of this in a telephone call on 2 July 2013 he became agitated and the call ended with him hanging up.

5.43. In Damon's last call he cancelled the appointment made to meet a worker and he talked about his mother, her health needs, and the fact that they were not getting any support. He mentioned receiving cognitive behavioural therapy from his college, his GPs suggestion that he have counselling, and he disclosed that he had called NHS Direct who told him he was suicidal, but it appears from the notes he was not asked how he was feeling at that time. The Victim Support IMR identified missed opportunities for probing further into Damon's concerns and how he was feeling. For example delving more into the counselling Damon was receiving could have provided a contact with whom to engage on his behalf to inform them of what had been disclosed.

5.44. Whilst Victim Support's remit would not encompass concerns for Damon's mother, the information from Damon that NHS Direct had assessed him as being suicidal and that he had concerns for his mother might have put them in the category of 'vulnerable adults'. Therefore a referral to Social Services may have been appropriate. The IMR felt this was a missed opportunity.

5.45. Damon was given emotional support from Victim Support and he was provided with the contact numbers for the Samaritans and the mental health charity Mind. He was also told that he could call again if he needed to. From the interaction with Victim Support there is a sense that Damon is emotionally vulnerable, isolated, and looking for support and someone to talk to from any source he can think of. His counselling sessions at college were due to come to end on 18 March 2013 although he last attended in January 2013, but there is a possibility that he may have felt bereft of access to this support. His agitation when told by Victim Support that they did not offer counselling might reflect this.

### Royal Free Hospital:

5.46. Songul and Damon had minimal contact with the Royal Free Hospital. Songul was seen yearly since 2006 for check-ups of her eye health in connection with her diabetes. Nothing remarkable was noted during these appointments.

5.47. Damon had just one appointment at the hospital in November 2007 at the request of his GP in connection with an eye problem. His GP's referral letter mentions that Damon is 'an anxious man' and experiencing stress due to his 'ailing mother' confirming the number of years that Damon had been a carer and his emotional disposition.

### The Police

5.48. Apart from the fatal incident the primary Police contact relevant to this Review relates to the call from a concerned neighbour which resulted in officers visiting the family home on 17 July 2013. The caller reported hearing shouting which made them fear Damon was harming his mother.

5.49. The officers appeared to assess the situation well, and in line with good practice spoke to Songul on her own using the telephone interpreting service Language Line to enable them to converse with her. Songul was noted to be

agitated at being separated from Damon and another son who was visiting from Iran, and she was adamant that she was well looked after. In speaking to her visiting son officers were told that Songul could be "very difficult at times due to her conditions". The officers assessed that Damon was clearly struggling to look after his mother, but were told that they were not eligible for Social Services support.

5.50. The officers concluded their visit and appropriately completed an 'Adult Came to Notice' report, a system introduced to deal with incidents involving a vulnerable adult. However, although the Police IMR found the report was printed off and there is reference to it being faxed to Adult Social Care, no evidence could be found that it was received and no fax sent receipt was found. It can only be surmised that this important notification was not sent. A secure email system has been introduced for such referrals since this time.

Barnet College:

5.51. Damon attended the college between October 2009 and May 2013 for a range of courses. He was open with the college that he was on anti-depressants, but they were unaware of any more serious mental health problems. The college dealt appropriately with the assault by another student in February 2013 by trying to bring about reconciliation between the two, but Damon 'refused to participate and became agitated'. The college IMR goes on to describe that Damon 'found it hard to let the matter drop and came across as anxious and neurotic and made the point that he could have retaliated but he didn't'. Damon was advised that he could take the matter up with the Police which he did.

5.52. The college counsellor met with Damon on 14 occasions between October 2012 and January 2013; Damon had self referred with the presenting problem being identified as depression and anger. Although Damon discussed his caring role for his mother at no time did he express anger towards her, and no safeguarding issues were identified. The counsellor who saw Damon was experienced and aware that safeguarding concerns would supersede the code of confidentiality in counselling. The sessions had been booked up to 18 March, but he did not attend after January 2013. His lack of attendance for his remaining sessions coincides with Songul's admission into hospital in February and the safeguarding alert procedures which carried on into March. The college have identified the need to follow up with individuals who suddenly stop attending counselling. Their IMR observes that if Damon's behaviour had changed there was a chance that his counsellor could have been alert to this; however, none of his tutors identified any issues which led them to make a safeguarding referral.

Immigration Services:

5.53. Immigration Service records show that Songul had been entering the UK as a visitor since 2000. She re-entered on 3 July 2007 on a visitor's visa with clearance to remain until 3 January 2008. An out of time application to remain was submitted on 7 March 2008 and this was refused on 31 March 2008 with no right of appeal. However, on 24 April 2008 the Home Office was asked to reconsider Songul's case, but the refusal was upheld. The same request was made again on 20 June 2009 and once more the application was refused on 8 July 2009. A further application was submitted for indefinite leave to remain under article 8 of the Human Rights Act on 2 October 2009 and this was refused with no right of appeal on 14 December 2009.

5.54. The last correspondence received by the Immigration Service was a letter on 29 July 2013. The letter stated that documents were awaited to submit a fresh application, however no application was received. There was no record of any removal direction on Songul's file.

NHS Direct & its replacement NHS 111:

5.55. Damon made a call to NHS Direct in June 2013 and told Victim Support that he had been assessed by them as being suicidal. The NHS Direct Legacy Department has provided information on their contacts with Damon which took place in August, September, and October 2012. None of the calls relate to Damon's mental health, and there were no assessments of his mental state.

5.56. Damon phoned NHS 111 four times not long before the fatal incident. The third call was full of shouting and anger, and Damon sounded anxious and stressed. There is no evidence in Damon's GP chronology notes that his GP received notification of Damon's state of health from NHS 111. NHS England was contacted about protocols for information sharing with GPs regarding their patients, but no response was received. Their website only mentions data sharing for purposes of monitoring the service – there is no statement visible regarding the sharing of information with GPs or for safeguarding purposes.

***3. To assess whether agencies have sufficient and robust relevant policies and procedures in place, and whether these are up to date and fit for purpose in assisting staff to practice effectively where domestic abuse is suspected or present.***

5.57. The Barnet Adults and Communities IMR reports that the department's Intranet Safeguarding Adults page provides comprehensive and necessary information for the Adults and Communities' Staff. It includes information, for example, regarding domestic violence and MARAC. Information is clear and accurate and is regularly updated to ensure changes are incorporated. Information provided explains how to recognise domestic violence, when to refer, and which agencies have expertise to deal with the issue.

5.58. However, Adult Social Care did not follow the Pan London Safeguarding Adult procedures in their entirety as required. Of particular note is the absence of an initial risk assessment and strategy meeting. The safeguarding alert was not discussed with the Police in line with procedures, and domestic abuse and MARAC were not considered. Songul was also interviewed in the presence of Damon in the initial stages of the alert. Again this raises the question did the social workers involved recognise that the alert met the definition of domestic abuse?

