DOMESTIC HOMICIDE REVIEW

Case of Adult Alice
Death June 2021
Hertfordshire Community Safety Partnership

Authors: Neelam Sarkaria and Gerry Campbell MBE

18 February 2025

The Authors and the Domestic Homicide Review Panel would like to express their sympathy and their sincere condolences to the family for the loss of a loved sister, stepdaughter, and friend. The Independent Chair and Authors of this Review would like to thank everyone who has contributed to this Review. The Independent Chair would also like to thank the Domestic Homicide Review (DHR) Panel's members and the Authors of the individual agency reports for their valuable time and thoughtful deliberations, which have contributed to the findings of this Review.

The DHR Panel would also like to extend its gratitude for the kind support of the Hertfordshire County Council Team for providing key administrative support and the Hertsmere Community Safety Partnership.

Abbreviations

ACEs	**Adverse Childhood Experiences**
ASC	**Adult Social Care**
BPLT	**Barnet Psychiatric Liaison Team**
CLCH	**Central London Community Health**
CBT	**Cognitive Behaviour Therapy**
CPS	**Crown Prosecution Service**
CRHTT	**Crisis Resolution Home Treatment Team**
CRiS	**Crime Report Information System**
CSP	**Community Safety Partnership**
DA	**Domestic Abuse**
DASH	**DA, Stalking, Harassment, Honour based Abuse**
DV	**Domestic Violence**
DVIP	**Domestic Violence Intervention Programme**
DVPP	**DV Perpetrator Programme**
ED	**Emergency Department**
EPR	**Electronic Patient Record**

GBV	**Gender-Based Violence**
HTT	**Home Treatment Team**
HBC	**Hertsmere Borough Council**
HCC	**Hertfordshire County Council**
IAPT	**Improving Access to Psychological Therapies**
IMR	**Individual Management Review**
IRER	**Interpersonal Relationship and Emotional Regulation**
IRIS	**Identification and Referral to Improve Safety**
LAS	**London Ambulance Service**
MASH	**Multi-Agency Safeguarding Hub**
MCA	**Mental Capacity Act**
MHA	**Mental Health Act**
NCRHTT	**Night Crisis Resolution Home Treatment Team**
RMN	**Registered Mental Health Nurse**
MPS	**Metropolitan Police Service**
SNEIL	**Social Care Direct**
URT	**Urgent Response Team**

VAWG	**Violence Against Women & Girls**
WDP	**Westminster Drug Programme**

Contents

Please note, the Executive Summary is a standalone document to this report.

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1.1 Introduction

1.1.1 This report of a Domestic Homicide Review (DHR) hereinafter referred to as 'the Review', examines agency responses and support given to Alice (not her real name), a resident in Hertfordshire prior to her death, which took place in June 2021 resulting from an attack in her home by son Neil. The matter came to light following an emergency call from neighbours that afternoon.

1.1.2 In addition to agency involvement, the Review also examined the past to identify any relevant background or activity before the homicide, whether support was accessed within the community and whether there were any individual or structural barriers denying or preventing the relevant parties from accessing support. By taking a holistic approach the Review sought to identify learning and appropriate and effective solutions to support making the future safer.

1.1.3 The Review considered agencies contact/involvement with Alice and Neil from the beginning or the first contact with statutory agencies up to the discovery of Alice's body in June 2021. The Review has included relevant facts from their earlier life in the background information.

1.1.4 These events led to the commencement of this Review, which was commissioned by Hertfordshire County Council (HCC) on behalf of Hertsmere Community Safety Partnership (CSP). HCC coordinate the DHRs on behalf of Hertfordshire's 10 CSPs. The inaugural Panel meeting was held on 15 December 2021 and there have been 5 subsequent meetings of the Panel to consider the circumstances of Alice's death.

1.1.5 The key purpose for undertaking this Review was to:

a) 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;

b) 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;

c) apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;

d) prevent domestic abuse (DA) and homicide and improve service responses for all DA victims and their children by developing a coordinated multi-agency approach to ensure that DA is identified and responded to effectively at the earliest opportunity;

e) contribute to a better understanding of the nature of DA;

and

f) highlight good practice.

One of the operating principles of this Review has been to be guided by compassion, empathy, and transparency with Alice's 'voice' and that of her extended family at the heart of the process.

1.2 Timescales

1.2.1 HCC, in accordance with the Home Office's December 2016 '*Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews*' (the statutory guidance) commissioned this Review on receiving notification of this domestic homicide in June 2021. The Home Office were notified of the decision in writing on 6 July 2021 and once the procurement process was completed, an Independent Chair (the Chair) was appointed.

1.2.2 HCC commissioned the Chair for this Review.

1.2.3 The Home Office guidance states that a review should be completed within six months of the initial decision to establish one. It is recognised by all agencies that such a timeline is of notable challenge. That said, fundamentally it is important that local agencies have individual and multi-agency learning reviews and implement the lessons quick time without waiting for a DHR to be conducted and its report published.

1.2.4 The first Panel meeting was held on 15 December 2021 to ensure agencies could attend. There was a marginal delay to holding this inaugural Panel meeting as the criminal justice proceedings had not concluded until late November 2021.

1.3 Confidentiality

1.3.1 To maintain anonymity, the various individual parties referred to in this Review have been provided with alternative identities, also known as pseudonyms. The use of pseudonyms also supports and empowers individuals to participate in such Reviews:

- Victim - Alice
- Perpetrator - Neil
- Victim's brother - Keegan
- Victim's sister 1 - Tracy
- Victim's sister 2 - Sharon
- Perpetrator's former partner - Sarah
- Victim's former husband and perpetrator's father - Jonas
- Victim's Neighbour - Ingrid
- Victim's Step-Father - Peter
- Victim's best friend - Joe
- Victim's best friend's son - Jodey
- Sarah's former partner - Harry

1.3.2 Details of confidentiality, disclosure and dissemination were discussed and agreed, between the Domestic Homicide Review Panel (the Panel) members during the inaugural Panel meeting on 15 December 2021. The Panel agreed that all information discussed at its meetings was to be treated as confidential and not disclosed to third parties without the agreement of the Panel responsible agency's representative. That is, no material that states or discusses activity relating to specific agencies can be disclosed without the prior consent of those agencies and the Panel's Chair. All agency representatives were personally responsible for the safe keeping of all documentation that they possessed in relation to this Review and for the secure retention and disposal of that information in a confidential manner.

1.3.3 The findings of this Review are confidential until it has been approved for publication by the Home Office. In the meantime, information is available only to participating officers/professionals and their line managers.

1.3.4 The victim, a white female, was aged 63 years of age at the date of her tragic death.

1.3.5 The perpetrator is a white male aged 31 years of age at the date of his commission of this tragic murder.

1.4 Terms of Reference

1.4.1 The full terms of reference are included in Appendix 1. The essence of this Review is to establish how well the agencies worked both by themselves and together, and to examine what lessons can be learnt for the future to prevent similar tragedies. Agencies were asked to review all contact from the *point of their first contact* with Alice and Neil but will focus in particular (but not exclusively) on the period from the first contact with the relevant agency, to the period of time when Alice was killed. This timeframe was set to gather and analyse contact between agencies and the subjects of this Review that may have had an effect upon the family. Those agencies who had contact were required to complete Individual Management Reviews (IMRs) for submission to the Panel.

1.4.2 The Key Lines of Enquiry identified for this Review include:

- What signs or signals were present that could indicate that Alice was experiencing DA, or any other abusive behaviour from Neil? What was the power and control dynamic? Was there a cultural and/or religious aspect to this dynamic? Were there any cultural or religious issues or practices which may have led to Alice being exposed to the risk of violence or abuse by Neil.

- What was your agency's response to effectively assessing, identifying and planning to meet Alice's needs and what opportunities were missed to identify risk(s) faced by them? What individual and / or structural barriers affected this if any? Consider if culture and/or religion affected this in anyway?

- Did your agency effectively identify Neil's ongoing needs? What plans were arranged to meet his short-long term needs?

- Was Neil receiving a coordinated level of service and how was this influenced by any potential cultural, religious and/or language barriers?

- Did your agency identify whether those living with Neil required support from public authorities and/or voluntary sector? What individual and / or structural barriers affected this if any? Identify any potential cultural, religious and language barriers in your agency's delivery of services (if any).

- How well did your agency "see beyond" the immediate sphere of professional and legal requirements – including statutory duty, in the provision of your services? Was any action limited by policy and / or practice?

- For professionals working with Alice and Neil what were the signs and signals that could indicate there was DA including coercive control towards other family members or anyone else?

- Give examples of any good work that your agency has undertaken in promoting support for marginalized communities particularly women by raising awareness, preventing and/or tackling DA and equipping them to access support services? How does your agency assess the effectiveness of this work?

- Further to the previous point, what works well (and why) and what could have been improved by your agency's approaches and responses?

1.5 Methodology

1.5.1 The approach adopted was to seek IMRs from all organisations and agencies that had contact with Alice and Neil after they had provided chronologies detailing contact. It was also considered helpful to involve those agencies that could have had a bearing on the circumstances of this case, even if they had not been previously

aware of the main individuals involved. Details of those agencies providing IMRs and chronologies are outlined below.

1.5.2 Once the chronologies and IMRs were provided, Panel Members were invited to review them all individually, and then confidentially discuss the contents at subsequent Panel Meetings. This became an iterative process where further questions and issues were then explored.

1.5.3 The Panel agreed that a post-implementation audit should be undertaken by the Hertsmere CSP 12 months after publication of this Overview Report to ensure that the recommendations confirmed as being necessary through the Review have been implemented, and that they are achieving the positive impact intended. HCC are implementing a monitoring process for actions and there will be ongoing reviews of the actions progress.

1.6 Involvement of family, friends, work colleagues, neighbours and wider community

1.6.1 The DHR Chair has been the point of contact with Alice's family through their Victim Support Caseworkers via letter and email. The DHR Chair contacted Alice's surviving three siblings Tracy, Sharon and Keegan who have all declined to participate in this statutory learning review, including any meeting.

1.6.2 The DHR Chair has also contacted Alice's best friend Joe and his son Jodey for this Review. The meeting has been declined together with any future involvement with the process.

1.6.3 Contact has also been made with Alice's neighbour, Ingrid, who has indicated that she does not wish to participate in this Review process.

1.6.4 Alice's stepfather, Peter, contacted the CSP via his Victim Support caseworker to express his desire to be involved with this DHR but later declined. Contact was re-established with him through his victim support caseworker resulting in Peter and another member of the family reading the content of this Report and providing their feedback.

1.6.5 The DHR Panel was unable to identify the occupation and employment status of Alice. No evidence has been presented that she has been employed.

1.7 Involvement of Perpetrator and/or his family, friends, work colleagues, neighbours and wider community

1.7.1 The DHR Chair invited Neil to meet through his mental health clinician. Neil did not wish to be involved and engaged with the DHR process. This was a view shared by his consultant psychiatrist.

1.7.2 The DHR Chair wrote to Jonas, Alice's former husband and Neil's father, to ask whether he wished to be involved in this DHR and no response was received.

1.7.3 Alice's siblings Tracy, Sharon and Keegan did not wish to be involved in the DHR. Contact was established with Peter, Alice's stepfather, through the Victim Support Caseworkers who were provided with copies of the Report for the family to review and reconsider engagement. Peter has confirmed that the family have agreed the content of this Report.

1.7.4 In light of paragraph 1.8, the DHR Reviewers were thankful that they have been able to undertake a detailed interview with Neil's former partner Sarah.

1.8 Contributors to the Review

1.8.1 The following agencies were contacted in Hertfordshire and the London Borough of Barnet, but recorded no involvement with the victim or perpetrator:

Spectrum CGL (drug and alcohol services)

HCT (community health care)

National Probation Service

Refuge (Independent DV Advisor (IDVA) service provider in Herts)

Hertsmere Borough Council

West Herts Hospital Trust

Improving Access to Psychological Therapies (IAPT) Barnet

Barnet Children's Services

Barnet Multi-Agency Risk Assessment Conference (MARAC)

Barnet Housing Department

Herts MARAC

National Association for Parents Abused in Childhood

Barnet Carers

Westminster Drug Project

Barnet Drug and Alcohol Service

1.8.2 The Crown Prosecution Service (CPS) was invited to join the Panel in light of the involvement with the Perpetrator. The following agencies contributed to this Review:

Agency	**Contribution**
Hertfordshire Police	Chronology and IMR Letter
Metropolitan Police Service	Chronology and IMR Letter
Royal Free London NHS Foundation Trust (including UCLH)	Chronology and IMR
Barnet, Enfield & Haringey Mental Health NHS Trust	Chronology and IMR
Central London Community HealthCare NHS Trust	Chronology and IMR
East and North Hertfordshire NHS Trust	Chronology and IMR

Hertfordshire Partnership NHS Foundation Trust	Chronology and IMR
Victim's GP (Barnet)	Chronology and IMR
Perpetrator's GP (Barnet)	Chronology and IMR
East of England Ambulance Service NHS Trust	Chronology and Letter
London Ambulance Service NHS Trust	Engagement Report and IMR
Hertsmere Borough Council/ Hertfordshire County Council	Provision of information
Solace Women's Aid	Chronology and IMR
Crown Prosecution Service (CPS)	Chronology and IMR
London Borough of Barnet	IMR

1.9 The Review Panel Members

1.9.1 The list of the Members of the Panel who oversaw this Review is fully outlined below:

Sajida Bijle	Chief Executive, Hertsmere Borough Council
Vicky Boxer	Senior Social Worker, Spectrum CGL
Sian Carter-Jones	Head of Safeguarding, Barnet, Enfield & Haringey Mental Health NHS Trust
Betsy Lau-Robinson MBE	Head of Safeguarding Adults, mental Capacity Act and Prevent at University College Hospital NHS Trust
Sarah Corrigan	Children's Safeguarding Lead, E&N Herts Hospital NHS Trust
Katie Dawtry	Development Manager, DA, HCC
Rebecca d'Cruze	Safeguarding Specialist Practitioner for Children, East of England Ambulance Service

Keith Dodd	Head of Adult Safeguarding, Hertfordshire County Council
Stephenie Evis	Named Nurse for Adult Safeguarding Hertfordshire and West Essex Integrated Care Board (ICB)
Clare Griffiths	Deputy Head of Service, Hertfordshire DPU, NPS
Catherine McArevey	Specialist Safeguarding Practitioner, Hertfordshire Partnership NHS Foundation Trust
Elaine Joyce	Safeguarding Duty Worker (Paramedic), East of England Ambulance Service
Valerie Kane	Community Safety Manager, Hertsmere Borough Council
Sam Khanna	Detective Chief Inspector, Hertfordshire Constabulary
Clare Matier	Detective Inspector, Hertfordshire Constabulary
Amar Patel	Acting Detective Inspector, Metropolitan Police Service
Michael McInerney	Detective Sergeant, MPS Homicide and Serious Crime Review Team
Neelam Sarkaria (Chair)	DHR Independent Chair & Report Writer
Gerry Campbell	Independent Reviewer and Report Writer
Helen Swarbrick	Head of Safeguarding, Royal Free London NHS Foundation Trust
Nicky Vellacott	Named Nurse for Safeguarding Adults & Children, Central London Community Health Trust
Graeme Walsingham	Detective Chief Inspector, Hertfordshire Constabulary

Dawn Bailey	West Hertfordshire Hospital Trust
Dr Hannah Bartlett	GP
Naomi Bignell	Hertfordshire Community Health Trust
Tracey Cooper	Head of Adult Safeguarding Herts Valleys and East & North Herts CCGs
Enda Gallagher	Named Nurse Adult Safeguarding East & North Herts Hospital NHS Trust
Mohammed Shofiuzzaman	Royal Free London NHS Foundation Trust
Caroline Sweeney	Barnet, Enfield & Haringey Mental Health NHS Trust Solace Women's Aid
Jayne Wilkes	Senior Crown Prosecutor, London North, Crown Prosecution Service
Heather Wilson	Designated Professional for Adult Safeguarding, North Central London Integrated Care Board

The Panel were reminded of their role including the need to maintain independence and confidentiality at each meeting.

1.10 Authors of the Overview Report

1.10.1 The Panel was chaired by the DHR Review Chair, Neelam Sarkaria.

1.10.2 Neelam is an expert consultant on the rule of law, criminal justice sector reform, Gender-Based Violence (GBV), equality and diversity, and gender mainstreaming in the UK and internationally cross several continents. She currently provides justice, policing and rule of law expertise to United Nations (UN) Women under the Spotlight Initiative in the Caribbean, and UK government projects in Jordan, Somalia and Montenegro. Neelam is a barrister with a strong prosecution, Violence Against Women and Girls (VAWG) and Whitehall policy background of more than 24 years. As a former Non-Executive Director (5 years) overseeing the Civil Nuclear Constabulary (CNC),

she led work on People, Gender and Inclusion and Audit and Risk on behalf of the Board. Neelam recently supported the CNC's work on gender and more broadly on Diversity and Inclusion. She has drafted the CNC Gender Responsive Policing Strategy, the first in UK policing for the CNC to detail the organisational policing response to gender.

1.10.3 Neelam has expertise in gender equality as former Chair and of the Association of Women Barristers and the Bar Council of England and Wales Equality, Diversity and Social Inclusion Committee. She now sits as a part-time Tribunal Judge and regulatory Chair. Neelam has provided technical assistance for a range of UN manuals most recently the UN Women Handbook on Gender Responsive Policing Services for Women and Girls subjected the Violence drafting the chapter on the Justice Continuum. She is published co-author of Harmful Traditional Practices (Parador) and has written many articles.

1.10.4 Neelam is independent and has no connections with any of the individuals or agencies who form part of this Review. There were no conflicts of interest.

1.10.5 Neelam was supported Gerry Campbell; a former Metropolitan Police Service Detective Chief Superintendent with 37 years' experience of dealing with Community Safety and Public Protection matters with a focus on VAWG including DA and the management of offenders. Since leaving the Police Service he has been employed as a Strategic Programme Lead for VAWG with a London Council and as the Chair and Director of Strategy for a Charity supporting South Asian women disowned by their families. In addition, Gerry is an advisor to UK National and International organisations including the UN entities. He has worked at a strategic level across a number of international jurisdictions on these subject areas. Gerry is a published author on VAWG/GBV.

1.10.6 Neelam and Gerry are referred to as the DHR Reviewers in this Report.

1.11 Parallel Reviews

1.11.1 The criminal investigation and the criminal justice proceedings against Neil and on the death of Alice have now all concluded.

1.11.2 The HM Coroner's Court Inquest was opened and a decision has subsequently been made following the criminal proceedings not to proceed, it is assumed, in light of the trial outcome.

1.11.3 A parallel NHS Board Level Review has been conducted and a final report submitted 5 April 2022 contained recommendations and learning for the Barnet, Enfield and Haringey Trust.

1.12 Equality and Diversity

1.12.1 The nine protected characteristics (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation) as defined by the Equality Act of 2010 have all been considered within this Review. The Review identified that the relevant characteristics which applied to Alice include gender, disability and marital status as possible barriers to her accessing services.

1.12.2 Alice was divorced and lived with her son in London and laterally in HBC. She provided unpaid care for Neil as his mother. Information provided to the Review by the Police confirmed that Alice divorced from her former husband Jonas and lived alone with Neil. She moved from London to Hertfordshire. Alice also had complex needs living with depression, drugs and alcohol issues whilst also experiencing DA in her former marriage. The Chronology available to the Panel highlighted that Alice's mental health problems and issues with alcohol were longstanding. The cannabis use in her former marriage was highlighted by Neil during his interview with the DHR Reviewers. Alice was also a victim of historic sexual abuse which was disclosed in counselling and was the subject of abuse from Neil. The Panel identified the difficulty and barriers faced by the victim of child-to-parent abuse during their deliberations, particularly the fear of reporting a loved one for a crime against them, which the Panel concluded was applicable in Alice's case.

1.12.3 Neil is a single, white male who has received treatment for long-term mental health following diagnosis of generalised anxiety disorder and drug use. The Review identified that disability is the relevant characteristic which applied to Neil. Neil's recurring mental health problems are a notable feature of this DHR evidenced in the treatment of his former partner and his mother Alice; both females in his life. At the time of the index offence Neil was a regular cannabis user.

1.12.4 The DHR Reviewers considered the issue of socio-economic background. Whilst Neil was privately educated and accessed private healthcare, and Alice was an owner occupier, the DHR Reviewers were unable to explore this with the family (Alice's siblings and stepfather) due to the lack of direct involvement in the Review process. No assumptions can therefore be drawn on this matter.

1.12.5 The DHR Reviewers noted the 2018 Bristol University study looked at 400 cases of domestic violence and found that, "Incidents in which the victim/survivor was referred to /supported by a specialist domestic violence advocate were significantly more likely to be crimed [ie. recorded as an offence] (48%), compared with 32% without such support."[1] More research, and better data on victim withdrawal from the criminal justice system, disaggregated by protected characteristic, is needed to be able to fully quantify the relationship between access to specialist services and progress through the criminal justice system.[2] Alice had not accessed support for her experience of DA or wanted to engage with the criminal justice system through reporting her experiences. She sought to protect her son Neil.

1.13 Dissemination

1.13.1 Once finalised by the Panel, the Executive Summary and DHR Report, which incorporates an action plan was presented to HBC and HCC for approval. After being

[1] Bates, L., Lilley, S-J., Hester, M. and Justice Project Team (2018), Policy Evidence Summary 3: Specialist advocacy for domestic and sexual violence. Bristol: University of Bristol.
[2] ibid

agreed, the Report was sent to the Home Office for review by its multi-disciplined and experienced DHR Quality Assurance Panel.

1.13.2 The recommendations are owned by the CSP as the accountable body and is responsible for implementing the recommendations and disseminating learning through professional networks and with local communities, as well as receiving reports on the progress of an action plan.

1.13.3 Progress reports in implementing the recommendations will be communicated to the CSP.

1.13.4 The Victim's family will be provided with copies of the Executive Summary and DHR Report as will the Police and Crime Commissioner and the DA Commissioner.

1.13.5 The Report will be published in line with the statutory guidance for the conduct of DHRs[3] and as determined by the CSP.

1.14 Background Information (The Facts)

The Death of Alice

1.14.1 In June 2021, Alice a resident of Hertfordshire, was attacked and stabbed to death inside her home by her now convicted son, Neil. As highlighted previously, the tragic incident came to light following an emergency call at 12.39pm from a neighbour to reports that a woman could be heard screaming.

1.14.2 Upon the arrival of the Police, smoke could be seen coming from the kitchen. The Police Officers forced entry to the property and found Alice lying on the lounge floor with stab wounds, whilst her son Neil was found in the smoke-filled kitchen covered in blood and with the gas hob turned on. Neil was also found strangling the family pet dog too.

[3] Home Office, Domestic Homicide Review – statutory guidance, December 2016 accessed via https://www.gov.uk/government/publications/revised-statutory-guidance-for-the-conduct-of-domestic-homicide-reviews

1.14.3 The Police Officers made the scene safe as best they could whilst the Fire Brigade and Ambulance Services were called too.

1.14.4 Despite the medical support that she received, tragically, Alice was pronounced dead at the scene. Neil was arrested on suspicion of murder.

1.14.5 It is of note that the day before at about 6.26am a call was received from Alice's neighbour stating a disturbance had been going on for the past hour and they could hear shouting and arguing, as well as the sound of something being broken. Herts Police Officers attended and upon their arrival they reported hearing screaming coming from the address. Neil presented himself naked at the front door, in what has been described as an "*agitated state*" and covered in white paint.

1.14.6 The Herts Police Officers assessed that Neil was suffering from a mental health episode and additionally lacked mental capacity. Alice was removed from the address to a nearby Police vehicle for her safety.

1.14.7 Alice had informed the Police Officers that Neil had urinated upon her and poured paint around the house.

1.14.8 Paramedics were called to the location. It is reported that as Neil was not fully coherent and not answering questions properly. Paramedics invoked their Mental Capacity Act (MCA) powers and took Neil under Police escort to Barnet Hospital to be assessed.

1.14.9 Herts Police records note that an enquiry with the hospital confirmed Neil had been seen by the mental health team at 12.20pm the day before the tragic homicide and they recommended he went to a recovery house. At 4.00am [sic the following day] Neil declined to go to the recovery house; he wasn't held under the MCA or mental health section and was at the hospital on a voluntary basis. The hospital arranged transportation for him to return to his home address. Neil was discharged at 5.49am on that morning. A decision was made by healthcare professionals to discharge Neil to the Crisis Team in Hertfordshire. Neil was discharged to Barnet hospital sometime after.

1.14.10 Herts Police note that after the incident the day before Alice sent a message to Jonas, her former husband, saying:
“I don't want to speak. I'm shell shocked but [Neil] has had a bad psychotic break and has been sectioned and is now at Barnet hospital having been restrained. Became religious, delusional and not our son at all. Will let you know when I have news. Started last night and continued at five this morning. I will clear the wreckage he has made and try to keep busy. He answered the door naked. Not [Neil] at all”.

1.14.11 From open-source research it was reported that ‘ On the morning of her death, the 63-year-old told a friend: *“If I don’t see you tomorrow, you know [Neil] has killed me.”*

Cause of Death

1.14.12 A pathologist carried out the forensic post-mortem examination. The cause of death was stabbing wounds to the chest.

Sentencing of Neil

1.14.13 Neil appeared at St Alban’s Crown Court via video link from a secure ward of a mental health hospital in March 2022. At an earlier hearing January 2022), Neil pleaded not guilty to murder, but guilty to manslaughter on the grounds of diminished responsibility. This was accepted by the prosecution.

1.14.14 Judge Michael Kay QC sentenced Neil to a Section 37 MHA 1983 Hospital Order with Section 41 restrictions.

Family History – Victim

1.14.15 Alice resided in Hertfordshire with her son Neil at the time of her death. She was divorced from Jonas, Neil’s father.

1.14.16 Records indicate the Alice and Neil resided in North London previously and had not lived in the area for long. She moved to Hertfordshire following her divorce in 2018/19.

1.14.17 The DHR Reviewers were assisted by the healthcare records which present a picture of Alice's childhood and adult life. Alice's father took his life when she was 16. Alice had, in the view of the DHR Reviewers, complex needs due to Adverse Childhood Experiences (ACEs) living with depression, drugs and alcohol issues whilst also experiencing DA in her former marriage to Jonas. The DA in Alice's former marriage is mentioned by Neil to professionals detailed later in this Report. The Consolidated Chronology details that she was a victim of child sexual abuse and physical abuse. She struggled with living with her son Neil. Neil as a child and young person was exposed to the effects of DA too. He also used cannabis with his mother Alice. There is a Police record of a domestic dispute from 13 August 2002, between Alice and when they were still married, whilst residing in London.

1.14.18 Alice experienced DA at the hands of Neil, which is articulated elsewhere in this Report.

1.14.19 There are no details known to the Review through the Panel Members about Alice's extended friendship group and her employment history. Police conducted enquiries and no information emerged. The DHR Reviewers attempted to meet with Alice's best friend Joe and son Jodey but this meeting and involvement with the DHR process was declined.

Family History - The Perpetrator

1.14.20 At the time of the homicide, Neil was a single man who lived with his mother, Alice.

1.14.21 Neil had always lived with Alice; whether it was in London or Hertfordshire.

1.14.22 The Herts Police information submitted to the Panel provided useful detail concerning Neil's background as a child and young person. Jonas, Alice's former husband, had apparently stated that from the age of 5 years, Neil was privately educated starting at a preparatory school. From the age of around 13-14 years, Neil apparently struggled with being in a school environment. An agreement was reached with the school that he would go into school in the morning, collect his work and complete it at home. He would then return the completed work at the end of every day.

Neil was described, according to the Police information as not *"full of confidence but was always fit and healthy".* However, that said, there were elements of vulnerability identified by the Police relating to Neil's mental health from an early age.

1.14.23 Sarah, Neil's former partner, informed the DHR Reviewers that Neil attended University at the London School of Economics (LSE) where he was apparently awarded a degree in naval history after about 5 – 6 years according to her recollection. The DHR Reviewers were unable to verify this with Neil's family and Police enquiries were conducted with the university that confirmed that there were no remarkable features of Neil's time at the LSE. Sarah advised the DHR Reviewers that Neil 'dropped out' of university and attributed this to a number of factors including cannabis use and his parents.

1.14.24 The DHR Reviewers meeting with Sarah revealed that Neil was physically and psychologically abusive towards her during their relationship. Sarah met Neil in August 2014 in a London bar and had an on/off relationship with him for 9 months or so. She described Neil as charming, well spoken, well-presented and well-read when they first met; a nice person. Sarah stated that he was also sensitive about his appearance and what other people thought about him.

1.14.25 During the relationship with Neil, Sarah resided with him at Alice's house. Sarah told the DHR Reviewers that Neil was '*very manipulative of his mother'* using and abusing '*his position as a son'*. Sarah describes that Neil '*guilt tripped'* his mother, which was supported by put downs and belittling, which the DHR Reviewers identified as forms of controlling or coercive behaviour.[4]

1.14.26 Sarah described the subtle ways that Neil mentally abused Alice: through self-pity and self-hatred which he projected onto his mother. She described Neil's rages and verbal abuse and witnessed him calling Alice a "*fucking c**t".* Neil treated his mother like a maid, according to Sarah, and demanded that his food was presented on his plate in a particular way and left outside his bedroom door. Sarah witnessed

[4] Controlling or coercive behaviour is criminalised by virtue of Section 76 Serious Crime Act 2015 accessed via https://www.legislation.gov.uk/ukpga/2015/9/section/76/enacted

Neil controlling Alice's behaviours, for example, insisting that Alice had only 2 beers per night. The DHR Reviewers noted that the alcohol controlling behaviour was in 2014 and a snapshot in time which has not been further evidenced by other contributors to the Review. Alice's self-disclosure to health professionals regarding her drinking is detailed elsewhere in this Report.

1.14.27 Sarah described Neil as a daily user of cannabis. There was also a general acceptance of use of cannabis in the house. The DHR Reviewers noted that this was confirmed in disclosures by Neil of his childhood.

1.14.28 The DHR Reviewers noted that Sarah witnessed Neil kicking his mother down the stairs, which was just before, according to Sarah, he physically attacked Sarah. She described multiple situations in which Neil has been aggressive, violent, intimidatory, harassing, controlling and coercive towards her and others:

(i) When they first met Neil turned up at Sarah's flat, which she shared with a friend. Neil put his foot in between the door and its frame, which prevented her friend from closing the door.

(ii) Early in the relationship Sarah recalled an argument, in which Neil sat by the door so that Sarah couldn't get out.

(iii) Whilst Sarah and Neil were in America on holiday together, she was attacked by Neil. Neil had a scarf around Sarah's neck whilst he had a knee on her chest. Sarah describes that she thought that she going to die. Sarah described Neil's face as twisted. He spat at Sarah whilst trying to gouge her eyes out. Sarah recalled that Neil also damaged her mobile telephone. The day after this incident, Sarah recalled that Neil telephoned his father during which he used language like 'garrotting' and also asked him for money to replace Sarah's damaged mobile telephone.

(iv) Whilst they were both staying at Sarah's friend's house, they were drinking cocktails together and it got to a point when Neil wanted to go. When no-one was looking Neil apparently punched Sarah in the stomach.

(v) After Sarah and Neil's relationship ended, she started a relationship with another man. On one occasion Sarah reported that Neil turned up at their shared address and stabbed Sarah's then partner Harry with a screwdriver, causing facial and other injuries leaving him hospitalized. Neil was arrested for this vicious assault, no prosecution followed. The CPS decision-making is detailed later in this Report.

(vi) Neil stalked Sarah over a 6 years' period, some of which was focused on her former partner Harry. He used mobile phone messages to recapture things from the past, which, in her view, were designed to intimidate her partner Harry. Neil messaged Harry's work, according to Sarah, and said that he was an abuser and also messaged Harry's former wife. In addition, Sarah recounted an incident involving Neil when out with her baby. She bumped into Neil in a shop. Sarah had apparently already informed Neil not to contact her but he proceeded to shout congratulations in her face. In the DHR Reviewers view, this was passive aggressive behaviour.

