HUNDREDFAMILIES CASE REVIEWS AND RELATED NEWS ARTICLES: LONDON

Contents

1. Hakim Abdillahi

In 2004, Hakim Abdillahi comes to the attention of London mental health services due to difficulties with his neighbours, and his statement that he would jump off a bridge. He is diagnosed with anxiety and later with a personality disorder. He is prescribed a variety of antipsychotics over time, and rotated through 3 antidepressants: paroxetine, sertraline, citalopram and back to sertraline again at a daily dose of 150mg. During this treatment he becomes antisocial, paranoid, and aggressive. Prior to 2010 he had no history of violence but in Oct that year he assaults 2 people. By 2012 he is not doing well, but in Aug he is discharged back to the care of his GP, who he sees Aug 6. After seven years on various SSRIs, his GP agrees he can stop taking them and sets a plan to wean him off his sertraline within 6 weeks. On Aug 14 he is "delusional" (delirious) and phones emergency services. Nobody tells his health team and the next day he brutally stabs a friend/neighbour to death. The news article appears to believe that HA stopping his medication was the reason for the murder, but this is not the same as suspecting that withdrawal might have played a role. The review report focuses on coordination among services and does not consider the medication potentially relevant.

Tragedy: Pensioner Eleftheria Demetriou was stabbed by Hakim Abdillahi who believed that she was the anti-Christ — (The Daily Mail)

http://www.dailymail.co.uk/news/article-2343362/African-killer-entered-Britain-false-passport-butchered-pensioner-stopped-taking-medication-personality-disorder.html

By Jaymi Mccann

Published: 19:51 GMT, 17 June 2013 | Updated: 19:51 GMT, 17 June 2013

African killer who entered Britain on false passport butchered pensioner after he stopped taking medication for personality disorder.

- Hakim Abdillahi repeatedly stabbed pensioner Eleftheria Demetriou
- Did so with such ferocity the blade snapped off during the attack last August
- The 38-year-old believed that she was the anti-Christ
- Prosecutors said the killer was friends with his victim whom he used to call 'grandma'

A delusional killer who entered the country on a false passport was today sentenced to remain indefinitely in hospital for butchering a pensioner who he believed was the anti-Christ.

Hakim Abdillahi, 38, repeatedly stabbed Eleftheria Demetriou, 79, with such ferocity last August the blade snapped off.

Abdillahi, who came to Britain from African country Djibouti in 1999 pretending to be six years younger, launched the frenzied attack a month after being discharged from hospital where he was treated for a personality disorder.

But on August 15 Abdillahi - who was bullied in his homeland for being effiminate - killed the widow after stopping taking his medication and turning instead to cannabis and khat.

Today, Abdillahi, from Wood Green, north London admitted manslaughter at the Old Bailey.

Kaly Kaul QC, prosecuting, said the killer was friends with his victim whom he used to call 'grandma'.

In the days before attacking the pensioner Abdillahi was behaving erratically and making alarming claims about doing God's work and hunting the anti-Christ.

After killing the mother-of-one he rang 999 but the ambulance service believed they had been called out to a cardiac arrest.

When they arrived at the victim's home, which was on the same estate as Abdillahi's, paramedics found her body with multiple stab wounds and a cushion over her face.

Miss Kaul said the killer, normally thought to be 'gentle and quiet', remained at the scene and was compliant.

Abdillahi, who was convicted of battery in February 2011, told police at the scene 'You should be happy the anti-Christ is dead', the barrister said.

Independent investigation into the care and treatment of Mr Q - A report for NHS England, London Region

http://www.hundredfamilies.org/wp/wp-content/uploads/2013/12/HAKIM_ABDILLAHI_Aug12.pdf

April 2015

DATE	REPORT PAGE	INFORMATION
Late January 2004	18	Mr Q moved to Haringey on 14 January 2008 because of difficultly he was experiencing with his neighbours in Wembley. As a result of the move his psychiatric care was transferred from CNWL to BEH. Mr Q first came into contact with BEH later that month having been found threatening to jump off Holloway Bridge. He was prescribed 1mg lorazepam (used to treat anxiety) at night and 20mg paroxetine (for anxiety) once a day.
Oct 26 2004	16	Mr Q was seen by a CMHT doctor on 26 October 2004. Mr Q described having anxiety problems on and off for several years. He told the CMHT doctor that he had experienced problems with other Somalis who had come to his house and taken advantage of his generosity. He had found this situation increasingly