5.59. In reviewing the Pan London Safeguarding Adult policies and procedures 2011 (Reviewed January 2014) It is noted that the definition used for defining domestic violence (page 15) is from the Association of Chief Police Officers 2004. The Panel has been informed that due to the recent Social Care legislation the Pan London Safeguarding Adult policy has not now been reviewed and areas are assumed to be developing their own new policy. It is to be hoped that any new policy will adopt a more up to date definition of domestic abuse, for example the Home Office definition in the introduction to this Review.

5.60. Barnet Hospital has guidance in place on safeguarding adults, capacity assessment, raising concerns, and the use of interpreters. These have been

reviewed in light of this case. The IMR comments that at no point was domestic abuse suspected by hospital staff and that the safeguarding alert was raised in relation to the inappropriate contact between Damon and Songul. This suggests that domestic abuse, especially non-violent forms of abuse and coercive control are not readily identified by hospital staff since the relationship between Damon and Songul *would* define the situation as domestic abuse i.e. they were family members.

5.61. Barnet Hospital has Trust guidance and best practice on the use of interpreters which advises against the use of family members as interpreters. In this case an interpreter was organised, but Damon would not let them be used. Staff did not challenge this and endeavour to see Songul alone with an independent interpreter. Songul's GP IMR also recognises that they did not see Songul with an interpreter and the practice has discussed the issue of patients who consistently attend with a family member, friend, or carer to interpret for them. In their IMR they confirm that in future they will ensure that such patients are offered appointments alone with an interpreter and are able to communicate freely. However, this is with the caveat that the patient agrees to this.

5.62. Barnet Hospital's guidance on capacity assessment is in line with best practice, but it does not appear that a capacity assessment was considered or carried out regarding Songul whilst she was in the hospital, although it was considered by the hospital social worker as advised by their team manager, however, the assessment was not undertaken satisfactorily.

5.63. The Mental Health Inquiry confirmed that the Mental Health Trust has policies and procedures for safeguarding adults and domestic abuse, however, there are hints in the Inquiry report similar to the hospital, that non-violent forms of abuse or coercive control may not be recognised as domestic abuse i.e. 'Domestic abuse was not considered as a separate entity because there was no evidence that the Perpetrator had harmed his mother'.

5.64. In addition the following agencies reported that they have Safeguarding Adult policies in place: Longrove Practice, Vale Drive Medical Practice, Barnet Hospital, Victim Support, Central London Community Healthcare.

***4. To examine the knowledge and training of staff involved in relation to safeguarding of vulnerable adults, the identification of indicators of domestic abuse, the application and use of appropriate risk assessment tools and safety planning including:***

- ***The DASH risk assessment checklist and referral mechanism to MARAC***
- ***Agencies own specialist risk assessment tools to assess risk posed by a perpetrator and/or risk posed to victim and follow up processes;***
- ***Knowledge and use of appropriate specialist domestic abuse services.***

5.65. In addition to Intranet resources staff in the Adults and Communities department has various training provided to staff at different levels and the IMR states it is the responsibility of staff to ensure that they carry out all of the training available to them. The staff supervision template includes a section on safeguarding and training issues which are monitored through this framework. Some training provided by the London Borough of Barnet is mandatory for staff to ensure that the employees maintain their Health and Care Professionals Council registration. In depth domestic abuse training is not part of mandatory training.

5.66. Staff in the Mental Health Team have undertaken mandatory safeguarding training at level one/two delivered internally which contains components of domestic abuse. Any training outside of these levels is delivered by partners and is not mandatory. Adult Safeguarding training which has a domestic abuse component is available for clinical staff on a quarterly basis. This includes identifying domestic abuse, CAADA DASH risk factors and MARAC referral pathway.

5.67. Songul's GP practice confirm that all practitioners involved in her care attend regular mandatory safeguarding training and so were knowledgeable about potential indicators of domestic abuse. However, their IMR points out that adult safeguarding training has only recently become mandatory and may not have been in place for the full time that Songul was seen at the practice. The IMR author was not able to confirm individual practitioner's knowledge of the DASH risk assessment, but the practice holds details of local services to refer to and has a safeguarding lead GP.

5.68. Victim Support, Barnet College, Community Health Walk- In Centre, and others confirm that all their staff, and where relevant volunteers, have mandatory safeguarding training.

5.69. However, it is questionable whether the domestic abuse component of safeguarding training cited by all the agencies in this Review is comprehensive enough given the time constraints inevitably in place by incorporating such a complex subject into something equally vital as safeguarding. Whereas domestic abuse does need to be considered a safeguarding issue, it also needs sufficient time and exploration of the different forms of abuse and coercive control to equip practitioners to identify it in order to take the appropriate steps and risk assessment.

5.70. No one appears to consider Damon's confrontational and at times aggressive behaviour towards practitioners or others, such as towards staff in the Patient Liaison Service and the hospital physiotherapists, as a form of coercive control; using aggression to intimidate to get his way. His behaviour did not figure in their assessments during 2013, unless the Police vulnerable adult assessment following their call out can be classed as such, but this did not go further as it was probably not sent. No one saw his behaviour through a lens of domestic abuse and a DASH risk assessment was not considered because domestic abuse was not considered. All agency's IMRs state that training is available and safeguarding training is mandatory, but the practice in this case raises the question are the right staff accessing the dedicated domestic abuse training on offer to give them the depth of knowledge and the skills they need.

5.71. Given the many restructures which have taken place, and which continue to take place within public and voluntary sector services it is essential that heads of organisations recognise the effects of staff turnover in this area of work. Not only is there a loss of staff who have received domestic abuse and safeguarding training, but a loss of organisational and team memory, a loss of inter-agency relationships, knowledge of services users, lessons learnt, and what works and what does not. The value of multi-agency training in such circumstances should not be underestimated.

*5. Examine the effectiveness of single and inter-agency communication and information sharing, both verbal and written*.

5.72. Patient confidentiality issues impeded the sharing of information between Songul and Damon's GPs. Songul's GPs did not share information with Damon's GP concerning the home situation and the impact it was having on Damon, nor did the Community Mental Health Team contact his GP despite their assessment that he was under 'severe carer stress', and on their third visit in extreme pain from sciatica. Both the GP practice and the Mental Health Team reports relate that it would have been inappropriate to contact Damon's GP without his express permission, but no one considered asking his permission and there is no evidence that Damon was asked if his GP could be contacted. A reasonable person might be surprised that this information sharing for the benefit of a carer/patient's wellbeing did not take place.

5.73. Of particular concern is the fact that Damon called Social Care Direct on 10 July 2013 sounding distressed and asking for social worker 6 to phone him urgently, but this did not happened. It is of concern on two levels: (1) that a distressed phone call requesting an urgent return call should be communicated via email and not through a telephone call to the social worker direct either landline or mobile seems very inappropriate and lacking in appreciation of the possible consequences of inaction. By all means follow up a call with email confirmation of the call from the service user, but prompt action should have been taken to contact social worker 6 by phone; failing the availability of the social worker their manager should have been phoned. (2) There was no record on the Wisdom database of the call or action taken indicating that no action was taken and Damon was not called back. The information about the call came to the IMR author from a copy of an email supplied by a team manager. At the time of the call the case was still open to the North Locality Team. If managers were copied in to the email to social worker 6 why did they not check on the outcome with the social worker?