(vii) Sarah informed the DHR Reviewers for the first time that she had sustained 2 black eyes at the hands of Neil in April 2015 as he "tried to gorge my eyes". Sarah had started a new role in North London and attended work with two black eyes stating that she had been in a car crash. Sarah's new boss sent her home that day. The DHR Reviewers considered whether Neil was exerting economic control over Sarah in an attempt to prevent her from going to work. Sarah's employer sent her home and the DHR Reviewers were unable to verify the additional role that this employer may have played, together with Sarah's co-workers, in preventing, responding and tackling DA.

1.14.29 The DHR Reviewers noted Neil's emerging pattern of behaviour towards Sarah – Neil had previously tried to gorge out Sarah's eyes in America. The incident is supported by the Consolidated Chronology which details Neil's disclosure to the Domestic Violence Intervention Programme (DVIP) Service, and during his subsequent counselling.

1.14.30 Little is known about Neil's employment history, apart from disclosures that Neil made to mental health professionals. In 2018 Neil was employed part time in a dog grooming shop and stated that he got on well with the owner. The employer, however, has not been identified by the Police. Neil later joined a team for events photography, although not on a regular basis. He also went overseas for a job opportunity.

1.14.31 In June 2021, Neil was arrested at home by Herts Police Officers for Alice's murder.

1.14.32 Neil was subsequently charged with Alice's murder and was detained in custody pending his appearance at the Magistrates Court. At the Magistrates Court he was remanded into custody pending his appearance at St Albans Crown Court.

1.14.33 The DHR Reviewers have outlined the involvement of the statutory agencies with Alice and Neil below.

1.15 Chronology

1.15.1 The Chronology for this Review is as follows:

Date	Agency	Relevant event, significant details of contact, including whether the victim was seen/ wishes and feelings sought and recorded
13/08/2002	**MPS**	Police attended the home address of ALICE and her then husband JONAS after an allegation of assault. On Police arrival, ALICE had left with the couple's child (details not provided). JONAS explained he suffered from diabetes and had low blood sugar levels, which made him agitated. As a result, he had an argument with ALICE, and had lashed out at her unaware of whether he had made contact. ALICE later corroborated the account provided, and also stating that JONAS had not previously been violent towards her. The LAS were in attendance to assist Jonas. No allegations were made and the case was closed. Research conducted did not reveal any history of DA recorded by the MPS.
07/01/2015	**GP 1**	**NEIL** attendance: Generalised Anxiety Disorder review. He disclosed parents getting divorced and that he was back with his ex- girlfriend. Using cannabis. GP discussed medication, on waiting list for therapy, and offered referral for BDAS.

12/01/2015	**IAPT**	**NEIL** Letter from IAPT summary of treatment plan.
25/01/2015	**GP 1**	**NEIL** Attendance for review. Described as "Coping". Stopped cannabis 2 weeks before and relationship with girlfriend calmer; she is drinking less. Still awaiting group therapy, doing web-based CBT. GP encouraged continuing cannabis avoidance and discussed focussing on one thing at a time.
25/01/2015	**Solace (DVIPP)**	**NEIL** attended DVIP group contributing that there had been "too much" understanding talk and closeness from his ex-partner after his violence. He was able to see this as his way of talking him down but at the time he had thought it meant everything was ok.
28/01/2015	**GP 1**	**NEIL** attendance. Generalised Anxiety Disorder review. Awaiting IAPT small group therapy. Smoking cannabis most days with his mother. Discussed and encouraged to see BDAS regarding drug use.
10/03/2015	**GP 2**	**NEIL** attendance. Reporting problems sleeping and vivid dreams since stopping cannabis. Short term zopiclone given to help sleep.
11/03/2015	**UCLH**	**ALICE** seen in Hepatology outpatient clinic for ongoing treatment of Hep C. ALICE history of low mood, heavy alcohol intake and frequent drug use. Further outpatient appointment for continued treatment.
30/03/2015	**GP 1**	**NEIL** attendance. Doing well with stopping cannabis and drinking reduced. Reporting issues with anger. Seeing IAPT but also to contact Mind for Anger Management.
08/04/2015	**Solace**	**NEIL** transferred to a group in Waterloo (London). Solace called and left a voicemail for SARAH to alert her to this change.
13/05/2015	**UCLH**	**ALICE** seen in Hepatology outpatient clinic. Referral to Royal Free Hospital for ongoing treatment and support with new medication.
05/06/2015	**IAPT**	**NEIL** Letter closing referral and summarising group work attended.
20/07/2015	**GP 3**	**NEIL** Attended pre-holiday regarding medical issue.
20/08/2015	**UCLH**	**ALICE** seen in Hepatology outpatient clinic. ALICE has commenced a course of treatment at the RFH with new medication. Treatment for 12 weeks. RFH will review at week 2, 4, 8 and 12 in clinic with blood tests. Further outpatient appointment.
03/09/2015	**GP 1**	**ALICE** attendance for dermatology. Told GP she found living with her son's (NEIL) outbursts difficult. She said she wasn't stressed or depressed by this. GP noted she was on the verge of tears at one point. Mental State Examination was normal.
04/09/2015	**MPS**	NEIL's partner SARAH called Police stating that NEIL would not allow her to leave the property. On Police arrival it was alleged that NEIL's partner returned home (ALICE's address) intoxicated. An argument ensued between NEIL and SARAH as he had been woken up. ALICE entered the couple's room and separated them suggesting that NEIL should leave the house to give his partner an opportunity to gather some belongings and spend the rest of the night at a local hotel, which was agreed. On arrival of officers, no allegations were made and no injuries identified. NEIL was not present and not spoken to by officers. SARAH declined to answer any

		'DASH' risk assessment questions and left the property. Research revealed there were no previous Police recorded DA incidents. Recorded as a 'non-crime' domestic incident.
16/09/2015	**GP4**	**NEIL attendance.** Doing well. Relationship better. Smoking cessation advice.
22/09/2015 & 22/10/2015	**RFH**	**ALICE RFH** outpatient appointment
27/10/2015	**GP 5**	**NEIL** attendance. Attended about anger "years of intense rage. He has attacked girlfriend and mother. Loses any concern about consequences when he is in this state. He self identifies that abandonment and betrayal trigger this response. Afterwards he feels guilt, shame and regret." Also using cannabis mixed with tobacco daily. Mental State Examination normal. Advised IAPT or private.
17/11/2015	**RFH**	**ALICE** Regular appointment.
23/11/2015	**Solace**	**NEIL** assessed as appropriate for DVIP perpetrator group and placed on a waiting list.
25/11/2015		**ALICE** outpatient appointment discharged.
04/01/2016	**Solace**	**NEIL** attended first DVIP group and stated he was there because his last relationship had seen him being violent and abusive. Following the attachment demonstration, he was the only one to respond with his reaction. Talked about how scared he used to get as a child when his father would have diabetic seizures and start behaving erratically.
11/01/2016	**Solace**	**NEIL** attended DVIP group. Another positive session contributing well. Talked about problems with his parents growing up and the lack of boundaries which as a child was "cool" but actually wasn't good for children.
18/01/2016	**Solace**	**NEIL** attended DVIP group. Contributed to discussions following role-plays, including recognition that minimising and blaming are done in part to protect the ego and are lies told to one's self to make self feel better. Gave a very powerful disclosure of worst violence with no self-justifying and describing slapping (with resultant bruises to back of neck), verbal abuse and "garrotting" her with a blanket until she went red (his words).

20/01/2016	**GP 1**	**ALICE** attendance. "Lives at home with son aged 25. Son continually puts her down telling her she is useless (because she can't get a job), ugly, calls her ”your stepfather's slut” (she was abused sexually by stepfather from age 10). Husband left unexpectedly Dec 2014 for another woman; husband was equally abusive over many years marriage. Says she feels controlled by son having to do his bidding and feels useless and worthless. Cries every day. Wakes up feeling sad. She hides her feelings from son and friends. Feels ashamed. No ethyl alcohol or ethanol. No drugs. Def no risk DSH: I asked her and she says no as son needs her. Feels abused. Medication Citalopram. Examination: Dress/ behaviour normal. Speech normal. No thought disorder. No DSH ideation. Affect not depressed but tearful. Comment Abusive home situation. Depressed. RV 2 weeks" (sic). Referred to Barnet IAPT.
25/01/2016	**MPS**	Called to an incident – believed assault committed by NEIL against his ex-partner’s current partner. On arrival, NEIL and another male were found with injuries, however neither wished to explain what had happened and no witnesses were identified. Both men were arrested on suspicion of assault.
26/01/2016	**MPS**	**From 25/01/2016.** Both suspects were in custody. Police sought charging advice from CPS Direct for NEIL (Wounding and Affray) and HARRY (Affray). Case not treated as DA by Police or CPS. Prosecutor discussed the case with OIC and agreed that both suspects should be bailed pending further enquiries regarding an identified eyewitness. Both suspects released on bail pending further lines of enquiry set out in a CPS action plan
27/01/2016	**Solace**	**DVIPP**. Advisor call with SARAH (ex-partner of NEIL). SARAH stated there was a major incident the day before between NEIL and SARAH's new boyfriend. However, SARAH couldn't speak as she was working. Asked for a call back another time.
01/02/2016	**Solace**	**DVIPP.** NEIL attended DVIP group with black eyes. He said he had been "goaded" by ex-partner’s new partner into going to her home - which he recognised was wrong thing to have done - where he was "set upon" by him. Said he felt guilty about this further violence in her life and needs to pull back.
02/02/2016	**MPS**	Following NEIL’s arrest for wounding, he sent an email to his ex-partner explaining he was sorry that he had attended her address and for the incident that took place. The message was passed to Police via a solicitor as NEIL was in breach of his bail condition not to contact his ex-partner. NEIL was warned by the Police about his behaviour. No further action taken.
02/02/2016	**GP 1**	**NEIL** attendance. Review. Describes his situation as no better but no worse. No deliberate self-harm ideation. Medication reviewed.
08/02/2016	**Solace**	**DVIPP. NEIL** attended the DVIP group. Said he had been asked by the Police from last week’s incident whether he "would ever harm" his ex-partner. Had said he wouldn't in future but that he had in the past and was now worried his honesty might

		be used against him. Described as being less actively engaged than in previous weeks.
19/02/2016	**CPS**	MPS submitted a request for pre-charge advice to the CPS for offences of affray and causing GBH said to have taken place on 25/01/2016. An action plan was set by the Prosecutor for the Police to seek a further statement from a witness.
19/02/2016	**MPS**	Police investigator submits results of Action Plan from 26/1/16 consultation to the CPS Direct Case Management System requesting further charging decision.
22/02/2016	**Solace**	**DVIPP. NEIL** attended DVIP group. Seems to be moving somewhat backwards into a position of less accountability for his behaviour, perhaps from fear that he might be charged regarding the fight he had with his ex-partner's new boyfriend, and whether his past violence towards her will be brought up.
25/02/2016	**CPS**	**CPS** - The case was re-submitted by the MPS and a decision was taken by the Prosecutor that the evidential stage of the Code for Crown Prosecutors was not met in respect of any offence.
29/02/2016	**Solace**	**DVIPP. NEIL** attended DVIP group. Appears his fears of a conviction ruining his life are declining and now appears to be backing away from the initial willingness to be accountable with which he started the programme. Contributed well to discussions about physical signals and how SARAH would know he was angry, including sulkiness, facial expressions and tone of voice. Initially laughed at a statement about being nasty when denied sex but stopped suddenly when he gauged SARAH's reaction. Came across as insincere engagement after that.
02/03/2016	**GP 6**	**NEIL** attendance. Psychiatry referral agreed. Would like diagnosis of Borderline Personality Disorder which would be helpful to him. Discussed this won't change his treatment. "Good insight". Taking SSRIs and diazepam as prescribed. Dose reviewed. Referred to Community MHT.
03/03/2016	**GP (London Practice)**	**NEIL** attendance. Referral with concerns relating to management of his anxiety disorder and question of borderline personality disorder. Referral states that he is attending support group for DV and is on bail for GBH. Referral to BEHMHT.
07/03/2016	**Solace**	**DVIPP. NEIL** attended DVIP group. Still trying to establish whether he will be able to continue if re-bailed, or whether he will be eligible for building better relationships programme. Made some contributions but talking less and less each week. No telephone contact with SARAH as she does not want any updates. Hearing about anything related to NEIL makes her feel upset.
14/03/2016	**Solace**	**DVIPP. NEIL** attended DVIP when asked for an example of someone or something he'd had to let go, he said that his dad (JONAS) had been endlessly abusive to his mum (ALICE) and then, on Boxing Day, had vanished from the home. Later found out JONAS had resumed relationship with a woman he'd had affair with when NEIL was 12 and was wanting the house sold as part of divorce.

18/03/2016	**LBB**	**Social Care Direct (NEIL**) received a telephone call from IAPT counsellor to report some concerns about ALICE. Reports ALICE's history of being physically and sexually abused. Counsellor concerned she lives with her son NEIL (early 20s) and he is allegedly verbally and psychologically abusing ALICE as well as thrown objects at her. Arguments happen every few days in relation to the property as ALICE's ex-husband (JONAS) wants to sell the property but NEIL does not want this to happen. Counsellor reflects his worry about ALICE's safety. ALICE's ex-husband physically abused her due to his unmanaged diabetes. It was reported that ALICE was sexually abused by her step-father and this was many years ago. Case passed to Urgent Response Team (URT) as a safeguarding concern. Safeguarding concern form completed.
19/03/2016	**MHT**	**ALICE referral received from IAPT**. She presented with symptoms of severe depression. Complex history and very traumatic experience, yet, she has received no treatment or help throughout the years. Triaged by mental health team.
23/03/2016	**GP 6**	**NEIL** attendance: "Charges have been dropped, massive relief". New job in dog grooming. medication reviewed. Mental state examination normal. Mental health appointment letter copied to Practice and an appointment made for 8/04/2016.
23/03/2016	**BEHMHT**	ALICE. Appointment letter sent after team failed to make telephone contact. Appointment scheduled for 11/4/16 with Community psychiatric nurse. Appointment with CMHT offered.
29/03/2016	**LBB**	**URT** worker undertakes the following telephone contacts: -Counselling Service. Service able to disclose that they do not have the name of the son (NEIL) on record. -Mental Health Service in Barnet to gather information on NEIL. **-**London GP Practice and Safeguarding concerns are discussed. There as an agreement to prioritise referral to MHT. - attempts telephone contact to ALICE on her mobile phone and landline. No answers. Voicemail message left requesting contact on mobile. No voicemail on landline due to security.
29/03/2016	**GP 3**	**NEIL.** Contact from Barnet Social Services, Asked to prioritise mental health referral due to safeguarding issues at home. Letter sent to BEH.
29/03/2016	**LBB**	**Adults Social Care.** -Referral made by GP on 03/03/16 for NEIL stating suffering Generalised Anxiety Disorder. Case currently sitting with Non-Urgent Assessment Team NEIL has an appointment to be assessed on 09/05/16. - Duty GP spoken to. Updated with details of Safeguarding alert. Agreed to prioritise referral to MHT.

		-telephone calls to ALICE on her mobile and landline numbers. No Replies.
30/03/2016	**LBB**	**Adults Social Care** Email authority for the case Transfer to Locality, which takes place the same day to North Locality Team.
04/04/2016	**IAPT**	**ALICE.** Safeguarding referral sent to the local authority by IAPT. The safeguarding referral detailed concerns regarding ALICEs son verbally and psychologically abusing ALICE. It was documented that there have been occasions whereby he has thrown objects at her as well. Referral stated that there were arguments every few days. IAPT counsellor advises that he is worried about ALICE's safety - unsure as to whether the Police have been called out before. Safeguarding not processed due to refusal from ALICE.
07/04/2016	**BEHMHT**	GP letter received requesting that NEIL appointment be prioritised due to safeguarding referral sent to local authority for ALICE.
08/04/2016	**LBB**	Safeguarding referral from Counsellor received. Referral is passed on to the North Locality Team.
08/04/2016	**IAPT**	**ALICE** Letter from Mind Matters Barnet.
16/04/2016	**BEHMHT**	**NEIL.** Initial assessment by Doctor and Community Psychiatric nurse. Impression and diagnosis, substance related mood and behavioural disorder, on the background of underlying adjustment disorder with mixed disturbance of emotions. The suicidal risk low and others are medium. Plan: Start Olanzapine 5 mg as mood stablizer, cipramil 40 mg od ,diazepam 2.5 mg PRN and stop after 2 weeks. Continue with private therapist. Advised to address his tendency substance misuse. Have emergency no, discharge. closed to team.
21/04/2016	**BEHMHT**	**ALICE** was assessed by the Barnet Assessment service. She reported childhood sexual and physical abuse, and DA in her previous marriage. ALICE reported that a safeguarding referral was made for her regarding violence from her son, and her son is having counselling around his anger. She said there was an improvement. ALICE agreed for a referral to Network for help with her self-esteem and confidence and Sangam for counselling for her history of abuse. She was also given information on Citalopram on assessment, which no changes are recommended. Referral sent to the Network for counselling around self-esteem.
21/04/2016	**BEHMHT**	**ALICE** Letter from BEHMHT regarding Care Plan.
28/04/2016	**BEHMHT**	**ALICE** Letter from BEHMHT regarding Mental Health Assessment.
29/04/2016	**LBB**	**LBB**. Referral is received from BEHMHT for ALICE for needs assessment. The referrer mentions "[ALICE's]'history of abusive relationships and difficult marriage which also involved alcohol misuse. ALICE is now divorcing, her adult son is at home and she is struggling with practical issues around selling the family home, and she has low confidence which appears to be holding her back. She spends a great deal

		of time worrying about her son and future and does not appear to want to want to address her own issues at this time". Referral is passed on to the Network team which forms part of the Mental Health Service in LBB.
17/05/2016	**LBB**	**ALICE** sent two appointment letters by the Network to attend for a needs assessment.
17/05/2016	**LBB**	**ALICE** Copy of letter from The Network.
17/05/2016	**GP1**	**ALICE** attendance. Attended for radiology results. GP notes feeling less tearful, has been referred on by IAPT. Awaiting divorce. Mental State Examination normal
18/05/2016	**BEHMHT**	**NEIL** Mental Health Assessment letter - discharged from BEHMHT after assessment.
03/06/2016	**BEHMHT**	**ALICE** attended her meeting in the Network which was very short as ALICE expressed that she does not need the service now, she is doing much better and her difficulties were due to personal circumstances and worry about her 26-year-old son. Her son is now doing better, has a new girlfriend works and she is sorting out her personal affairs. Plan to discuss at clinical assessment meeting, close referral, inform the referrer and GP. Closed to the Network.
06/06/2016	**GP2**	**NEIL** Doesn't want to start medication recommended by psychiatrist. To continue current medication-SSRIs and Diazepam PRN.
10/06/2016	**LBB**	**ALICE.** An appointment is held by the Network and decision is made to close the referral of 29/04/2016. Closure letter dated 10/06/2016 is sent to ALICE's home address.
18/01/2017	**GP 1**	**ALICE.** Attended for repeat SSRI prescription. Mental State Examination NAD.
20/01/2017	**UCLH**	**ALICE** contacted team for further support as not been able to get further hepatitis assessment at RFH. Further outpatient appointment.
02/02/2017	**UCLH**	**ALICE** seen in Hepatology outpatient clinic after 2 years as treatment was handed over to RFH. ALICE to continue to be under regular surveillance every six months with an ultrasound scan and blood tests to screen for complications of cirrhosis. Further ultrasound scan and blood tests in June prior to appointment in July. Further outpatient appointment.
13/02/2017	**LBB**	**Adults Social Care** emailed to Safeguarding team from Client Case Management System Concern form completed.
13/02/2017	**LBB**	Locality worker contacts ALICE to discuss safeguarding concerns. ALICE informs her son is now working and situation is stable. ALICE does not feel at risk from her son. She is going through a divorce with her husband which may cause more friction, however ALICE is able to raise her concerns with the appropriate agencies if necessary. ALICE does not want a Safeguarding enquiry to be pursued. Number provided if the situation changes. Details noted.
13/02/2017	**LBB**	**Adults Social Care** request telephone call to ALICE to check that there are no outstanding issues in relation to previously concerns raised about physical and emotional abuse from son. Action for duty Social Worker.

13/02/2017	**LBB**	**Adults Social Care** NFA in relation to Safeguarding. There are no current concerns about behaviour of son and further enquiry is not required.
17/02/2017	**GP 6**	**NEIL** History of Generalised Anxiety Disorder. Seeing clinical psychologist privately. Arrested end Jan on suspicion of GBH, altercation with ex GF's new partner. History of DV - attending support group. Stopped smoking, reduced cannabis, buying diazepam online, taking since arrest. Concerned about Borderline Personality Disorder. "Good insight into own mental health, tries to use CBT strategies". Bought notes from his psychologist to go through with GP. Medication reviewed and appointment for 2 weeks to discuss psych referral.
29/03/2017	**Chase Farm Hospital**	**ALICE** outpatient appointment.
June 2017-Jan 2018	**GP 2**	**ALICE.** Attendances for medical investigations and treatment.
10/07/2017	**CLCH**	**ALICE** Referral into Adult MSK for Physiotherapy: Osteoarthritis Left wrist. Awaiting triage.
11/07/2017	**CLCH**	**ALICE** Practice appointment.
20/07/2017	**Chase Farm Hospital**	ALICE outpatient appointment Chase Farm Hospital.
23/08/2017	**Chase Farm Hospital**	ALICE outpatient appointment Chase Farm Hospital.
19/09/2017	**UCLH**	**ALICE** seen in Hepatology outpatient clinic. ALICE generally feels well and has no concerns. She is aware that she will need ongoing monitoring as her Fibroscan does indicate cirrhosis of her liver.
12/10/2017	**CLCH**	ALICE sent letter by MSK physiotherapy requesting ALICE to contact Edgware Community Hospital to make an appointment.
25/10/2017	**CLCH**	Clinic letter sent confirming MSK appointment on 9/11/2021.
09/11/2017	**CLCH**	**ALICE** did not attend appointment.
10/11/2017	**CLCH**	**ALICE** Clinic letter sent from MSK physiotherapy for appointment on 27/12/2017.
14/11/2017	**CLCH**	**ALICE** Clinic letter sent cancelling appointment on 27/12/2017 and rearranging for 3/1/2018.
03/01/2018	**CLCH**	**ALICE** seen in clinic for physiotherapy assessment. Self-management advice and strategies provided. ALICE discharged from MSK service.
01/02/2018	**UCLH**	**ALICE** seen in Hepatology outpatient clinic. Her most recent ultrasound scan on 13 September shows a fatty liver but no liver lesions and a possible stone in the left kidney measuring 2mm.Ongoing treatment. Further outpatient appointment.

19/06/2018	**GP 3**	**GP3** Attended asking for referral to mental health wants advice from a "personality disorder specialist" Problems still persisting "full of angst. Private psychologist is prohibitively expensive. Says he takes his anger out on his mother. Sometimes hates himself and think about burden on his mother. Buying diazepam/alprazolam online. Stopped SSRI 3 months before. Lives with his mother and dogs, gets angry at the animals but his mother bears the brunt of his anger. Said he has destroyed property by punching the walls, "mother protects him". Still using cannabis. Propanolol prescribed for anxiety. Referral to mental health link work service.
20/06/2018	**BEHMHT**	**NEIL referred by GP** to BEHMHT due to interpersonal relationship/persistent violent behaviour. Had a private psychologist and had short course of CBT with IAPT. Has had previous episodes of fights and assaulted an ex-girlfriend's boyfriend with a screwdriver causing him permanent scarring. Also violent towards his mother and threw boot at her and she bears the brunt of his anger but mother protects him and he has never been prosecuted. Recently feeling angry towards animals. He has destroyed property, punched walls. Plan for Link worker to complete tel. review in view of his risk to others. To explore Safeguarding concerns due to violence to mother and check if GP has made a referral for this. Referral to Locality Team to be considered for medical review and psychological assessment.
16/07/2018	**BEHMHT**	**NEIL telephone review** carried out. Plan: 1.NEIL declined engagement with Westminster Drug Project (WDP) at present as denied current illicit substance use. 2.Case to be referred to East Locality Team for discussion in the first instance due to his current presentation, risk to others and difficulty managing his symptoms. Felt it would not be unreasonable to explore possibility of psychiatric assessment and psychological review. 3.NEIL to be referred to the Network for better management of his symptoms, controlling his emotions and response to situations he does not find favourable and psycho-education and anger management problems. Referral to Network for support for better management of his symptoms. Referral for psychiatric review for diagnostic assessment with Dr S with additional staff member due to anger issues.
16/07/2018	**GP 3**	**NEIL** still not heard from mental health. Mother finding it hard at home, no physical violence. Verbal aggression and doors slammed. GP chasing link worker. Crisis team details given.
16/07/2018	**GP3**	**NEIL** Link worker responded, contacting him that week. Suggested referral to WDP and safeguarding referral for mother. GP arranged for mother to attend to discuss

		safeguarding. She assured on phone she doesn't feel in physical danger but "gets scared".
17/07/2018	**GP 3**	**ALICE** Attended re stress and depression. Described her son as "fragile" and herself as fragile. Said she had problems with son and ex-husband [JONAS] over the house. No physical aggression but verbal aggression. Asked for help for her son, said she felt there was nothing else the GP could do. She said her father committed suicide when she was 16. Difficult relationship with her ex-husband who has left. Requested a new anti-depressant. GP asked her about safeguarding referral, she became tearful and said she didn't want a referral only help for her son. GP discussed keeping her safe and she said she didn't feel in danger, living circumstances were just difficult.
19/07/2018	**GP 3**	**NEIL** Discussed referral to WDP for cannabis use. Referral declined.
07/08/2018	**BEHMHT**	**NEIL.** Seen on his own and history noted. Managed to get his history degree from LSE. However he still have tendency to lash out, mainly when he feel bad about himself" broken inside". Feeling empty. Preoccupied with his physical appearance. Lacking confidence, find difficult to express his opinion. Gets sensitive, some ideas of reference, people are laughing at him ," unable to make relations. Sleep and energy reasonably good. Stopped cannabis for nearly 5 weeks and stopped Skunk gradually. Bing alcohol socially. Death wishes, no active suicidal thoughts. Gets out bursts of anger and irritability .Find difficult to enjoy anything. Been threating towards his mother and once hit her with a boot this was in June. Regrets his actions, did show remorse. Also been abusive toward a friend. Current medication: None, stopped end of March been on it for years because he felt it was not working. Still lives at home with his mother she is 60, been for holiday to Greece did not enjoy it. Not in relationship for the last year. Started to join a team for events photography but not regular. Still do p/t in the grooming shop gets on well with the owner. No financial worries. Has tendency to spend money on holidays and things that he does not need. MSE: Casually but smartly dressed slim man with fashionable ponytail, polite ,coherent ,relevant low self-esteem have tendency to get angry, uptight and irritable easily, some sensitive ideas of reference, death wishes but no active suicidal thoughts. Attention and concentration are within normal range, adequate insight IMP; The overall features is that of emotional dysregulation with marked irritably and impulsive behaviour possible underlying affective disorder to consider EUPD. The suicidal risks and other are low to medium. Plan to start Lamotrogine 25 mg bd ,side effects discussed ,refer to psychologist for would like to have DBT.
07/08/2018	**BEHMHT**	**NEIL** letter, Mental health assessment.
09/08/2018	**GP3**	**GP3** Attended for review. Said she felt better on new SSRI. No thoughts of deliberate self-harm. Situation at home still difficult but she can handle it better. Offered mental health referral, declined. Given self-referral information for IAPT. She said she will feel better once her son is better.
14/08/2018	**BEHMHT**	**NEIL BEHMHT** appointment letter for the Network.

20/08/2018	**LBB**	**Adult Social Care** Contact/Referral (Adult)
20/08/2018	**LBB**	Referral from Barnet Link Working Team (BEH) for NEIL received due to difficulty managing his emotions and poor response to situations with anger issues. Referral informs about NEIL' history of violence to mother and her ex-boyfriend. He has been referred to East Locality Mental Health Team for medical review. He denied any current suicidal thoughts or any plan or intent and was able to guarantee his safety and identified his family as his protective factor. In view of his symptoms, the referrer feels that he would benefit from the Network service's input at this time. Referral is passed onto The Network team.
29/08/2018	**UCLH**	**ALICE** seen in Hepatology outpatient clinic. Referral to Gastro team done. Letter to GP with medical update. Letter also stated that unfortunately, ALICE is heading for a divorce and having a problem with her son who has got borderline personality disorder which is clearly making her life quite stressful. She was recently started on some antidepressants to manage her low moods. Further outpatient appointment.
11/09/2018	**BEHMHT**	T/c received from **NEIL to BEHMHT** stating that he had an argument with his mother, he lost his temper and pushed her mother on the floor. He said that he saw his therapist yesterday who advised him to inform his care team about the incident. NEIL said that he needs advice from his care team as to how he can get subsidy for accommodation. NEIL was advised to contact Barnet Adult East Locality Team.
11/09/2018	**BEHMHT**	**NEIL called BEMHT** to report that he saw his private Therapist yesterday, where he disclosed an incident and was advised to inform the team. NEIL reported that the incident happened last week Thursday, he got home, mother [ALICE] was drunk and they had an argument, he then pushed mother. She fell hit her head on the floor and passed out, he then called the ambulance as she was not responding to him. Reported that she came around in about a minute or two and asked him to cancel the ambulance which he did. At this point he helped her up, she presented as unsteady on her feet and disorientated, she later settled and has been fine, mother has an appointment to see her GP this morning. Staff asked NEIL if this type of incident had happened before. Worker read in the notes that GP saw mother and was advised by the Link worker to raise a safeguarding in July 2018. NEIL confirmed that it is not the first time, that he grew up in an abusive environment with alcoholic parents and that has made he an aggressive person especially towards mother when she is drunk. Worker spoke to mother to clarify and get collateral information, she confirmed that an incident happened but was not so bad; she was minimising it. She then told me that she has to go to see her GP now and unable to continue our conversation, reassured me she would disclose the incident to her GP. Expressed concern to both NEIL and mother that they cancelled the ambulance, she ought to have been seen and checked. NEIL confirmed that he has appointment with the Network tomorrow and is looking forward to getting help with anger management. NEIL denies having

		suicidal thoughts, intent or plan, no thoughts of harm to self or others, went on to say that he does not want to harm his mother and is at this point looking into moving out to live on his own.
11/09/2018	**GP 4**	**ALICE** Attended as she had been pushed by her son a week before. "He had been upset by her drinking". She tripped over a ball and hit the floor. Her son said she had been unconscious for a few minutes, but she told him not to call an ambulance. Discussed her concerns over son's mental health. Discussed option of calling Police if she feels at risk.
17/09/2018	**Network**	**NEIL** initial appointment. Areas explored in which NEIL would like to work on include violent outbursts; 0-100 without warning; low self-esteem; isolation; not establishing good relationships.6 individual sessions offered.
17/09/2018	**LBB**	**Barnet Wellbeing Hub** a new referral sent with concerns over an incident of physical violence from ALICE's son taken place 2 and 1/2 weeks prior to the referral date where ALICE was under the influence of alcohol she was pushed over by her son. She fell and hurt her chin and was knocked unconscious for a short time. Her son called 999 but when ALICE regained consciousness she cancelled the call to 999 stating she was fine. Case is passed onto the URT for screening.
17/09/2018	**LBB**	**LBB** Assessment of needs is being carried out by the Network and care and support plan created. NEIL agreed to attend 6 individual sessions to address his difficulties in managing his angry outbursts.
17/09/2018	**LBB**	**Adult Social Care** Reports of physical/verbal abuse. Safeguarding concern sent to URT. T/C from Barnet Wellbeing Hub.
17/09/2018	**LBB**	**ASC** Called ALICE to add further information regarding referral that has been raised. Son has not physically abused her but he has thrown items at her and once a shoe hit her. Telephone call from Barnet Wellbeing Hub.
18/09/2018	**LBB**	**ASC** REFERRAL REASON Reports of physical/verbal abuse. Referrer concerned for client's [ALICE's] welfare due to mental health issues of her son. Case allocated to URT worker to establish ALICE's safety, conduct further screening to ascertain whether this referral meets the threshold for further safeguarding input or requires other intervention. Safeguarding allocated in URT.
18/09/2018	**LBB**	**ASC** Welfare check T/C made to ALICE who informed that she is safe and OK and is not under any further threat from her son. Home Visit (H/V) booked for 12pm on 19/09/2018. Welfare check / safeguarding H/V appointment booked for 12pm on 19/09/18.
18/09/2018	**LBB**	A welfare telephone call made to ALICE who informed that she is safe and OK and is not under any further threat from her son. Home visit is booked for 12pm 19/09/2018.

