Hertfordshire Domestic Abuse Partnership

Welwyn and Hatfield Community Safety Partnership

Domestic Homicide Review

Overview Report

Into the death of Arthur (pseudonym) in August 2022

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A Tribute to Arthur

The Independent Chair and Domestic Homicide Review Panel offer their sincere condolences and deepest sympathy to all who have been affected by the death of Arthur, and thank them, together with the others who have contributed to the deliberations of the Review, for their participation, generosity of spirit and patience.

The Review Chair thanks the Panel for their enthusiastic engagement with this process and the Individual Management Review authors for their thoroughness, honesty and transparency in reviewing the conduct of their individuals' agencies.

1. Preface

1.1 Domestic Homicide Reviews (DHRs) came in to force on the 13th April 2011. They were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004). The Act states that a DHR should be a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by-

a) A person to whom she was related or with whom she was or had been in an intimate personal relationship or
b) A member of the same household as herself; held with a view to identifying the lessons to be learnt from the death.

1.2 There was also a change to the Multi Agency Guidance in December 2016 where Community Safety Partnerships have been encouraged to commission a review where an individual has taken their own life, and they were known to agencies as experiencing domestic abuse.

1.3 Throughout the report the term 'domestic abuse' is used in reference to 'domestic violence', as this is the term which has been adopted by the Strategic Partnerships Team in Hertfordshire.

1.4 The purpose of a DHR is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and agencies work individually and together to safeguard victims.
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.
- Apply those lessons to service response, including changes to inform national and local policies and procedures as appropriate,
- Prevent domestic abuse and homicide and improve service responses for all domestic violence and abuse victims and their children by developing co-ordinated multi agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity.
- Contribute to a better understanding of the nature of domestic violence and abuse.
- Highlight good practice

1.5 The criteria for a Domestic Homicide Review was met in relation to Arthur's death because during the criminal investigation of this incident information came to light that Arthur may have experienced some examples of domestic abuse in relation to social isolation, controlling behaviour and excessive use of restraint. Although the criminal investigation was closed in relation to Arthur's death, the Community Safety Partnership still felt that there may have been lessons to be learnt from Arthur's experiences. This review examines the circumstances surrounding the death of Arthur in a town in Hertfordshire in August 2022. The principles underpinning the review process have been followed in

accordance with the Home Office Multi-Agency Statutory Guidance on the Conduct of Domestic Homicide Reviews- Revised Version-December 2016 and pseudonyms have been used.

2. Introduction

2.1 Arthur was 57 years old at the time of his death. He was the father to three adult children, Benjamin, Sophie and Jeremy. It is understood that he had lived in Hertfordshire since 2007 when he was compelled to move to the area following a court order. This was following a criminal conviction of Actual Bodily Harm in September 2007, which is also reported to be against his ex-wife. Also, during this same time, it is reported that Arthur attempted to end his own life by stabbing himself in the stomach, this triggered some involvement with Hertfordshire Partnership University NHS Foundation Trust. He continued to receive a level of support from this organisation in 2008 onwards until his death. Albeit there were periods of time where it was reported that he did not engage, this might also have been because he felt unable to.

2.2 Between 2008 and the the time of his death Arthur was diagnosed with Aspergers, ADHD, Anxiety and Depression by two different mental health organisations. He was also assessed for an eating disorder in 2022 owing to concerns for his weight and relationship with food, however it was determined by clinicians that he would best be supported by a Community Mental Health Team and support from a community dietician.

2.3 It is reported as part of this review that Arthur's youngest adult son, Jeremy, moved in with Arthur in December 2021 to care and support Arthur. The family described the dynamic between Jeremy and Arthur as being 'odd', with Jeremy being controlling over access to Arthur and the pair of them being quite insular and detached all driven by Jeremy. It was recorded in one of the agency's records that a family member believed Jeremy had a controlling personality although his intentions were good.

2.4 Arthur's tenancy was with Paradigm Housing as a sole tenant. This housing provider contacted Arthur in August 2022 to ask that he vacate the property to enable maintenance works to be undertaken, Arthur gave permission for Paradigm Housing to speak with Jeremy his informal carer. Arthur and Jeremy were housed in temporary accommodation at a local hotel.

2.5 **Incident summary:**

2.5.1 On the evening of a night in August 2022, paramedics were called to the local hotel to reports of a male in cardiac arrest, the call having been made by Jeremy. Upon arrival of Police and ambulance staff, Arthur was declared deceased in the room at midnight and had a notable bruise to his neck. There was also evidence of a disturbance in the room, with some blood and a damaged shower hose.