5.74. The basic procedure of informing the Safeguarding Adults Manager about the safeguarding alert did not happen in this case. The focus was on a Mental Capacity Assessment not safeguarding, and the failure to follow the safeguarding alert procedures meant a full multi-agency approach was not taken. There is evidence of inadequate Social Care recording and transferring of information between systems and organisations which hampered efficient and vital information sharing. For example vague recording of safeguarding concerns and the content of a meeting between Damon, his sister and a social worker on 25 February 2013 was not recorded. Songul is said to be able to express her needs and wishes, but what they were is not recorded.

5.75. In contrast, the recording in the hospital notes by staff is highlighted in the IMR as being of an exceptionally high standard, and indeed the description of actions and behaviours that led to the safeguarding alert leave one in no doubt that their decision to raise a safeguarding alert was the correct step to take based on what they saw. However, the same level of detailed wording was not evident in their alert to the Hospital Social Work Team. If a description of the touching seen to take place on the ward was given verbally in the telephone call at 11:000hrs on 19 February from the occupational therapist to social worker 5 in the Hospital Social Work Team it was not recorded in the social work notes. Importantly there was no multi-agency strategy meeting held after the safeguarding alert was raised to share information as mentioned in paragraph 5.7.

5.76. The lack of clear and up to date recording in social work electronic records concerning the safeguarding alert, risk assessment, and other case details had an impact on the timely information available to practitioners that became

involved later, especially the social worker in the Community Mental Health Team. Euphemistic terms used in social work recordings relating to the alert such as 'inappropriate touching' and 'cuddles' did not adequately express what had happened, and in Mental Health notes the expression that Damon had 'high expressed emotions' is unclear in meaning and results in ambiguity and misunderstandings between practitioners. This can lead to inadequate risk assessments and the appropriate delivery of services. Such terms need descriptions and examples to explicitly describe what is meant.

5.77. After the initial visit the CMHT social worker asked the principle practitioner to check the Borough Swift database and this identified there was an allocated social worker and notes of the safeguarding alert gave the reason as possible sexual abuse because Damon was sharing a bed with his mother. The principle practitioner recalled that the notes on Swift confirmed the investigation did not substantiate the concern; Damon was sharing a bed with his mother to comfort her as she found it difficult to sleep without his presence, and he thought it not unusual to do that. The principle practitioner did not look at the full Safeguarding of Vulnerable Adults (SOVA) investigation that they could have accessed on the Wisdom database which is where the Borough uploads such reports. The principle practitioner informed the Mental Health Inquiry that the Wisdom database was not consistently available on the team's computers and access is tightly restricted. The Mental Health Inquiry Panel did not have full details of the SOVA investigation due to the ongoing investigations at the time.

5.78. It is clear that the databases which have to be used by Health and Social Care staff members of the Community Mental Health Team hampers efficient joint working. Health use the RIO database, and Social Care has both Swift and Wisdom. It is not possible to cut and paste information between the systems thus notes have to be typed up on the RIO database from information on the Social Care databases effectively creating double the work. It is not possible to print out reports from Swift, and access is limited and not always available. This leads to delays and difficulties in retrieving information. The Mental Health Inquiry points out that these difficulties have been experienced for a number of years.

5.79. The CMHT social worker asked for the consultant's letter to the GP to be copied to the Borough social worker which was appropriate and potentially very helpful. However, the Mental Health Inquiry Panel could find no evidence that this was done. No date is given for this action, but the consultant's letter to the GP was dictated on 29 August and typed on 12 September. The Borough closed their involvement on 27 August 2013 and no receipt of the letter is noted. It is probable that the letter would have arrived some weeks after the case was closed to the Borough social worker if it was sent.

5.80. Even though unsubstantiated, the lack of detailed information regarding the safeguarding investigation available to the Mental Health Team would inevitably limit the scope of the areas they looked at and impede a full assessment. Although the team were informed verbally of the investigation after the Swift records were accessed no social work entry was made onto the Health RIO database to this effect and there were no social work entries relating to the initial home visit. This lack of record would in effect limit future information available to the team in the absence of the social worker involved. Recording notes in a timely manner is sometimes difficult to achieve in a busy working day, but the implications of not doing so can be serious.

5.81. The Central London Community Healthcare Walk-In Centres use a different electronic records system from other services provided by them. This means that any safeguarding alerts recorded on Health's RIO database are not automatically available for Walk-In Centre staff on their database. Work is being undertaken to ensure that all alerts are on both systems. It is important that this is achieved, as there could be cases of victims of abuse being taken to Walk-In Centres rather than their GP or a hospital thinking they would have greater anonymity and not come to notice.

5.82. There was good communication between the CMHT consultancy psychiatrist and Songul's GP, with detailed assessments being forwarded updating them on the home visits and actions. Songul's GP Practice did find that detailed Mental Health notes of 2008 referred to in a letter in 2009 had not been received by the practice.

5.83. Following Damon's attendance at A & E for his back pain on 30 September and when he was advised to have mental health support, the discharge summary sent to his GP was almost blank apart from his personal details and date seen. The GP had no knowledge that Damon was assessed and recommended to see a psychiatrist but declined. This piece of information if pass on may have given the GP the impetus to make a referral for a mental health assessment and been able to persuade Damon that it was in his best interests for this to take place.

*6. Explore what issues if any prevented the perpetrator accepting the services offered to support him.*

5.84. Without interviewing the alleged perpetrator it is not possible to accurately complete this section fully. The following is based on information in IMRs.

5.85. It would appear that Damon discharged his mother from hospital on the night of 19 February against doctor's advice because he was angry and offended about the safeguarding alert and the connotations contained within in it i.e. that he was sexually abusing his mother. He wanted the alert rescinded and an apology. This prevented doctors from appropriately checking that Songul was fit to be discharged and to do this with suitable medication. Although it must be noted that Damon did return the next day to collect these items. Whether a more conventional discharge would have specifically included support for Damon is unlikely.

5.86. Although Songul and Damon did have a package of care approved by Adult Social Care it was not used. Damon did express the concern that having Social Care involvement could adversely affect his mother's application for leave to stay in the UK; it is unclear on what basis he had this perception. Songul is reported to have expressed a wish not to be cared for by anyone other than Damon, and he may have been acquiescing to her wishes. Damon also professed to feeling it was his duty to care for his mother because of his Islamic faith. Conversely, looking through a domestic abuse and coercive control lens it could be conjectured that keeping other people out of the home retained control and the isolation of Songul.