19/09/2018	**LBB**	**ASC** met with ALICE at home. Introduced and the reason for visit. [ALICE] related that NEIL is her only child and lives with her in the family home; NEIL is a graduate of LSE and works part time; NEIL experiences Borderline Personality Disorder and Generalized Anxiety Disorder and is known to the mental health services; she struggles to contain her alcohol consumption and level and this is a source of concern for NEIL; NEIL has had reasons in the past to worry about her alcohol habit and they have had discussions about this; she has just divorced and is going through the motion of selling the family home and this has impacted on her wellbeing including increased alcohol consumption level; she has reduced her alcohol consumption intake and working towards further reduction; on the day in question, she agreed that she had a few glasses of wine too many with a neighbour and her speech was slurred and this infuriated NEIL and he gave her a nudge and she tripped and hit her head against a dog feed tray and was slightly bruised and NEIL called 999 and she was attended to and she declined to go to the hospital; NEIL' action was not borne out of malice and their relationship has since returned to normal and they are working on their mother /son relationship; NEIL is equally receiving therapy from the mental health service; she does not have any social care needs and is independently mobile; and she will want the safeguarding concerns information gathering process to be terminated. CONCLUSION AND RECOMMMENDATION: ALICE is able to clearly express her wishes, she has capacity to make decisions regarding safeguarding concerns and has put a protection plan in place by working towards a better relationship with her son and managing her alcohol consumption. In view of the foregoing, I will recommend a termination of the safeguarding concerns information gathering process. NFA to URT.
20/09/2018	**LBB**	LBB ASC does not have care and support needs and has taken appropriate actions to address the underlying factors which contributed to her being pushed by her son. The concern of physical abuse by ALICE's son does not meet the criteria for section 42 enquiry, and she has also expressed the desire for the safeguarding concern to be terminated. Consequently, no further action into concern agreed. ALICE is able to take required measures to safeguarding herself from abuse of her son. Safeguarding Adults - Outcome: NFA into Concern Agreed.
19/09/2018	**BEHMHT**	Joint case meeting ALICE BEHMHT held to discuss incident when ALICE was pushed by her son, NEIL, whilst she was drunk. ALICE fell, hit her head and became unconscious. ALICE's son, NEIL called the paramedics but ALICE cancelled when she regained consciousness. She reported that he hit her in the past. ALICE has been referred to National Association for People Abused in Childhood and Barnet carers centre for care provided for son who has mental health issues and in the process of getting a diagnosis. Safeguarding referral made to Local authority.

19/09/2018	**LBB**	**LBB** Home Visit takes place. ALICE talks about her family life, her struggles with alcohol consumption and it being a concern for her son NEIL. She has just divorced and is going through the motion of selling the family home and this having an impact on her wellbeing. She informs that she has reduced her alcohol consumption intake and working towards further reduction. Discussion progresses onto the day of physical aggression from her son. ALICE informs that on that day she had a few glasses of wine too many with a neighbour and her speech was slurred and this infuriated NEIL and he gave her a nudge and she tripped and hit her head against a dog feed tray and was slightly bruised. NEIL called 999 and she was attended to and she declined to go to the hospital. Since then ALICE and her son have been working towards a better relationship with her son and managing her alcohol consumption. She informs that NEIL is receiving therapy from the mental health service. She informs that she does not have any needs for care and support and that she is independently mobile. ALICE is assessed as being able to clearly express her wishes, she has capacity to make decisions regarding safeguarding concern. She asks the safeguarding concerns to be closed. Following meeting with ALICE a decision is made to close the safeguarding concern with the rationale that ALICE does not have care and support needs, she has taken appropriate actions to address the underlying factors which contributed to her being pushed by her son. ALICE is able to take required measures to safeguarding herself from abuse of her so.
21/09/2018	**UCLH**	**ALICE** OGD done under Gastro team. Further outpatient appointment.
24/09/2018	**BEHMHT**	**ALICE** Telephone Call made to the local authority Safeguarding team to follow up on referral made. Barnet local authority reported that a home visit was carried out by social care staff and that the case was closed due to the finding of the home assessment.
27/09/2018	**UCLH**	**ALICE** OGD results came back clear, will continue to be monitored via outpatient clinic. No more episodes in records or notes at UCH. Further outpatient appointment
01/10/2018	**BEHMHT**	**NEIL** Attended therapy appointment where NEIL discussed scenarios in childhood that had caused him distress. NEIL informed therapist he would see Psychiatrist for further assessment and attend a further 5 sessions.
03/10/2018	**GP 4**	**NEIL** Low Mood. Requesting to start clinical trial SSRIs at Imperial.
09/10/2018	**BEHMHT**	**NEIL** re-assessed by Doctor and psychologist. No change made to diagnosis. Further psychological assessment for consideration of psychological therapy.
10/10/2018	**BEHMHT**	**NEIL** letter, Mental Health Review
15/10/2018	**BEHMHT**	**NEIL** Appointment at Network for support for managing emotions.
23/10/2018	**BEHMHT**	**NEIL** Appointment at Network for support for managing emotions. (6 offered in total)
12/11/2018	**BEHMHT**	**NEIL BEH** letter, discharge from the Network. Awaiting psychology appointment

13/11/2018	**BEHMHT**	**NEIL** RECOMMENDATIONS Having completed six individual sessions at The Network recognised that the work in hand now, is to put into practice the skills, knowledge and tools. Suggested that if there is an opportunity for NEIL and ALICE to be seen by psychology together it could be helpful to both. Having followed up your "opt in" for psychology, I received confirmation on 11.11.18 that you will be offered an initial appointment in January 2019.
13/11/2018	**LBB**	**LBB** Review of care and support plan agreed with NEIL in Sept 2018. NEIL reports that he has learnt much about himself and how he can manage his emotions better. he is fully aware that for change to happen he needs to practice the skills he has learnt. NEIL is awaiting an appointment with Psychology. NEIL will be referred back to his GP and he is awaiting an appointment from Psychology
13/11/2018	**LBB**	**LBB ASC** Discharge Summary-NEIL 12.11.18.
29/01/2019	**BEHMHT**	**NEIL BEHMHT** Barnet East Locality Team Psychology – Assessment. 1st Appointment Springwell Centre. NEIL attended assessment appointment, came a few minutes late due to difficulty in parking the car, did call to alert. NEIL was seen together with assistant psychologist SP, asked NEIL before the meeting if he was in agreement with this he said yes. NEIL said he's still struggling with the same sort of issues that he reported in the past, feeling quite irritable, angry at times and then at times exploding other times withdrawing or numbing himself. He did say he has stopped completely using cannabis, since the time he reported previously. He also has obtained his driving license, in fact he drove himself today. NEIL was quite anxious at the start of the session, talking fast. When pointed this to him he acknowledged and started to feel [calmer]. He gave an example of a car that was parked in private bay where he is due to park and he felt angry, he wanted to do something about it, in the end and with the help of a friend he wrote a note that he put on the windscreen and took the valve caps from the tyres. He still is living with his mother and still finds it stressful at times, they get into each other's nerves. He hopes to get a job and then be able to move to his own place. He has started looking for work, he wants now to work in Media. He has had a couple of interviews but got nothing yet. He struggles with regulating his emotions and with interpersonal relations. Discussed with him these as two main points of difficulties for him. No evidence of risk. Plan: 2nd Appt on Thurs 14th Feb 12pm.
14/02/2019	**BEHMHT**	**NEIL BEHMHT** Barnet East Locality Team. Psychology – Assessment. 2nd Appointment Springwell Centre. NEIL attended our last assessment appointment, came on time. Discussed how he felt regarding our previous meeting, NEIL stated that he feels it was helpful the discussion about his difficulties and he is interested in accessing the IRER Group as it seemed a suitable treatment for him at this moment. Discussed further how the group works and how it can help. Discussed waiting times and how he can make use of reviews appointments if needed. At the moment he feels

		stable and is happy to wait for treatment. No evidence of current risk. Plan : To refer NEIL to the IRER Group in Psychology Hub.
14/02/2019	**GP5**	**ALICE GP5** Attended for "low mood". Asking to restart SSRIs. Alcohol 10 units a week. Occasional cannabis. No active suicidal ideation made a suicide attempt aged 13-"issues at home". Previously had talking therapy. Son is being seen by Wellbeing hub. Says she is still going through divorce after 4 years. Plan to restart medication and contact GP urgently if she feels worse.
26/02/2019	**BEHMHT**	**BEHMHT** NEIL's mother (ALICE) called the network and said that she was wanting to know if therapist was able to write a supporting letter for her solicitor (in relation to her divorce) stating that NEIL was not able to live on his own. ALICE handed the phone to NEIL saying that because of confidentiality she was aware that he would need to be spoken to directly. NEIL explained that ALICE was wanting to evidence that she would need to continue supporting NEIL at home because of his mental health. NEIL informed that the previous entry had been read where he says how he wants to move out of the family home. This he agreed too and really didn't know why his mother was going down this road. Neil informed that a letter could not be written and that his ambition to strive towards living independently was suppported when he is in a financial position to do so.
26/03/2019	**GP 4**	**ALICE GP4** Attended for medical letter for her divorce.
20/05/2019	**BEHMHT**	**NEIL BEH** letter psychology treatment summary. Referred to interpersonal relations and emotional regulation group within psychology hub.
29/05/2019	**BEHMHT**	**NEIL BEHMHT** psychology assessment report sent to NEIL and copied into GP Initial Formulation: "As we discussed your struggle with emotional regulation and interpersonal relations, this seems to be in the context of personality disorder and long-standing traumatic experiences whilst you were growing up. It is significant the distress these difficulties bring you, although you keep a positive outlook and want to change things around. It was courageous of you to seek help and to engage with our service, with the Network and other resources. I do believe that you will find the treatment we discussed helpful, as the aim of this group is to help in understanding some of your difficulties but also to effect changes as you request i.e. to learn how to regulate your emotions". "It was remarkable how insightful you are regarding your difficulties and how you were able to articulate them. However, as we discussed insight is not enough and the group will allow you to experience your insights in the context of actual interpersonal relations with other group members and also to challenge your current understanding of your issues. As discussed this group is not diagnostically orientated, focusing more on the issues at hand. I hope you find the group experience helpful and useful".

		"Plan: As we discussed and agreed I have referred you to the IRER group in the Psychology Hub. You are now on the waiting list and as soon as you reach the top of the list you will be invited to a first review appointment. Should you need any further help you are welcome to contact us"
27/06/2019	**GP 7**	**NEIL GP7** Requesting diazepam for flight to Abu Dhabi for a temp job. Says he gets anxious and has taken before, bought it online. GP offered Propanolol, declined "agitated on refusal" GP apologised explained they'd prefer he sees a doctor who he has seen before. Appointment booked with previous GP.
01/07/2019	**GP 3**	**NEIL GP3** Attended as booked for diazepam request. On waiting list for Group Therapy Seeing a private counsellor monthly. Says no longer using cannabis or any drugs, last use June 2018 "feeling a little overwhelmed". Explained BEH letter from psychiatrist had advised against Diazepam. Discussed regular medication such as sertraline, declined.
07/01/2019	**LBB**	**NEIL. ASC** Adult Assessments; Barnet Consent to Information Sharing; Adult Signature Form; Person Copy of Support Plan Letter; Review of Care and Support Plan
07/01/2019	**LBB**	**NEIL LBB** Care and Support Plan.
02/08/2019	**BEHMHT**	**NEIL BEHMHT** Waiting list letter sent stating 'We are aware that you are currently waiting for a psychological intervention with the Barnet Psychology Hub. If you would like to be offered a review appointment while you are waiting, please contact the team on 0208 702 4394, and let us know if you would prefer this to be a tel. or face-to-face discussion with one of our clinicians".
11/09/2019	**GP 6**	**ALICE GP6** GP attendance for health concern described herself as in the middle of a five-year divorce that was very difficult. Says son has mental health issues which causes problems at home. She has been picking at her arms. Requested new anti-depressant.
25/09/2019	**GP 6**	**ALICE GP6** Attended for review. Feeling better, had been to court but said she handled it better. Review booked for 1 month.
02/10/2019 & 25/11/2019	**BEHMHT**	**NEIL** letter offering review appointment whilst on waiting list.
28/10/2019	**RFH**	**KB** outpatient appointment.
25/11/2019	**BEHMHT**	**NEIL BEHMHT** 2nd Waiting list letter sent stating 'We are aware that you are currently waiting for a psychological intervention with the Barnet Psychology Hub. If you would like to be offered a review appointment while you are waiting, please contact the team on 0208 702 4394'.
02/03/2020	**CLCH**	**CLCH ALICE** Tel. consultation regarding scan results and treatment required. ALICE discharged.

30/04/2020	**BEHMHT**	**NEIL BEHMHT** Letter sent regarding the Provision of Interpersonal Regulation and Emotional Regulation (IRER) group therapy stating 'I am writing to you as we are aware you have been waiting for some time for provision of psychological therapy through the Barnet Psychology Hub. As you might be aware as part of our Trust's plan to manage the COVID 19 virus, we have been advised to reduce and stop our non- urgent patients' visits. Therefore, I am writing to inform you that there will be a further delay in you being seen for psychological therapy. At present we are unable to estimate the length of the delay; however we shall endeavour to see you as soon as we can'.
04/05/2020	**BEHMHT**	**NEIL BEH** letter - delays due to Covid 19 - given crisis team details. Still on waiting list.
23/07/2020	**BEHMET**	**NEIL BEHMHT** Barnet Psychology hub – T/C to discuss group IRER. NEIL reported face to face group – will stay on list for next round. Bit better than has been at worst, feeling optimistic. No self-harm and suicidal thoughts – have moments, dark/suicidal thoughts, sleeping, no plans. Ok with email correspondence and weekly wellbeing emails.
01/10/2020 -01/2021	**GP 7**	**ALICE GP7** Tel. and F2F appointments for hip pain. Referrals made.
12/10/2020	**RFH**	**ALICE RFH** X-Ray pelvis (GP request)
26/10/2020	**BEHMHT**	**NEIL BEHMHT** opt in letter sent. Call from NEIL informing team he would still like to remain on the waiting list for Interpersonal Regulation and Emotional Regulation (IRER) group therapy.
26/10/2020	**BEHMHT**	**NEIL BEH** letter to be discharged from waiting list unless he requests to stay on it.
28/10/2020	**RFH**	**NEIL RFH** clinical drug trial for Covid vaccine.
05/11/2020	**CLCH**	**ALICE CLCH** Referral received from GP for physiotherapy for hip complaint. Clinic letter sent requesting ALICE to contact physiotherapist service for tel. consultation.
17/11/2020	**RFH**	NEIL Letter from RFH- Enrolled in Covid vaccine study.
20/11/2020	**RFH**	**NEIL RFH** clinical drug trial for Covid vaccine.
23/11/2020	**CLCH**	**ALICE CLCH** not available for Tel. consultation. Tel Appointment rearranged 14/12/2020.
24/11/2020	**CLCH**	**ALICE CLCH** Physiotherapist informed that ALICE attended clinic for face-to-face appointment as didn't realise it was via tel. ALICE contacted via phone to discuss. ALICE not available.
14/12/2020	**CLCH**	**ALICE CLCH** Tel; consultation for physiotherapy assessment. ALICE stated that she did not want physiotherapy but investigation into pain she is experiencing. Son [NEIL] came onto phone stating that his mother is unkempt, mobility limited and experiencing high pain level. Feels physiotherapy is not the way forward as mother unable to do the exercises advised. ALICE and son requested further investigation due to impact pain is having on her life.

17/12/2020	**CLCH**	**ALICE CLCH** Referral made to RFH for scan.
01/02/2021		**ALICE** Attended for Covid vaccine.
12/02/2021	**RFH**	**ALICE RFH** MRI lumbosacral spine.
01/03/2021	**GP 7**	**ALICE GP7** Tel appointment for back pain MRI results and referrals
01/05/2021	**GP 4**	**ALICE GP4** Tel appointments x 2 re: back pain requested private hospital referral. Referred.
10/05/2021	**BRHMHT**	**NEIL BEHMHT** Tel. contact with NEIL for update on waiting time for IRER. He reported feeling ok, living with the mother distressing sometimes. Happy to start psychological intervention both in group and individually. Concerned his presentation would be too complex for the make use of IRER. No self-harm, aware of Crisis Team number.
19/05/2021	**BEHMHT**	**NEIL BEHMHT** t/c to NEIL. Offered first appointment the 1st June.
21/05/2021	**BEHMHT**	**NEIL** Letter from BEH - has reached top of waiting list- appointment offered for psychology,
01/06/2021	**BEHMHT**	**NEIL BEHMHT** first therapy session. First face to face therapy session with NEIL at Springwell. NEIL arrived on time, he was appropriately dressed, made good eye contact throughout the session, appeared verbose at times, anxious and reactive. Discussed structure of therapy, length, attendance, DNA Policies and confidentiality. NEIL asked if possible to get in possession of his clinical documentation in case he wanted, explaining he is not proud of his stuff. Informed that asking for them is a right of his and explained how to find information to make a request. Discussed will be using the first sessions to make a brief assessment of his current situation and needs, NEIL was ok with that and reported his situation has changed significantly since the assessment. He managed to obtain the driving licence which has meant more freedom, independence and confidence. NEIL reported it has been difficult to live with his mother in the last 8 months, since they have moved in a new flat. NEIL reported his mother might be possibly struggling with hoarding which he related to her mother traumatic experiences. NEIL explained things are generally going better, had a major breakthrough in awareness December last year, which led to feeling liberated and in touch with his identity. We discussed what goals and expectations NEIL has got in terms of therapy. NEIL firstly asked what kind of theoretical framework therapy offered is informed by, explaining he knows different theoretical approaches since he would like to start a psychotherapy training, explaining he hopes we can be able to speak the same language. Clarified that therapy will be informed by an integrative approach. NEIL started explaining that he is a saviour and frequently finds himself in that position. Asked if he still feels that he might have problematic personality traits as he discussed during the assessment he said that he was looking for a label at that time and that now he wouldn't think about his problem in that way. NEIL explained he experiences emotional flashbacks, related to his traumatic experiences, feels himself

		being too cynical about society, having narcissistic traits, dismissing and giving little value to people. NEIL explained he would like to work with trauma with his future clients. Also, explained that having therapy as a client will be a valuable experience for the future, professionally-wise. In general, not clear what he would actually work on apart from a generic learning about him-self. We discussed his previous experiences of therapy. 1st therapy during school year with counsellor, didn't like to be asked to play and stopped. **2013**, counsellor, intervention because fear of leaving the house, stopped, counsellor not specialist in that field, he knew what he was looking for, stopped **2016**, private therapy with a clinical psychologist, 6-12 months, breakup with partner, paid by the father, therapeutic relationship didn't work, stopped (psychologist suggested pathway with network, 8 sessions, group intervention for perpetrator of DV. (good experience). Asked if there were abusive elements coming from his side in that relationship, NEIL said yes. **2019,** transpersonal psychotherapist, 6-12 months, good experience but missing what he was looking for. Discussed the fact that all therapists have been women, NEIL said there might be something about feeling threatened by men he would relate to his father, being judged, criticism. Asked if he felt threatened by me he said yes, despite me being easy going. Also, he said that he felt annoyed by me asking about previous therapies since he thought I was going to say he is not suitable for therapy.
01/06/2021	**Clementine Churchill Hospital**	**ALICE** Letter Clementine Churchill hospital seen 20/05/202 with son to discuss treatment options.
08/06/2021	**BEHMHT**	**NEIL BEHMHT** 2nd therapy session. Themes covered echo 1st therapy session.
06/2021	**East of England Ambulance Service**	**East of England Ambulance Service** Call following a mental health concern. Police on scene. Report given by the Police that the patient had walked into the street naked and had white paint on him. Deemed him to lack capacity and conveyed under Police supervision to Barnet ED for further assessment.
06/2021	**MPS**	**MPS** called to ALICE's home address following reports of a domestic incident between mother and son. On arrival, officers found NEIL in an agitated state, naked and he was covered in white paint. Paramedics were called alongside Police and due to NEIL's behaviour, he was taken to Barnet Hospital for a mental health assessment. Within the Police log, it was recorded that NEIL referred to officers present as 'Devils'. It appears that NEIL was released some time the following day (without being sectioned and discharged into the care of his mother ALICE. Records from Barnet hospital appear to show the following comments being made to hospital staff by NEIL whilst in their care. NEIL stated that he had parasites in his skull, that he was the king of the universe and that he felt unsafe and unclean hence squirting alcohol gel on himself. NEIL appears to have refused oral medication which he claimed was

		poisonous and when offered Weetabix for breakfast, he claimed that it was 'poo' before breaking the bowl, refusing to eat and claiming that he was fasting.
06/2021	**Herts Police**	**Herts Police Assault Without Injury - Common Assault.** Officers were called by neighbours to reports of screaming and shouting coming from within ALICE's address. Upon arrival officers heard shouting coming from within and then proceeded to knock. Suspect then presented at the door naked and clearly having a mental health episode. Officers managed to get Mum out of the address and upon speaking with her she has divulged her son has assaulted her by urinating upon her whilst she was in the bath and also damaged the house by throwing paint around. **Outcome - male lacked capacity and officers entered the address to restrain him and allow a capacity assessment to be conducted on him. Ambulance attended and removed his capacity. Officers removed male to the ambulance and escorted them to hospital.** Body worn captured of incident. No DASH completed at the time and was unable to be completed due to victim's murder the next day.
06/2021	**Herts Police**	**Herts Police Concern For Safety/Domestic Report.** Informant [neighbour] reported a disturbance at 06:27 ongoing for the past hour. Something being broken was heard, along with shouting and screaming 'DON'T DO IT' coming from the mother. Upon Police attendance, officers spoke to the mother (unnamed but likely ALICE) and established they'd need more units as NEIL was psychotic. NEIL came to the door naked and started pouring paint everywhere when his mother came downstairs and smashing up his own property. NEIL stated he was living in Trump Towers, was very paranoid, talked about officers being the devil and attempted to reach for officer's taser. Ambulance called by officers as NEIL was deemed not to have capacity. NEIL was placed in leg restraints and cuffs and restrained under Section 6 for paramedics and Police officer safety**. Outcome - NEIL left in care of nurses at BARNET HOSPITAL, where MPS officers were also present and would contact Herts if needed.** No offences as NEIL smashing up his own property.
06/2021	**Herts Police**	**Herts Police Possession of Class B - Cannabis.** Whilst dealing with NEIL in his home address for concerns for his mental health, officers saw two small jars of a green herbal substance on a bedside cabinet. **Seized, and** later deemed it would not proportionate or in the public interest to continue with this investigation.
06/2021	**Barnet Hospital**	**NEIL** was brought in by Police and ambulance to the emergency department in June 2021 at about 8am due to a mental health crisis. Agitated and unable to express wishes. Reviewed by the medical team and his care was handed over to the Mental

		Health Team from BEHMHT.1:1 registered mental health nurse in place - assessed by psychiatric liaison nurses - agreed admission to recovery house.
06/2021	**BEHMHT**	**NEIL BEHMHT** Access & Flow. Barnet PLN Marshall phoned requesting a Crisis House bed. Advised that there is no Crisis House bed available and to review patient with a view of going home with family member under the support of BCRHTT until a Crisis bed becomes available. Identified patient could be referred to Herts mental health service.
06/2021	**RFH**	**NEIL** A&E attendance. Seen and sent home by mental health
06/2021	**BEHMHT**	**NEIL.** Crisis Resolution Home Treatment Team (CRHTT) – Night team assessment. History: Background / Referral information: Hallucinating, delusional, agitated, talking about religion, smoked weed, lives with his mother. In A&E he urinated on the floor, kicked a nurse, NEIL reported that most of the time he feels lost and, in a trance, has to uses weed to revive himself. He reported that he quit his job because he was stressed and burnt out and his behaviour was affecting others. Psychological Intervention offered:- Under the care of the Barnet Psychology team. Mum reported that for the last few weeks he has been obsessed with spiritual and religious beliefs, reading up on Philosopher Paul Young and acting his concepts, he recently converted to a vegetarian, talking about saving the world. Forensic history: Nil Medication: Nil PRN: lorazepam. MSE: Casually dressed slim young man, polite, cooperative, coherent, forthcoming with information. Stated feeling generally better now. Spoke about been subjected to abusive and traumatic experience at different times and his tendency to lash out and getting aggressive both physically and verbally. No death wishes or suicidal ideation.no psychotic features. Attention and concentration are within normal range, adequate insight. Calmed and settled behaviour and engaged well with the team. Reported fixed and persecutory delusions is always there. Presented as calmed and settled in mood. Thought disordered, flight of ideas, preoccupied with philosophical and religious beliefs. Has insight into his mental health issues. Reported poor sleeping. Good appetite, usually has two meals a day. Unemployed, supporting by his mother. Lives with his mother. Reported regular use of cannabis, wanting to stop. Was advised to self-refer to drug and alcohol service. Visual and auditory hallucinations – seeing images and flashes. NEIL was able to communicate, weigh, retain and understand information given to him regarding the safety plan and agreed to be discharged to his mother's address. Risk to self: medium at the time he was assessed. Risk to others: reported having arguments with his mother but not always. No Risk from others. Diagnosis substance related mood and behavioural disorder, on

		the background of underlying adjustment disorder with mixed disturbance of emotions. NEIL has agreed to be discharged home under the care of Hertfordshire HTT Telephone call made to ALICE, NEIL's mother who has agreed with the plan and happy to receive him.
06/2021	**BEHMHT**	**NEIL BEHMHT** Night Access & Flow Bed Coordinator / Night Manager. Informed by NCRHTT staff J that patient has been reviewed in A&E Dept and discharged back home and he will be referred to Herts CATT for follow up. Barnet Liaison Nurse informed. Name taken off admission board.
06/2021	**Barnet Hospital**	**NEIL Barnet Hospital** assessed by psychiatric liaison - no crisis bed available - discharged home with community crisis team follow-up - mother in agreement.
06/2021	**BEHMHT**	**NEIL BEHMHT** Barnet Psychiatric Liaison Team. Telephone call received from bed manager to advise that patient had been reviewed by the night crisis team in Barnet A&E. They have agreed to discharge patient home with the crisis team in Herts. Night crisis team will contact Herts crisis team to refer patient. No further role for psychiatric liaison.
06/2021	**Crisis Resolution Home Treatment Team (CRHTT)**	**NEIL.** Referral screened as no contact had been possible with NEIL. Notes highlight that NEIL has history of aggression towards his ex-girlfriend and new partner, he also assaulted a nurse at Barnet A&E before being assessed. It was reported that NEIL presented as psychotic, thought disordered with paranoid and delusional ideas and fixated on religious beliefs. It was reported that NEIL had capacity to understand the assessment and treatment plan. Risk assessment indicates " No evidence of risk". Felt following screening that NEIL presents with high risks of harming others and that it was not safe to attend his home address to assess, so the decision was made to assess at Civic Centre the next day.
06/2021	**HPFT**	**HPFT** Telephone call attempted several times to both NEIL and his mother about SW CRHTT plan to assess but without success. No contact could be made by phone so TEXT messages were sent to both NEIL and his mum to inform of SW CRHTT Assessment Plan.
06/2021	**HPFT**	**HPFT CRHTT** Telephone call from Barnet MHLT reporting that NEIL has been seen due to his spiritual and religious beliefs. He was reported as presenting as thought disordered with flight of ideas. Referred to HPFT SW CRHTT.
06/2021	**HPFT**	**HPFT CRHTT** attempted telephone call to NEIL but no response (exact time of call not recorded). Purpose to make an appointment for assessment following referral received in early hours of the morning from Barnet. Not previously known to HPFT. This service received A&E clinical notes and risk summary
06/2021	**MPS**	Called to ALICE's home address by neighbours reporting that a female had been stabbed at the location.

06/2021	**Herts Police**	There was an altercation inside the home address between the ALICE and NEIL. Police forced entry and arrested NEIL; ALICE was found lying in the prone position in the kitchen/diner. Despite medical intervention, ALICE was pronounced deceased at scene. NEIL arrested for murder and detained under s136 MHA for assessment.
06/2021	**Herts Police**	Informant reporting screaming coming from the neighbour's address Male voice could be heard believed to be occupier's son. Stated there was smoke coming out of the address from a possible fire in the kitchen. A neighbour spoke to ALICE at the window where the smoke was coming from, where she stated she had been stabbed and that NEIL had set fire to something in the address**. All 3 emergency services were called to the address.** Officers forced entry to the address where they found ALICE stabbed on the floor and NEIL trying to kill the dog. NEIL detained. Outcome - ALICE declared deceased at 1.42pm by a doctor.
06/2021	**East of England Ambulance Service**	**East of England Ambulance** 999 Call - Coded Stabbing. RRV on scene. CPR carried out by Police on ambulance crews' arrival.
06/2021	**Herts Police**	**Herts Police Detainee: NEIL.** Circumstances: Police responded to a call at address from a neighbour due to seeing smoke from the address and hearing screaming from inside. Upon arrival, suspect refused to engage. Police forced entry to protect life and limb. Police found ALICE stabbed on the floor. Suspect was detained and handcuffed. NEIL was not fit to be interviewed as he required a medical assessment. He was assessed at his cell NEIL did not appear to remember stabbing his mother or setting fire to the address. Section 136 Mental Health Act (MHA) recommended. **NEIL was detained under s136 MHA at 5.57pm**
06/2021	**SHPFT**	**SHPFT street Triage** received Police request for information re: diagnosis and risk, which was facilitated. Informed that Neighbour had called Police as could hear screaming and shouting. Police attended, a female had been stabbed and a fire had been set within the address. NEIL had attempted to stab the family dog. NEIL was arrested for murder. SW CRHTT and Clinical Lead both informed.
06/2021	**ENHT**	**ENHT NEIL** was brought into the emergency department under Section 136. Noted he had committed a serious offence but not detailed what. NEIL was seen by the mental health team and he was discharged back to custodial services. Noted to have a personality disorder, anxiety and depression. HPFT mental health team based at Lister ED conducted an assessment.
06/2021	**HPFT**	**HPFT** T/C from Street Triage informing SWCRHTT re: incident and arrest. PLAN to await further feedback from Street Triage.
06/2021	**HPFT**	**HPFT** On call Clinical Lead informed of incident by street triage. Advised completion of Datix and informed 2nd on call.