2.5.2 Owing to the nature of their caring relationship and some concerns raised by family members during the course of the Police investigation. A referral was made to the

Community Safety Partnership to explore whether the criteria was met for a Domestic Homicide Review.

2.5.3 A Home Office Postmortem was conducted which was inconclusive, the bruising on the neck was superficial and not a contributory factor. Therefore, all criminal investigations into Arthur's death have now concluded. There are no further investigations that can be done to ascertain whether there was third party involvement in Arthur's death which would meet the criminal standard.

2.5.4 The Coroner's Inquest is still outstanding, and likely to take place after the conclusion of both this Domestic Homicide Review.

2.5.5 The key purpose of this review is to enable lessons to be learned from Arthur's death. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened, and most importantly, what needs to change in order to reduce the risk of such a tragedy happening in the future. Although there is not a lot of information known about Arthur and Jeremy and in particular their caring relationship. The Community Safety Partnership still recognised the importance to explore any learning opportunities in relation to identification of carers, support for carers, recognising the use of restraint by carers versus abuse.

2.5.6 The Review considers all contacts/involvement agencies had with Arthur and some contacts with Jeremy during the period January 2017 to August 2022, as well as any events, prior to 2017, which are relevant to mental health, violence, and abuse.

3. Timescales

3.1 On 21st December 2022 the Strategic Partnerships Team of Hertfordshire County Council received a Domestic Homicide Review Referral relating to Arthur from Hertfordshire Constabulary. Following an initial information sharing gathering exercise with a range of local statutory and voluntary sector agencies a decision was made on 24th January 2023 by the Chair of the Strategic Partnerships Team together with the Chair of the Community Safety Partnership to commission a review as a result of the criteria being met and the opportunity to learn from Arthur's death. It is the responsibility of the Strategic Partnerships Team to coordinate Domestic Homicide Reviews on behalf of the County's 10 Community Safety Partnerships.

3.2 The Home Office Multi Agency Statutory Guidance advises that where practically possible the DHR should be completed within 6 months of the decision made to proceed with the Review. However, between September 2021 and January 2022, there were a steep increase in the number of domestic homicides being committed in Hertfordshire. During this short period there were four homicides which met the criteria for a Domestic Homicide Review. This exceeded the average number of domestic homicides in Hertfordshire in a year. Therefore, this unfortunately had a cumulative effect on availability of Panel members and accredited and independent Chairs. The police investigation into Arthur's death also did not conclude until the summer of 2024.

3.4 An Independent Chair was commissioned to begin the Domestic Homicide Review from September 2024. Panel meetings took place in October 2024, January 2025, February 2025, August 2025 and September 2025. The reason for the delay between February 2025 and August 2025 was to enable permission to be granted from the Coroner's Court so that the Panel could consider some of the information brought to light through the criminal investigation in relation to use of restraint that was included in the coroner's bundle. The Review was completed in November 2025 and forwarded to the Home Office in December 2025, following sign off by the Community Safety Partnership. The Overview Report was also shared with the coroner at the conclusion of the review.

4. Confidentiality

4.1 The findings of this Review are restricted to only participating professionals and their line managers, until after the Review has been approved by the Home Office Quality Assurance Panel.

4.2 As recommended within the 'Multi Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews' to protect the identity of the deceased, and her family, the following pseudonyms have been used throughout this report.

4.3 The name Arthur is used for the deceased, who was 57 years at the time of his death and chosen by the Review Panel. The name Jeremy is for his youngest adult son, a pseudonym chosen by the Review Panel. Jeremy was his informal carer from December 2021 until the time of his death. Both Arthur and Jeremy were White British.

4.4 After this Overview Report has been through the Home Office Quality Assurance process, a decision on whether to publish it will be made by the Strategic Partnerships Team. If it is to be published, the Report and appendices will firstly be fully redacted.

4.5 A redaction may simply replace a name with a pseudonym or may be the removal of personal and sensitive details about an individual, i.e., medical information. Redactions will not be used to protect the identities of the organisations participating in the Review.

4.6 The sharing of information between organisations in relation to the Review was all underpinned by a Confidentiality Statement which each individual read and signed at the beginning of the review (Appendix B). An information sharing protocol was and currently is in place which all agencies represented on this panel are signatories to, this agreement is underpinned by the Crime and Disorder Act 1998 which the Strategic Partnerships Team have in place, supported by the Community Safety Partnership.