		stressful. This resulted in him taking an overdose of paracetemol and cutting his wrists in August 2004. He said that the overdose was impulsive and followed an argument with a friend. Following his discharge from hospital on 2 September 2004, Mr Q was prescribed citalopram (an antidepressant) 20mg once daily and he subsequently arranged with the Housing Association for a transfer to London. He said he had many friends in London and now felt that his problems had been completely resolved. He denied any depressive anxiety.
Feb 2009	21	5.6.2 Comment In February 2009 the clinical records state that Mr Q got into an "altercation", although it is not documented what this entailed, or whether it was violent. There is nothing in the clinical records to suggest that this incident was explored and it is not mentioned in the risk overview. On 24 February 2009 Mr Q was seen by Staff Grade Psychiatrist 1 for a medication review. Mr Q reported poor sleep, vivid nightmares and seeing white smoke in his living room. He said that he heard voices and had a spirit inside him for most of the day. The plan was to discontinue Paroxetine and start sertraline (antidepressant) 25mg and zopiclone (a hypnotic to aid sleeping) 3.75 mg daily.
March 2009	21	Mr Q attended North Middlesex Hospital's A&E department with psychiatric symptoms once in February and three times in March 2009. During March he said that he was not taking his psychotropic (antidepressant and hypnotic) medication.
January, February 2010	24	Mr Q attended North Middlesex Hospital's A&E department twice in January 2010 with psychiatric problems and was diagnosed with an anxiety disorder. The clinical records state that Mr Q had stopped taking quetiapine and noted on 5 January 2010 that he had failed to pick up his prescriptions for the previous two weeks. The quetiapine was stopped and he was started on the antidepressant citalopram 20mg daily as the only regular medication. Mr Q attended the Haringey personality disorder service sporadically throughout January and February 2010. He was not taking medication at this time. A referral was made to ARCU for telephone support and he had the option to attend ERC if in crisis. On 8 and 9 April 2010 two separate doctors recorded that Mr Q was attending police stations and mosques most nights due to anxiety that made him feel unable to stay at home.
Oct 2010	24	A CPA review on 5 October 2010 recorded that Mr Q had increased his khat use and was experiencing memory problems. It was noted that he had made progress over the last year but still needed to think about his feelings and responses in order to manage his thinking more effectively.
Oct 14 2010	17 24-25	5.2 Forensic history There are no reports of violence in Mr Q's clinical records prior to an incident involving two other patients in 2010. On this occasion he was charged with two counts of common assault and given a probation order. Mr Q attacked two patients during a therapy group at the Halliwick Day Unit, St Ann's Hospital, on 14 October 2010. One of the patients verbally challenged him so he hit her over the head with a clipboard, pulled her hair and threw two chairs, one of which broke a window. The second patient was hit in the eye

		when she tried to intervene. Unit staff informed the police of the incident. Mr Q later telephoned the unit to apologise.
summer 2011	29	5.9.3 Comment Mr Q's mental health was clearly deteriorating in the summer of 2011. There is nothing in the clinical records to indicate that steps were taken to try to address this/identify the cause of the deterioration, nor that his management plan or risk assessments were updated to reflect his presentation.
July 2012	34-35	5.10.4 Comment Despite Mr Q being twice assessed as "clearly unwell" in March and May 2012, mental health services seem to have effectively lost sight of him. He attended only one meeting with the care coordinator in April, one in May and was then not seen at all until July, when they planned to discharge him. In Specialist Practitioner in Psychotherapy 1's email to Consultant Psychiatrist 1, on 17 July 2012, Specialist Practitioner in Psychotherapy 1 appears to put Mr Q's non-engagement in the context of their therapy sessions coming to an end. She writes, "My hunch is it may be the way he can manage the ending with me (which may be why he doesn't return my calls)". It is unclear from the clinical records whether Consultant Psychiatrist 1 contacted Mr Q as requested, and if so what the outcome was. There is no documentary evidence to suggest that anyone treated Mr Q in a responsive way to his worsening condition. There was a lot of conjecture but no one really attempted to get to the bottom of his changing needs. The focus appeared to be on his impending discharge, which was not reviewed in the light of his recent presentation. Mr Q attended a session with his care coordinator on 19 July. A discharge CPA meeting was planned for the following week. **The review team discussed reducing his sertraline dose from 150mg to 100mg daily.** Mr Q continued to experience paranoia about other people and had an on-going problem with a neighbour. He reported feeling better than when he began treatment and that he now felt more aware of other people's feelings.
August 6, 2012	36	Specialist Practitioner in Psychotherapy 1 completed a discharge summary for Mr Q on 10 August, although the summary was not sent to Mr Q's GP until 22 August (a week after the incident). 5.10.6 Comment Mr Q was discharged back to his GP having had the opportunity to attend weekly sessions with Specialist Practitioner in Psychotherapy 1 for the last three years. There was no reduction in management or a trial to see how Mr Q would manage with no support in place (other than his GP). Mr Q spoke to his GP on 6 August. He felt that he didn't need sertraline (antidepressant) any more. **His GP agreed and put him on a weaning-off plan for six weeks.**
Aug 14, 2012	38	In the early hours of 14 August 2012 Mr Q phoned the emergency services. The emergency operator described him as a: "… very delusional male rambling about having killed the demons and everything is now clean." The London Ambulance Service (LAS) were asked by the emergency operator to attend Mr Q's home address. They asked for support from the Metropolitan Police Service (MPS) but there was no unit available to assist them at that time.