06/2021	**HPFT**	**HPFT NEIL** seen at Hatfield Police station whilst being detained on allegation of murder. Custody suite had requested review due to gravity of offence. Mental state examination notes NEIL to be suspicious and guarded with some delayed response. Initially he seemed to be ok until asked about his mental state and what happened today. He claimed to not remember what ever happened today. Could not remember stabbing mum, setting fire to address or attempt to strangle dog. He could not remember how he got to be in Barnett A&E or other circumstances why he was given some medication. He has denied hearing voices but on observation, seems distracted and at times was closing eyes at though in a prayer, so was felt to be hiding symptoms. Recommendation made for s136 referral for MHA Assessment.
06/2021	**HPFT**	**HPFT** At shift handover by the Police Triage team at the Police Headquarters in Welwyn Garden City, request for the Police triage team to see NEIL in custody at Hatfield Police station. NEIL was assessed by Street Triage. On assessment NEIL was dressed in a custody tracksuit and was sitting on his bed space. He was calm and he was asked about the events of today. He said that "it was all a blur" and he had no recollection of what had happened. He remembered a window being smashed and he asked the paramedic "is it normal to have a seizure. He asked to see a solicitor and about his rights. assessment concluded and recommendation for Section 136 confirmed.
06/2021	**HPFT**	**HPFT** T/C received from the Police control room, reported that NEIL relapsed in mental state, believed he is the king of the universe, stated he had parasites all over his body and cover his body with alcohol gel, complain of not feeling safe. He has been detained under s136. No capacity at s136 suite so advised to remain in custody pending update to plan.
06/2021	**HPFT**	**HPFT AMHP** report added to records. Notes that initial plan had been for Assessment by day team the following day under 136. However, 136 was subsequently discharged by on call doctor who stated no acute mental illness at time of his triage following transfer back to custody suite in early hours. Following review of notes, AMHP felt that 136 should not have been discharged without AMHP review so also reviewed NEIL and agreed that forensic route would be most appropriate option.
06/2021	**HPFT**	**HPFT** T/C made to Oscar 1 following Call received from s136 suite reporting that NEIL has been taken from custody in Hatfield to Lister A&E to be seen. It was felt that he should have remained within custody in light of his crime and past assault of a nurse within Barnet A&E yesterday. He is under arrest for murder of his mother, he also had attempted to stab the dog and set fire to the property. Custody Suite advised that medical staff in Custody and made the decision that he would be better placed in A&E. Handcuffed to officers. Explained that the stay in A&E will be lengthy as beds nationally are not available and that NEIL poses a risk to members of the public, NHS staff, officers and himself. Informed that NEIL is currently calm, but if he becomes

		agitated more officers will be deployed, and if unable to manage him in the department that he will be returned to custody. 2nd on call manager updated. Discussed with AMHP on duty who advised that assessment would need to wait for daytime as information needed to be properly collated and discussed.
06/2021	**HPFT**	**HPFT** Discussed with 2nd on call registrar who agreed to discuss with gatekeeping consultant and then call back. 0015: Received phone call from 2nd on Call asking for on call doctor to have a discussion with gatekeeping consultant.
06/2021	**HPFT**	**HPFT** s136 Triage by 1st on call doctor. Presented with evidence of acute psychotic episode with thought insertion, thought withdrawal, paranoia. Evidence of physical harm which involved murdering his mother today to 'cleanse her spirit'. Does not have any insight into his condition. Mentally very unwell and unstable. Very high risk to both self and others.
06/2021	**ASS - Herts**	**ASS** Approved Mental Health Practitioner interviewed NEIL in the Stevenage Police Station custody suite at 6.20am.NEIL had already been discharged from s136 for consideration via the criminal justice route.
06/2021	**HPFT**	**HPFT** Telephone call with Barnet MHLT. Informed that NEIL was seen in A&E at Barnet, he was medically cleared. He was then seen by MHLT who referred to crisis team. NEIL was discharged from Barnet A&E for plan to be managed in community. On call gatekeeping consultant updated with information from Barnet MHLT. Lister A&E staff and Police officer at Lister ED informed re: plan for discharge back to custody and for forensic route to be taken. S136 nurse updated at 01:30.
06/2021	**HPFT**	**HPFT** Telephone call with on call gatekeeping consultant. Agreed that NEIL is too high risk to both self and others and has committed a serious crime (murder) to be admitted to any of HPFT units at present, and too high risk to stay in ED. For patient to be sent back to custody, and for forensic team involvement. Police officers and Lister ED to be updated with plan.

2. Overview

2.1 Hertfordshire Constabulary (Herts Police)

2.1.1 Before June 2021, Herts Police had no previous contact with either the victim or the perpetrator in this case.

2.1.2 There is a Herts Police record of a domestic dispute on 13 August 2002 involving Alice and her former husband Jonas whilst they were residing in London.

2.1.3 Further to the Herts Police information previously presented regarding June 2021 their IMR depicts that the attending Police Officers used the National Decision Model guidance to gather as much information to assess the threat and risk posed by Neil. On the day before the tragic homicide, the Officer identified the safest way to enter and restrain Neil under Section 6 MCA to enable an assessment to be undertaken by paramedics.[5]

2.1.4 The Police gained entry and Neil was located upstairs in his bedroom where he was found lying on his bed naked in darkness. He was shouting that he was God and using expletives including sexualised language whilst talking about killing 'Bogarts'.[6] Within seconds Neil informed the officer that he loved him and continued to shout about God. Neil was then safely handcuffed and restrained by Police.

2.1.5 Neil was deemed not to have mental capacity by the paramedics, detained, placed into an ambulance and transported under Police escort.

2.1.6 Herts Police have since assessed that the Police Officer's action was in accordance with their Organisational Procedure and the MCA. The Police Officer concerned has recently received training in relation to the MCA and related legislation concerning Police powers. At the time, the Police Officer had identified that the MCA was the appropriate way of safely and lawfully getting Neil the help he required. The DHR Reviewers were advised that MCA training was delivered to officers between May 2021 and August 2021, and new recruits receive an input during their initial training.

2.1.7 Neil was conveyed to Barnet Hospital where he arrived at 7.56am. At 9.09am the officers left him in the care of nurses. Herts Police advise that there was no further contact with Neil or nurses from mental health and therefore Police were unaware of his disposal until they arrived at his address the following day to deal with the murder.

[5] The MCA Codes of Practice provides that 'In emergencies, it will almost always be in the person's best interests to be given urgent treatment without delay'.

[6] By J.K. Rowling. Originally published on 10 August 2015. A Boggart is a shape-shifting creature that will assume the form of whatever most frightens the person who encounters it

2.1.8 The Herts Police information notes "*it would not be expected for them to be informed by the mental health department with the disposal of every patient. However, given the circumstances of Neil's admission, (causing damage, assaulting his mother and his general demeanour), part of any risk assessment before his discharge should have been to inform the Police"*. It is unknown whether any risk assessment was carried out before Neil was being placed back at the home address. Herts Police states that had they been informed of this development, they would have documented their own risk assessment, which could have included a discussion with the appropriate doctor/nurse as to Neil mental health on release, any risk he posed to himself or his mother, but also to any member of the public. The Chronology confirms that Alice agreed that Neil could return to their home address. There is also no specific policy or arrangement regarding notification to Police, or Police risk assessment following the release of individuals from mental health or other medical establishments, though there is currently a policy being drafted with HPFT in relation to "right care /right person"[7] that will include a section 136 element and this issue.[8] There is a Force Control room policy that requires all calls to service to be subject of a THRIVE risk assessment which would have included the release of the perpetrator in the case of Alice had contact been made with the Force Control Room.[9]

2.1.9 The DHR Reviewers note that the response documented in the preceding paragraph would have been an area of effective practice had the pre-discharge assessment been undertaken.

2.1.10 The Herts Police detail that Neil was a regular user of cannabis which was also found at his address. In the view of the Police contributors to the Review, cannabis

[7] Right Care, Right Person (RCRP) is a partnership between the police and health services that aims to ensure people with mental health needs receive the right care. RCRP is being rolled out across the UK to improve outcomes and reduce demand on services. The Metropolitan Police began to use this approach in November 2023.
[8] Section 136 of the Mental Health Act 1983 allows police to take someone to a place of safety if they appear to have a mental disorder and need immediate care. This can include people with dementia, autism, or other developmental disorders.
[9] College of Policing - The THRIVE (threat, harm, risk, investigation, vulnerability and engagement) definition of vulnerability. This states that a person is vulnerable if, as a result of their situation or circumstances, they are unable to take care of or protect themselves or others from harm or exploitation.

was perhaps a contributory factor to Neil's demeanour, and that they could have put some measures in place to reduce any risk posed to Alice.

2.1.11 The criminal offences committed by Neil according to Police records, included damage to the property and assault on his mother, Alice – DA crimes, as well as possession of cannabis. Alice did not apparently wish to report these crimes, given that they were committed as a consequence of Neil's mental health. Herts Police recorded these offences on the Police computer system, Athena, as per the National Recording Crime Standards.[10] The DHR Reviewers noted the absence of information to confirm whether the incident was flagged or recorded as a DA crime.

2.2 Metropolitan Police Service (MPS)

2.2.1 The MPS informed the Review through its IMR submission that there was minimal information and contact with Alice and Neil.

2.2.2 Details which were available to the MPS suggested that in 2002, Alice was married to Jonas with whom she had a child Neil and they lived in the London area. Alice moved to Hertfordshire with her son after her divorce.

2.2.3 The MPS has informed the Review of the following records:

> **13 August 2002 –** Whilst outside the scope of the Review's Terms of Reference, this entry has been rightly highlighted by the MPS. The Police were called to the London home address of Alice and her husband Jonas in response to an allegation of DA. It is unclear who called the Police. Upon Police arrival, it appeared that Alice had left the address with the couple's child (details not provided, but believed to be Neil, then aged 12 years). Jonas apparently explained that he suffered from diabetes and had low blood sugar levels, which made him extremely agitated. He explained that because of this, he had

[10] See College of Policing, Collection and Recording Authorised Professional Practice accessed via https://www.college.Police.uk/app/information-management/management-Police-information/collection-and-recording

become embroiled in an argument with Alice, however he could not remember much about what had happened. Jonas stated that he recalled lashing out at her but he was not sure if he made contact. He added that if he had made contact, he was so weak that it would not have caused Alice any harm. The DHR Reviewer's noted that Jonas' behaviour was separately confirmed by Neil when seeking support as a perpetrator of DA. In the assessment of the DHR Reviewers, Jonas' mention of his diabetes could be seen as minimisation of his actions towards Alice. His lack of personal responsibility is notable as the information available to the Panel suggested that Jonas had been abusive to Alice on previous occasions. The DHR Reviewers were unable to explore Alice's relationship with Jonas, Alice's siblings and Alice's friends due to their lack of engagement.

Police records confirm that when Alice was subsequently spoken to by the Police, she corroborated the account provided by Jonas that he was diabetic. She detailed that Jonas had not previously been violent towards her, and that on the day Jonas had not compensated his blood sugar levels by going to the gym. The London Ambulance Service (LAS) were in attendance to assist her husband when she left the house with their child. No allegations were made and the case was concluded with no further action. Research conducted at the time did not reveal any recorded history of DA between parties.

04 September 2015 - Police were called by Neil's female partner [Sarah] stating that Neil would not leave the property. On Police arrival, it transpired that Neil's partner had returned to the home she shared with Neil's family after socialising with friends from work. An argument ensued between Neil and Sarah, according to Police records, as she had apparently woken him up. During the argument, Alice entered the couple's room and separated them suggesting that Neil should leave the house for a short while to give his partner an opportunity to gather some belongings and spend the rest of the night at a local hotel. This was agreed.

Shortly after Neil had left, Sarah telephoned the Police. Upon arrival of Police Officers, no allegations were made and Sarah had no visible injuries. Neil was

not present. Sarah declined to answer any DA, Stalking, Harassment, Honour based Abuse (DASH')[11] risk assessment questions and left the property with Police. She was driven to a local hotel. Research revealed there was no intelligence to support any previously reported and recorded DA incidents between Neil and Sarah. The report was recorded as a 'non-crime' domestic incident on the Crime Report Information System (CRIS) and no further action was taken.[12]

25 January 2016 - Police were called to an incident involving an alleged assault committed by Neil against his former partner's [Sarah] current partner Harry. Neil had apparently contacted his former partner on the phone whilst she and Harry were socialising at a friend's house where an argument ensued. During the argument with Neil, Sarah passed the phone to Harry who spoke to Neil.

Following the call, Neil attended the address and knocked on the door. Harry opened the door, and fearing that he may be assaulted, punched Neil in the face as a pre-emptive strike. The two then began to fight. Upon Police arrival, Neil and Harry were both found with injuries, however neither wished to explain what had happened and no witnesses came forward to detail events. It was alleged that Neil had used a screwdriver to inflict deep lacerations to Harry's face and chest resulting in a hospital admission. By contrast, Neil sustained minor bruising to his face. Both males were arrested on suspicion of assault and refused to assist the Police with their enquiries. The case was subsequently concluded with no further action following advice from the CPS.

The MPS Reviewer has helpfully added further comment to this incident to assist this Review: *'This appeared to be a vicious and violent assault committed by Neil against his ex-partners (then) partner, which did not result in any action being taken against him. The incident was investigated and given the severity of the injury sustained to one of the males, the case was referred to the CPS*

[11] For further information relation to the DASH risk assessment model visit https://safelives.org.uk/sites/default/files/resources/Dash%20for%20IDVAs%20FINAL_0.pdf

[12] CRIS- Crime Reporting Information System.

on two occasions for charging advice, once whilst Neil was in custody and again following the completion of a CPS action plan. It appeared that in the absence of sufficient evidence, the case did not pass the evidential test as required by the 'Full Code Test' (Realistic prospect of conviction) for Crown Prosecutors and therefore could not proceed'.

02 February 2016 - Following Neil's release on bail regarding the assault in the preceding paragraph, Neil contacted Sarah via email, in breach of a bail condition that had been imposed. Neil had explained in the message that he was sorry for the incident and what had happened. The message was passed to Police via Sarah's solicitor. In the circumstances, Neil was warned by the Police about his behaviour and reminded of his bail conditions. There were no further reported breaches of bail conditions. The Police took no further regarding the original bail breach.

The MPS Reviewer has again helpfully added further comment to this incident to assist this Review: '*The MPS IMR author assessed that the action taken in response to the incident was proportionate. Notwithstanding the seriousness of the weapons enabled serious assault, the MPS IMR author opines that it would have been unlikely that Neil would have been convicted for this offence even if he had been charged, taking into account all of the information available'*.

2.3 GP Alice

2.3.1 Alice was a registered patient at a GP Practice located in London, which is supported by IRIS (Identification and Referral to Improve Safety).[13] On her move to Hertsmere she remained with this Practice.

2.3.2 The GP Practice's records are informative. The IMR documents interactions with Alice when she clearly expressing suffering from the impacts of DA. The GP had identified the signs of a *"power / control dynamic towards Alice from both her son and ex-husband*." Alice describes abusive behaviour on several occasions during GP

[13] For more information on IRIS visit https://irisi.org

consultations – verbal abuse, coercion, and control. Alice also details avoiding friends and isolation as a direct result of her abusive home situation. The DHR Reviewers found this to be consistent with the information before the Panel. Alice had one best friend Joe who has refused to engage with the DHR process. During consultations Alice asked for help for Neil. The specific nature of the support requested for Neil is not detailed, however, Neil's mental health is a recurring theme in professional interactions with Alice detailed elsewhere in this Report. The DHR Reviewers noted the absence of a record detailing the support suggested by the GP and is a learning point for this Review. Alice, in the view of the DHR Reviewers, recognised her son's needs and sought help whilst not addressing her own needs, particularly the emerging depression resulting from her role as carer.

2.3.3 Further to the preceding paragraph the GP Practice notes the following:

> 3/9/2015 - Alice reported difficulties living with her son – Neil. *"She says living with his outbursts difficult but def [definitely] no fear for her safety and she is not stressed / depressed by caring for him".*
>
> 20/1/2016 - Alice reports abusive behaviour from son – verbal. *" Husband also equally abusive over many years of marriage"*. [Alice] *"Described feeling controlled and feeling useless. Hides her feelings from son and friends. Felt ashamed."* The DHR Reviewers noted the absence of a referral to DA Services by the GP following Alice's disclosure of her experience of abuse from her former husband and son. This is all the more notable as the London GP Practice attended by Alice is supported by the IRIS programme.

2.3.4 Alice commenced medication for depression and was also referred to Improving Access to Psychological Therapies **(**IAPT) on 20 January 2016 for psychological support. She was also subsequently referred to the Network. There were 2 further consultations with the same GP, where it is recorded "*things more settled*".

- 16/07/18 - GP consultation "*levels of unpleasantness at home*" *"no physical violence – door slamming and shouting".* Mother "*does not feel*

in physical danger but feels scared". In the DHR Reviewers' opinion these comments are of note and not detailed in the Chronology.

- 17/07/2018 – Alice's home situation was apparently discussed as well as safeguarding concerns. [The] *"patient becomes tearful… Discussed keeping her safe – she does not feel in danger but difficult living circumstances."* A review appointment was to be set for 1 month later. Alice was offered the services of the well-being hub, which were declined at that time. The Consolidated Chronology reveals that Alice said she had problems with son and ex-husband over their house and experienced verbal aggression, but no physical aggression. Alice asked for help for her son, but she felt there was nothing else the GP could do. In the DHR Reviewers view, the GP surgery had a responsibility to suggest avenues of support or referral pathways for Alice.

- 11/9/2018 - Alice attended the Practice and reported an incident relating to Neil, in which he was verbally and physically abusive. It seems that the GP advised calling the Police if she felt her safety is at risk. The 11/9/2018 GP consultation states *"son has mental health issues which is also causing a strain at home*". It was documented Alice was physically assaulted by her son Neil. Alice attended the GP Practice after being pushed by her son a week before. *"he had been upset by her drinking".* The DHR Reviewers noted the absence of support provided to Alice to identify the root cause of her relationship with alcohol. Alice informed the GP that she had tripped over a ball and hit the floor. Her son said she had been unconscious for a few minutes and had told him not to call an ambulance. There was a discussion about her concerns over her son's mental health as well as the option of calling the Police if she feels at risk. The DHR Reviewers noted the GP's limited approach to the management of the risks that Alice was exposed to by advising her to call the Police if she felt at risk, rather than determining that she was at risk and required support.

- 17/9/2018 - Describes aggressive language from son, also *"throws things\ destructive*". Alice describes avoiding friends as a result of difficulties. [Alice] Asking for help for son. The information provided by the GP Practice identifies that the GP assessing Alice on this day is unsure what can be done to help and support Alice aside from getting support for Neil.

2.3.5 Alice mentioned difficulties with Neil once again during consultations on 14 February 2019 and 11 September 2019 but there is an absence of documented discussions regarding referrals to other agencies / support services or safeguarding. The GP failed to identify the patterns of DA and the potential for this behaviour to escalate. The DHR Reviewers noted that whilst the GP is part of the IRIS programme, there was no evidence that there was a referral to the IRIS programme with the clear evidence of DA. This was a missed opportunity and is an area for improvement.

2.4 GP Neil

2.4.1 Neil was registered at the same Practice as Alice. On 17 February 2016 a GP consultation took place and Neil reported being arrested on suspicion of Grievous Bodily Harm. The notes state that there is a history of domestic violence (DV). Neil reported attending a DV support group for perpetrators, regarding a former partner [Sarah] and her new partner [Harry].

2.4.2 According to the GP information, Neil was referred to a mental health team in March 2016. There was a subsequent follow up letter requesting an urgent assessment due to safeguarding concerns raised at home. The GP Practice, it is noted, was contacted by social services due to reports of verbal / physical abuse towards the mother by Neil.

2.4.3 The GP records reveal that on 19 June 2018 a consultation took place with Alice detailing *"Mother bears brunt of difficulties – he [Neil] describes throwing a boot at her".* The GP's notes also state "mother protects him". The DHR Reviewers concluded that the GP's use of victim blaming language may have affected decision-making regarding further action to support Alice. With regard to the adult/child parent

abuse, the Panel found Alice's behaviour to be consistent with the position of a parent experiencing DA who fears that reporting such abuse would result in repercussions towards their child placing the parent in a difficult position, and this remains a key theme of this Review. The DHR Reviewers were advised that there is no Adult Social Care Policy in relation to reports of verbal/physical abuse from adult children towards parents. This is an area of development.

2.4.4 Records shows that Neil was referred to the mental health team again in June 2018. Neil was then under the care of the East Herts locality team and a psychologist. The GP's notes suggest Neil was actively requesting referrals to the mental health team and willing to engage.

2.4.5 There is additional learning for the GP practice regarding the maintenance of staff attendance at IRIS training.

2.5 Barnet Enfield and Haringey (BEH) Mental Health Trust

2.5.1 The Barnet Enfield and Haringey (BEH) Mental Health Trust (BEHMHT) information provided to the Panel details contact with both the perpetrator, Neil and victim Alice since 2016.

2.5.2 On 3 March 2016, according to BEHMHT records, a GP referral was received for Neil. The referral detailed concerns relating to management of Neil's anxiety disorder and the question of a borderline personality disorder. The referral recorded states '*Neil is attending a support group for DV and that he is on bail for GBH after assault on his old partner's (Sarah) and her new partner (Harry)*'. The DHR Reviewers noted that the Solace IMR referred to later in this Report indicates that Neil self-referred to the DVPP in November 2015, commencing in January 2016. The Consolidated Chronology suggests that he later lost interest.

2.5.3 Shortly after the initial referral for Neil, Alice was referred on 19 March 2016 to BEH MHT by the IAPT Service. Alice presented to IAPT with symptoms of severe depression according to records. The information submitted highlights that Alice had a complex history and very traumatic experiences, yet she received no treatment or

help throughout the years. The DHR Reviewers noted the ACEs that Alice experienced coupled with the lack of ongoing support to address the associated trauma, and the experience of DA at the hands of Jonas and her son Neil, contributed to Alice's complex needs. As a victim of DA she sought to protect her son before herself.

2.5.4 Neil had been known to BEHMHT services since March 2016 following a referral from his GP to the Barnet Referral HUB in BEHMHT. The GP referral highlighted long standing difficulties with anxiety (Generalised Anxiety Disorder) since 2013 for which he was taking prescribed medication (selective serotonin reuptake inhibitors (SSRI) and benzodiazepine) and regularly attending private psychological therapy sessions. The DHR Reviewers noted the difficulty associated with access to private treatment notes which are not readily available to the NHS service providers including GPs. It is unclear if the private clinicians provided information to the NHS providers. The absence of this information in the Consolidated Chronology is apparent. This is an area of development for this Review.

2.5.5 On 7 April 2016 the Barnet Assessment Service received a further letter from the GP requesting Neil's appointment is prioritised because a Safeguarding Alert had been submitted by IAPT (which at that time was not part of BEHMHT) regarding violence toward his mother (Alice). BEHMHT's information identifies that the alert had been reviewed, but no safeguarding concerns were noted that required addressing. Neil and Alice had been unaware of the Safeguarding Adult referral according to records, and both disagreed with mental health services that it had been a necessary step. The DHR Reviewers concluded that this is an area of development. The need for a coordinated enquiry/response to undertake an assessment of ongoing risk is apparent as parental carers can often be overlooked. The DHR Reviewers concluded that the Think Family approach is key here is assessing the impact on Alice of Neil's treatment. Professionals need to look beyond the patient and assess the risk to other members of the household.

2.5.6 In May 2016 Neil was assessed by the consultant psychiatrist in the Barnet East Locality Team. During consultation Neil shared information about his background history including that he had been assessed at the Tavistock Hospital at the age of 8 years, which Neil thought had been linked to problems with separation anxiety and

school avoidance. The Panel did not have access to any information from the Tavistock Hospital. Neil also reported to the consultant that he had a history of physical violence toward his now ex-girlfriend (Sarah) who he had dated in 2015.

2.5.7 BEHMHT notes indicate that following this consultation, Neil was diagnosed by the consultant psychiatrist with a substance related mood and behavioural disorder with the background of underlying adjustment disorder. Neil was assessed as a low risk to himself, but a risk to others and advised to commence mood stabilising medication (oral olanzapine) in addition to his existing treatment of SSRI (oral sertraline). He was also advised to continue attending his private psychological therapy sessions to address his tendency to engage in substance misuse. Neil's RiO Risk Assessment document was updated, and he was discharged from MH services. He completed a short course of Cognitive Behaviour Therapy (CBT) via IAPT.

2.5.8 In April 2016 a safeguarding referral was sent to the local authority by the IAPT. The safeguarding referral detailed concerns regarding Neil and how he was being verbally and psychologically abusive to Alice. BEHMHT's records show that there were occasions whereby Neil threw objects at Alice. The Consolidated Chronology highlights an incident in 2018 too when a boot was thrown at Alice and this is confirmed in the GP notes. Of note, the referral apparently stated that there were arguments every few days and that the IAPT counsellor advised that he was worried about Alice's safety. This safeguarding referral was not processed as Alice apparently stated that she would like the safeguarding withdrawn due to her son already having support. The DHR Reviewers noted Alice's pattern of behaviour where she would continue to protect her son Neil notwithstanding the ongoing DA that she was facing, seeking support for him over and above her own needs. REO supports this. The DA was not recognised by professionals, particularly the adult child to parent, where the parent is a carer. The DHR Reviewers considered the safeguarding mechanism within Hertfordshire and were advised that there is no specific policy of sharing information with other agencies across the partnership where adult child to parent abuse takes place. This is due to the personal nature of safeguarding to the individual which provides them with the autonomy of decision-making (subject to the MCA).

2.5.9 The BEHMHT records detail that there is no record of a referral or consideration being made / given to the DA Multi-Agency Risk Assessment Conference (MARAC) or to an IDVA.

2.5.10 On 21 April 2016 records show that Alice was assessed by the Barnet Assessment Service. She reported childhood sexual and physical abuse as well as DA in her previous marriage. Alice reported that a safeguarding referral was made for her regarding violence from her son Neil. In the assessment Alice reported that her son was having counselling around his anger and she reported that there was an improvement. Alice agreed for a referral to Network for help with her self-esteem and confidence and Sangam for counselling for her history of abuse, she was also given information on Citalopram medication on assessment, to which no changes are recommended.

2.5.11 Whilst a referral was sent to the Network for counselling around self-esteem, it is unclear if a referral was made to Sangam. The plan references 'attend counselling at Sangam', according to the BEHMHT this indicates that contact may have been made but the DHR Reviewers noted that the records do not verify that a formal referral was ever made.

2.5.12 On 3 June 2016 Alice attended her meeting in the Network, which was very short as Alice expressed the view that she no longer needed the service, as she was doing much better and her difficulties were due to personal circumstances and worry about her (then) 26-year-old son. It was reported that her son (Neil) was doing better, had a new girlfriend, was working and Alice reported that she was sorting out her personal affairs. The case was closed and the GP was informed.

2.5.13 In June 2018 Neil was re-referred to BEHMHT by his GP requesting assessment and treatment for personality disorder. The GP referral reported long standing difficulties with interpersonal difficulties and violent behaviour. Neil was living with his mother and their two dogs, but Neil had reported getting angry with animals. The DHR Reviewers noted that this was an emerging theme of his behaviour evidenced at the time of the tragic incident. The GP noted that his '*mother bears the brunt of difficulties'*. Neil had described throwing a boot at her, and that he had

destroyed property and punched walls. Neil was continuing to use cannabis on a regular basis. He had decided not to take the mood stabilising medication as advised by his doctor. Neil reported that he had stopped his SSRI treatment 3 months previously. The DHR Reviewers considered whether there are policies in place to address patient non-compliance with medication. The BEMHT has confirmed that this assessment is undertaken on a case-by-case basis. Neil received treatment in the community and would have been encouraged to take his medication. The DHR Reviewers noted that there was no exploration of Neil's cruelty towards animals and this is considered in this Report's Analysis section (link cruelty to animals to violent behaviour and where pets are members of the family).

2.5.14 The aforementioned GP referral was reviewed by the Barnet Link Working Team in June 2018. The Team apparently noted the history provided by the GP and planned for a Link worker to complete an initial review by telephone in view of Neil's risk to others; to explore safeguarding concerns due to violence to Alice; to check if Neil's GP had made an adult safeguarding referral; and to refer to Barnet East Locality Team for medical review and psychological assessment. The DHR Reviewers were concerned that there was an absence of an agency leading Neil's care. The agencies collectively sought to address their assessment of the risk that Neil posed to Alice but not in a consistent, coordinated, and collaborative manner.

2.5.15 In July 2018 Neil engaged with an initial telephone assessment with the Barnet Link Working Team, during which he shared that he had attended the DVIP as advised by his private therapist. Neil shared that he felt he was a risk to his mother, and that he had '*no control'* over his emotions at times. He declined and never attend the local support service Westminster Drug Project (WDP) stating that he had been abstinent from cannabis for a few weeks. The DHR Reviewers attempted to access the DVIP records which are no longer available and were therefore unable to explore this further. Neil's self-declaration of the risk he posed to his mother was not acted upon. The additional area for development is that of information retention in DA cases as it is well documented that victims are subjected to repeated DA before they report matters to the Police.[14]

[14] https://safelives.org.uk/about-domestic-abuse/what-is-domestic-abuse/facts-and-figures/length-of-abuse/

2.5.16 Neil was subsequently offered and engaged in talking therapies provided by The Network in Barnet to address his emotions and feelings of anger. He was also referred to the Barnet East Locality Team for medical assessment and to review his case under the care management format.

2.5.17 In August 2018 Neil was assessed in person by the Consultant Psychiatrist in the Barnet East Locality Team, the same clinician who had assessed him in May 2016. BEHMHT's records stated that Neil was recognised to be suffering with problems relating to emotional dysregulation with marked irritably and impulsive behaviour. Differential diagnosis referred to a possible underlying affective disorder, whilst also to consider emotionally unstable personality disorder. Neil's RiO Risk Assessment document was updated, with the suicidal risks and risk to others formulated as low to medium.

2.5.18 In September 2018 Neil telephoned the Barnet Psychology Hub at the advice of his private therapist. The DHR Reviewers were unable to establish how long Neil had been receiving private treatment but noted that a period of 6-12 months was detailed for this therapy. The BEHMHT has confirmed that the detailed access to the notes is not available. However, Neil's account is recorded that he had an argument earlier that week with Alice and had pushed her to the floor resulting in her hitting her head and losing consciousness for a few minutes. Neil stated that he called and later cancelled an ambulance at Alice's request. Telephone contact was made with Neil's mother by a BEHMHT psychologist who then spoke to Alice on the phone. It was documented that Alice apparently appeared to minimise the extent of the DV incident. It is unclear if this conversation took place in the presence of Neil which could have resulted in Alice's response. The cancellation of the ambulance where a head injury has taken place is noteworthy. Matters relating to adult safeguarding were not raised by the treating team and the DHR Reviewers considered this as an area of development. The minimizing of DA in a mother/son relationship can be linked to the mother's desire to prevent the arrest of their child as detailed elsewhere in this Report. Additionally the degree of control exercised by Neil of this incident is apparent.

2.5.19 A telephone call was made to the Safeguarding team in Barnet local authority to follow up on the safeguarding referral . Barnet local authority reported that a home visit was carried out by social care staff and that the case was closed due to the finding of the home assessment.

2.5.20 Neil engaged with a course of 6 one-to-one sessions with The Network throughout September to November 2018, following which he was identified as being suitable for longer-term psychological treatment and was referred to the Barnet Psychology Hub in mid-November 2018. His first appointment date offered was for January 2019. Neil attended for two psychology assessment sessions in January and February 2019 and agreed for referral to the Interpersonal Relationship and Emotional Regulation (IRER) Group led by the Barnet Psychology Hub. Neil's RiO Risk Assessment document was updated following two appointments. The risk assessment recorded in 2018/19 is low for the overall score.

2.5.21 Neil remained on the waiting list until the outbreak of Covid-19 (March 2020); at which point he was informed in April 2020 that his psychological treatment with IRER would be delayed. Neil was contacted in April 2020 by mental health services requesting him to make contact about how he wished to proceed with engagement with psychological services. During telephone contact with Barnet Psychology Hub in July 2020 he requested his preference to wait for face-to-face contacts rather than proceed with telephone psychology consultations. He agreed to engage with weekly email '*wellbeing checks'* with Barnet Psychology Hub. In October 2020 Neil emailed confirming he wished to remain on the waiting list.

2.5.22 Barnet Psychology Hub made telephone contact with Neil on 10 May 2021 to discuss the waiting list timeframe according to records. Neil reported feeling ok, but that he found living with mother distressing sometimes. There was no further exploration of this noted by the BEHMHT. There is no indication given at the time regarding the timeframe for prioritisation of appointments. BEHMHT patients were RAG rated in terms of prioritisation.