5.87. Damon was sent a carer's assessment to complete by social worker 6. However, there is no evidence that he completed and returned it. There is no record of it on the system although the fact that he was asked to complete it is. Sending a carer an assessment to fill in makes the assumption that they are

capable of doing so. It would have been good practice to follow up the lack of its return in case Damon had difficulty completing it.

*7. To consider what impact the victim's immigration status had on how agencies responded to her needs.*

5.88. Songul's immigration status had a significant impact on how Social Care responded to her needs. As previously mentioned, for some years Songul's access to Community Care Services was affected by Social Care's assumption that she was ineligible due to having no access to public funds. This proved not to be the case and she and Damon had gone without support for years when they had a right to receive it. Neither were they referred to other voluntary sector services such as Farsophone's community centre. Was this gate-keeping of resources? Discriminatory practice? Or simply that Songul was seen as not the responsibility of the organisation?

5.89. Damon was under the impression that Social Care involvement would negatively affect Songul's application for leave to remain in the UK and this seems to have stopped them accepting support. No one thought to check whether Damon's concern was well founded in order to allay his fears to potentially unblock the route to services.

5.90. Songul's access to healthcare did not appear to be affected in any way. Barnet Hospital was aware of her immigration status about which Damon was very open. Their overseas patient officer had discussed the situation with him, but had not made any progress prior to her discharge from hospital. No requests for payment were made, nor were Damon or Songul informed that this would happen. Access to GP Services, the Royal Free Hospital, and the Walk-In Health Centre was equally unaffected.

### Early Leaning from the Review

5.91. The Panel was concerned about the apparent lack of rigour in assessing carers in terms of their mental health and the stresses they may be experiencing, and the lack of statutory regulation which hampers the gathering of such information. Robust frameworks are needed to make information sharing faster.

5.92. The Panel also discussed the apparent fear among some practitioners to challenge cultural assertions and to delve deeper into practices involving those from ethnic minorities. The Panel identified a need for training which would increase practitioners' confidence in challenging abuse and practices said to be culturally appropriate, and to increase their knowledge of different cultures and customs relevant to their work and local populations.

5.93. The two issues above were taken to the Joint Safeguarding Children & Adults Board by representatives of the DHR Panel to alert them to the concerns and allow time for suitable training to be planned.

## 6. Conclusions

6.1. It has been interesting to observe that for the most part agency records predominantly contain descriptions of interactions with Damon and his characteristics, whilst a rounded picture of Songul as an individual feels lightly

sketched. This is probably due to the fact that most communication with her took place through Damon or occasionally through an interpreter. However, when it came to assessments Songul's needs predominated. Assessment of Damon as a carer, when it did take place, assessed his practical needs and not his mental wellbeing and the effects of the acknowledged stress he was experiencing, even though he was known to suffer from depression and anxiety. A word constantly used by a variety of agencies in describing Damon whenever he is under any pressure or things did not go his way is "agitated", and yet his mental health was not questioned. Even when his GP noted that he appeared 'paranoid' during an appointment on 1 October 2013 just four days before he killed his mother, the seriousness of his mental state was not recognised.

6.2. Information was not shared which could have brought together a more holistic picture. Even during the safeguarding alert when one would hope a wider range of information would be gathered, procedures and processes were not all followed. It is to be hoped that by putting the safeguarding of adults on a statutory footing information sharing for safeguarding assessments will in future be achieved without difficulty. Communication methods of retrieving, recording, and sharing information were also hampered by uncoordinated IT systems, and at times the gaining of information was effectively prevented by Damon blocking the use of interpreters or subjecting staff to intimidation which was not adequately challenged or dealt with.

6.3. This has been a complex case to examine, and the Panel has wrestled with the analysis of the information which has emerged during the Review. The questions we have discussed are:

6.4. Could Damon's position be seen as one where he was controlled and emotionally abuse by his mother, rather than Damon abusing and controlling her? She expected him to care for her; it was his duty. She refused care from anyone else and was reluctant to consider attending a day centre to give him a break, even when he was suffering severe sciatic pain she did not reduce her expectations of him. If he went out Songul would phone him anxious for his return. His brother, who was visiting in July 2013 when the Police were called out, reported to officers that their mother could be "very difficult due to her conditions and it can be a lot to take on by yourself." Damon also told Mental Health staff and Songul's GP that his mother was not always cooperative. There are frequent allusions to Songul doing less than she was capable of; she was reported to be more mobile for physiotherapists than she was for Damon, and she did nothing for herself apart from serve herself a glass of milk from the fridge. Did the pressure of caring for his mother under these conditions exacerbate his depression and anxiety levels and tip him into a more severe mental illness? Arguably it did.

6.5. Yes, Damon touched his mother in an intimate manner which was genuinely and rightly viewed as inappropriate, but as he had been providing her personal care for 12 years could he have become immune to the connotations of this? Is it because he was a man and performing personal care that his actions were suspect? Would the same perception of inappropriate touching have resulted if Songul's daughter had acted in this way? Or in the situation of a close female relative caring for a man? It may have been construed as showing a lack of dignity for the person cared for, but would it have been viewed so seriously? Did Damon touch his mother's body physically in the manner reported because he was in a healthcare setting where there is an expectation that professionals are used to seeing patient's bodies? Was Damon, as he said, demonstrating to practitioners what was *not* appropriate and this was misunderstood? Or could

his behaviour have been one of the first signs that his mental illness was emerging more visibly? With the benefit of hindsight his mental health assessment for the court surmises that his mental health appeared to have started to deteriorate from around March 2013. It may be that the pressure of the safeguarding alert and his aggressive combative behaviour around that time was the beginning of this deterioration.

6.6. Damon reported that he slept in the same bed as his mother to comfort her and that this was appropriate in his culture. This has been dismissed by our Panel adviser on Iranian culture and customs, and confirmed by other contributors. There is a sense that some practitioners felt unable to adequately challenge his assertion, apart from the consultant psychiatrist who did so during a home visit. Damon's agitated, aggressive behaviour towards staff who challenged him verged on intimidation, notably during a ward meeting and when he sought out the physiotherapist who made the safeguarding alert. It is not therefore surprising given Damon's tall stature and intimidatory behaviour that staff found this difficult to handle. Staff should always be protected in such situations and his behaviour should have been challenged more effectively by management and security. It would have been appropriate for him to be removed from hospital premises during some incidents, but this was not done.

6.7. References are made in agency records of Damon being a caring person who loved his mother and wished to do the best for her. There is evidence that Damon was frustrated at times that his life was not his own; he wanted a wife and family, but no one would meet his precondition that a prospective partner must live in his home with his mother. He had been caring for her for many years and he had seen his personal freedom and opportunities for a life outside the home diminished as Songul's health deteriorated and her needs increased. Were his outbursts of anger with professionals borne out of frustration with services, or his increasing agitation a manifestation of emerging psychosis? It is clear from the chronology, and confirmed in the psychiatric assessment for the court that his stress levels were increasing from March 2013 and his mental health was becoming affected. In the Barnet College IMR Damon is described as 'caring and responsible' and at no time did he express anger towards his mother or resentment about looking after her; his anger was directed at others. This affected how he was assessed in terms of risk.