		The LAS did not enter Mr Q's address alone as they were not happy to approach if Mr Q was delusional. It was approximately three hours later that Mr Q was seen by LAS & MPS. We have not seen any further information from this evening and nothing to suggest that this incident was shared with mental health services.
August 15, 2012	7	3.2 The incident Mr Q stabbed and killed a 79-year-old woman (a neighbour) on 15 August 2012. Mr Q and the victim were neighbours. During the trail the court heard that they had been friends and he had referred to her as 'grandma'. It is documented that the victim was very well-liked in the area and many of her neighbours referred to her as 'aunty' or 'grandma'. On 15 August 2012 Mr Q visited the victim at her home address. While in her home, Mr Q stabbed her multiple times and she subsequently died from wounds to the heart and spleen. After the attack Mr Q called 999 and when police arrived he told them: "I was told to deal with her - you should be happy the antichrist is dead", the prosecuting QC said during the trial. Mr Q was arrested sitting outside the victim's house on the pavement half naked, covered in blood. He was later charged with murder.
	94	21.7.2 Preventable In the interviews that we have carried out and in our review of the clinical records we have not identified any words, actions or behaviour that should have alerted staff that this tragedy would occur.

2. Richard Henry

Richard Henry comes to the attention of mental health services in March 2011 because he tries to enter a house, has a stand-off with police and throws objects at them. Mental health officials suspect he has been using street drugs. They decide that he was experiencing psychosis and that whatever its cause, he should take antipsychotics. RH resists taking these meds and a treatment order is issued to force him to take the antipsychotic, starting April 5, 2011. Eventually RH's care including the antipsychotic prescription reverts to his GP, who is not aware of the treatment order. RH frequently does not take his medication and for a while he seems to be doing fine taking it off and on . Nov 9, 2011, he reports not having taken it for a week (i.e. since approximately Nov 2), and also reports housing problems. A new prescription is issued but it appears he did not fill it, and he missed his meeting with London Probation Trust. On Nov 19, he stabs his girlfriend to death. Whether or not he was experiencing medication withdrawal, or whether the frequent starting and stopping the medication was a problem is not clear, and the issue is not explored. The BBC report implies that because he has "paranoid schizophrenia" – a diagnosis never mentioned before the incident – that he needed the medications. However the actual role of the medication is impossible to determine given the information provided and the perspective of the review.

Richard Henry detained for killing Carmel Charles — (BBC News)

http://www.bbc.com/news/uk-england-london-21544890

22 February 2013

A trainee painter and decorator has been ordered to be detained in a mental hospital for killing his girlfriend.

Richard Henry stabbed 20-year-old Carmel Charles 17 times in Catford, south London, when he "flipped" on 19 November 2011, the Old Bailey heard.

Henry, 22, who has paranoid schizophrenia, had stopped taking his medication and was a user of skunk cannabis, the court was told.

He admitted manslaughter on the grounds of diminished responsibility.

Michelle Nelson, prosecuting, said: "There was no argument. They were laughing and joking."

'Heard voices'

But then Henry's uncle heard Miss Charles praying and making noises.

He found her clutching her chest and Henry standing over her with an 8in (20cm) knife.

The jury heard that Henry told police he sometimes thought his girlfriend was the devil and had attacked her after hearing voices saying "kill".