2.5.23 Records reveal that Neil attended his first one-to-one psychology session with Barnet Psychology Hub on 1 June 2021 and again on 8 June 2021. During the second

session he shared with the therapist that '*he used to experience outbursts of anger in which he would become physically aggressive, putting his hands around his mother's or ex-partner's neck, then escalating the degree of aggression and violence'*. This appointment was the last contact with BEHMHT prior to Neil presenting to Barnet ED two days before the tragic incident. The DHR Reviewers considered the high-risk indicator of strangulation in DA and were concerned that Neil's admission 12 days prior to the tragic domestic homicide of strangulation towards his mother was not escalated.

2.5.24 Neil was taken to Barnet General Hospital Emergency Department via East of England Ambulance Service and Police after his mother had called them on the morning of 19 June 2021 due to Neil's aggressive behaviour at the family home. This in the view of the DHR Reviewers, demonstrated the escalation in risk towards Alice. The fact that she called the Police and sought an intervention was indicative of the threat and risk she was experiencing.

2.5.25 The BEHMHT's information highlights that Neil was assessed by the Barnet Psychiatric Liaison Team (BPLT), and a referral recommendation for admission to a BEHMHT Crisis Prevention House was made. Following that referral, Barnet Crisis Resolution and Home Treatment Team (BCRHTT) accepted Neil for admission to Crisis Prevention House, however there were no beds immediately available.

2.5.26 After a prolonged wait in Emergency Department (ED), according to BEHMHT, the Night Crisis Resolution Home Treatment Team (NCRHTT) Senior Nurse assessed Neil in the early hours in June 2021 in the ED. This was at the request of the BEHMHT Access and Flow Bed Management Team. Neil was deemed suitable to be discharged to his home address where he lived with his mother, with a referral to the Hertfordshire Crisis Assessment and Treatment Team (HCATT) for community follow-up to take place later that day. Neil was discharged from the Barnet Hospital ED at 1.43am and transport arrived at approximately 4.00am. The DHR Reviewers noted that Neil was discharged due to the lack of beds and was risk assessed as medium at the time. The plan was to discharge him home with support from Barnet/Herts CRISIS Team. It is noteworthy that other professionals deemed Neil to be a risk earlier and would not meet him at his address, yet he was deemed suitable for discharge to stay with Alice,

his mother and carer, who had been subjected to recent DA. The Consolidated Chronology confirms that Alice consented to Neil's return home notwithstanding her concerns the day before.

2.5.27 On the date of the tragic incident, the Hertfordshire Crisis Assessment and Treatment Team contacted the Barnet Psychiatric Liaison Team and informed them that Neil had allegedly stabbed his mother earlier in the day, set fire to his home, and injured the dog. Neil had been taken into Police custody.

2.5.28 BEHMHT's notes state that the 72 Hour post incident report from South West Crisis Resolution and Home Treatment Team (Hertfordshire Crisis Team), indicated that Neil may have used helium canisters and potentially other substances after leaving Barnet ED. Southwest CRISIS resolution are the source of this information.

2.6 Central London Community Healthcare (CLCH) NHS Trust[15]

2.6.1 Alice was known to CLCH Adult Community Services (Barnet division) from July 2017 until Jun 2021 according to their records. Alice was under the care of CLCH Musculoskeletal and Physiotherapy Services and over this time had a total of four relevant contacts; one face-to-face and 3 by telephone latterly as a result of COVID-19 public health restrictions.

2.6.2 The CLCH records reveals that the face-to-face session took place at the clinic in 2017 following a GP referral made on 10 July 2017 relating to a hand and elbow complaint. The remaining 3 contacts took place by phone following a second referral from the GP for leg and hip complaint. The DHR Reviewers noted the absence of information detailing how these injuries came about, and whether such enquiries were made. This is relevant in light of the DA history, and is it unclear if the treating clinicians were cognisant of potential risk associated with DA.

2.6.3 The CLCH highlight the telephone call of 14 December 2020. It was recorded that Alice's son came onto the telephone voicing concerns about her presentation,

[15] CLCH became the provider for West Hertfordshire Community services in 2019. However the MSK and physiotherapy used by ALICE were in the Barnet Locality which were well established in CLCH

mobility and the impact pain was having on her life. Neil apparently stated that Alice didn't want physiotherapy but wanted an investigation. Alice was referred to a local hospital for further investigations. The CLCH recognise that it is unclear whether further attempts were made to contact Alice to speak to her alone. Whilst CLCH may not have known about the DA between Neil and Alice, the DHR Reviewers noted that Alice's GP would have had an overview of her healthcare including her home circumstances.

2.7 Royal Free London (RFL) NHS Foundation Trust

2.7.1 Both Alice and Neil had minimal involvement with the RFL.

2.7.2 Alice attended appointments as an outpatient for respiratory and hepatology related health concerns on five occasions between 17 November 2015 and 28 October 2019.

2.7.3 In June 2021, Neil attended the RFL about an unrelated matter not connected to this Review.

2.7.4 In June 2021 Neil was brought to Barnet Hospital ED by the Police due to a mental health crisis. It is noted that Neil remained in the ED where he was medically reviewed and cleared. His mental health needs were assessed and managed by BEHMHT.

2.7.5 The RFL's review of the electronic patient records (EPR) for both Alice and Neil has revealed that the mental health staff had completed their entries.

2.8 East and North Hertfordshire NHS Trust (ENHT)

2.8.1 ENHT do not hold any background information relating to the Alice.

2.8.2 Neil was known to ENHT on one occasion only; that is following his arrest after the homicide. Neil was brought into the ED under section 136 MHA accompanied by the Police and was under arrest for a serious offence.

2.8.3 Neil was seen by the mental health team, (under HPFT Service) and he was discharged back to the Police at 4.00am. It was recorded in ENHT records that Neil has a background history of personality disorder, anxiety and depression.

2.8.4 ENHT Adults Safeguarding Team assisted the Panel by collating local information. An audit of the relationship profile of DA victims to their perpetrators was conducted. The audit was based on 100 consecutive cases of DA reported by service users between November 2021 – July 2022. The key findings were that 58% of the victims were female and experiencing DA in a romantic relationship, whilst 15% were male victims. 19% of the reports of DA were amongst adults who were being abused by their children, whilst a further 5% were as a result of parents abusing adult of children. This equates to 24% intrafamilial abuse.

2.9 Hertfordshire Partnership NHS Foundation Trust (HPFT)

2.9.1 The HPFT's information has identified that whilst in the ED the day before the tragic event, Neil was presenting as experiencing hallucinations, delusional and agitated, reporting that he has been smoking weed as well as an unknown man-made substance. He was observed to urinate on the floor in the ED, had kicked a nurse and subsequently remained with a 1:1 registered mental health nurse (RMN) escort together with hospital security. To manage his agitation Neil was given 2.5mg Haloperidol as well as a dose of IM Lorazepam for him to be assessed more thoroughly.

2.9.2 Upon further assessment around 1.00pm the same day according to records, Neil reported he was '*king of the universe'*, feeling that he had parasites in his skull and felt unclean, at which point he squirted alcohol gel on himself and also at the RMN escorting him. He believed he was being poisoned, seeing images flying around him and felt these were very unusual experiences. He reported to be fasting and feeling that he needed to get knowledge to survive; with his speech content focusing on being a saviour and being of religious connotation.

2.9.3 It was noted that the Barnet MHLT continued to liaise to identify a bed space at the Crisis House, and at around 2.00am on the day of the tragic homicide a request

was made to review Neil with a view to being supported by the Barnet Crisis Resolution and Home Treatment Team. Neil was re-assessed and although much of the content of the assessment remained as detailed above according to HPFT, it is recorded that Neil was cooperative, coherent, calmer and generally more settled.

2.9.4 The HPFT's records detail that Neil demonstrated insight. A referral was made to the HPFT Night CRHTT around 4.00am to inform them that Neil would be going home and in need of support. The IMR notes that an e-mail was received with the assessment details, progress notes and risk assessment by HPFT Night CRHTT at about 5.22am. This was subsequently forwarded onto the HPFT South West CRHTT to follow up during the day time.

2.9.5 Due to the level of risk identified by HPFT a plan was made for Neil to be seen at the office rather than a home visit according to records. A follow up telephone call was made to Neil to make an appointment but there was no response. The team then contacted the BEHMHT Liaison Team who provided Alice's contact number. Multiple attempts were made to contact Neil and his mother to arrange an appointment the day after the tragic homicide.

2.9.6 On the date of the tragic incident at 1.27pm the Police requested information from the HPFT street triage (Police liaison) team as Neil was in custody for the offence of murder. Neil was seen in custody by a clinical practitioner from the HPFT Street Triage team at 4.09pm who identified that Neil presents a risk to others and risks of further deterioration in mental health if support is not provided, therefore further assessment and support for section 136 MHA was recommended. Neil was seen again at 6.31pm by a clinical Social Worker from the street triage team who confirmed that a section 136 MHA has already been recommended.

2.9.7 At 6.43pm a charge nurse from Kingfisher Court section 136 suite (place of safety) has documented a telephone call from the Police control room. At that point there was no capacity at Kingfisher Court and due to the level of risk the Police Officer was advised to keep Neil in custody.

2.9.8 At 11.19pm records reveal Neil had been taken from Police custody to the Lister hospital ED to be seen. The clinical nurse specialist was informed that the medical staff in custody decided that ED was the best place [sic of safety] for Neil. It appears that the clinical nurse specialist disagreed with this decision. The on-call manager was contacted by the nurse who agreed that ED was inappropriate due to the risks that Neil posed to others.

2.9.9 The information provided details, that a discussion also took place with the Out of Hours Approved Mental Health Professional (AMHP) who advised that any MHA Assessment will have to wait until discussion can take place in the morning.

2.9.10 It is detailed that a subsequent decision was made that Neil was too high risk to be admitted to any HPFT Unit, too high risk to stay in the ED and that he be sent back to Police custody. The DHR Reviewers note that a number of professionals felt that Neil was high risk and posed a risk to others yet it was deemed appropriate to release him to the care of his lone mother shortly before the tragic homicide.

2.10 Solace Women's Aid (Solace)

2.10.1 The Panel had the benefit of information from Solace. Solace is a voluntary sector organisation of 46 years standing, providing specialist services for women, children and men experiencing domestic and sexual abuse and violence and other forms of GBV and harmful practices.

2.10.2 Solace services comprise of supported accommodation, community-based advice and support, therapeutic services, services for children and young people and rape crisis services. Solace provides services in 21 London Boroughs, has over 300 staff and in 2020-21 worked with over 23,416 survivors of abuse.

2.10.3 Solace was commissioned by Barnet Council to work in partnership with DVIP to offer the "partner support" element to a DVPP (DV Perpetrator Programme) within Barnet.

2.10.4 The Panel was provided with helpful information regarding the DVPP. DVPP is a programme for men who have had some history of being violent or abusive towards a partner and want support changing this behaviour. It is a group-based programme that runs for approx. 26 weeks. Each session lasts 2.5 hours. The programme is psycho-educative in approach. As such it draws upon multi-disciplinary learning from a range of sources including Dialectical Behavioural Therapy (DBT); CBT; and motivational interviewing techniques; combined with teaching from talking type therapies. Groups cover a range of different topics which are designed to challenge the use of DA and beliefs that support this behaviour, while at the same time increasing understanding, empathy, and accountability.

2.10.5 Solace advised the Panel that individuals who are linked to the perpetrator and identified as being at risk of DA such as partner, ex-partner and/or family member are offered assistance through the linked support service. This support is centred around safety planning and reducing the risk of harm but can also focus on identifying other needs for support such as homeless, substance misuse, financial, legal support and so forth.

2.10.6 Solace identify that the dual approach towards perpetrator change and offering support to the partner, is vital in terms of ensuring safety and the integrity of the programme.

2.10.7 The perpetrator programme facilitator (in this particular case DVIP) works closely with the support service (in this case Solace) and regularly discuss issues such as perpetrator attendance, disclosures of abuse and risk concerns. Confidentiality for the DVPP is limited and so perpetrators need to agree to have attendance details and disclosures of abuse shared with the link support service and other professionals if required.

2.10.8 As part of their acceptance onto DVPP attendees must acknowledgement that they are a perpetrator of DA.

2.10.9 Solace's information highlighted that Neil self-referred to DVIP in November 2015 for a place on the Barnet DVPP commencing on 4 January 2016. At referral

stage, Neil's former partner Sarah was identified as at risk and potentially requiring partner support. The self-referral is of note given that Neil must have acknowledged he is a perpetrator of DA to be accepted onto the programme. Neil said that he was no longer in a relationship with Sarah but that they were still in contact.

2.10.10 The Solace records reveals that DVIP referred Sarah to them for support on the 22 November 2015 and she was allocated a Solace IDVA linked to the DVPP contract. Records reveal that Sarah's record was open to Solace until 8 April 2016.The IDVA called Sarah on 6 occasions from 3 December 2015 - 22 January 2016 without answer. Solace reports that these attempts at contact are in line with their service standards. On 27 January 2016 the IDVA spoke to Sarah by phone, and Solace records reveal that Sarah reported *"there had been a major incident with Neil and her current partner, which had been reported to the Police ….."* Records show that Sarah said she *"felt confident to report future incidents to the Police…and would like a referral to counselling ……..".*

2.10.11 The IDVA, according to Solace, attempted telephone contact with Sarah on the 5 and 12 February 2016 and with no response. During this time Neil was still attending the DVPP and confirmed that there had been an incident with Sarah's partner and he had Police bail conditions. The IDVA spoke to Sarah on 25 February 2016 where a SafeLives DASH risk assessment was completed, which was assessed as "medium risk".[16] It was also reported that Sarah declined further updates on Neil's involvement with the programme. Solace's IMR reveal that Neil was being transferred to a DVPP in Waterloo. Solace did not cover the support element of the DVPP programme in Waterloo, so the case was subsequently closed.

2.10.12 Following Alice's death, Solace provided further support to Sarah.

2.11 Crown Prosecution Service (CPS)

2.11.1 The CPS records state that on 19 February 2016, the MPS submitted a request for pre-charge advice to the CPS in relation to offences of affray and causing grievous

[16] For further information relation to the DASH risk assessment model visit https://safelives.org.uk/sites/default/files/resources/Dash%20for%20IDVAs%20FINAL_0.pdf

bodily harm in relation to Neil is said to have taken place on 25 January 2016. At the same time, on the same file, the Police also submitted a request in relation to a man whom is referred to HS for the purpose of this report, for an offence of affray. An action plan was set by the prosecutor for the Police to seek a statement from a further witness. On 25 February 2016 the case was re-submitted, and a decision was taken by the prosecutor that the evidential stage of the Code for Crown Prosecutors was not met in respect of any offences.[17] The Panel has since been advised by the CPS that the first submission of this case was in fact 26 January 2016 where an Action Plan was set. The Police responded to the Action Plan and the case was resubmitted on 19 February 2016, and a final decision made on 25 February 2016.

2.11.2 The CPS has recounted the brief facts of the alleged offences of 25 January 2016 in its report to the Panel. Neil had been in a relationship with Sarah. That relationship ended in October 2015 and Sarah began a relationship with Harry in November of 2015. Neil could not accept the relationship with Sarah had ended and was harassing both Sarah and Harry by text messages and telephone calls. On 25 January 2016 Neil telephoned Sarah and then attended at Sarah's address. Both Sarah and Harry went to the front door and Harry punched Neil to the face. Neil then used a screwdriver to cause several lacerations to Harry. Most notably a long laceration to Harry's face, which later needed 14 stitches. The Police had been called by Harry before Neil arrived. Both men were arrested and interviewed. In interview both claimed they were acting in self-defence. Neil said that the screwdriver was on the ground outside Sarah's address.

2.11.3 Upon first submission to the CPS the Police file contained witness statements from Sarah, neighbours who did not see the assault, the record of the 999 calls and hospital notes for Harry. There was no material, according to the CPS, about Neil's mental health and it unclear if this information was ever requested or would otherwise have altered the decision. On 26 January 2016 the prosecutor asked the Police to speak to a further witness and re-submit the file. The Police resubmitted the case on

[17] CPS, Code for Crown Prosecutors, 26 October 2018 accessed via https://www.cps.gov.uk/publication/code-crown-prosecutors

19 February as they had completed the requested actions. Upon re-submission that witness had been spoken to but declined to give a statement.

2.11.4 The CPS has advised the Panel that a decision was taken on 25 February 2016 by them that the evidential stage of the Code was not met for any offences against Neil or Harry. It was noted that the pre-charge decision does not address each offence as against Neil and Harry, although in general terms the rationale for the decision appears to be that there was insufficient evidence as to who was the aggressor and that the level of force used by Neil could not sustain an argument of unlawful force.

2.11.5 It is of note the CPS has accepted that their decision could have focused more on who was the aggressor and asked the Police to explore further lines of enquiry. The CPS has noted that this may have resulted in a prosecution but acknowledge it is now difficult to assess that with any certainty. The case ought to have been expressly flagged by the Police and the CPS as a DA case. This would not however have made any difference to the evidence of the assault.

2.12 London Borough of Barnet Council (Barnet Council)

2.12.1 Records reveal that Barnet Council's Adult Social Care (ASC) had 3 contacts with Alice between March 2016 and September 2018.

2.12.2 On 18 March 2016 Barnet Council's front-door ASC team, Social Care Direct received a telephone call from a Barnet IAPT counsellor reporting concerns about Alice. He stated that Alice was a woman in her 50s and had a history of being physically and sexually abused. The counsellor advised that Alice lived with her son Neil (who was in his early 20s), and he was allegedly verbally and psychologically abusing Alice as well as throwing objects at her. The counsellor further recounted that arguments happen every few days in relation to the property where Alice lived as her former husband apparently wanted to sell the property, but her son [Neil] did not want this to happen. The counsellor advised ASC that he was worried about Alice's safety and was unsure as to whether the Police have been called out before.

2.12.3 The counsellor further advised ASC that Alice's former husband Jonas physically abused her, attributing the violence and abuse to his poorly managed

diabetes and the resulting frustration. By additional background the ASC record's also highlight that the counsellor added that Alice had been sexually abused by her stepfather many years previously.

2.12.4 The counsellor also reported that Alice had revealed that Neil had a social worker in the mental health team and a psychotherapist allocated to him. ASC reported that Neil did not have any involvement from ASC.

2.12.5 A safeguarding referral was made by the counsellor for Alice, which was received on 8 April 2016 and updated and was subsequently communicated to the Urgent Response Team (URT) for further screening.[18]

2.12.6 Records reveal that on 29 March 2016 the URT made telephone contact with BEHMHT to gather information on Neil. Records show a referral was made by a GP on 3 March 2016 for Neil who was said to be suffering a generalised anxiety disorder. At that time the case was 'sitting with the Non-Urgent Assessment Team in the mental health trust'. Neil had an appointment to be assessed on 9 May 2016.

2.12.7 On 29 April 2016 BEHMHT referred Alice to the Network for an assessment and support with self-esteem. In the referral Alice is said to have '*a history of abusive relationships, a difficult marriage and alcohol misuse'*. The referral records that Alice spent a great deal of time worrying about her son and his future and did not appear to want to address her 'own issues at this time'.

2.12.8 Alice attended her appointment with the Network on 3 June 2016. The appointment concluded with Alice informing staff that she did not need the service as she was doing '*much better'* and her difficulties were due to personal circumstances and worry about Neil.

2.12.9 On 17 February 2017 an ASC locality team worker contacted Alice to discuss safeguarding concerns according to records. It is unclear whether this was in response to the referral the year before. Alice informed them that Neil was working and the

[18] The Urgent Response Team is a Barnet Council ASC team.

situation was stable. She was going through the process of a divorce with her husband Jonas, which Alice identified may cause more friction, however she felt able to raise her concerns with the appropriate agencies if necessary. Records show that during the call, Alice stated that she didn't feel she was at risk from Neil and that she did not want the safeguarding to be pursued. This is in the view of the DHR Reviewers another example of Alice minimising the impact of abuse against her and focusing on the welfare of her adult child as mother and care.

2.12.10 On 17 September 2018 Barnet Wellbeing Hub[19] sent a new referral with concerns over an incident of physical violence from Neil taking place 2 1/2 weeks prior to the referral date, where Alice was pushed over by Neil. She fell and hurt her chin and was knocked unconscious for a short time. Neil called 999 but when Alice regained consciousness, she cancelled the call to 999 stating she was fine. The information available to the DHR Reviewers confirms however that a male made the call cancelling the ambulance.

2.12.11 Two days later, on 19 September 2018, Alice was visited at home by an Urgent Response worker. Alice apparently talked about her family life, her struggles with alcohol consumption and her son Neil being a concern. She reported that she was working towards reducing her alcohol consumption. Alice recounted that she was just divorced and was going through the motion of selling the family home and this having an impact on her wellbeing. The discussion progressed onto the day of the physical aggression from Neil. Alice disclosed that on that day she had a few glasses of wine too many with a neighbour and her speech was slurred and this infuriated Neil. He gave her a nudge and she tripped and hit her head against a dog feed tray and was slightly bruised. The DHR Reviewers noted Alice's attempt to divert attention to her drinking as opposed to the assault from Neil.

2.12.12 During the same meeting with the URT worker, Alice advised that since this incident Alice and Neil have been working towards a better relationship and better management of her alcohol consumption. Neil was also receiving therapy from the

[19] The Well-Being Hub is a VCS community mental health service focusing on self-help, recovery and wellbeing, commissioned by the CCG

mental health service. Alice advised that she didn't have any care and support needs and that she was independently mobile. The URT worker assessed that Alice was able to clearly express her wishes, and to have capacity to make decisions regarding any safeguarding concern. Alice asked for the safeguarding concerns to be closed, which it was with no further contact being made with Alice. It is unclear if the URT worker identified DA, undertook a risk assessment for DA at the point of closure and the level of risk identified. Had a high level of risk been identified it is unclear what action the URT worker would have taken.

2.13 London Ambulance Service NHS Trust (LAS)

2.13.1 The LAS review of its own records has revealed that one call was made on 30 August 2018 at 17:48 hours requesting service. An ambulance was requested to attend (an address known to the Panel). It was reported that Alice had fallen, was unresponsive, and had hit her head on the floor. In addition, it was documented that her son was on scene; although the name of her son was not recorded on the call record.

2.13.2 Of note, a further call was received 9 minutes later at 17:57 hours requesting for the ambulance to be cancelled, a male caller, whose details were not recorded, reported that the patient had recovered. Accordingly, no resources were dispatched the request for an ambulance was then cancelled.

2.13.3 No immediate action was undertaken the request for an ambulance was cancelled there was no evidence of DA or that either party had any care and support needs.

2.14 Hertsmere Borough Council (HBC) Context

2.14.1 HBC has had one DHR in the borough, but the report is pending re-submission to the Home Office and is still awaiting final outcomes.

2.14.2 Within the Hertsmere Community Safety Action Plan there is a section entitled: *Tackle DA / Increase the reporting of DA incidents and raise awareness of the service*s.

2.14.3 HBC also participates in the St Albans & Hertsmere DA Forum and has done for the last six years with the provision of the current Chair. The Forum works to an Action Plan. The meetings are held 4 times a year and includes a range of partners. In conjunction with Welwyn Hatfield DA Forum an annual conference for DA practitioners has been held annually since 2006.

2.14.4 The HCC has undertaken a Review of previous DHRs and produced an Action Plan. A key action arising is that after the final meeting of this DHR Panel, the Panel will meet without the Chair to agree actions from the recommendations. This meeting will be led by a member of the SPT. The actions will be SMART (Specific, Measurable, Achievable, Realistic and Timely) and put into an action plan. This action plan will set out who will do what, by when and what the intended outcome is with a completion date. The action plan will set out how improvements in practice and systems will be monitored and reviewed. This action plan is sent to the Home Office alongside the overview report and executive summary.

2.14.5 HCC are in the process of commissioning software called Modus to assist with DHRs. All panel members and CSPs will have logins to the system and it will be updated with all of the agreed actions. The person responsible for each action will be able to log on and update their action themselves. Everyone involved in that DHR will be able to view the actions and any updates. As the actions will be SMART, there will be a timeframe agreed at the action plan meeting as detailed above. If there has been no update on Modus by the deadline, a member of the SPT will contact the agency responsible. If the action has not been completed by the original timeframe, the agency can still provide an update as to the progress.

2.14.6 The advantage of using Modus is that it is utilised in Hertfordshire for MARACs and is widely used across the East of England region by domestic abuse agencies and therefore some DHR panel members may have an understanding on how to use it. The impact of any substantial changes from DHR actions will be monitored as part

of the Hertfordshire DA Strategy. Evaluation reports will be shared as they become available.

Covid Response

2.14.7 Hertfordshire DA Partnership developed temporary governance arrangements to ensure all agencies can coordinate the response during the Coronavirus pandemic. The 'Emergency Response Group', chaired by the Director of Children's Services & Chair of the DA Executive Board met on a weekly basis to discuss key data and information and provide strategic direction. Four subgroups reported to this including:

- **Communications group:** key communications leads from Hertfordshire County Council, Hertfordshire Constabulary and Clinical Commissioning Groups met on a weekly basis to discuss communications activity over the coming week.
- **Provider group:** representatives from frontline services providing support to victims of DA and their families met on a weekly basis to discuss current challenges, particularly in relation to service capacity.
- **Data and Monitoring group *(virtual):*** the group did not meet, but individuals provided data on a weekly basis to a coordinator who developed a data briefing each week to inform decision making at all other groups.
- **Multi Agency Risk Assessment Conference (MARAC) oversight group:** strategic leads met to discuss the MARAC system supporting high risk victims and their children.

2.14.8 A weekly bulletin that provided an overview of the key messages from the above groups is cascaded to partners, across the wider partnership.

2.14.9 The Emergency Response group agreed to promote one telephone number for victims to make contact. The Herts Independent Violence Advisory (IDVA), for a temporary period, provided a triage service where they assessed the risk of harm to victims and the commencement of safety planning. As the IDVA service work with victims at the highest risk of harm or homicide, they provided an immediate response.

Those that were assessed as standard or medium risk or have accommodation-based needs were signposted to the relevant organisations, such as Safer Places.

2.14.10 The DA Partnership developed a shared campaign to place posters promoting support options for victims in spaces accessed. The Strategic Partnerships Team worked with the national organisation Hestia on their awareness raising campaign in Boots pharmacies nationwide. Additionally, the DA Partnership worked with Safer Places to promote the local J9 community campaign.

3. Analysis

3.1 Analysis

3.1.1 The information available to this Review suggested that there were a number of missed opportunities for intervention to support Alice who was experiencing DA from her son Neil. Health professionals, particularly the GP, did not recognise Alice to be a victim of DA at the hands of Neil. There was a failure to recognise the signs, indicators and flags of DA. Additionally, the events leading up to the tragic homicide demonstrated a lack of understanding and awareness of Alice's position as mother, carer and DA victim at the hands of her son Neil. It is notable that health professionals felt unsafe in Neil's presence due to the threats and risks that he presented prior to the homicide but there appeared to be a failure to recognise the impact of the risk on Alice. Professionals relied on Alice's decision-making but this in reality was Alice's attempt to protect Neil her son as a mother and carer for him. Events escalated and the day before the homicide Alice called the Police for assistance.

3.1.2 The analysis below detail Alice's life experiences as a young person as well as the specific emerging issues for each agency.

Adverse Childhood Experiences (ACEs)

3.1.3 Alice, in the view of the DHR Reviewers experienced ACEs[20]. She was the victim of child sexual abuse and physical abuse as a child. She also experienced DA at the hands of her former husband Jonas. Neil witnessed DA towards his mother, and both Alice and Neil misused alcohol, drugs and suffered from poor mental health.

3.1.4 The DHR Reviewers considered the individual impact of ACEs on Alice. As an adult, and a mother Alice endeavoured to protect her son and sought out support services for him notwithstanding the violence and abuse perpetrated against her by him. Alice had complex needs which are borne out of her experiences as a child and young person.

3.1.5 Neil witnessed DA in his household against Alice by his father Jonas. The impact of DA on children of the family is well documented, and Neil in adult life physically abused his former partner, Sarah. He also has complex needs including poor mental health as well as alcohol and drug usage.

3.1.6 The key findings of dozens of studies using the original ACEs data are: (1) ACEs are quite common: more than two-thirds of the population report experiencing one ACE, and nearly a quarter have experienced three or more. (2) There is a powerful, persistent correlation between the more ACEs experienced and the greater the chance of poor outcomes later in life, including dramatically increased risk of heart disease, diabetes, obesity, depression, substance abuse, smoking, poor academic achievement, time out of work, and early death.[21]

3.1.7 ACEs research shows the correlation between early adversity and poor outcomes later in life as evidenced in Alice's drug and alcohol abuse. Toxic stress explains how ACEs "get under the skin" and trigger biological reactions that lead to

[20] ACEs originate in a study conducted in 1995 by the Center for Disease Control and the Kaiser Permanente health care organization in California. In that study, "ACEs" referred to three specific kinds of adversity children faced in the home environment—various forms of physical and emotional abuse, neglect, and household dysfunction.

[21] Bellis, M.A., Hughes, K., Leckenby, N. *et al.* National household survey of adverse childhood experiences and their relationship with resilience to health-harming behaviors in England. *BMC Med* **12**, 72 (2014). https://doi.org/10.1186/1741-7015-12-72

those outcomes. In the early 2000s, the National Scientific Council on the Developing Child coined the term "toxic stress" to describe extensive, scientific knowledge about the effects of excessive activation of stress response systems on a child's developing brain, as well as the immune system, metabolic regulatory systems, and cardiovascular system. Experiencing ACEs triggers all of these interacting stress response systems.

3.1.8 While trauma has many definitions, typically in psychology it refers to an experience of serious adversity or terror—or the emotional or psychological *response* to that experience. **Trauma-informed care** or services are characterized by an understanding that problematic behaviours may need to be treated as a result of the ACEs or other traumatic experiences someone has had, as opposed to addressing them as simply wilful and/or punishable actions. It is clear from the evidence available to this DHR that Alice's needs were not being met. The lack of professional curiosity in relation to her vulnerability is notable.

3.1.9 ACEs have a negative impact on a child or young person's physical and mental health affecting their life course or life expectancy.[22] The following are examples of ACEs and research has found that children or young people who have been subjected to multiple ACEs (4 or more) are more likely to be exposed to and experiencing substance use, violence, early pregnancy, incarceration and DA (Bellis et al, 2014)[23]:

- Physical abuse
- Sexual Abuse
- Emotional Abuse
- Living with someone who abused drugs
- Living with someone who abused alcohol
- Exposure to DV
- Living with someone who has gone to prison
- Living with someone with serious mental illness

[22] Hardcastle K, and Bellis M (2018)
[23] Mark A. Bellis, Helen Lowey, Nicola Leckenby, Karen Hughes, Dominic Harrison, Adverse childhood experiences: retrospective study to determine their impact on adult health behaviours and health outcomes in a UK population, *Journal of Public Health*, Volume 36, Issue 1, March 2014, Pages 81–91, https://doi.org/10.1093/pubmed/fdt038

- Losing a parent through divorce, death or abandonment

In this UK study, Bellis found that 47% of people experienced at least one ACE with 9% of the population having 4+ ACES (Bellis et al, 2014).

3.1.10 The exposure to ACEs in early childhood can lead to the following affecting children's and young people's life course[24]:

(i) Disrupted nervous, hormonal and immune development
(ii) Social, emotional and learning problems
(iii) Adopt health harming behaviours and crime
(iv) Non-communicable disease, disability, social problems and productivity

3.1.11 Notwithstanding the many impacts of ACEs, often leading to complex needs in adulthood, the DHR Reviewers' are of the view that the relevant is responsible / accountable for their offending (unless deemed otherwise) and that the impacts (as described) are mitigation to harm causing and crime.