6.8. However avoiding hindsight, and from the information known to agencies at the time, Songul's homicide was not predictable. Had different actions been taken at the end of September and beginning of October 2013 to refer Damon to Mental Health Services to secure a diagnosis and treatment for his deteriorating and 'psychotic' mental ill-health, a risk assessment may have predicted that he posed a risk to his mother or others at that time. Research shows that the risk of violence appears to be greatest in untreated individuals during a first episode of psychosis, and although matricide is fortunately infrequent it is considered to be committed by those with severe psychiatric disorders[17]. Research by Marleau et al agrees with other literature that a 'majority of adult parricide offenders suffer from mental illness, specifically paranoid schizophrenia (56%). They also observed that all of the adult offenders were found insane at the time of the offence'[18]. A correlation has

[17] Carabellese F et al (2013) 'Mental illness, violence and delusional misidentification: The role of Capgras' syndrome in matricide' in *Journal of Forensic and Legal Medicine 21 (2014) 9-1.*

[18] Marleau, J. D., Auclair, N., & Millaud, F. (2006). Comparison of factors associated with parricide in adults and adolescents. *Journal of Family Violence, 21*,321-325. in Rhona Mae Amorado1, Chia-Ying Lin, Hua-Fu Hsu (2008) Parricide: An Analysis of Offender Characteristics and Crime Scene Behaviors of Adult and Juvenile Offenders (page 6)

also been found between the age of the offender and parental victimization; those between 20 to 50 years of age were most likely to kill their mothers[19]. Damon was in this age group.

6.9. Although in the circumstances present at the time Songul's death was not predictable, there are a number of reasons why her death could have been preventable:

a) Had Immigration Services followed up on their refusal to grant her leave to remain in the UK on 14 December 2009 (with no right of appeal) with a removal notice and she had been returned to Iran she would not have been in Damon's care at the time.

b) Had the existence or severity of Damon's mental ill-health been recognised and he had been immediately referred to Mental Health Services for treatment it is possible he may have been admitted to hospital, and with successful treatment it is most unlikely that he would have harmed his mother.

c) A more rigorous investigation at the time of the safeguarding alert which included a robust assessment of Damon, his ability to carry on caring for his mother, and the impact on his own mental wellbeing could have had the potential to identify the increasing instability in his mood and thus sources of risk. Including information from his GP would have revealed his history of mental ill health and opened the door for a more informed risk assessment and appropriate services for him as well as his mother.

d) A more thorough holistic carer's assessment which included information from his GP would, or should, have raised concerns that his anxiety and behaviour were not just due to 'carer stress', but that he was mentally unwell and the stress of caring for his mother and the safeguarding alert had exacerbated his illness. Signs of mental illness were missed; the carer's assessment appeared to concentrate on purely practical resolutions to the family situation.

## Lessons Learnt

### Lack of Awareness of Domestic Abuse

6.10. The 2011 Pan London Safeguarding Adults policies and procedures highlights the fact that 'Approximately one in five homicides in London are domestic related, with the murder of a parent by a son being prevalent. Therefore, it is important that all agencies are as robust in their interventions with interfamilial domestic violence as they are with intimate/ex-partner relationships, and appropriate support services are sought to meet the needs of the adult who is experiencing domestic violence' (page 15). Songul's homicide demonstrates why this statement is so relevant and needs to be emphasised across all services and within training programmes. Practitioners and managers need to suspend their disbelief that someone who outwardly cares for a close relative, such as a parent, can cause them harm.

[19] Heide, K. M. (1993a). Parents who get killed and the children who kill them. *Journal of Interpersonal Violence, 8,* 531-544.(page 4) In ibid above

6.11. There was no consideration of the relationship between Songul and Damon and framing the safeguarding alert in terms of domestic abuse and the triggering of a risk assessment such as the DASH risk assessment tool or referral to MARAC. It is doubtful that evidence available at the time would have resulted in this case meeting the criteria for MARAC, but it was not even considered nor was the MARAC referral route of professional judgement. However, such a mechanism would have provided a forum for multi-agency information sharing, which arguably should have been done through Safeguarding Adult procedures, but this did not take place. Barnet has a significant population of older residents with 47,000 over 65 year olds in the borough at the last census[20]. Given this fact and the increasing older population nationally and the likely rise in the number of carers as a consequence the Panel felt that, along with Health and Social Care staff having greater awareness of domestic abuse in a family setting such as this, it would be helpful if the DASH risk assessment took account of the cared for/carer relationship. This is particularly vital where a vulnerable adult/high risk carer dynamic exists and the imbalance of power which results in such relationships.

6.12. Given the many restructures which have taken place, and which continue to take place within public and voluntary sector services it is essential that organisations recognise the effects of staff turnover in this area of work. Not only is there a loss of staff who have received domestic abuse and safeguarding training, but a loss of organisational and team memory and of service users, a loss of inter-agency relationships, lessons learnt, and what works and what does not. The value of multi-agency domestic abuse training in such circumstances should not be underestimated, and that training needs to emphasise all aspects of domestic abuse and coercive control so that practitioners move away from thinking of domestic abuse as violent acts only.

### Information Sharing

6.13. The failure to fully follow safeguarding procedures lead to a flawed process and inadequate gathering and sharing of information. Had the GPs been contacted and told about the safeguarding alert they would have felt at liberty to disclose information as part of that process. Nevertheless, there are also lessons from this case for GPs that where the welfare of a patient and their carer are at risk or under great strain every effort should be made to gain consent to share information to ensure that the best and most effective support can be given to both. If agreement for sharing information with a GP in another practice cannot be gained from a patient the risks to both patient and carer's safety should be assessed and information sharing under safeguarding procedures considered. Where information of concern comes from the person being, or suspected of being abused, great care must be taken to guard the source of the information to protect the individual from risk of further abuse and harm.

6.14. In this case there was no information sharing between GP practices regarding the immense stress Damon was under and the impact on his mental health of caring for his mother for the procedural reasons of patient confidentiality. Damon's GP's lack of awareness that he was his mother's sole carer because they thought a female relative was also caring for her also meant that the impact of his depression, anxiety and paranoia on his ability to care safely for her was not considered. Given the welfare issues for both carer and cared for, this type of assessment should have been made.

[20] http://data.london.gov.uk/datastorefiles/documents/2011-census-first-results.pdf

6.15. Information sharing between agencies was at times untimely or inadequate and sometimes nonexistent. Of particular concern is the lack of information sharing between Adult Social Care and GPs during the safeguarding alert process, the hospital A & E department and Damon's GP after his last attendance, and within the Community Mental Health team regarding timely information from Adult Social Care.