He said: "I just flipped out."

Tests showed he had been smoking skunk for some time but not immediately before he attacked Miss Charles at his flat in Ravensbourne Park.

Judge Richard Hone ordered that Henry be detained indefinitely under the Mental Health Act.

The judge said: "People should know that people who take skunk cannabis and who are psychiatrically fragile can suddenly explode into psychotic and quite awful violence."

Domestic Homicide Review: The London Borough of Lewisham

http://www.hundredfamilies.org/wp/wp-content/uploads/2013/12/RICHARD_HENRY_Nov11_DHR.pdf

Executive Summary

On 19 November 2011 police were called to an address in Lewisham where the subject of this review, AB, a 22 year old female had been staying with her boyfriend CD. AB had been stabbed and CD was arrested. A murder investigation was launched and CD was charged with the offence of murder. He was

found guilty of the offence of manslaughter on the grounds of diminished responsibility and sentenced to a hospital order under S37 Mental Health Act 1980 without restriction of term.

The perpetuator CD

37. In February 2011 it was reported to police that CD had recently been seen to be in possession of a knife and information was passed to the police intelligence unit, but no further investigation took place.

38. On 11th March 2011 CD attempted to gain entry to a house (possibly of a previous friend) which led to the involvement of SLaM and a later referral to London Probation Trust (LPT).

119. CD lived in the Lewisham area with his mother. He did not have record of any significant contact with statutory agencies until early 2011. In March 2011 CD had been taken into custody having attempted to gain entry to a house and was pursued by police. CD had climbed a roof and threw objects at police and was later arrested after a long negotiation.

39. CD was admitted to Ladywell Mental Health Unit (Lewisham), for an assessment of his mental health including the possibility of drug induced psychosis and acute stress reaction. CD was prescribed anti-psychotic medication but he consistently refused to take this medication.

40. On 5th April 2011, after continued refusal to take medication, CD was restrained and medication administered under S.2 of the Mental Health Act. Now under the care of Maudsley Hospital (SLaM) he was prescribed medication and discharged on 13th April 2011 to the care of the Community Mental Health team at Lewisham. CD's formal diagnosis was of "Mental Disorder" and his risk was reviewed by SLaM and defined as being high, but low in relation to 'others'.

41. CD was also assessed at Lewisham Early Intervention Service as presenting low risk to himself or others. Information was passed to CD's GP confirming clear signs of psychosis and confirming his medication. CD was seen at home in June 2011 and assessed as being asymptomatic, making good progress and looking at vocational opportunities. At this time he also appeared to be complying with his anti-psychotic medication.

42. LPT records relating to CD show that he self-reported that the offence for which he was under their supervision took place at the home of his ex-partner and he had thrown a brick through the window to gain entry when no-one answered the door. The LPT IMR indicates that this may have been a case of DV and this should have led to further actions within LPT (e.g. a spousal risk assessment and enquiries with the police) but these did not happen. The police view is clear that this incident was recorded as an attempted burglary and there is no evidence to support the classification of this offence as a domestic violence (DV) incident.

43. LPT Risk Management Plans require that enquiries should be made with police Borough Intelligence Units (BIU) but this did not happen.

150. LPT were responsible for managing the community order. There is no evidence that details of the court sentence and mental health requirement of the community order were communicated to SLaM.

SLaM sought information from CD on the nature of his sentence in the absence of other information. LPT records indicate one attempted contact with the Community Psychiatric Nurse after sentence. It is not known whether SLaM action on CD's failure to take medication could have been more robust if they had been made aware of the mental health element to the community order. The failure of CD to take medication is not noted on LPT records.

151. The primary care for CD is provided by his GP. The GP has recorded occasions when CD had not been taking prescribed medication. It is not clear that this information was communicated to SLaM who were providing the secondary care. The GP was the primary carer prescribing anti-psychotic medication to CD but was not aware of the existence of the mental health requirement of the court order.

152. In September 2011 CD visited his GP who recorded that he had not taken medication for three weeks. He was seen two days later during a home visit from his community health team. He was assessed as having good insight into his illness and not reporting any side effects. SLaM records do not reflect the information provided to the GP that CD was not taking medication. CD was subject to a medical review where he seemed to be functioning well. CD met with the LPT Offender Manager and discussed his sentence plan, which focused on mental health, employment and training. CD was risk assessed as presenting medium risk to public and known adults. CD attended all scheduled appointments with LPT in September and October.