Financial Abuse

3.1.12 The DHR Reviewers were of the view that Neil appeared to be financially dependent on Alice as his employment was not consistent. The DHR Reviewers were unable to confirm Alice's and Neil's financial position and whether there was any financial control or abuse. Alice informed health professionals that Jonas was forcing the sale of the matrimonial home on the break-up of her marriage, suggesting that she was concerned about her position. Alice was also isolated and the DHR Reviewers have been unable to establish what support she received from her immediate family. There is no mention of her siblings and stepfather in Alice's interactions with health and social care professionals.

Killing of Family Pets

3.1.13 The DHR Reviewers also considered the mistreatment and abuse of animals as a significant indicator of violence towards humans, up to and including intimate

[24] Hardcastle K, and Bellis M (2018)

partner abuse, sexual assault, rape, murder. Research confirmed that all too often mental health professionals and prosecutors miss the seriousness of any cruelty towards animals and the significant role animal cruelty plays in the perpetuation of violent and non-violent criminal behaviour.[25]

3.1.14 The literature supports that animal cruelty is one of the earliest markers for future acts of both violent and non-violent criminal behaviours. Whether animal cruelty occurs prior to or subsequent to witnessing or experiencing any type of abuse is unknown. What is known is the connections between experiencing abuse, witnessing DA, and animal cruelty. This means that the directionality of cruelty to animals is not always clear, that is, which occurs first, the negative environmental factors (abuse) or animal cruelty.[26]

3.1.15 The link between mistreatment of pets and violence is therefore well established. It is notable that the SafeLives DASH checklist also includes a question to ascertain whether any cruelty towards animals has taken place.

3.1.16 Neil had witnessed DA and was witnessed by Police on the date of the tragic homicide to strangle the family pet dog. Little is known of any previous incidents involving the family pet dog but it is clear that Neil had previously liked to work with dogs in a grooming parlour. Neil's disclosure to his GP detailed below relating to June 2018 is the only information that was available to the Panel. Neil had informed his GP that he lived with his mother and dogs, and 'gets angry at the animals' but his mother bears the brunt of his anger. As the research as detailed it is unclear whether Neil's propensity to commit violence against animals existed before he witnesses DA but is anger towards the family dogs is self-disclosed.

DA and DA Homicide

3.1.17 The DA Act 2021 (incepted on 29 April 2021) creates a statutory definition of DA, emphasising that DA is not just physical violence, but can also be emotional, controlling or coercive, and economic abuse.

[25] Johnson SA. Animal cruelty, pet abuse & violence: the missed dangerous connection. *Forensic Res Criminol Int J* . 2018;6(6):403-415. DOI: 10.15406/frcij.2018.06.00236
[26] ibid

3.1.18 Homicides are recorded to be “domestic” when the relationship between a victim aged 16 years and over and the perpetrator falls into one of the categories, which was recognised by the then cross definition of DA i.e. spouse, common-law spouse, cohabiting partner, boyfriend or girlfriend, ex-spouse, ex-cohabiting partner or ex-boyfriend or girlfriend, adulterous relationship, son, or daughter (including step and adopted relationships), parent (including step and adopted relationships), brother or sister, other relatives.

3.1.19 DA is a form of GBV/Abuse whereby women are disproportionately victimised by men who are disproportionately the perpetrators. Whilst there is data in this field, it is recognised that DA alongside other forms of GBV/abuse is both under-reported and under-recorded. There are two sources of data, which highlights part of the picture - that provided by the Police Forces in England & Wales and the Crime Survey for these countries.

3.1.20 The forty-two Police Forces in England and Wales recorded a total 845,734 DA-related crimes to year ending March 2021.[1] This represents an increase of 6% from the previous year.[27] In addition, of all crimes recorded by the police in the year ending March 2021, 18% were DA related. An increase of 3% compared to the previous year.

3.1.21 The Crime Survey for England and Wales (CSEW) latest DA estimates were to be found in its November 2020 release as the face-to-face crime survey was suspended on 17 March 2020 due to the COVID-19 pandemic. It was replaced with the Telephone-operated Crime Survey for England and Wales (TCSEW).

3.1.22 The CSEW survey highlighted that an estimated 2.3 million adults aged 16 to 74 years experienced DA in the last year (1.6 million women and 757,000 men), a slight decrease from the previous year.

[27] ONS, DA in England and Wales overview: November2020 accessed via https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/bulletins/domesticabuseinenglandandwalesoverview/november2020

This Crime Survey data represents: [28]

- an estimated 7.3% of women (1.6 million) and 3.6% of men (757,000) experienced DA in the last year
- women aged 16 to 19 years were more likely to be victims of any DA in the last year than women aged 25 years and over
- an estimated 6.5% of women aged 55 – 59 years and 4.4% of women aged 60 – 74 years experienced one or more incidents of DA in the previous 12 months.
- women were more likely to be victims of DA than men
- for partner abuse, those in the White and Mixed ethnic groups were significantly more likely to be victims than those in the Asian ethnic group.

Of the crimes recorded by the Police, 26 of the police forces recorded the following victim characteristics:[29]

- in the year ending March 2021, the victim was female in 73% of DA-related crimes. It was 74% in the previous year
- in the year ending March 2021, the proportion of female victims in the age 60 – 64 category was 43.3%, compared to 26.4% for men
- between the year ending March 2018 and March 2020, 76% of victims of domestic homicide were female, and 14% of victims of non-domestic homicide were female.

Femicide

3.1.23 The Femicide Census report published 20 February 2020 regarding UK femicides (the intentional killing on women) in 2018 details 149 women killed by 147 men in the UK in 2018, 12 women (8%) were killed by sons or step-sons.

3.1.24 Femicide has been used to describe killings of women by intimate partners and family members; it has also been used to describe gender-related killings in the community. The term femicide was introduced in the last century to describe killings

[28] ONS, DA victim characteristics, England and Wales: year ending March 2020 accessed via https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/domesticabusevictimcharacteristicsenglandandwales/yearendingmarch2020

[29] ONS, Domestic abuse victim characteristics, England and Wales: year ending March 2021 accessed via https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/domesticabusevictimcharacteristicsenglandandwales/yearendingmarch2021

of women that were gender related in order to recognise the impact of inequality and discrimination, identified internationally as a root cause of VAW.

3.1.25 Femicide has been identified globally as a leading a cause of premature death for women yet there is limited research on the issue in Europe. The Global Study on Homicide in 2011 indicated that while there has been a decrease in homicides worldwide there has been an increased in the number of femicides. In the United Kingdom, over the last ten years on average a woman is killed by her male partner or former partner every four days. Frequently these murders have been premeditated and follow a pattern of violence and abuse that terrorise the victim.

3.1.26 The calculation for “a woman is killed by her male partner or former partner every four days”.1248 women, 738 have been killed by a partner or former partner. This figure comes from the Femicide Census 2017 which comprises 1248 women from 2009 – 2017 (3287 days in total) and includes two leap years.

Matricide

3.1.27 Research from the United States has identified that most men who committed matricide had a schizophrenia diagnosis (weighted mean 72%, range 50% to 100%); other diagnoses included depression and personality disorders. This in the view of the DHR Reviewers accorded with Neil’s presentation. The research details that many men were experiencing psychosis shortly before the crime, and their acts were influenced by persecutory delusions and auditory hallucinations. Neil experienced problems with his mental health at the time of the commission of this tragic homicide and had received support from a range of services. Approximately one-quarter of sons killed their mothers, according to the research, for altruistic reasons, such as to relieve actual or perceived suffering. Nearly all men in the study were single and lived with their mothers before killing them, and many of the perpetrators' fathers were absent. The DHR Reviewers noted that Neil was single at the time of this tragic homicide and leaving at home alone with his mother. Mothers often were the only victims of their sons' violent acts. In addition to delusional beliefs, sons were motivated to kill their mothers for various reasons, including threatened separation or minor arguments (eg, over food or money). Many of these homicides took place in the home. Sharp or blunt objects were the most common weapons, but guns and strangulation/asphyxiation

also were used. Approximately one-half of the men used excessive violence; for example, 1 victim had 177 stab wounds. After the crimes, the perpetrators generally expressed remorse or relief.[30]

Domestic Homicide

3.1.28 The Vulnerability Knowledge and Practice Programme (VKPP) Domestic Homicides and Suspected Victim Suicides during the Covid-19 Pandemic 2020-2021 counted 215 deaths between 23 March 2020 and 31 March 2021.[31] The type of death was most commonly (current or ex) intimate partner homicide (49%) followed by the murder of an adult family member by an adult (18%), suspected victim suicide (18%), child death (12%), and other (3%). Overall, of the 215 victims, 73% were female.

3.1.29 Where known, over three-quarters of victims were recorded as White (76%). In total, 24% of victims where ethnicity was known were recorded as BAME14.The next largest ethnic groups were Asian/Asian British andBlack/African/Caribbean/Black British both with 10%.

3.1.30 UN Women has recorded that GBV, already a global crisis before the pandemic, has intensified since the outbreak of COVID-19.[32] Lockdowns and other mobility restrictions have left many women trapped with their abusers, isolated from social contact and support networks. Increased economic precarity has further limited many women's ability to leave abusive situations. COVID-driven economic and social instability will also heighten the risk of child marriage, female genital mutilation and human trafficking. At the same time, the pandemic has exposed women leaders to backlash, leading to threats, abuse and harassment both online and offline.

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[30] West, Sara G.; Feldsher, Mendel. "Parricide: characteristics of sons and daughters who kill their parents: schizophrenia, difficult relationship are common among adult perpetrators." The Free Library 01 November 2010. 17 August 2022 <https://www.thefreelibrary.com/Parricide: characteristics of sons and daughters who kill their...-a0259009884>.

[31] Home Office, Vulnerability Knowledge and Practice Programme (VKPP) Domestic Homicides and Suspected Victim Suicides During the Covid-19 Pandemic 2020-2021 accessed via https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1013128/Domestic_homicides_and_suspected_victim_suicides_during_the_Covid-19_Pandemic_2020-2021.pdf

[32] UN Women Report, "Measuring the shadow pandemic: Violence against women during COVID-19"

3.1.31 The new UN Women report, **"Measuring the shadow pandemic: Violence against women during COVID-19"**, based on survey data from 13 countries, shows that almost 1 in 2 women reported that they or a woman they know experienced a form of violence since the COVID-19 pandemic. Women who reported this were 1.3 times more likely to report increased mental and emotional stress than women who did not. The findings also revealed that about 1 in 4 women are feeling less safe at home while existing conflict has increased within households since the pandemic started. When women were asked why they felt unsafe at home, they cited physical abuse as one of the reasons (21 per cent). Some women specifically reported that they were hurt by other family members (21 per cent) or that other women in the household were being hurt (19 per cent). Outside their homes, women are also feeling more exposed to violence, with 40% of respondents saying they feel less safe walking around alone at night since the onset of COVID-19. About 3 in 5 women also think that sexual harassment in public spaces has got worse during COVID-19.

3.1.32 Socio-economic stressors such as financial pressure, employment, food insecurity and family relations stood out as having a significant impact not only on experiences of safety (or violence), but also on women's well-being overall. However, there is strong evidence that ending violence against women and girls is possible.

The Metropolitan Police Service (MPS)

3.1.33 It is the DHR Reviewers view that even with the benefit of hindsight, it is difficult to identify what lawful, effective and enforceable control measures could have been put into place to prevent such far-reaching consequences for Alice.

3.1.34 In respect of the MPS contact with Alice and Neil, there was no reported DA between them apart from the incident the day before the tragic homicide. The DHR Reviewers however, concluded that had a DA MARAC case conference been held regarding Neil's previous abuse of Alice as a victim of DA, this information would have been known to the Police in 2020. The DHR Reviewers identified the following high-risk factors:

- mental health

- drugs
- alcohol
- the victim's perception of danger
- depression
- coercive control
- Isolation
- strangulation

3.1.35 Whilst Alice's case may not have appeared as a visible high risk and an automatic referral to the MARAC due to the responses to 14 or more questions on the DASH referral form, a number of high-risk factors existed as highlighted above. These were all red flags, and professionals should have exercised professional judgment in referring Alice to their local DA MARAC. It is of note that a victim's consent is not required for referral to a DA MARAC. Neil had also admitted to professionals that he used a weapon – a boot – to assault his mother. His previous relationship with Sarah included strangulation, stalking, and an alleged serious assault of Sarah's new partner with a screwdriver in January 2017. Neil also breached his bail conditions for this alleged offence by contacting Sarah.

3.1.36 The MPS maintain that there was no information to suggest that Neil had mental ill health or drug misuse issues when the MPS were interacting with him nor did the officers detect such issues. There was therefore no reason for the officers to consider an adult coming to notification (ACN) referral to adult social services based on the information that they had possession of.

GP

3.1.37 Alice attended the GP and reported low mood and abusive home life with Neil. Referrals to support services/ raising safeguarding concern discussed in 2018 but Alice declined, notes suggest Alice's focus was on accessing support for her son. Alice attended the GP on 17 July 2018 regarding "stress and depression". Alice apparently described her son and herself as being 'fragile'.

3.1.38 No further discussions are documented regarding offering further support. There was no follow ups arranged after the GP consultations with Alice. In addition, there is also no specific mention of referral to specialist DA support services such SOLACE Women's Aid or to the IDVA coordinator as part of the IRIS programme, who would have met with Alice, conducted a DASH risk assessment and where necessary made a referral to a specialist support organisation. Notwithstanding, that Alice's focus was her adult son's health, Alice was exposed to repeat risk and an IRIS coordinator could have identified the high-risk nature of this DA leading to a referral to the DA MARAC. These are missed opportunities.

3.1.39 The evidence provided to the Panel by the GP suggests that there were no explicit warnings to other GP practitioners documented within the GP notes to indicate abuse. The history, therefore, according to the practice was not immediately visible to clinicians without looking back into past records which a GP may not automatically do for every consultation. This is likely to have led to missed opportunities. This is in itself a missed opportunity.

3.1.40 There are no further discussions documented regarding offering further support, or a follow up arrangement after the consultation regarding physical assault (alleged perpetrator Neil).

3.1.41 There is also no specific mention of DA support (eg SOLACE). These are potential missed opportunities.

3.1.42 Neil was referred to the mental health team in March 2016 with a subsequent letter requesting urgent assessment due to safeguarding concerns raised at home; the GP Practice was contacted by social services as there were reports of verbal / physical abuse towards his mother).

3.1.43 A subsequent referral was made to mental health team in June 2018. Neil was then under the care of the East locality team and psychologist. The entries indicate:

- 17/2/2016 GP consultation. Neil reported being arrested on suspicion of GBH. Notes state history of DV. Neil reported attending DV support group for perpetrators. This was in relation to ex-partner/ her new partner.

- 19/6/18 GP consultation. *"Mother bears brunt of difficulties – he describes throwing a boot at her*". Notes also state "*mother protects him*". The use of this language in context is also victim blaming i.e. holding Alice partially or totally responsible for the abuse that she is experiencing.

- Neil attended his GP Practice. The records note that he was asking for referral to mental health and wants advice from a "personality disorder specialist" [The] Problems still persisting. [He was] "full of angst" and that Private psychologist is prohibitively expensive. He further says "….he takes his anger out on his mother". Neil goes on to say "Sometimes hates himself and think about burden on his mother." Neil apparently reported self-medicating as he was buying diazepam/alprazolam online and stopped taking SSRI 3 months before. Neil stated that he lived with his mother and dogs and gets angry at the animals but his mother bears the brunt of his anger. He said that he has destroyed the property by punching the walls. [His] "mother protects him". It was recorded at this time that Neil was still using cannabis and was prescribed medication (Propanolol) for anxiety and was referred to the mental health link work service.

- 20/6/18 Neil was referred by his GP to BEHMHT due to interpersonal relationship/persistent violent behaviour. He revealed that he had a private psychologist and underwent a short course of CBT with IAPT. It was further noted "Has had previous episodes of fights and assaulted an ex-girlfriend's boyfriend with a screwdriver causing him permanent scarring. Also violent towards his mother and threw boot at her and she bears the brunt of his anger but mother protects him and he has never been prosecuted. His anger towards animals was mentioned together with his destruction of property. A plan was developed for the link worker to complete telephone review in view of his risk to others. The record further noted "*To explore Safeguarding concerns due to violence to mother and check if GP has made a referral for this."* It is of note that there is no record of who explicitly Neil presented a risk too.

- 16/7/18 GP consultation *"levels of unpleasantness at home"* "*no physical violence – door slamming and shouting*". Mother *"does not feel in physical danger but feels scared*". This final comment, which is a quote from Alice is very telling of her feelings of safety and the threat / risk she was exposed to from Neil. There is a perception that Alice's focusing on her son's treatment and support for him, whilst minimising her own experiences. This comment, according to the GP speaks volumes regarding her feelings.

3.1.44 The GP has highlighted that the entire staff have completed DA training through IRIS within the last year (post this tragic homicide) and discuss safeguarding cases on a weekly basis at the clinical meeting to ensure that cases of DA are handled appropriately, and all relevant support is offered. Health information material on DA is also displayed in the practice. The DHR Reviewers noted the absence of a mechanism for GPs to review their learning from cases involving DA to inform best practice and practice development.

3.1.45 This is a tragic case which highlights the complexity of an abusive home life including involving individuals with complex needs. There is clear learning for the GP practice, which they have recognised and acknowledged. It is of note that the entire staff of the GP practice have undergone DA training through the IRIS Programme within the previous 12 months. The practice's GPs discuss safeguarding cases at a weekly clinical meeting to ensure that DA cases are handled appropriately, and all relevant support is offered. Health information material relating to DA is also displayed in the practice. The DHR Reviewers noted the absence of information sharing within the GP surgery where Alice and Neil were both being treated. Both had separately disclosed the DA that was taking place by Neil towards Alice. The lack of triangulation of information by the surgery regarding the household experiences of DA is notable and had this been identified the DHR Reviewers were of the view that appropriate referrals for support could have been made.

Barnet Enfield and Haringey Mental Health Trust (BEHMHT)

3.1.46 Neil was taken to Barnet General Hospital ED via East of England Ambulance Service and Police after his mother had called them on a morning in June 2021. Neil arrived at hospital with a Police escort.

3.1.47 The historic information available to the DHR Reviewers indicates that BEHMHT were aware of previous incidence of abuse between Neil and Alice based on Neil's self-disclosure following the DA towards Alice in September 2018. Neil was asked if such behaviour had previously occurred and records show that Neil confirmed that it is not the first time, Neil detailed that he had grown up in an abusive environment with alcoholic parents and that this has made him an aggressive person especially towards [his] mother when she is drunk. The DHR Reviewers noted that Alice sought to protect her son Neil by minimising the events and reassuring the professional concerned that she would inform her GP of what taken place.

3.1.48 On 11 September 2018 Alice saw her GP, according to GP records, and disclosed the incident stating that she was pushed by Neil but tripped over a bowl and fell to the floor. Neil had been unhappy about her drinking.

3.1.49 The DHR Reviewers noted Neil's behaviour in the months before the September 2018 incident. On 16 July 2018 BEHMHT contacted Neil on the telephone for a review and records reveal:

(i) Neil declined engagement with Westminster Drugs Project as at that time he denied illicit substance use;

(ii) The case was referred to East Locality Team for discussion in the first instance due to his presentation. At that time Neil was deemed to be a risk to others and he had difficulty managing his symptoms. The mental health professional thought it would not be unreasonable to explore the possibility of psychiatric assessment and psychological review;

(iii) At this time Neil was to be referred to the Network for better management

of his symptoms, controlling his emotions and response to situations he does not find favourable, psycho-education and anger management problems.

3.1.50 The DHR Reviewers noted that the referral for psychiatric review for diagnostic assessment was with 2 staff members present due to anger issues. There was an acknowledgement by health professionals that Neil's anger was a potential area of risk for their staff. Of note whilst there was recognition that Neil posed a risk to others, it is not explicitly identified that Alice was at risk as parent and carer. Recognising the risk that Neil posed to others it is unclear what the health professionals did to manage Neil's risk of anger management problems and other mental health symptoms.

3.1.51 On 7 August 2018, as confirmed in the Chronology, Neil was seen on his own at BEHMT and stated that he still had a tendency to lash out, mainly when he feels bad about himself; he described himself being "*broken inside*" and feeling empty. The records indicate '*Neil has a preoccupation with his physical appearance and he is described as lacking in confidence and is find[ing] it difficult to express his opinion, gets sensitive, that people are laughing at him and he is unable to make relations. Neil reports that [he has] stopped cannabis use for nearly 5 weeks and has stopped using 'Skunk' gradually. He is drinking alcohol socially. Neil reports that he has no active suicidal thoughts. Neil reports that he gets outbursts of anger and irritability and finds it difficult to enjoy anything. In addition, Neil reports being threatening towards his mother (Alice) and once hit her with a boot in June [2018]. Neil states the regrets his actions, [and] did show remorse. He has apparently been abusive towards a friend*'.

3.1.52 it was unclear to the DHR Reviewers what proactive action had been taken to protect Alice following Neil's disclosures. On 11 September 2018 Neil called BEMHT to report that he saw his private therapist yesterday (10 September 2018), where he disclosed an incident and was advised to inform the team. The DHR Reviewers have not had sight of any private records indicating that the private therapist disclosed or escalated this incident to the public authorities. Neil reported that the incident happened last week Thursday, he got home, mother was drunk and they had an argument, he then pushed his mother (Alice). She fell [and] hit her head on the floor and passed out, he then called the ambulance as she was not responding to him. He reported that she came around in about a minute or two and asked him to cancel the

ambulance which he did. At this point he helped her up, she presented as unsteady on her feet and disorientated, she later settled and had been fine. Alice had an appointment to see her GP on the morning of 19 September 2018.

3.1.53 The DHR Reviewers note that there is a need to raise the importance of safeguarding concerns amongst the agencies within local authority boundaries and across borough boundaries.

Central London Community Healthcare NHS Trust (CLCHT)

3.1.54 The DHR Reviewers noted that whilst one face interaction took place in 2017, and remaining three contacts on the telephone, the professionals concerned dealt with the symptoms Alice was presenting with resulting from her injury, no documented enquiry as to the cause took place. This is relevant in light of the DA history, and is it unclear if the treating clinicians were cognisant of potential risk associated with DA.

3.1.55 The telephone consultation on 14 December 2018 assumed that Neil was speaking on his mother's behalf with her consent. Did Neil have the authority to do so? Alice was not spoken to on her own and it is unclear whether any consideration was given to Alice's ability to speak freely or whether she was being subjected to coercive control. The referral from the GP, in addition, did not detail the history of DA.

3.1.56 Whilst, DA is described as an integral part of the CLCHT's safeguarding training and staff have access to an adult safeguarding lead and advisor, the safeguarding team via the SPOC and a safeguarding advisor specialising in DA for support, guidance, advice and supervision. This is positive. Whilst there are numerous advisory and other support mechanisms in place at the CLCHT, this support may only be accessed if staff members identify the DA in the first place. This absence of an audit process to ensure compliance requires development, as well as a process for bedding learning from lessons learned.

Royal Free London (RFL) NHS Foundation Trust

3.1.57 A review of the EPR for both Alice and Neil has been undertaken by RFL. The mental health staff had documented records in the RFL EPR to enable the ED staff to

view their assessment and planning which is effective practice. The information available to the Review indicates that patients are not routinely screened for DA during outpatient clinic appointments unless there are signs/signals noted. This is dependent upon a medical professional having sufficient knowledge and understanding of DA. On review of the patient records, RFL has confirmed that there was nothing to indicate that DA was raised as an issue or was otherwise identified by a staff member. In the psychiatric liaison notes, no concerns regarding Neil hitting or otherwise abusing Alice were raised.

3.1.58 The RFL has routine screening for DA in high-risk areas such as maternity and community gynaecology clinics, but not in the ED where DA victims may self-present. The RFL and Barnet Hospitals have IDVAs co-located on site, whose expertise can be a great source of advice and support if it is accessed. That said, a healthcare professional would only be accessing such support if they have identified DA in the first instance.

3.1.59 The co-location of IDVAs within hospitals, GP Practices, Walk In Centres etc is positive and where it is established and marketed it works well, with increased referrals to the service from confident staff.

3.1.60 The RFL has a DA & VAWG policy in place, which is supported by:
a. DA awareness in all levels of the mandatory safeguarding training provided by the Trust, which is supported by IDVAs and external organisations such as Iranian Kurdish Women's Rights Organisation (IKWRO) and Jewish Women's aid.
b. Awareness raising campaign to increase support for staff who are affected by DA Advice and guidance about DA, and organisations who can support, are available on the Trust intranet and through the safeguarding newsletter.
c. Monitoring DA referral data overseen by the Trust's integrated safeguarding committee

East and North Hertfordshire NHS Trust (ENHT)

3.1.61 ENHT's involvement with Neil was following the homicide in June 2021 and no learning or recommendations for ENHT have therefore been identified.

3.1.62 It was reassuring to note that ENHT remained a DHR Panel member to establish any learning that could benefit future service provision and provided support to the Panel.

Hertfordshire Partnership NHS Foundation Trust (HPFT)

3.1.63 The DHR Reviewers noted the apparent absence of a Care Coordinator for Neil and it is unclear whether consideration had been given to such a provision. A number of NHS Foundation Trusts are involved in the care of Alice and Neil which highlights the need for coordination of care.

3.1.64 The risk assessment provided for the Crisis Resolution Home Treatment Team (CRHTT) by the Mental Health Liaison Team at Barnet A&E raises some questions over how safe it was to discharge Neil to the CRHTT. The case was discussed, according to the records, at the HPFT moderate harm panel and a three-day report prepared to review the incident and identify if there was any immediate learning for the HPFT. HPFT, in their own assessment did not identify any immediate learning.

3.1.65 The HPFT information included in the referral from Barnet A&E contained a risk summary dated June 2021 relating to DA with a former girlfriend (Sarah) in 2015 and an assault on her boyfriend in 2016.

3.1.66 The HPFT note that there was no opportunity to consider offering a carer's assessment for Alice as the incident happened on the day the referral was received in June 2021. A carer's assessment may have highlighted, according to HPFT, the risks to Alice. The CRHTT Policy v1.4 13.7 states "*where carer appears to be providing support, offer support to carer and sign for a carer's assessment when appropriate*." Whilst the process of consideration of carers needs is documented it is unclear how learning is captured and lessons learned are implemented.

3.1.67 HPFT advised the Panel that staff made multiple attempts to contact both Neil and his mother by telephone and by text to discuss a plan to assess at a place other than the home address due to the risks involved. The DHR Reviewers noted that Neil had been assessed as suitable for release to the lone care of his mother the day

earlier. The risk assessment provided to the South West CRHTT team by Barnet MHLT did not accurately reflect the risks posed by Neil as the referral form received from Barnet CRHTT includes two risk assessments in June 2021 stating no current evidence of risk to report and no evidence of risks above retrospectively. The DHR Reviewers noted the difficulty where assessments are not undertaken in the home, and the issue of poor information sharing amongst the statutory agencies relating to previous incidents.

3.1.68 The Southwest CRHTT, according to HPFT, were able to identify these risks and plan care appropriately. The risks that Neil posed to others was correctly identified. There was no opportunity to see Neil, according to HPFT, and complete further assessments. The practice, in HPFT's view, when the referral was received demonstrates that the team did recognise that Neil continued to pose a risk to others despite the incorrect information provided in the risk assessment by Barnet CRHTT. This, according to HPFT, demonstrated effective practice with no over reliance on assessments provided by others.

3.1.69 The HPFT has a Lone Working Policy and a comprehensive training programme available to all staff. DA or sexual violence is included every month throughout the year. It has developed a DA policy for staff and there will be training provided for managers to support employees with this either as victims or perpetrators. HPFT are also undertaking work to identify and respond to sexual safety, this also involves analysis of themes to establish if risk can be identified at an earlier stage. The corporate safeguarding team provide additional support and oversight across the HPFT.

3.1.70 The need to provide continuous training for all staff for DA has been recognised, together with the team feedback regarding identifiable best practice. The DHR Reviewers queried, having considered that it was too risky to meet at the home address, what control measures were put into place or considered to manage the threat and risk presented by Neil. The DHR Reviewers concluded that no such measures had been put in place prior to this tragic homicide but should have been given the level of risk involved.

Solace Women's Aid (Solace)

3.1.71 Neil self-referred to the DVPP in 2015. The nature of his referral to the group was such that there was a self-admission that he was a perpetrator of DA. At the point of referral to the group in November 2015 an email from the DVIP worker to the Solace IDVA on the 23 November 2015 said "*D had been violent to his ex-partner Sarah and violence often happened when she (Sarah) tried to end the relationship".*

3.1.72 Throughout the group Neil only described violent and abusive situations with reference to Sarah and the Solace IDVA continued to contact Sarah to offer support to her. Feedback that was provided by DVIP after the weekly DVPP made reference to Neil's childhood and specifically mentioned his father. The following extracts from notes on the case management system provide a helpful summary:

Talked about how scared Neil used to get as a child when his father would have diabetic seizures and started to behave erratically
Neil talked about problems with his parents growing up and the lack of boundaries which as a child was "cool" but actually wasn't good
When asked for an example of someone or something he'd had to let go, Neil said that his dad had been endlessly abusive to his mum [Alice] and then, on Boxing Day, had vanished from the home without explanation. Later found out he had resumed a relationship with a woman he'd previously had an affair with when Neil was 12 and was wanting the house sold as part of divorce. Feels he (Neil) has to let go of his dad for now, but hopes some reconciliation possible later.

3.1.73 With reference to the comments that Neil made about his childhood, Solace highlight the additional difficulties that mothers who experience DA face from their children. They often have additional barriers to seeking help for the abuse as they often do not want to take action, in terms of legal or Police protection, against their children. This, in Solace's view, could have been even more significant for Alice if she had experienced years of abuse from her spouse/Neil's father and had become desensitised to the abuse. The DHR Reviewers have concluded that Alice's protection of Neil is a recurring theme in this homicide. Alice in our view had accepted her situation and this was perpetuated by her complex needs.

3.1.74 In Solace's assessment, Neil may have learnt abusive behaviours from his father even though on some level he was able to reflect that they were wrong. The DHR Reviewers considered that Neil also experienced ACEs which are discussed earlier in this report.

3.1.75 The Panel have been informed that the DVPP records for Neil have been destroyed. As a result reliance has been places on Solace records alone. The DHR Reviewers noted that Alice was not identified as being as risk of DA and enquiries to identify who else may be at risk from Neil. This is pertinent as Neil proceeded to assault Sarah's new partner shortly after starting the DVPP programme. The key area requiring development is that of a process to reassure commissioners of services that relevant enquiries are being conducted during the duration of DVPP programme.

2.1.76 Solace advised the Panel that they currently review risk on a regular basis: feedback after each DVPP session is shared and discussed between the DVPP facilitator and the IDVA. Their policy details that the monthly case review meetings are held and recorded to discuss cases in depth and to assess any comments or concerns raised in the DVPP sessions, or IDVA case work. This is to identify any changing or new risks.

3.1.77 Solace services and practices are reviewed by multiple quality systems: dip sampling, internal and external audits, accreditation and kite marks, service user feedback, internal KPI's and external reporting to commissions and funders. Some of their work is externally evaluated and published. They have recently just published their 5-year strategy (2022-2027) and intersectionality is a key principle of the work that they do.[33] They are focused on continuing to recognise the multiple and intersecting barriers that women face and will work with partners to ensure that the services are accessible to all women.

3.1.78 The service provision is choice and consent based for all survivors, but particularly for the support element of the DVPP service, this is even more so. Many

[33] https://www.solacewomensaid.org/about-us/our-strategy-and-impact#:~:text=In%20March%202022%2C%20Solace%20launched,services%20for%20women%20and%20children.

survivors when contacted by the Solace IDVA may be out of immediate risk and wishing to move on and draw a line under what has happened to them. Survivors may feel there is no benefit to engagement in a linked programme and may find reminders of what has happened to them as setting them back in their recovery or re-triggering their abuse experiences. For this reason, referrals are likely to be closed after a few unsuccessful contact attempts as workers will assume that further contact is unwanted by the survivor.