6.16. There was no system for confirming the receipt of 'Adult Comes to Notice' alerts, therefore it was not recognised that the Notice generated by the Police to Adult Social Care for their call-out in July 2013 had not been received or checks that it was in fact send. It is essential that the new secure email method of sending generates a received and read receipt to ensure that this process can be audited. The fact that the 'Adult Came to Notice' report did not reach Adult Social Care from the Police may have been significant as it brought to light from another source the building stress in the household.

6.17. Damon himself did not share information about his use of illicit substances or non-prescribed drugs, therefore his GP and medical staff seeing him in A & E or in Walk-In services were unable to raise his awareness of the adverse effects of this use on his mental health when combined with his other medication.

### Professional Confidence and Assertive Practice

6.18. The service user should be the focus and should be interviewed or assessed without the presence of the person suspected or alleged to be causing them harm. Where a carer or family member is unwilling or obstructs this happening practitioners need to have the professional confidence to follow procedures. Management support should be sought and provided in pursuit of best practice in such circumstances. If necessary guidance and training should be developed to support this in practice.

6.19. Damon's GP appears to be the only person to identify that he was showing signs of paranoia at the beginning of October 2013, however, no referral for an emergency mental health assessment was made as Damon refused this and the GP believed he would improve with the use of medication as he had in the past. The hospital A & E department also suspected Damon was mentally unwell when he was seen on 30 September, but accepted his word that he was already receiving support. From this we can learn that practitioners need to take heed of their own assessment and be assertive in making referrals to Mental Health when their skills and instincts tell them all is not well. Whilst appreciating referral is patient driven if they are believed to have capacity, when their behaviour is seen as bizarre or unusual a more assertive approach may be necessary. When a patient is on medication for mental illness they should be reviewed by Mental Health services periodically to ensure that the prescription and the dose is appropriate for the current episode, especially when they have not been assessed by the specialist service for some significant time; taking this as a routine approach could be used with a patient who is reluctant to accept a referral.

6.20. Staff need to have the confidence to constructively challenge decisions they disagree with and to be knowledgeable and supported in the policies and procedures to do so. This should be done whether it relates to challenging a safeguarding alert decision, or the ability to prevent a vulnerable adult from being removed from a place of safety such as a hospital.

6.21. Staff intimidation can be very undermining to a practitioner's confidence in their practice; in this case the intimidation was not adequately and explicitly challenged before it reached the stage of needing to call security. Such behaviour needs to be assertively and safely challenged when and wherever it takes place. Equipping staff to handle aggressive or intimadatory behaviour should be part of all practitioners training and they need management support and good supervision in dealing with such incidents. There is learning here too for staff in envisaging how the aggression and intimidation made them feel and how such behaviour will make the vulnerable person feel, both in their witnessing of the behaviour to staff, and the potential for this to be happening within their home to them.

### Risk Assessment

6.22. The Assessment of risk at the time of the safeguarding alert was inadequate and no protection plan was put in place. Later risk assessment centred on the risk of relationship breakdown between Damon and professionals, or the offer of respite care to prevent the risk of Damon having difficulty in coping with his mother's care. No checks were made with the Police at the time of the safeguarding alert to either inform them of the concerns or check for any relevant Police history to inform risk.

6.23. Risk assessment should be integral to any assessment, not just safeguarding, and the areas considered need to be holistic, so that carers are always included, particularly were carer stress is high. Whichever risk assessment tool an agency expects their practitioners to use it is important to recognise that risk is dynamic and risk factors can change. The following guidance[21] needs to be borne in mind:

- *Risk can only be minimised and not completely eliminated or avoided. It must be recognised, assessed and managed, as far as is possible;*
- *Risk strategies must adhere to evidence-based practice, where available, and should use a formulation approach with structured professional judgement to translate risk assessment information into appropriate risk management plans;*
- *Risk is dynamic and occurs in a context resulting from the interaction between individuals, situation and environments.*
- *Assessment is an ongoing process, recognising that risk factors will vary in significance for each individual service user as his/her circumstances change;*
- *Risk assessments and management plans should be regularly updated and reviewed as part of the overall care plan; (*and recorded on the relevant database for practitioners to access at all times*****)
- *As risk assessment is part of routine practice, training must be ongoing to ensure staff competency is maintained*

***** Independent Chair's addition.

### Adequate and Up to Date Recording and Database Access

6.24. Adequate and accurate recording is a cornerstone of effective communication. Management needs to ensure that practitioners are meeting the required

[21] The Department of Health, Social Services and Public Safety (DHSSPS) '*Promoting Quality Care Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services'* As revised May 2010 page 8/9.

standards in their recording and that systems and equipment support them in achieving this. The information retrieval and communication methods in the multi-disciplinary Community Mental Health Team appear particularly unwieldy, requiring double or triple entry of information on different databases, and limited practitioner access which hampers timely sharing of information to the detriment of assessments. The Walk-In health centres also have systems which do not coordinate with those used elsewhere in Health and does not show any safeguarding flags or markers. Fortunately the Police have introduced a secure email system for their 'Adult Brought to Notice' alerts and no longer use fax.

6.25. The reasons for safeguarding alerts need to be detailed and communicated clearly with the reasons for concern and what was seen or heard described. Vague phrases such as 'inappropriate touching', or specialist terms such as 'high expressed emotions' should be avoided or their meaning clearly described to avoid ambiguity and confusion. In this case the reasons for the safeguarding alert were not clearly recorded and these phrases were not defined. This vagueness resulted in a lack of appreciation later on of the behaviour and concerns which caused the alert. The use of specialist terms between disciplines which may be crucial to an assessment for example 'high expressed emotions' should have their meaning clearly described for those outside the specialism.

### Assessment of Carers

6.26. There was inconsistency in undertaking a carer's assessment and the depth and range of these assessments appears to be inadequate. A wider range of information needs to be gathered to provide an holistic assessment of a carer's own health and wellbeing not just assessment of practical aids or respite. Such an assessment could also identify potential areas of tension and risk. The current Adults and Communities Carer's Needs Assessment Form has one question headed 'General health and wellbeing' (question 2 page 3). It covers diagnosis and registered disability, whether the caring role interferes with sleep, affects the carer's mood or how they feel, or causes any pain or strain. Whilst the form is probably designed to be simple to complete this section could be improved by enquiring separately into different aspects of health i.e. physical health, mental health and wellbeing with those sections broken down to ask more specific questions.

### Inadequate Knowledge of Legislation

6.27. Practitioner's had inadequate knowledge of legislation regarding the eligibility for community care in relation to a service user's immigration status and the Human Rights Act. This had a significant impact on Songul and Damon's access to support for many years. The Adult Social Care and Hospital IMRs also highlighted a lack of knowledge of the Mental Capacity Act and the related assessment guidance. Where relevant a service user's immigration status needs to be clarified at the beginning of an assessment and their eligibility for services confirmed from the start.

### The Use of Interpreters

6.28. Damon was habitually used as his mother's interpreter with the result that had she wished to express concerns about his care or treatment of her she would not have been able to do. The guidance for using interpreters was not always followed. Good practice in the use of interpreters needs to be reinforced and should be used for all relevant interviews and assessments, even when family

members act as interpreters. The risks associated with family members or carers interpreting in safeguarding or domestic abuse cases needs to be reinforced as this gives additional opportunities to control and manipulate information available for assessments.