153. At the start of October 2011 the Offender Manager left a message for the Community Psychiatric Nurse but there is no record of any follow up to this message. CD was seen by his mental health team on two occasions in October and he was described as feeling better, it was again noted that he had not been taking medication.

154. On 2nd November 2011 CD met with his Offender Manager and indicated that accommodation was a problem. **On 9th November CD's GP noted that he had not been taking medication for a week** and a new prescription was issued, on that same day CD missed an LPT appointment. CD then attended LPT offices on 17th November a day late for the rescheduled appointment. CD had mistaken the 17th for 16th November. This was the last contact before CD was arrested for the murder of AB on the 19th November 2011.

3. Tania Clarence

This case is a reversal from the usual case in which the review or investigation mentions medication and the news article is silent on it. In this case, the news article mentions that smothering the children was part of a murder-suicide attempt on the part of the mom, Tania Clarence. She smothered the children and attempted suicide by cutting her wrists, having first apparently tried to overdose on pills but this did not work. So, there was medication involved. The review report talks only about special needs children and is silent on the medication and the suicide attempt. The reviews analyzes the case case as if there had been no suicide attempt involved, thereby focusing on factors that may have been important, but were not the complete story.

Murder accused mom's notes of despair — (iol news)

http://www.iol.co.za/news/crime-courts/murder-accused-moms-notes-of-despair-1681751

London - Tania Clarence, who is accused of murdering her three children in London, left three notes to her husband, two of which gave her husband, Gary, instructions on what to do when he arrived at their house. The first note, details of which were revealed at London's Old Bailey on Tuesday, and which was found on the bannister of their south London home, read in Afrikaans: "Gary, don't let Taya go into the kids' bedroom or our bedroom."

A second note, found in the couple's bedroom, pleaded with her husband, saying: "Gary, I don't want to be saved please. I cannot live with the horror of what I have done. **I thought the pills would work but they didn't.**"

A third note was addressed to the nanny but was not read out in court on Tuesday. Clarence, 42, is charged with killing the girl and two boys by smothering them at the family home while her banker husband Gary was on holiday with their eldest child, Taya, 8, in South Africa. On Tuesday, she was refused bail, but was instead released from custody and moved to a psychiatric unit under Britain's Mental Health Act. She appeared in custody by video link, dressed in a black training top and jeans, sitting on a chair in a prison room. She continually dabbed her eyes with a tissue and look pale and tired as she listened to proceedings in Court 3 at London's Old Bailey.

During the bail hearing, Crown Prosecution Service lawyer Zoe Johnson said the dead children – Olivia, 4, and twins Ben and Max, 3 – had all suffered from spinal muscular dystrophy, type two, which caused a range of physical disabilities and shortened life expectancy. Johnson said their nanny and a neighbour had called at the house on the night the bodies were discovered. She said: "The nanny had keys to the premises and she opened the door to see the house in darkness. There was a note on the bannister at the bottom of the stairs addressed to Mr Clarence, written in Afrikaans.

The note has been translated and it said: 'Gary, don't let Taya go into the kids' bedroom or our bedroom'."But they (the nanny and the neighbour) went upstairs. "They got to the first floor and saw Mrs Clarence in the bedroom and she was telling them to go away and saying it was too late – and was clearly depressed and disturbed. They asked if she had taken anything and she said: 'I took something on Tuesday but it did not work'." Johnson said the nanny and neighbour – who cannot be named for legal reasons – used the light on their cellphones to see Clarence. She said: "Mrs Clarence had tried to commit suicide by using a blade on her wrist." The neighbour checked one of the bedrooms where he found the dead twin boys. Officers found Olivia and all three were pronounced dead. After the police arrived at the R21 million house in New Malden, Clarence burst into tears as she told a police officer: "I'm sorry, I'm sorry."

When asked why, she replied: "I killed them. I suffocated them."Clarence was taken to hospital where doctors treated a self-inflicted cut to her left wrist that measured 3cm. After that she was taken to a

police station for interview when she allegedly said: “Why do I have to do this? I am guilty.” Judge Brian Barker, Recorder of London, cited “exceptional circumstances”, saying: “There is a real risk that her state will deteriorate considerably if she remains in prison. She is not a risk to anybody else apart from herself.“This case is a case of enormous concern. It has many unusual features. There is a combination of circumstances here that makes this an exceptional case and allows this court to take an exceptional course.” Clarence’s defence lawyer Jim Sturman welcomed the move. The Mercury

Kingston LSCB Serious Case Review Family A

http://www.hundredfamilies.org/wp/wp-content/uploads/2013/12/Tania-Clarence-SCR-Nov-2015.pdf

Edina Carmi & Nicki Walker-Hall Panel chairs, Authors and Lead Reviewers

November 18, 2015

Summary of Case

The period covered by this serious case review is the 42 months from the premature birth of the twin boys, R and Q, in July 2010 to the date they and their sister P died in April 2014.