3.1.79 According to Solace, women such as Sarah may have support needs, could have benefitted from more sustained contact to identify unmet needs.

3.1.80 Solace noted that the IDVA did make additional attempts to contact Sarah. Whilst Solace promotional literature, paperwork and internal guidance for DVPP frequently refers to the term “partner support’, a change of terminology to include reference to family members may, in Solace’s view, prompt a more thought-out investigation by Solace staff and partner agencies. This could also contribute to raising awareness and to reframe that family members can also be at risk of DA. It is also worth noting that parents can also be at increased risk in the intimate partner relationship end as the perpetrators often move back in with parents/mum.

3.1.81 It is important that whilst the DVPP is running, according to Solace, that risk is constantly reviewed based on the perpetrator’s engagement, comments, and behaviour in the sessions. That any references to other parties are explored and appropriate safety measures are put in place. That these are documented on case notes and monthly case review meetings and that these are attached to the case management system.

3.1.82 When working in partnership with stakeholders, both agencies are proactive in ensuring that the right questions and paperwork are completed to assess needs and risk. It is not clear what happened in this case, but it is worth identifying and highlighting as a learning point the importance of asking critical questions. To ensure that the category of “professional judgement” is utilised when it comes to identifying high risk cases and referral to MARAC.

3.1.83 It is also worth examining a perpetrator's motivation in self referring to a perpetrator programme i.e. is it about genuine remorse and a desire to change or to avoid prosecution? Neil self-referred to DVPP after he physically attacked and throttled Sarah, perhaps recognising the severity of his violence and abuse. It is, of course a matter of speculation of why Neil self-referred to DVPP.

3.1.84 The support provided by Solace to Neil's former partner Sarah, who was referred as part of the DVPP, was effective. She was contacted in line with the internal procedures and the national tool Safe Lives DASH risk assessment was completed with her. Sarah was assessed at medium risk. There is a question around if she should have been referred to MARAC under "professional judgement" and this has been identified as a learning point.

3.1.85 Solace examined their current internal procedures and practice to inform this Review. The current process at Solace adheres to Respect National Guidance for Perpetrator Programmes and are deemed to be very robust at assessing risk and needs. Solace detail that the current assessment for suitability for the group takes approximately 1-2 hours and is on a 1-2-1 basis with the perpetrator and an appropriately qualified perpetrator programme facilitator. The assessment is reviewed during dip sampling. Questions and points of discussion are asked to the perpetrator to assess need, support and risk on a range of topics: current and past DA, family history including trauma, mental health, substance/alcohol, violence in other contexts whilst also mapping what other lead professionals are involved.

3.1.86 There are multiple and clear opportunities to identify those at risk from the perpetrator at several points throughout the perpetrators support journey:

- At point of referral.
- At point of assessment.
- At point of risk assessment (see section 3.5.2 for questions).
- Through contact with key agencies ie probation, social services, MARAC.

- Through contact with the person/s identified for support – a question on the DASH risk assessment asks the person “if the perpetrator has ever hurt anyone else?”
- Through weekly assessment with the perpetrator at the DVIPP.
- Through weekly feedback and contact with support partner worker.
- Through monthly case review meetings.

3.1.87 MARAC and safeguarding referrals are made as appropriate throughout and partnership working with stakeholders are encouraged. Solace are in the process of being accredited by Respect for our/their work with DVPP, this will further cement our/their best practice and ensure that we/they continue to work towards keeping women and children safe from harm by reducing the risk of abuse by reducing perpetrator behaviour.

Crown Prosecution Service (CPS)

3.1.88 The alleged assault on Sarah’s new partner Harry was not reviewed under the CPS DA policy, nor by a specialist DA prosecutor. It is the DHR Reviewers’ view that the circumstances of the allegation were such that the matter should have been dealt with as a DA matter and under the CPS DA Policy with appropriate enquiries regarding background.

3.1.89 The CPS has developed a prosecution approach which is applicable to DA cases, which looks at how strong cases can be presented at court without the need for the victim to attend. This is a positive development which enables cases to proceed where a victim may later decline to attend court, ensuring that the prosecution can proceed. This includes the use of technology such as Police body worn video footage and 999 calls where appropriate. Legal guidance has also been drafted and agreed following consultation.

3.1.90 In 2021, to ensure that victims and the services who support them understand the work CPS is carrying out, published a specific national DA programme of work. This programme has recently been reviewed with additional commitments for 2022-

23. It was published in April 2022 and can be found here: https://www.cps.gov.uk/domestic-abuse-context-and-challenges.

3.1.91 The CPS has developed a central repository of best practice to ensure this work is more readily accessible to DA leads.

London Borough of Barnet (Barnet Council)

3.1.92 On 19 September 2018 Alice provided a useful insight into her life with Neil to a representative of Barnet Council's ASC when they met to discuss the incident when she was pushed to the ground by Neil. She stated:

- Neil was her only child and lived with her in the family home
- Neil was a graduate of London School of Economics and worked part time
- Neil was experiencing Borderline Personality Disorder and Generalized Anxiety Disorder and he was known to the mental health services
- she struggled to contain her alcohol consumption and level and this was a source of concern for Neil
- Neil has had reasons in the past to worry about her alcohol habit and they have had discussions about this
- she has just divorced and was going through the motion of selling the family home and this has impacted on her wellbeing including increased alcohol consumption level
- she had reduced her alcohol consumption intake and was working towards further reduction
- on the day in question, she agreed that she had a few glasses of wine too many with a neighbour and her speech was slurred and this infuriated Neil and he gave her a nudge and she tripped and hit her head against a dog feed tray and was slightly bruised and Neil called 999 and she was attended to and she declined to go to the hospital (of note the LAS did not attend this call as their records highlight that a male cancelled the call)
- Neil's action was not borne out of malice and their relationship has since returned to normal and they are working on their mother/son relationship
- Neil was equally receiving therapy from the mental health service
- she does not have any social care needs and is independently mobile

- she wanted the safeguarding concerns information gathering process to be terminated. Alice has been referred to National Association for People Abused in Childhood and Barnet carers centre for care provided for her son who has mental health issues and in the process of getting a diagnosis. A check revealed that Alice was not known to the service suggesting she may not have followed through the referral. A safeguarding referral was made to the Local authority.

3.1.93 The DHR Reviewers considered that Alice's minimisation of the incident was consistent with her presentation as a vulnerable woman with complex needs. The Panel discussed the difficulties for parents in reporting the abuse they are subjected to by their children, particularly where the mother or father are not seeking a justice outcome but support for their child. Assuming that Alice had mental capacity to make her decisions, the DHR Reviewers queried what would be the level of threat and risk that Alice would need to face for Barnet Council to safeguard her. It is unclear if the ASC social worker considered a referral for Alice to the Barnet MARAC.

3.1.94 Barnet Council has a DA and VAWG strategy and action plan, a dedicated DA and VAWG team and commissions a range of services for those experiencing or at risk of DA. DA services are part of the Multi-Agency Safeguarding Hub (MASH). Barnet Council is committed to working with all partners and community groups following the DA Act 2021 to reduce the prevalence of DA and VAWG, and to improve the support and response for all victims and survivors in Barnet. Barnet Council has zero tolerance for abuse and violence, where perpetrators are held to account and victims and survivors are enabled to access the support and help they need.

3.1.95 The approach retains a clear focus on women and girls' experiences, whilst also recognising that anyone including men and boys can be victims and survivors. Their aim is to ensure that all victims and survivors receive appropriate service responses and are able to access support irrespective of additional barriers they may face when seeking help. Their well-developed quality assessment framework, according to the information provided to the Panel, supports them in assessing the effectiveness of the partnership work with VAWG and objectives set to adult MASH team. They also carry out internal and external audits, direct observations and self and peer audits of cases worked on in the last 6-month cycle. Findings and feedback are

discussed at the Quality Board and this informs our training programme for months ahead including spot purchased training tailored to specific learning and developmental needs of individual practitioners. Barnet Council funds support services, which include:

- DA Advocacy and Support Service
- Perpetrator Programmes
- DA Multi-Agency Risk Assessment Conference (MARAC)
- GP training - Identification and Referral to Improve Safety (IRIS) Programme
- Women's Refuges in the borough

3.1.96 Between August and December 2021, Barnet Council delivered a series of DA Act training sessions to raise awareness to multi agencies and inhouse agencies' staff to ensure that all front-line staff understand the changes brought about by the DA Act 2021. It was reassuring to note that Barnet Council's business continuity of DA support programmes was ensured during the Covid 19 pandemic including during lockdowns with service delivery methods modifying to reach victims/survivors. In addition, the frequency of the local MARAC changed from monthly to weekly meetings. To complement the DA MARAC there was also a multiagency risk panel to jointly plan support and responses to high-risk situations, which operated fortnightly during the pandemic using a multi-disciplinary team approach to managing risk and owning it as a muti agency process and not being held by an individual worker. During their latest external audit in January 2022, the approach to safeguarding and its principles were commended by the independent auditor and passed both in recoding and practice.

London Ambulance Service NHS Trust (LAS)

3.1.97 The LAS records did not identify evidence of DA or that either party had any care and support needs. However, the DHR Reviewers noted that the Alice sustained a head injury and had been unconscious, albeit for a short period of time, it was not known at that time how serious the injury was. Therefore had the ambulance crew proceeded to the scene, they may have identified the DA.

3.1.98 The DHR Reviewers identified the absence of key information, particularly the name of the person who called the LAS was not recorded. Was this accordance with

LAS policy or operating procedures? Additionally, a male caller cancelled the LAS, was his name recorded? The information available to the Panel confirmed that Neil made the call the initial call to the LAS and the follow up call cancelling the ambulance.

3.1.99 Since September 2019 the LAS has implemented level 3 training, which encompassed in-depth training in relation to DA, including how to recognise the signs of DA, how to safely discuss concerns with victims, and referral pathways to support. 3.1.86 During the Covid-19 period the LAS introduced DA stickers adorned with the DA National Helpline number, which were provided to ambulance staff. The stickers were placed on staff's uniform or service issued iPads for patients, service users and others to see. It was the LAS' aim to enable those who did not feel safe enough to disclose abuse to know how to access support. The LAS has not identified any issues arising from its management of this incident but is fully prepared to take on board any issues that may come to light. The DHR Reviewers, however, have concluded that Alice's and Neil's interactions with the other partner agencies tell a very different and at times conflicting 'story' detailed in our conclusion.

Hertfordshire County Council (HCC)

3.1.100 HCC coordinates DHRs on behalf of the 10 CSPs as part of the county-wide DA Strategy.

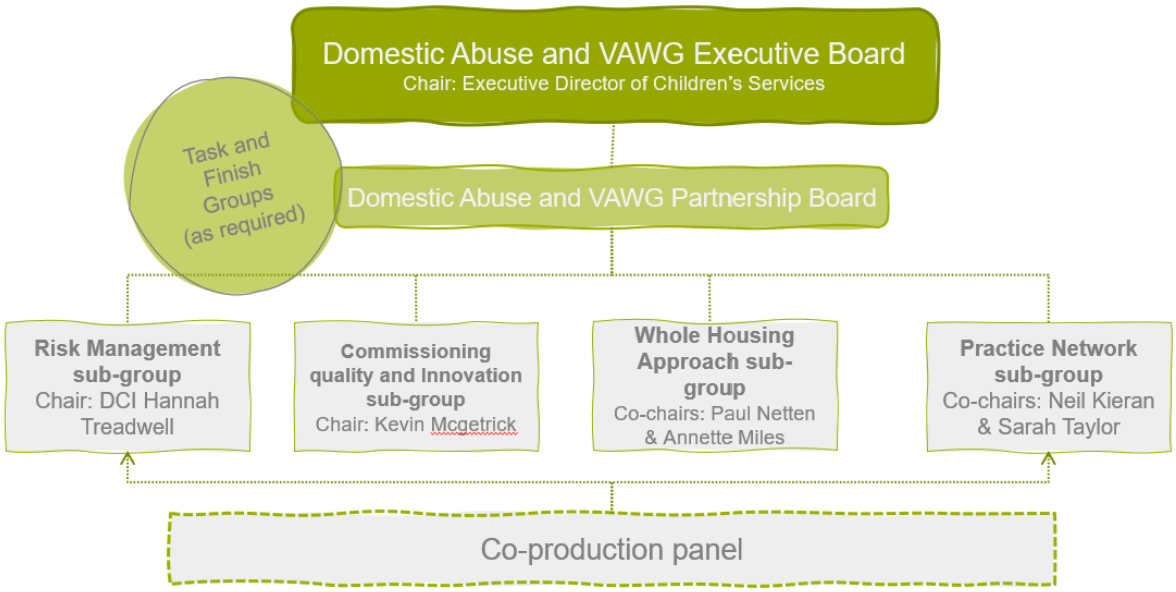
3.1.101 The Hertfordshire DA and VAWG Partnership recently published its 2022-2025 DA strategy and the final version will be officially launched in November 2022.

3.1.102 The Strategy is led and delivered through a multi-agency governance structure, consisting of a strong network of domestic abuse professionals across public and voluntary sectors. Key agencies involved in the partnership include:

- Hertfordshire Constabulary
- HCC's Children's Services, Adult Care Services, Public Health and Community Protection departments.
- Both Hertfordshire Clinical Commissioning Groups (CCGs), which have since been replaced by the Hertfordshire and West Essex Integrated Care System (ICS)

- Voluntary and Community Sector Agencies
- Hertfordshire Partnership University NHS Foundation Trust
- District and Borough Councils
- Hertfordshire Community NHS Trust
- Office of the Police & Crime Commissioner (OPCC)

3.1.103 To ensure alignment with the new Domestic Abuse Act (2021) and its requirements, this governance structure was recently refreshed. The new structure is shown below:



Governance structure for domestic abuse in Hertfordshire

3.1.104 The Strategic Partnerships Team, based in Adult Care Services at HCC, coordinate the delivery of the strategy, which includes the commissioning and monitoring of services to meet the needs of victims and survivors.

3.1.105 There are a number of services for victims and survivors of DA, and other forms of VAWG, in Hertfordshire. In 2022, HCC, in partnership with the OPCC and CCGs (now ICBS), commissioned its high-risk support offer, which includes two county-wide DA services. The first service procured was a countywide service to support victims of DA at any risk level, and their children, within safe accommodation, including refuge and move on support.

3.1.106 The second service commissioned was an Independent Domestic Violence Advocacy (IDVA) service, which supports those at the highest risk of harm or homicide.

3.1.107 The contracts for these services commenced on 01 July 2022 and will run until 30 June 2024, with the option for the HCC to extend for a further two years and then a subsequent year.

3.1.108 HCC commissioned SADA (Survivors Against Domestic Abuse) in April 2021 to deliver a housing navigator pilot (co-located advocacy in a whole housing approach) to work with victims at standard and medium risk of harm where they have a housing related support need.

3.1.109 The housing navigators work closely with the ten districts and boroughs in Hertfordshire's housing teams and provide housing related support and advice to victims of domestic abuse.

3.1.110 Referrals are made through the relevant housing team but can also be made directly to SADA. Successful Providers will be required to work alongside this model by assessing victims housing related and safe accommodation needs and referring them to the housing navigator service as appropriate.

3.1.111 There are over 30 service providers across Hertfordshire delivering support to victims and survivors. A large percentage of these are specialist providers, delivering support services to victims and survivors of DA. Some operate an equitable response across the county whilst others operate in specific locations or local authority areas.

3.1.112 In total, HCC can provide information on 37 DA services and 18 service providers in Hertfordshire. Of these, 14 services are women only services, 28 are for those aged 16 and over, two are for those aged 18 and over and four of the services listed provide support for the whole family. There are two services for alleged perpetrators.

3.1.113 There are currently only three service providers that have been formally commissioned by HCC to provide services to the whole of Hertfordshire on behalf of the county-wide DA Partnership, which are those outlined in Section 4.2 (Refuge, Safer Places and SADA). However, there are nine service providers providing service(s) accessible no matter where a victim or survivor may be within the county's boundaries. This does not necessarily indicate that these services are provided from multiple locations across the county, rather that the referral pathways do not limit accessibility to a specific area or location.

3.1.114 It is important to note that there are also programmes for perpetrators in Hertfordshire who wish to change their behaviour. The Strategic Partnerships Team is currently scoping these and, once complete, will give providers an outline of programmes available in the area they are covering under this contract and an define expectations in terms of onward referral.

3.1.115 The Hertfordshire Beacon is the victim services centre commissioned by the Police and Crime Commissioner to provide practical and emotional support to victims of crime, irrespective of whether the crime has been reported to police or not.

3.2 Conclusion

3.2.1 Alice had a complex history peppered with traumatic experiences, yet she received no sustained treatment or help throughout the years. She was isolated from her family and friends and did not work. The DHR Reviewers noted the ACEs that Alice experienced coupled with the lack of ongoing support to address the associated trauma, and the experience of DA at the hands of Jonas, her former husband, and her son Neil, contributed to Alice's complex needs. As a victim of DA she sought to protect her son as a mother and carer due to his mental health problems before herself and this enabled Neil to manipulate and control the agency professionals he has contact with such the LAS .The LAS call handlers did not take the names of the callers when an ambulance was requested for a relatively serious injury to Alice and cancelled nine minutes later by a male caller, Neil.

3.2.2 The DHR Reviewers considered that Alice's protection of Neil through reducing the significance of the incidents involving her son was consistent with her presentation as a vulnerable woman with complex needs. Alice was unable to follow through reports of DA, physical, abusive coercive and controlling behaviour, as she sought to protect her Neil. She was not seeking a justice outcome but support for her adult child. It was assumed that Alice had mental capacity to make her decisions and therefore did not receive the safeguarding support required, particularly when she directed that things had improved for her.

3.2.3 Risk assessments were not completed for example in September 2018 by ASC to assess Alice's needs, nor by the police officers the date before the tragic homicide. Most notably, Neil was deemed suitable to be released back into the care of his mother the day before the incident notwithstanding the DA that had taken place. Alice's agreement for Neil to return home was deemed sufficient without any understanding of the escalation of risk and consideration of Neil's behaviour in the events leading up to the homicide. The triangulation of information across the statutory agencies would have afforded Alice the opportunity to seek the support that she required.

3.2.4 The GP had access to information and disclosures detailing Alice's DA from Neil yet follow up did not take place through supportive discussions to assess Alice's ongoing needs.

3.2.5 Neil required a Care Coordinator for Neil and it is unclear whether consideration had been given to such a provision. A number of NHS Foundation Trusts were involved in the care of Alice and Neil and coordination was therefore required which would have facilitated the triangulation of information across health services.

3.2.6 Alice was the sole carer for her son. Neil lived with Alice after her divorce from his father Jonas and was dependent on Alice. Alice did not receive the required support as a parent carer for an adult child with mental health, drug problems and abusive behaviour towards Alice and his former partner. The pattern of abusive behaviour towards women is evident, as is the abuse of animals namely the family

pet. A carer's assessment would have afforded a further opportunity to assess Alice's needs further.

3.3 Lessons to be learned

The Police

3.3.1 Hertfordshire Constabulary's (Herts Police) information identified that the officers dealing with the incident the day before the tragic homicide did not complete a DASH risk assessment booklet. It was noted that from the time of their arrival, Neil was suffering from a MH episode and that Alice was not relaying the incident as DA. It has been recognised that a Herts Police DASH risk assessment booklet should have been completed. The DHR Reviewers agreed with this view.

3.3.2 With the benefit of hindsight the Herts Police Reviewers state that the assessment would have been standard/medium and wouldn't have demanded any "*further physical attention in the near future*", whilst recognising that it would have been the first step in the safeguarding process. Herts Police has assessed that further guidance and training is required in this area.

3.3.3 In addition to the above Herts Police has identified that a number of incidents attended by front line officers include addressing persons with mental health, so Officer awareness of their powers was identified as being paramount. It was noted that one of the attending officers to the incident had received MCA training 4 weeks previously. It was noted that the officer stated [the training] '*gave him the confidence to deal positively with the situation but believed further training is required.*'

3.3.4 Herts Police assert that the Constabulary takes a positive approach to DA 'by arresting the perpetrators despite possible reluctance' by victims. Herts Police assert that as Neil's behaviour was associated with a mental health episode requiring immediate medical intervention, it would not have been appropriate to arrest him at that time.

3.3.5 It is the Herts Police's position that on being discharged from the section 136 MHA provision, the arrest of Neil could have been considered for the identified

offences and bail conditions imposed, but this would not have been in accordance with the codes of practice of the MCA, which suggest Police refrain from arresting persons under continuous treatment for mental health.

GP

3.3.6 The GP Practice has identified the importance of open supportive discussions with patients who are potentially victims/ perpetrators of DA and maintaining and building these relationships in order to provide support. The DHR Reviewers concluded Alice may have opened up to her GP where a relationship of trust had been built up.

3.3.7 The importance of identifying escalating levels of abuse and responding to this by continuing to offer support and raise safeguarding concerns (where appropriate) has been identified as a learning point for the GP. The DHR Reviewers were of the view that the GP had oversight of Alice's care and was aware of her domestic circumstances.

3.3.8 The GP surgery has also acknowledged the importance of clear note taking, including adding medical record prompts (HARCS) to notify the team of concerns regarding abuse, but which are not visible on notes that are accessed by the patient or possible perpetrators.

Crown Prosecution Service

3.3.9 The CPS has accepted that their decision regarding the serious assault alleged to have been perpetrated by Neil on 25 January 2016 could have focused more on who was the aggressor and asked the Police to explore further lines of enquiry. Both Neil and the other arrestee say they were acting in self-defence. The CPS has noted that this may have resulted in a prosecution, but acknowledge it is difficult to assess that with any certainty.

3.3.10 The Panel has considered that had the CPS lawyer recognised that this incident was DA in origin, would the decision made regarding this 2016 assault have been different. All lawyers in the unit handling this case were DA specialists and should therefore have identified the presentation of DA. The matter could have been reviewed

by a CPS DA specialist leading to a potential difference to what may have been included in the action plan sent to the Police on 19 February 2016.

London Borough of Barnet (Barnet Council)

3.3.11 There is no evidence of cross reference to the safeguarding concerns raised in March 2016 and the history of DA experienced by Alice in discussions held by the Network in June 2016.

3.3.12 In February 2017 Barnet Council has identified that there is no evidence as to what extent Alice's history of abuse was discussed with her by the locality social worker, and what information about DA and prevention services was offered. The DHR Reviewers concluded that on the information available, the DA was not identified with no referral for Alice to DA services. Alice reported during this discussion that her son now had a job which had put some distance between them, they were no longer spending all their time together and Alice stated things had improved between them. Alice informed that she did not feel at risk from her son. She was divorcing her husband which was a difficult time but that she was managing. Alice was given the contact number if the situation changed.

3.3.13 According to the information available to the Panel, during the home visit in September 2018 Alice was assessed as not having eligible needs for care and support. Alice was assessed as being able to articulate her wishes in relation to the safeguarding. In following the national Making Safeguarding Personal Guidance, both ASC assessors found Alice had the mental capacity to make her own decisions regarding the two safeguarding concerns and not to progress them further. The DHR Reviewers concurred with the Barnet Council view that a referral to MARAC, however, would have provided more opportunity to share information held by different agencies. This would have provided a better opportunity to jointly risk assess, provide appropriate control measures to manage the threat and the risk, explore further partnership working and consider a suitable escalation process.

3.3.14 Barnet Council acknowledge that a detailed discussion with Alice regarding her needs and the support she required should have taken place. This could have included

an exploration of her alcohol consumption and an opportunity to consider a referral to CGL, GP or substance misuse services. The DHR Reviewers noted that the Barnet Council suggested approach is not perpetrator focused but rather seeks a change of behaviour by the victim. Barnet Council has not identified that Alice's alcohol consumption was a possible coping mechanism in light of her complex needs. Whilst Barnet Council state that there should have been a greater emphasis on information and advice about prevention and support available through the community and voluntary care sector, the DHR Reviewers noted that this could only have taken place if there was clear signposting to relevant services for adult child to parent DA. This is particularly relevant since Alice sought to protect her son and was isolated from friends and family due to the shame and embarrassment that she reported.

3.3.15 Barnet Council has identified that there was no evidence of a detailed discussion with Alice regarding her caring responsibility to Neil, the possible impact on her wellbeing, her ability to objectively risk assess triggers and patterns of Neil behaviour and Alice's ability to protect herself, other than her stating that she would call for help if needed. The DHR Reviewers concluded that the role of parent carers can often be overlooked. A carer's assessment was not undertaken and a heavy onus was placed on Alice – could Alice have objectively risk assessed the triggers and patterns of Neil's behaviour? Fundamentally the issue is what proactive measures by Barnet and its partners risk assessment were put into place to manage the threat and risk posed by Neil to Alice. All professionals have the ability to refer a client to a DA MARAC.

3.3.16 There was a lack of evidence, according to Barnet Council, of timely feedback and information exchange between its own ASC and BEHMHT in response to the two safeguarding referrals. This could have potentially provided a better opportunity for a multiagency approach and joined up risk management strategy, i.e. referral to MARAC and IDVA with a joined-up risk ,management strategy. This could have been supported through a better understanding of the family history and the extent of domestic situation between Alice and Neil. The emphasis on providing information about prevention support in relation to DA and substance misuse could have been explored in more detail with Alice and should have been documented more clearly.

3.3.17 The learning identified by Barnet Council includes the:

a. Adherence to ASC risk assessment policy and clear recording of risks using designated template;

b. Provision of timely and comprehensive feedback to referrers, ensuring consent from adult at risk is sought;

c. Clear understanding of the importance of information sharing across partner agencies ensuring compliance with Data Protection and GDPR.

Exploring the any barriers to better coproduction and partnership working.

Hertfordshire Partnership NHS Foundation Trust (HPFT)

3.3.18 HPFT advised the Panel that staff made multiple attempts to contact both Neil and his mother by telephone and by text to discuss a plan to assess Neil at a place other than the home address due to the risks involved. The DHR Reviewers noted that Neil had been assessed as suitable for release to the sole care of his mother the day earlier. The risk assessment provided to the South West CRHTT team by Barnet MHLT did not accurately reflect the risks posed by Neil as the referral form received from Barnet CRHTT includes two risk assessments in June 2021 **stating no current evidence of risk to report and no evidence of risks above retrospectively.** The DHR Reviewers noted the difficulty where assessments are not undertaken in the home, and the issue of poor information sharing amongst the statutory agencies relating to previous incidents.

3.3.19 Neil was seen by several mental health service providers yet was deemed suitable to be released into the care of Alice the day before the tragic homicide. His history of mental health, DA towards his mother and the fact that Alice had been subjected to abuse the day before her death should have resulted in more detailed and thoughtful enquiry before Neil's release into her care.

3.4 Best Practice

3.3.1 It is recognised that the Herts Police Officers who attended the incidents provided an excellent service in what subsequently became a very harrowing experience for them.

4. Recommendations

4.1 The recommendations below are, in the main, for the partnership as a whole but organisations have identified internal recommendations that may replicate or otherwise complement these. It is suggested that the single agency action plans should be the subject of review via the Review Action Panel, hence the first recommendation.

DHR Panel Recommendations

4.2 **The DHR Panel has identified the following recommendations:**

Recommendation 1: That all agencies that have been required to submit IMRs report progress on their internal action plans to the Hertsmere CSP and London Borough of Barnet CSP.

Recommendation 2: That the learning from this Review should be brought together with the learning from other Domestic Homicide Reviews into an Action Plan by Hertfordshire County Council, Hertsmere District Council and Barnet Council and monitored to inform overarching strategy, policy, practice and training.

Recommendation 3: That Hertfordshire County Council and Barnet Borough Council, its constituent relevant departments and the wider partnership should consider the further enhancement of its whole family[34] practice approach to ensure that the support needs of family members and the threat/risk they are exposed to are acted upon when a person comes into contact with services.

[34] The Whole Family or Think Family Approach enables a whole family picture to be developed and better understood to provide the right services to the right people. This approach aims to identify risks and needs within families at the earliest opportunity and identifying support to address needs and mitigate risks

This includes but is not exclusive to DA, mental health, substance misuse and adult safeguarding.

Recommendation 4: That Hertfordshire County Council and Barnet Borough Council supports and encourages a culture of 'professional curiosity' and 'check and challenge' across the partnership in the discharge of safeguarding duties to improve learning, behaviours, decision making and service delivery through the Practice Governance Board

Recommendation 5: That Hertfordshire County Council and Barnet Borough Council Community Safety Strategy Strategic Needs Assessment encompasses DA (Intimate Partners and Family Related violence/abuse) to better understand the prevalence of the problem and its underpinning drivers:

- **by agreeing priorities and service provision that meet the needs of the people of Hertfordshire County Council and Barnet Borough Council and are cognisant of the gaps within partnership working including the need to work in partnership with local people and non-government organisations (NGOs),**
- **demonstrating a specific focus on people as 'unofficial' carers and victims/survivors of DA, and**
- **to inform the delivery of the local DA Strategy and its accompanying action plan.**

Recommendation 6: That the Barnet, Enfield and Haringey Mental Health Trust develops a Policy and Operating Practice regarding documenting risk assessments relating to patients who are discharged back to their families and home in line with the think family approach.

Recommendation 7: That Hertfordshire County Council, Hertsmere District Council and the Hertfordshire Constabulary and its health care partners review its approach to referrals of DA cases (victims or perpetrators) to the MARAC and MAPPA from acute settings.

Recommendation 8: That the Hertfordshire County Council and the London Borough of Barnet reviews, evaluates and identifies areas for improvement in the routine DA training/awareness programme for all staff of relevant agencies and charities to:

- **Emphasise the importance of referrals to the DA MARAC (via the "Single Front Door") in cases where any professional believes there is an increasing trajectory of risk to a vulnerable person, even though the immediate situation does not meet the formal referral criteria.**
- **The intersectional needs, complex needs and the situational barriers to disclosure, which may be experienced by DA victims.**
- **DA Operational Board at County Council / District Council level.**

Recommendation 9: That the Community Safety Partnership Members in Hertfordshire County Council and London Borough of Barnet develop a practice guidance to assist professionals within their agencies to effectively manage complex and high-risk cases where victims decline agencies assistance and support e.g. use of DVPOs.

Recommendation 10: That the members of the Community Safety Partnership with responsibility for VAWG provide assurance to Hertfordshire Council, Hertsmere District Council and the London Borough of Barnet as to the effectiveness of its training programme for local professionals relating to DA.

Recommendation 11: That steps are taken for healthcare providers namely GPs, hospital trusts and urgent care centres to triangulate health records of family members where there is known DA recorded

Agency Identified Recommendations

Hertfordshire Constabulary

Recommendation 1: Guidance to be given on the completion of DASH books where Mental health illness is the primary concern.

Recommendation 2: Further detailed training in the Mental Capacity Act to be included at training days.

Recommendation 3: Where a patient is being discharged by a mental health unit and their admission included Police involvement, consideration to be given to informing the Police, prior to the discharge, to allow any risk assessment deemed necessary.

Recommendation 4: Procedures to be reviewed between Hertfordshire Police and local mental health NHS for protocol in regard to the managing of patients in similar circumstances.

GP

Recommendation 5: To continue to ensure all staff are aware of how to identify and respond to signs of DA. This will be achieved by maintaining IRIS practice in the London Borough of Barnet, with both clinical and non-clinical staff taking part in refresher training and new staff being offered training. They described this as achievable within the Practice's allocated educational sessions.

Recommendation 6: For clinic staff – to continue to actively discuss cases within the clinical meeting, ensuring clinicians and patients are supported correctly, and medical records are kept appropriately.

Barnet Enfield and Haringey (BEH) Mental Health Trust

Recommendation 7: For all staff to follow the Trust Clinical Risk Assessment and Management Policy, remembering to update the Rio Risk Assessment with information newly obtained in consultation/assessment. This is to ensure new information is addressed within Safety huddles/MDT reviews and staff are routinely updating the risk assessment tool on RiO.