### The Protection of Vulnerable Adults

6.29. Finally, this Review reinforces the case for adult protection to be on the same statutory footing as child protection as highlighted in Prevention in Adult Safeguarding: Adults' Services Report 41[22]. This would place local authorities and others under a duty to share information and to cooperate in the protection of our vulnerable adults within the same statutory framework as the Children Act and Working Together.

## Identification of good practice:

6.30. Staff who made the safeguarding alert withstood intimidation and kept to their assessment that Damon's behaviour with his mother was not appropriate. Their frustration in feeling that their concerns were not taken seriously must have compounded the tension which emanated from raising the alert. Paragraph 2.4.2.4 page 71 of the Pan London Safeguarding Adult policy sets out an appeals mechanism for a safeguarding alert manager to follow. Staff need to feel confident to use this route if they are to challenge another agency's decision making constructively, and managers need to support their staff through this process.

6.31. After many years of being erroneously told that Songul was ineligible for support services, social worker 5 with the backing of their manager sought legal advice from the Local Authority legal department and Songul's immigration status was checked with the UK Border Agency to determine her immigration status. This clarified that she was able to receive community care services.

6.32. The consultant psychiatrist challenged Damon about his sleeping arrangements with his mother and appeared to achieve a change. In recognition of their distrust in services The Community Mental Health Team were working to build up a relationship with Damon and Songul in order for them to accept support.

6.33. The fact that the PALs office thought to contact the hospital social worker to inform them of Damon's aggressive and challenging behaviour when he visited their office was good practice, and should have informed a social work risk assessment.

6.34. Police officers attending Songul and Damon's home after reports of shouting on 17 August 2013 exhibited good practice by using Language Line interpreting services to interview Songul on her own.

## Recommendations:

[22] Prevention in adult safeguarding Adults' Services Report 41. Published May 2011 (Review May 2014) http://www.scie.org.uk/publications/reports/report41/files/report41.pdf accessed 13.10.14

6.35. The recommendations below have been informed by those contained in agencies IMRs, from the lessons learnt from this Review, and by the Panel's long deliberations. The author sought the views of College of Policing What Works Centre which is currently reviewing the DASH risk assessment tool regarding the suitable lead agency to which National recommendation 1 should be addressed. The author also canvassed the views of Professor Gene Feder via the Royal College of General Practitioners regarding National recommendation 5.

National Level:

**Recommendation 1:** Consideration should be given to amending the CAADA DASH risk assessment to include a question asking whether the perpetrator is a carer for a vulnerable adult. This would reflect the additional power imbalance and vulnerability that can result from this relationship, and the inevitable increase in these roles due to the country's growing older population.

**Recommendation 2:** That the Department of Health and NHS England should provide clear and binding guidance and resources for the provision of DHR IMR reports from GP practices which are independently authored and which meet the terms of reference required for the Review.

**Recommendation 3:** NHS England should review the policies and procedures under which NHS 111 operate where a vulnerable patient may be at risk to themselves or others due to mental illness to ensure that their GP is informed as soon as possible and/or emergency services are called to assist the patient.

**Recommendation 4:** That the Government consider introducing new statutory processes to ensure a duty to protect vulnerable adults is in place similar to the duty and procedures in the Children Act and Working Together.

**Recommendation 5:** That GPs have a protocol setting out steps for sharing information with a carer's GP where that carer is not registered at their practice, and where there is concern about that carer which may impact on their patient who is cared for resulting in an increased risk of harm or threat to their wellbeing. Caution must be exercised if the information about the carer's health or behaviour comes directly from the patient, as disclosure of its source may increase risk of harm.

**Recommendation 6:** That the chair of the Community Safety Partnership write to the Solicitor's Regulatory Authority director of Regulatory Policy to request that amendments are made to the code of ethics, or that guidance is issued, which will enable solicitor's to assist with information for Domestic Homicide Reviews where their client's death has met the statutory requirement to undertake such a Review under Section 9 of the Domestic Violence, Crime and Victims Act 2004.

6.36. Local Level:

Multi Agency:

**Recommendation 1:** An electronic flag on agency systems to highlight when someone is a carer for a vulnerable adult should be implemented. This is both to alert practitioners to the vulnerability of the cared for adult, and to highlight the needs and stresses involved in being a carer of someone with significant additional needs.

**Recommendation 2:** Ensure there is best practice guidance on the use of interpreters in safeguarding and domestic abuse cases for practitioners and this is included in safeguarding and domestic abuse training. This should include the risks associated with using family members as interpreters.

**Recommendation 3**: All agencies who had involvement with this Review to ensure that the full Overview Report, its findings and learning is disseminated to decision makers, trainers, and the key staff involved by July 2015 or as soon as practicable following confirmation from the Home Office that the Review can be published.

6.37. **Barnet, Enfield & Haringey Mental Health Trust:**

**Recommendation 1:** That a formal protocol should be developed in Mental Health Services for Older People (MHSOP) to ensure that practitioners who are screening referrals for allocation will have a clear criteria to refer to when they are assessing risk, to support their professional judgement.

**Recommendation 2: (a)** Team Manager to ensure that the Team adhere to Trust Policies regarding information sharing and standards of record keeping and completion of carer's assessments (CPA Policy), in regard to information obtained from SWIFT under section 75 agreement.

**(b)** Verbal conversations &information obtained from SWIFT to be documented in RIO so that all staff have access to this information. All reports or letters received by the team should be scanned and uploaded onto RIO. These should be audited by Team Manager.

**Recommendation 3:** The Trust to take action to ensure that staff are appropriately skilled to work with challenging behaviour when exhibited by carers, and are aware of their responsibilities towards carers. The Trust should make available training to develop practitioner's skills to meet these requirements.

**Recommendation 4:** A comprehensive Review should be undertaken into the mechanisms and agreements by which the London Borough of Barnet and the Barnet & Enfield Mental Health Trust work together and share information with the aim of achieving a formal agreement for a more integrated way of working which results in timely information sharing and more coordinated systems between services for the benefit of service users.

6.38. **Adults & Communities:**

**Recommendation 1:** The Adult and Communities Carer's Needs Assessment Form to be reviewed and consideration given to separating the questions on General health and wellbeing into 'Physical Health' and 'Mental Health/Wellbeing' to enable greater depth of information to be given in each section. Also consider prompt questions being added under each section to determine level of severity of health issue.

**Recommendation 2:** Ensure that all practitioners & locum practitioners have regular & updated mandatory training on the Mental Capacity Act (MCA) 2005. Focus to be on the application of the 2nd principle in relation to service users where there are communication barriers i.e. where first language is not English or who do not share a common language with their worker. The 2nd principle is:

'*A person must be given all practicable help before anyone treats them as not being able to make their own decisions*.' (MCA 2005). Training to include tools for use when assessing mental capacity e.g. use of interpreters, *Makaton, Talking Mats* & other non-verbal communication. Confirmation of training to be audited.