During this period the life of the family, and particularly of the mother, changed dramatically with an adjustment from being a family of four, to a family of six, with three of the four children being diagnosed with SMA2. This diagnosis meant a huge emotional and practical adjustment for the parents and the children's complex health needs meant that the family had support from nannies and from a large number of health practitioners, both in the community and from the three hospitals involved, as well as the local social care team for children with disabilities.

The mother had responsibility for the domestic sphere, having given up work when she became a parent. Because of the children's disturbed sleep patterns, the mother was reported to never have a full night's sleep and often presented to professionals as tired and tearful. There were professional concerns about mother's ongoing low mood, but she told professionals, including her GP that she did not want or feel she needed any help for this.

The parents wanted their three disabled children to have a good quality life, and experience as little pain as possible. They did not want medical intervention for the children if this would cause their children pain. They characterised this as putting a priority on the quality of their children's lives as opposed to extending the length of their lives. The children's specialist and expert doctors though were of the view that medical intervention was needed for P in order to decrease her current discomfort as well as to be able to maximise her potential. It was possible that her brothers would also need such intervention eventually.

Alongside the concerns about the possibility of medical intervention, some allied health professionals involved with the children were of the view that the mother did not consistently accept and act on their advice about feeding, physiotherapy, speech and language therapy and the use of aids.

The level of concerns led to professionals discussing whether the child protection threshold had been met, but this was never agreed. Legal advice though was sought by two of the local authorities and by two of the hospitals, regarding the possibility of legal intervention.

The debates between parents and professionals over what was the best health care for the three children continued throughout the period under review. In the last months, there appeared to have been progress made. In particular the professional network was under the understanding by April 2014 that the father had agreed to P having a gastrostomy1 and that he was giving serious consideration to the potential benefits of spinal surgery, albeit he was worried that this may cause his daughter a great deal of pain and might not lead to significant improvements in her life. It was not clear if the mother was in agreement with this view, as the parents had consistently made it clear from the summer of 2013, that all such discussions about medical intervention be undertaken with the father.

The father was away during April 2014, first on a trip to the USA and then taking the eldest child to see paternal family in South Africa. During this period maternal grandmother stayed with mother and P, whilst Q and R stayed with the family's main nanny. Mother asked for her sons to be returned home the same day as maternal grandmother left. That evening she smothered her three youngest children.

Relevance to wider context of safeguarding children with disabilities

The tragic death of these three children, has been an enormous shock to all those that knew them and their parents.

Whilst the tragic outcome here is extremely unusual, this case itself raises many of the common professional dilemmas faced by practitioners who are supporting a family where there are safeguarding concerns for children with complex health needs. At the heart of this is the tension about whether to focus primarily on providing support to the family so the parents are better able to care for their children or to also move into more assertive intervention using child protection processes. Allied to this are also the challenging ethical dilemmas around quality of life, palliation and parental views.

It is not unusual for parents of disabled children to feel grief and depression on hearing of a child's diagnosis and the loss of the type of life that they had imagined living and the achievements they wished for their children. It may though take some time to come to terms with the diagnosis and understand the quality of their child's life and appreciate her/his enjoyment of life.

It is usual for parents to feel physically exhausted through the demands of looking after their children, as well as through the constant demands of appointments with health practitioners if the children have complex needs.

SMA Support UK has advised the authors that 'whilst the emotional impact of a diagnosis is initially devastating and the caring role is hard work, the majority of families 'find a way to manage and do a

wonderful job caring for' and 'encouraging the hopes and dreams of their children with SMA Type 2, who go on to live productive and fulfilling adult lives'. (See the Kingston Safeguarding Children Board website for further information from the SMA Support UK).