Recommendation 8: All staff to ensure adherence to safeguarding record keeping standards and procedures. This is to embed a more extensive understanding of DV and abuse (its impact and need for early intervention) across the Trust.

Recommendation 11: To conduct a clinical pathway review for acute presentations within ED between Psych Liaison to CRHTT using QI methodology. All divisional CRHTT to involve a senior clinician in the team discussion (within hours) or on call SPR (out of hours) when a decision to change the clinical pathway is made.

Recommendation 12: Teams to ensure that when there are significant changes in a patient's care affecting their care pathway, a multi-disciplinary team approach is employed, and seniority of attendees is taken under consideration. All staff to undertake bespoke mental health training to address this issue. A multi-disciplinary team and multi-agency forum is to be set up to discuss issues highlighted in relation to MHA assessments.

Recommendation 13: Due to the risk of incomplete multi-agency handovers, staff should ensure that they undertake a thorough assessment of the referred patients, including presenting complaint and its surrounding circumstances, psychiatry history, medication history including medication administered in the Emergency Department and document this in the patient's notes as appropriate.
The crisis prevention houses to have clear operational criteria shared with all relevant teams likely to refer patients to them, including Emergency Department liaison, crisis teams and access and flow. Referrals for admission to any inpatient setting should be clear in what needs to be achieved by the admission so that the access and flow team will be able to direct the patient to the most appropriate setting.

Recommendation 14: All staff should be reminded of documentation standards and expectations of the same.

Hertfordshire Partnership NHS Foundation Trust

Recommendation 15: DA training will be accessible to all clinical staff at least once a month.

Solace

Recommendation 16: Paperwork, information, promotional and resource leaflets associated with the DVPP programme to reference not only current/ex partners but also family members who are at risk of DA. This would then go some way to ensuring

that those at risk of DA are identified and referred for appropriate support. Solace Violence Prevention Programmes Development & Implementation Manager and Solace Head of Quality and Service Improvement are to be jointly responsible for reviewing all current literature for Solace programmes to be completed by 30/4/2022.

Recommendation 17: To ensure that when working in partnership that we are asking critical questions and being proactive when asking for copies of relevant paperwork and evidence our request and outcome on case notes. This would ensure that we are working towards providing a more complete and risk/needs focused approach towards support for those referred. Solace Head of Quality and Service Improvement to include appropriate internal policies and procedures by 30/6/2022.

Recommendation 18: Discussion around resources and how Solace ensures that they are able to manage working with multiple people identified at risk from the perpetrator on a DVIPP when resources are limited. To ensure that each person identified is given an individual risk led approach.

Recommendation 19: For assessing team to ensure that when there are significant changes in a patient's care affecting their care pathway, an MDT approach is employed, and seniority of attendees is taken into consideration.

Recommendation 20: Review Solace training and guidance on MARAC referrals to ensure section on reasons when you would refer for 'professional judgement is included. The Solace Head of Quality and Service to review and implement by 30 June 2022.

Appendix 1: Domestic Homicide Review 'ALICE' Terms of Reference

This Terms of Reference describes the work that the multi-agency panel in Hertsmere is undertaking for this statutory independent domestic homicide review (DHR).

We will:

- Identify what lessons may be learnt from the case focusing on the ways in which local professionals and agencies worked individually and collectively to safeguard the victim to prevent future domestic homicides
- Determine how those lessons learnt may be taken forward

- Examine and, where possible, make recommendations to improve risk assessment/ /identification/management mechanisms and system coordination arrangements within and between all the relevant agencies
- Assess whether the relevant agencies have appropriate and sufficiently robust procedures and protocols in place to identify, prevent, tackle and respond to domestic abuse, including the extent to which they are understood and adhered to by their staff to identify areas of improvement and good practice
- Improve service responses by better understanding the overall "whole-system" needs of local people and where necessary, making changes to policies, practices, procedures and protocols[35]
- Enhance the overall effectiveness of efforts to better identify, prevent and tackle domestic abuse and its impact on victims through improved inter and intra agency working
- Maximise opportunities for fast time learning and overall partnership improvements as well as well as medium to longer term sustainable enhancements
- Examine and make recommendations if appropriate to improve the accessibility of services to marginalised people / communities
- Identify what should change within agreed and reasonable timescales[36]

By:

- Recognising that the victim's family are a fundamental part of the DHR and ensuring that they are given the opportunity to contribute to and be involved in the DHR from its inception in accordance with their wishes
- Undertaking Individual Management Reviews (IMRs) in all organisations that were involved with Alice and Neil[37] since the start of their involvement with the relevant agency. Analyse those reports in terms of understanding what happened, why, where things went well, where things did not go well and what could have been done differently

[35] Whole systems need is based on whole systems thinking, that the parts of a system are all connected and, therefore, influence each other
[36] The timescales will be highlighted in the agencies' Individual Management Reviews (IMRs)
[37] Individuals' initials are being used at present pending the relevant parties selecting their own pseudonym (as relevant)

- Taking into account any immediate learning and action arising from those IMRs then review the learning and, through a consolidated chronology, and joint discussions identify key lines of enquiry (KLOE) to explore further
- Interviewing family members, professionals, the perpetrator and any other person as identified as particularly relevant to the KLOE and taking into account the interview records
- Analysing the aggregated information and identify areas of strength in practice and areas where there is learning for the partnership system in Hertsmere, Hertfordshire and nationally, which will contribute to preventing similar incidents arising, and ways in which similar incidents could be managed differently as a partnership

The key questions we will initially focus on are:

- What signs or signals were present that could indicate that Alice was experiencing [38]domestic abuse, or any other abusive behaviour from Neil? What was the power and control dynamic? Was there a cultural and/or religious aspect to this dynamic? Were there any cultural or religious issues or practices which may have led to Alice being exposed to the risk of violence or abuse by Neil.

- What was your agency's response to effectively assessing, identifying and planning to meet Alice's needs and what opportunities were missed to identify risk(s) faced by them? What individual and / or structural barriers affected this if any? Consider if culture and/or religion affected this in anyway?
- Did your agency effectively identify Neil's ongoing needs? What plans were arranged to meet his short-long term needs?
- Was Neil receiving a coordinated level of service and how was this influenced by any potential cultural, religious and/or language barriers?
- Did your agency identify whether those living with Neil required support from public authorities and/or voluntary sector? What individual and / or structural barriers affected this if any? Identify any potential cultural, religious and language barriers in your agency's delivery of services (if any).

[38] Including Honour Based Violence/Abuse

- How well did your agency “see beyond” the immediate sphere of professional and legal requirements – including statutory duty, in the provision of your services? Was any action limited by policy and / or practice?
- For professionals working with Alice and Neil what were the signs and signals that could indicate there was [39]domestic abuse including coercive control towards other family members or anyone else?
- Give examples of any good work that your agency has undertaken in promoting support for marginalized communities particularly women by raising awareness, preventing and/or tackling domestic abuse and equipping them to access support services? How does your agency assess the effectiveness of this work?

- Further to the previous point, what works well (and why) and what could have been improved by your agency’s approaches and responses?

The following overarching principles and approach describe how we are going to work individually and together to do deliver against the terms of reference.

We will:

- Recognise that the victim’s family is a fundamental part of the DHR and that they are given the opportunity to contribute to and be involved in the DHR from its inception
- Ensure that the victim’s family’s voice is listened to and heard. Additionally, we will ensure that the victim’s family are regularly updated with progress at agreed intervals by the DHR Chair or Supporting Reviewer
- Take any cultural, religious and language issues into consideration
- Ensure that the DHR is conducted professionally, effectively, efficiently and in a respectful way

[39] Ibid

- Be open, honest, transparent and respect the opinions and contributions of the Panel Members
- Draw on the strengths, knowledge, skills and experiences of the multi-agency professionals in the DHR Panel

Timescales and Parameters

The timescales for the submission of the agencies' IMRs will be determined by the content of the chronologies provided by the multi-agency partners.

It is proposed that this IMR submission time line is 8 weeks from (to be determined).

Partner agencies will report from the last 6 years or the point of their first contact (if the contact is within this 6 years' period) the relevant parties subject to this DHR.

Appendix 4: Action Plan

Recommendation (SMART goal)	Scope of recommendation (i.e. local or regional)	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date	Date of completion and Outcome
Recommendation 1: That all agencies that have been required to submit IMRs report progress on their internal action plans to the Hertsmere CSP and London Borough of Barnet CSP.	Local	All recommendations to be actioned by all individual agencies and monitored by Hertfordshire County Council in line with the agreed deadlines provided.	Hertfordshire County Council and London Borough of Barnet CSP	As stated in the 'Action to take' section, all agencies are responsible for their own actions and updates are regularly monitored by Hertfordshire County Council.	December 2024	By December 2024, all actions to be finalised.
Recommendation 2: That the learning from this Review should be brought together with the learning from other Domestic Homicide Reviews into an Action Plan by Hertfordshire County Council, Hertsmere District Council and Barnet Council and monitored to inform overarching strategy, policy, practice and training.	Local	For Hertfordshire County Council to: 1, Bring together learning from multiple DHRs and identify themes. 2, Use major themes to identify gaps where training is needed and inform policy and practice.	Hertfordshire County Council, Hertsmere District Council and Barnet Council	1, The DHR team at Hertfordshire County Council has carried out a thematic analysis and a report was written on outstanding actions to identify themes across DHRs. This was followed by a second report that outlined the actions that we generally struggled to complete, the reasons why we found them challenging and some possible solutions.	June 2023 June 2024	Complete, June 2023. 1, As a result of the thematic review, a new approach is implemented, and Action setting meetings are organised at the end of each DHR where agencies agree on actions together. This helps to make sure that organizations are not given actions which are outside their remint and then result in an outstanding action.

				2, The Strategic Partnership Team at Hertfordshire County Council is scoping the current DA and VAWG related training within Hertfordshire County Council and the DA Partnership with the aim to develop a coordinated training programme to ensure that DA related training meets the needs of professionals and addresses the gaps in knowledge. 3, The DHR team at Hertfordshire County Council is working on how to better disseminate learning from DHRs and work is ongoing on creating a thematic library of recommendations and a 7-minute learning template for all cases.	December 2024	2, We expect that by June 2024 a coordinated training program to be ready that includes internal as well as external programmes. 3, By December 2024 a thematic library of recommendations to be ready which will help the DHR team to create presentation on various themes and spread the learning wider and have greater presence at various meetings and events. A template for the 7-minute learning for at least 1 recent DHR is expected to be ready and tested with partner organizations.
Recommendation 3: That Hertfordshire County Council and Barnet Borough Council, its constituent relevant departments and the wider partnership should consider the further enhancement of its whole family[40] practice approach	Local	Hertfordshire County Council to develop a template for survivor led safety planning and to include, if appropriate, family, friends and the local community.	Hertfordshire County Council and Barnet Borough Council	The development of a consistent template (risk assessment and referral form) is part of the work that is being done on the One Stop Shops project and will be co-produced by the Co-Production Panel. It will be part of the project specification that each organization that would like to be part of the One Stop Shops will agree to a	Ongoing	As the OSS are a large, multi-agency project, and dependent on funding, we envisage the OSS to be live in spring/summer 2025.

[40] The Whole Family or Think Family Approach enables a whole family picture to be developed and better understood to provide the right services to the right people. This approach aims to identify risks and needs within families at the earliest opportunity and identifying support to address needs and mitigate risks

to ensure that the support needs of family members and the threat/risk they are exposed to are acted upon when a person comes into contact with services. This includes but is not exclusive to DA, mental health, substance misuse and adult safeguarding.				template that will be used and accepted by all participating organizations. Family and friends are involved to the extent that victim-survivors are always encouraged to have a 'code word' with a friend or family member in case they need them to call the police on their behalf.		
Recommendation 4: That Hertfordshire County Council and Barnet Borough Council supports and encourages a culture of 'professional curiosity' and 'check and challenge' across the partnership in the discharge of safeguarding duties to improve learning, behaviours, decision making and service delivery through the Practice Governance Board.	Local	Hertfordshire County Council to encourage professional curiosity across the partnership.	Hertfordshire County Council and Barnet Borough Council	Hertfordshire Safeguarding adult board provides training on 'Professional Curiosity & Difficult Conversations'. The session covers the concept of professional curiosity and attempts to define this in the context of safeguarding. It considers professional skills, attitudes and behaviours required to develop a more curious practice. Helps to understand the barriers to curious practice, reviews challenges practitioners may face and gives advice on the use of strength based questions and motivational interviewing.	Ongoing	This training is ongoing and is provided a few times a year. The next available training is in July 2024.
Recommendation 5: That Hertfordshire County Council and Barnet Borough Council Community Safety Strategy Strategic Needs Assessment encompasses DA (Intimate Partners and	Local	1, Hertfordshire County Council to: A, Prioritise service provisions that meet the needs of the people of Hertfordshire.	Hertfordshire County Council and Barnet Borough Council	1: A, Hertfordshire County Council has recently completed two major projects: the Pathways project which asked 643 victim-survivors about what they would have benefitted from through their DA journey. The second project, called Community mapping, that looked at all	Ongoing.	1A and 2, The One Stop Shops project is just starting and will be ongoing. There were many different groups identified in the Community mapping project that should be given more support, unofficial carers being one of them,

Family Related violence/abuse) to better understand the prevalence of the problem and its underpinning drivers: • by agreeing priorities and service provision that meet the needs of the people of Hertfordshire County Council and Barnet Borough Council and are cognisant of the gaps within partnership working including the need to work in partnership with local people and non-government organisations (NGOs), • demonstrating a specific focus on people as 'unofficial' carers and victims/survivors of DA, and		B, Work in partnership with local people and non-government organizations. 2, Focus on people who have been identified as victim-survivors of DA and are also unofficial carers.		available DA services in each double-district area of Hertfordshire and looked at the population data and the needs identified by victims and made recommendations on what services would each area benefit from. Based on these projects, the One Stop Shops project is about to start which will bring together DA services and address the gaps identified in services in each area of Hertfordshire. B, There is work ongoing with the Co-production Panel to involve local people in DA related decisions. Please see outcomes for further detail. 2, The Community Mapping project identified several people within Hertfordshire, especially in the Stevenage and North Herts area, who are being unofficial carers and services provisions and support for them will be incorporated into the aims of the One Stop Shops.		thus, support for them will be incorporated into this project. To prioritise the service provision that meet the needs of the people in Hertfordshire, currently, the Hertfordshire Domestic Abuse and Violence Against Women and Girls Partnership wants to expand and develop support provided in the community, specifically for those from under-represented or marginalised groups, to ensure they have access to DA support services that are right for them and invited applications through the Grassroots Fund. This will include support for the people from the communities such as: Male, LGBTQ, Older people (over 65), Black or from other globally diverse communities, At risk of or experiencing multiple disadvantages, Refugees/asylum seekers, Those with No Recourse to Public Funding (NRPF), From the gypsy or traveller community, People with disabilities, People who are neurodiverse and other groups not accessing traditional domestic abuse services. One of the main aims of this programme is to improve access to domestic abuse support in Hertfordshire for all residents, particularly those who do not currently access the traditional

• to inform the delivery of the local DA Strategy and its accompanying action plan.						services. Outcomes are yet to be confirmed in May 2024. 1B, A Co-production Panel made up of people with lived experience of domestic abuse was introduced in 2021. The Panel forms part of the Hertfordshire DA&VAWG Partnership's governance structure, acting as a critical friend across the partnership and supporting the delivery of the County's Partnership Hertfordshire Domestic Abuse Strategy 2022-2025. This is currently being built upon by a revised countywide domestic abuse co-production approach, being procured to an independent facilitator organisation in 2023. The service to be procured is made up of two workstreams: A Co-Production Panel: A 'shadow board' style Co-Production Panel, consisting of victims and survivors with recent experience (within last 10yrs), which will work as part of Hertfordshire's governance structure, informing decisions made locally, in relation to the response to domestic abuse. This will be 'panel-led', meaning that the panel will lead on its own

						objectives and workplan. The commissioned independent organisation will support the panel to work in partnership with the Hertfordshire's Domestic Abuse Partnership on co-production projects. A Co-Production Collective: A network of Hertfordshire residents with lived experience of domestic abuse, regardless of how recent this may have been. This network will underpin the co-production panel to ensure there is a collective authentic voice guiding the work of the co-production panel.
Recommendation 6: That the Barnet, Enfield and Haringey Mental Health Trust develops a Policy and Operating Practice regarding documenting risk assessments relating to patients who are discharged back to their families and home in line with the think family approach.	Local		Barnet, Enfield and Haringey Mental Health Trust			Clinical Risk Assessment & Management Policy updated in November 2021, due to be reviewed again late 2024. Consideration of risk to family included.
Recommendation 7: That Hertfordshire County Council, Hertsmere District Council and the	Local	The Risk Management Sub-group to review approaches to MARAC.	Risk Management Sub-group	The referral criteria to MARAC are set nationally and the MARAC Team at Hertfordshire provides MARAC Rep training to all partner agencies to make	Ongoing.	Ongoing.

Hertfordshire Constabulary and its health care partners review its approach to referrals of DA cases (victims or perpetrators) to the MARAC and MAPPA from acute settings.		MAPPA referrals to be dealt with by the Chrysalis centre.		sure that front line professionals are aware of the criteria and how to utilise them. MARAC is audited annually where referrals are being looked at to identify any issues or emerging trends. In terms of the MAPPA referrals, a new initiative of the Chrysalis Centre has taken over all perpetrator related programmes and meetings in Hertfordshire. This project is at its early stages.	Ongoing.	Ongoing. As some of the funding is from the MoJ, there will be ongoing evaluation of the Chrysalis centre.
Recommendation 8: That the Hertfordshire County Council and the London Borough of Barnet reviews, evaluates and identifies areas for improvement in the routine DA training/awareness programme for all staff of relevant agencies and charities to: • Emphasise the importance of referrals to the DA MARAC (via the "Single Front Door") in cases where any professional believes there is an increasing trajectory of risk	Local	1, Hertfordshire County Council to review DA awareness training with focus on the barriers to disclosure. 2, MARAC training to be reviewed.	Hertfordshire County Council and the London Borough of Barnet	1, The Strategic Partnership Team at Hertfordshire County Council is scoping the current DA related training within Hertfordshire County Council and the DA Partnership with the aim to develop a coordinated training programme to ensure that DA related training meets the needs of professionals and addresses the gaps in knowledge. 2, MARAC training is provided by the MARAC team audited annually by the Risk Management Sub-Group, Including on where cases meet criteria other than 'visible high risk'.	June 2024 Ongoing	Expected completion by June 2024. Ongoing.

to a vulnerable person, even though the immediate situation does not meet the formal referral criteria. • The intersectional needs, complex needs and the situational barriers to disclosure, which may be experienced by DA victims. • DA Operational Board at County Council / District Council level.						
Recommendation 9: That the Community Safety Partnership Members in Hertfordshire County Council and London Borough of Barnet develop a practice guidance to assist professionals within their agencies to effectively manage complex and high-risk cases where victims decline agencies	Local	Hertfordshire County Council to look at policies and procedures for working with individuals and families who find it difficult to engage.	Hertfordshire County Council and London Borough of Barnet	For one of our recent DHRs (DHR Lilly – not published) Hertfordshire County Council collected information on policies and procedures for working with individuals and families who find it difficult to engage. We consulted Hertfordshire and West Essex Integrated Care Board, Hertfordshire Partnership University NHS Foundation Trust.	June 2023	Completed, June 2023. **Hertfordshire and West Essex Integrated Care Board:** The CHC team in the ICB do not have a specific policy relating to non-engagement. Their feedback states that generally it is not something they struggle with as people want the free care packages on offer.

assistance and support e.g. use of DVPOs.						**Hertfordshire Partnership University NHS Foundation Trust'**s 'Did Not Attend (DNA) / Not Brought In (NBI) Policy' is provided below: Did+Not+Attend+DNA++Not+Brought+I **Other DA partners:** DA partner organizations are aware that high risk overrides consent and victim-survivors should be referred to MARAC to enable relevant safety planning.
Recommendation 10: That the members of the Community Safety Partnership with responsibility for VAWG provide assurance to Hertfordshire Council, Hertsmere District Council and the London Borough of Barnet as to the effectiveness of its training programme for local professionals relating to DA.	Local	Internal and external DA and VAWG related training to be scoped and reviewed.	Hertfordshire County Council	The Strategic Partnership Team at Hertfordshire County Council is currently reviewing internal and external DA and VAWG related training and reviewing this against the requests that the partnership is receiving in term of training.	June 2024	Once the internal and external training is reviewed and gaps are identified, the Strategic Partnership Team will commission training to fill the gaps and create a baseline training requirement for professionals to have in terms of DA and VAWG training.
Recommendation 11: That steps are taken for healthcare providers namely GPs, hospital	Local		Hertfordshire and West Essex Integrated Care Board			*Recommendations for GPs and how they should be turned into actions are currently being reviewed by*

trusts and urgent care centres to triangulate health records of family members where there is known DA recorded.						*Hertfordshire and West Essex Integrated Care Board.*
Agency specific recommendations						
Herts Police						
Recommendation 1: Guidance to be given on the completion of DASH books where Mental health illness is the primary concern.	Local	Since this recommendation was made, DARA was rolled out within Herts Police to replace DASH.	Herts Police	Hertfordshire Police started using DARA (Domestic Abuse Risk Assessment) on 1st July 2023 which is a new way of identifying risk on the frontline of policing. DARA now rolled out in force to replace DASH. Provides a far more holistic view of incidents. Comms and training provided to the whole force.	Septembe r 2022	Completed, September 2022. DARA rolled out and training provided to the whole force.
Recommendation 2: Further detailed training in the Mental Capacity Act to be included at training days.	Local	Training to be included on the Mental Health Capacity Act.	Herts Police	Training delivered force wide in Autumn 2022 training cycle, including reference to this case.	Autumn 2022	Completed, autumn 2022. Training delivered.
Recommendation 3: Where a patient is being discharged by a mental health unit and their admission included Police involvement, consideration to be given to informing the Police, prior to the discharge, to allow any risk assessment deemed necessary.	Local	To be processed by the Trust Security & Liaison Group, Hertfordshire Police.	Herts Police	This recommendation is now being processed with the Trust Security and Liaison Group for adding to policy.	Complete d.	Completed. This is now a standard procedure with patients who are being released from any of the Hertfordshire Partnership NHS Foundation Trust's sites.

Recommendation 4: Procedures to be reviewed between Hertfordshire Police and the local mental health NHS for protocol in regard to the managing of patients in similar circumstances.	Local	To be processed by the Trust Security & Liaison Group, Hertfordshire Police.	Herts Police	This recommendation is now being processed with the Trust Security and Liaison Group for adding to policy. RIGHT CARE RIGHT PERSON policies all in the process of being written so in order to align with these, this policy will change when RIGHT CARE RIGHT PERSON protocols have been agreed.	Complete d.	Completed. It is accepted practice now for Health to inform police regarding high-risk discharges and the team at Hertfordshire Partnership NHS Foundation Trust to discuss high risk releases with the Mental Health Police Team and hold professionals' meetings to discuss individual cases.
GP						
Recommendation 5: To continue to ensure all staff are aware of how to identify and respond to signs of DA. This will be achieved by maintaining IRIS practice in the London Borough of Barnet, with both clinical and non-clinical staff taking part in refresher training and new staff being offered training. They described this as achievable within the Practice's allocated educational sessions.	Local		GP			*Recommendations for GPs and how they should be turned into actions are currently being reviewed by Hertfordshire and West Essex Integrated Care Board.*
Recommendation 6: For clinic staff – to continue to actively discuss cases within the clinical meeting, ensuring clinicians and patients are supported correctly, and	Local		GP			*Recommendations for GPs and how they should be turned into actions are currently being reviewed by Hertfordshire and West Essex Integrated Care Board.*

medical records are kept appropriately.						
Barnet Enfield and Haringey Mental Health Trust						
Recommendation 7 For all staff to follow the Trust Clinical Risk Assessment and Management Policy, remembering to update the Rio Risk Assessment with information newly obtained in consultation/assessment.	Local	To ensure new information is addressed within Safety huddles/MDT reviews and staff are routinely updating the risk assessment tool on RiO.	Barnet Enfield and Haringey Mental Health Trust	Risk Management Procedure updated in November 2021.	November 2021	Complete. All teams have daily safety huddles. Patient risk is discussed routinely. All patients in EDs and wards are discussed at twice daily MDT and risk levels reviewed, in line with policy.
Recommendation 8: All staff to ensure adhere to safeguarding record keeping standards and procedures.	Local	To embed a more extensive understanding of domestic abuse (its impact and need for early intervention) across the Trust.	Barnet Enfield and Haringey Mental Health Trust	A, To incorporate Multi-Agency Risk Assessment Conferences (MARAC) Safelives training within the current Trust Domestic Abuse training as well as learning from Domestic Homicide Reviews (DHRs). B, Roll out Trust wide Domestic Abuse (DA) & Domestic Abuse Act 2021 Training. (minimum requirement of twice yearly). C, To implement and roll out a new Trust wide Domestic Abuse Directory signposting specialist support services for victim survivors and perpetrators. D, To disseminate a 7-minute briefing which summarises learning from DHRs via Trust communications and the Patient Safety Reflections Newsletter.	December 2022	All Actions Completed December 2022. Evidence available upon request. Domestic abuse and sexual safety co-ordinator (DASSC) is now in post. DA directory has been published. – Available upon request Completed. Domestic Abuse Training is delivered across the North London Mental Health Partnership (BEH & C&I MHT) on a bi-monthly basis. Individual teams training is also available to all services. DASSC regularly develops resources for staff are regularly made available through managers and the Domestic Abuse Network and

				To submit a Business Case for the proposed creation and recruitment for a new Band 7 Domestic Abuse Advisor who will be overseeing the roll out of Domestic Abuse Ambassadors within the Trust.		published via the intranet (i.e 7 minute briefings, MARAC guidance, support services, safety planning guidance etc). – Available upon request services, safety planning guidance etc). – Available upon request). The DA Policy has been updated and was published in December 2022 – available upon request. The DASSC provides full case review with frontline practitioners where there are concerns of domestic abuse which includes support around risk management, safety planning and relevant referrals to enhance safeguarding. A weekly drop-in surgery runs for staff to discuss cases and seek further advice and guidance on next steps from the DASSC. The DASSC attends divisional and ward managers meetings to share information, training and lessons learned from serious case reviews.
Recommendation 9: To conduct a clinical pathway review for acute presentations within ED between Psych Liaison to CRHTT using QI methodology.	Local	All divisional CRHTT to involve a senior clinician in the team discussion (within hours) or on call SPR (out of hours) when a decision to change the clinical pathway is made.	Barnet Enfield and Haringey Mental Health Trust			Complete. Escalation flowchart developed, includes MDT and SPR involvement. Circulated for awareness, and is displayed in team offices.

						No agency staff currently on team. Bank staff are long term and well inducted into local practices.
Recommendation 10: Teams to ensure that when there are significant changes in a patient's care affecting their care pathway, a multi-disciplinary team approach is employed, and seniority of attendees is taken under consideration.	Local	All staff to undertaken bespoke mental health training to address this issue. A multi-disciplinary team and multiagency forum is to be set up to discuss issues highlighted in relation to mental health act assessments.	Barnet Enfield and Haringey Mental Health Trust			Complete. Training that addresses issues has been delivered and is available across the trust. MDT meets twice daily. MHAA risks discussed. Band 7 social worker employed. They managed MHAAs on behalf of LA and attend MDTs.
Recommendation 11: Due to the risk of incomplete multi-agency handovers, staff should ensure that they undertake a thorough assessment of the referred patients, including presenting complaint and its surrounding circumstances, psychiatry history, medication history including medication administered in the Emergency Department and document this in the patient's notes as appropriate.	Local	1, The crisis prevention houses to have clear operational criteria shared with all relevant teams likely to refer patients to them, including Emergency Department liaison, crisis teams and access and flow. 2, Referrals for admission to any inpatient setting should be clear in what needs to be achieved by the admission so that the access and flow team will be able to direct the patient to the most appropriate setting.	Barnet Enfield and Haringey Mental Health Trust			Completed – December 2022 1. Crisis prevention houses operational policy in place. Covers all areas listed. 2. Formal admissions - Collaborative review of MHA assessment undertaken (incl Access and flow, s12 Doctors and AMHPs). For informal admissions, local crisis teams do gatekeeping with clear plans of patient management in community.

Recommendation 12: All staff should be reminded of documentation standards and expectations of the same.	Local		Barnet Enfield and Haringey Mental Health Trust			Completed A group has also been set up to review clinical standards as part of their remit.
Hertfordshire Partnership NHS Foundation trust						
Recommendation 13: DA training will be accessible to all clinical staff at least once a month.	Local	Minimum 1 Domestic Abuse Training webinar per month to be included in Training schedule for 2024-25. This to include: Domestic Abuse and Mental Health, Routine Enquiry Training, Basic Risk assessment training, Coercion and Control and Domestic Abuse and Suicide awareness.	Hertfordshire Partnership NHS Foundation trust	Training planning meeting held to decide training schedule for 2024-25. Training Delivered Training planning meeting held annually to review and develop training programme	8th February 2024 Monthly throughout 2024-25 Annually: Jan/Feb	Monthly training delivered and training planning meeting is held annually.
SOLACE						
Recommendation 14: Paperwork, information, promotional and resource leaflets associated with the DVPP programme to reference not only current/ex partners but also family members who are at risk of DA. This would then go some way to ensuring that those at risk of DA are identified and referred for appropriate support.	Local	Solace Violence Prevention Programmes Development & Implementation Manager and Solace Head of Quality and Service Improvement to be jointly responsible for reviewing all current literature for Solace programmes to be completed by 30/4/2022.	SOLACE	Updates received on 08/02/2024 state that Solace does not provide DVPP programmes any more.	08/02/2024	Incomplete as SOLACE does not provide this program any more.

Recommendation 15: To ensure that when working in partnership that we are asking critical questions and being proactive when asking for copies of relevant paperwork and evidence our request and outcome on case notes. This would ensure that we are working towards providing a more complete and risk/needs focused approach towards support for those referred.	Local	Solace Head of Quality and Service Improvement to include in appropriate internal policies and procedures by 30/6/2022.	SOLACE	Solace's Customer Relationship Management system is robust and access to notes and support paperwork can be requested on an ad-hoc basis through Subject Access Request and/or depending on the level of risk attached to the request.	08/02/2024	SOLACE has a robust system for notes and information can be requested on an ad-hoc basis.
Recommendation 16: Discussion around resources and how Solace ensures that they are able to manage working with multiple people identified at risk from the perpetrator on a DVIPP when resources are limited. To ensure that each person identified is given an individual risk led approach.	Local	Solace Head of Quality and Service Improvement to discuss with Director of Services and develop protocol by 31/7/2022.	SOLACE	Solace has robust safety protocols that include risk assessment processes. We apply these at all times when supporting a survivor of DA and these can be evidenced through our CRM system which contain details notes related to each individual. Solace no longer provides DVPP.	08/02/2024	Safety protocols, including risk assessment processes, are in place and can be evidenced through CRM systems. SOLACE no longer provides DVPP.
Recommendation 17: For assessing team to ensure that when there are significant changes in a patient's care affecting	Local	Solace Head of Quality and Service to review.		As above, Solace follows a strict protocol when risk assessing women. We risk assess every case accurately and those deemed to be at higher risk are supported accordingly.	08/02/2024	Solace follows strict protocols when risk assessing and provides support accordingly.

their care pathway, an MDT approach is employed, and seniority of attendees is taken into consideration.						
Recommendation 18: Review Solace internal training and guidance on MARAC referrals to ensure section on reasons when you would referral for “professional judgement” is included.	Local	Solace Head of Quality and Service to review and implement by 30/6/22.	SOLACE	As part of our Risk Management training, we provide detailed MARAC training which includes tools to work best with other professionals.	08/02/2024	Solace provides detailed MARAC training, including tools for best practice when working with other professionals.