**Recommendation 3:** Best interest assessors (BIAs) and the Mental Capacity Act/Deprivation of Liberty Safeguards Lead to take a role in the education of the workforce on the ground in relation to the Mental Capacity Act (MCA) by providing practice advice and supervision to practitioners when they carry out mental capacity assessments. More staff should to be trained as BIAs to increase skills and competency levels in all cases where mental capacity is an issue.

**Recommendation 4:** The Mental Capacity Act quarterly practice fora should include as agenda items a focus on challenging case examples with a focus on applying the MCA. Any practice issues learnt from them should be shared widely among practitioners e.g. In team meetings. MCA case discussion to become a standing item to be added to the forward plan agenda of the MCA quarterly practice board by March 2015.

**Recommendation 5:** Safeguarding Adults training for all practitioners and Safeguarding Adults Managers to ensure that the principle of always hearing the voice of the adult at risk directly during investigations, and the need to meet with service user without the alleged abuser being present, is embedded in training. Training to include practical tools to enable appropriately assertive practice to manage conflict and aggression, family/carers preventing access to a vulnerable service user, and where family/friends may be intimidated into condoning the situation.

**Recommendation 6:** To support Recommendation 5 and to reinforce practice Adults and Communities to develop policy and practice guidance on working with carers under stress, with carers as alleged perpetrators of abuse, and for situations where the alleged carer/ perpetrator is preventing access to the adult at risk, and identify an appropriate risk assessment for these situations.

**Recommendation 7:** To assist practitioners and their supervisors in confirming the validity of practices, and challenging situations where alleged cultural practices may be causing harm, Barnet Borough Council to work in partnership with local agencies and groups to provide a directory of resources that are willing and able to assist with information clarifying the various cultures and customs within the Borough's communities.

**Recommendation 8:** Policy guidance to be developed and cascaded to practitioners on the eligibility for a care and support assessment for those with uncertain immigration status. This should include the need to establish a service users immigration status and eligibility for community care services as soon as possible and methods of achieving this.

**Recommendation 9:** Adults and Communities should review its mechanisms for recruiting, supervising and performance monitoring of locum practitioners. This should include consideration of whether the Council has access to sufficient choice and quality of locum/agency workers through its agency worker system. Locum workers should be trained and briefed on local procedures and resources. Completion of this review and any changes made to existing processes December 2015.

**Recommendation 10:** Updated recording guidance & standards should be issued and all practitioners should have access to regular training & guidance in excellent recording. Recording issues should be addressed in supervision & clear, explicit, timely and pertinent recording of all case work should be an objective for all front line practitioners & supervisors, <u>especially in safeguarding cases.</u> Interviews conducted in a language other than English must be clearly stated in assessments and case notes whether this took place through an interpreter, or using the practitioner's own skills if they are fluent in the language.

6.41 **Police and Adults and Communities:**

**Recommendation 1:** **(a)** An agreed secure system is put in place to ensure the safe and traceable receipt of vulnerable adults referrals on an 'Adult Coming to Notice Merlin Report' between the Police and Adults & Communities. The process should include a confirmation of email delivery, and read receipt to the sender. Both agencies should log the notifications. This process should aim to be in place by September 2015.

**b**) A 'flag' should be put in place within the IT system used by Adults & Communities practitioners to indicate a high priority MERLIN Report has been received on a service user and/ or carer.

6.42 **Royal Free London NHS Foundation Trust:**

**Recommendation 1:** The Trust to review the MCA policy and Capacity assessment tool and for this be included in training and disseminated through Trust briefings.

**Recommendation 2:** The Trust to review safeguarding training and offer bespoke training to staff on new policies and procedures including the escalation and information sharing process.

**Recommendation 3:** The process of discharge letters to be altered by the Trust to have a fail-safe device that unpopulated letters from the Emergency Dept cannot be sent. Specific patient information where a safeguarding alert has been raised should always be included in discharge letters.

6.43 **London Community Health Care:**

**Recommendation 1:** The flagging of the electronic records health care settings (Walk In Centre/ Urgent Care Centre) is extended to include vulnerable adult alerts.

**Recommendation 2:** Further development of bespoke training for adult services in relation to domestic abuse should be arranged to include recognition, routine enquiry, and sign posting of clients to appropriate services where domestic abuse is suspected.

6.44 **Barnet Clinical Commissioning Group:**

**Recommendation 1:** To monitor the implementation of the action plans for the Royal Free London Foundation NHS Trust, Central London Community Health Care Trust and the Barnet Enfield and Haringey Mental Health Trust.

**Recommendation 2:** To request that electronic patient records for Primary Care contain a flagging and tagging system for domestic abuse and MARAC.

6.45 **GP Practice:**

**Recommendation 1:** Practices should review use of family, friend, or carer to consistently interpret for patients. Whilst an interpreter at every appointment may not be possible, practices should aim to ensure that such patients are reviewed with a trained interpreter annually to ensure they can be seen alone & can communicate freely. To assist acceptance of the policy patient information should be available stating this is routine practice at the surgery and assurance of confidentiality given. A surgery leaflet & posters could be made available in waiting rooms explaining the system.

6.46 **Victim Support:**

6.47 **Recommendation 1:** Using the learning from this Review training to be provided to staff and volunteers by Senior Service Delivery Managers in each London Borough to increase staff and volunteers' understanding of the wider support needs affecting service users other than issues arising from crime. This should include safeguarding, issues and onward referral to appropriate statutory and voluntary support agencies.

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10 August 2015

Dear Ms Lukhman

Thank you for submitting the Domestic Homicide Review report for Barnet to the Home Office Quality Assurance (QA) Panel. The report was considered at the Quality Assurance Panel meeting on 22 July 2015.

The QA Panel would like to thank you for conducting this review and for providing them with the final report. The Panel concluded this was an excellent report which was balanced, robust, thorough and honest. In addition, the report was victim focused and sympathetic and gave a good narrative around gender. The Panel recommended that the report be used as a model of good practice. I am pleased to inform you that the Panel has judged this report as adequate.

The Panel made the following specific comments which you may wish to consider before you publish the final report:

- The Panel suggested that you may wish consider including a recommendation around the difficulty of getting the immigration solicitor to engage in the DHR process;

- Similarly, the Panel thought you may wish to include a recommendation around the need to expedite immigration cases to establish whether an individual is eligible to access community care services;

- The Panel noted the use of family members as interpreters and felt a recommendation around the possible risks associated with this may be useful;

- You may wish to reconsider use of pseudonyms;

- There is a typing error in the final line in paragraph 1.10 of the executive summary: ‘intimated’ should be ‘intimidated’

The Panel does not need to see another version of the report, but I would be grateful if you could include our letter as an appendix to the report.

Yours sincerely

Christian Papaleontiou
Chair of Home Office DHR QA Panel