1. Adel El Hage

Summary: The independent review speculates about AH's mental state in the summer and fall of 2002, although they note that: "understanding of his mental state was incomplete". This is retroactive, speculative diagnosis. However it is known for sure that on Jan 18, 2003, AH went to his GP requesting, and getting, medication . (the case review report does not specify what kind of medication, or the condition it is intended to treat). On Feb 22 he stabs his wife to death. In jail, he commits suicide by electrocuting himself. There is not enough available information to determine what happened, including what role may have been played by medication.

Husband pleaded for execution — (BBC News)

http://news.bbc.co.uk/2/hi/uk_news/england/2905745.stm

Last Updated: Tuesday, 1 April, 2003, 10:08 GMT 11:08 UK

A devout Muslim killed himself after confessing to his wife's murder and pleading to be sent to Saudi Arabia for execution, it has emerged.
It has been revealed the trial judge at St Albans Crown Court told Adel El Hage, of Elstree, Hertfordshire, he could only apply English law to his case.
Thirteen days later El Hage was found electrocuted in his cell at Woodhill Prison, Milton Keynes.
Details of the case can be reported following a decision of Judge Findlay Baker QC lifted a press ban.
El Hage, who was 30 on the day he died, had called the police early on 22 February to his home in Beethoven Road.
His wife, 22-year-old Salma Abusedra, was dead with knife wounds to the chest.
Libyan-born El Hage, who was unemployed, confessed to the killing when he made a preliminary appearance at St Albans Crown Court on 4 March.
Speaking through an Arabic interpreter, he said he was a Muslim who believed in Islam.
"I hope Your Honour will understand what I want to say very clearly. I am going to shortcut all of these proceedings.
"The Koran says if one kills someone else he should be executed.
"I am a Muslim and I would like to die as a Muslim. This is what Islam is all about.
"I confess in front of you that I did kill my wife and I am confessing now because I want to go back to God and I would like the law of the Koran to be applied to me."
He said he knew there were no executions in the UK, so he wanted to be sent to somewhere like Saudi Arabia where Koranic law applied.
He said if his request was refused, he would not eat or drink.

"I am going to resist until I die and I don't think I am going to wait."
El Hage assured the judge he was well, fit and in a very good state of mind.
Governor investigating
Remanding El Hage in custody, Judge Baker said he could not dispense any law other than that of this country.
Prison staff found El Hage dead 13 days later.
He had electrocuted himself using a socket in his cell.
A senior governor from another prison will be investigating the death at Woodhill.
An inquest into El Hage's death has been opened and adjourned by the North Bucks coroner Rodney Corner.

Independent investigation into the care and treatment of Mr A

http://hundredfamilies.org/wp/wp-content/uploads/2013/12/ADEL_EL_HAGE_MrA_LON_02.03_Summary.pdf

Commissioned by NHS London

Excerpts:

Summary of the incident

Mr A was a 29 year old man, born in Libya, with a poor command of English, resident in the United Kingdom since 1996. He had been married for 5 years and had a 3 year old child. His wife was from the Emirates ethnically but had been brought up in the UK and was a fluent English speaker. In October 2002 she was approximately 6 months pregnant. Mr A appears to have developed a paranoid psychotic illness in approximately April 2002, either a depressive psychosis or primary psychosis with depression. He was referred for psychiatric assessment on 17th September 2002 by his GP and an appointment offered for 14th October. On 7th October he made a threat to kill his wife. He was assessed on 7th, 8th and in more detail on 9th October but for a number of reasons understanding of his mental state was incomplete. He was treated and followed up in outpatients on 14th and 24th October but did not attend a scheduled appointment for 25th November and was offered another for 20th March 2003.

Perhaps as a result of the long intervals between planned appointments and communication problems with primary care, he did not receive regular prescribed medication although he made his first request for medication to his GP on 18th January 2003 and at about this time Mrs A gave birth to her second child. On 22nd February Mr A was charged with fatally stabbing his wife and remanded to prison. On 15th March 2003 Mr A was found dead in his prison cell and an inquest on 7th and 8th August 2003 at Milton Keynes Coroner's Court returned a verdict of suicide. His children left the UK to live with his wife's parents. The Trust carried out an internal investigation and made a number of recommendations.

6.2 Failure to ensure Mr A had regular prescriptions In view of the long periods between the fortnightly prescriptions it is highly likely that Mr A either had long periods without treatment or took medication in quantities less than prescribed, and therefore was not receiving optimal treatment. It is possible that the incident itself resulted from a relapse in paranoid and/or depressive thinking after his prescription of the 18th January 2003 had run out.