5. The Terms of Reference

Specific Terms of Reference for this Review:

5.1 To provide an overview report which articulates the life of the victim through his eyes to understand the reality of his experiences with professionals working with and offering support to him and being cared for by his adult son.

Each Agency will be asked to:

5.2 Comment on the specific areas set out in the key lines of enquiry found within section 10 of this document.

5.3 To identify the history and context of the relationship between Arthur and Jeremy who were father and son and provide a detailed chronology of relevant agency contact with Arthur; specifically, his experience of agencies and his relationship with Jeremy, who agencies have identified to have shown signs of abusive behaviour towards Arthur.

5.4 To examine whether there were signs or behaviours exhibited by Arthur as being a victim of domestic abuse or Jeremy as the alleged perpetrator, in their contact with services which could have indicated the level of risk.

5.5 To report their involvement with both Arthur and Jeremy to assess whether the services provided offered appropriate interventions, risk assessments, care plans and resources. Assessment should include analysis of any organisational and/or frontline practice level factors which impacted upon service delivery. Specifically, how Jeremy was identified as a carer to Arthur, and what was offered in support of this to both individuals.

5.6 To examine whether there were any indicators or history of domestic abuse and/or coercive control? If so, were these indicators fully realised and how were they responded to? Was the immediate and wider impact of domestic abuse between Arthur and Jeremy fully considered by agencies involved? And how was information shared between agencies?

5.7 To consider whether there was any collaboration and coordination between agencies in working with Arthur and Jeremy, individually and as a Father and Son? What was the nature of this collaboration and coordination, and which agencies were involved with whom and how? Did agencies work effectively in any collaboration?

5.8 To consider what learning, if any, there is to be identified in the care management of Arthur who had a number of mental health diagnoses, was cared for by his adult son and there was some albeit limited information that Jeremy appeared at times controlling of his father. Is there any good or poor practice relating to this case that the Review should learn from? Each agency is asked to examine best practice in their specialist area and determine whether there are any changes to systems or ways of operating that can reduce the risk of a similar fatal incident taking place in future?

5.9 To examine whether communication and information sharing between agencies or within agencies was adequate, timely and in line with policies and procedures?

5.10 To examine whether there were any equality and diversity issues or other barriers to Arthur and Jeremy in seeking help?

5.11 To examine whether either Arthur or Jeremy were assessed or could they have been assessed as an 'adult at risk' as defined within the Care Act 2014. If not were the circumstances such that consideration should have been given to this risk assessment? Was Jeremy identified as a carer and what did this look like in terms of carer's support and assessment?

5.12 To provide an assessment of whether family, friends, neighbours or key workers were aware of any abusive or concerning behaviour that occurred prior to Arthur's death, and if they were whether they shared this information with any agencies.

5.13 To assess whether agencies have domestic abuse policies and procedures in place, whether these were known and understood by staff, are up to date and fit for purpose in assisting staff to practice effectively where domestic abuse is suspected or present.

5.14 To examine the level of domestic abuse training undertaken by staff who had contact with Arthur or Jeremy, and their knowledge of indicators of domestic abuse, both for a victim and for a potential perpetrator of abuse; the application and use of the DASH risk assessment tool; safety planning; referral pathway to Multi Agency Risk Assessment Conference (MARAC), or to appropriate specialist domestic abuse services.

5.15 The Independent Chair in consultation with the Police Family Liaison officer will be responsible for making contact with family members to invite their contribution to the Review, to keep them informed of progress, and to share the Review's outcome.

Key lines of enquiry

The following are key lines of enquiry which will be explored further with the relevant agencies in the review:

5.16 The reasons for Arthur and Jeremy's temporary residence in the local hotel and the hotel's awareness of their relationship and Arthur's health and social care needs. What domestic abuse awareness training do hotel staff have in identifying the signs when individuals are placed in temporary public accommodation by the local authority?

5.17 The support offered to Arthur as a result of his multiple mental health diagnoses and Jeremy as his adult son.

5.18 The differences in how agencies should respond to carer's abuse and domestic abuse and specifically the use of restraint.

5.19 The timeline in how long Jeremy had been 'caring' for Arthur, how long had they lived together?

Legal advice and costs

5.20 Each statutory agency will be expected and reminded to inform their legal departments that the review is taking place. The costs of their legal advice and involvement of their legal teams are at their discretion.

5.21 Should the Independent Chair, Chair of the CSP or the Review Panel require legal advice then this will be sought following discussion with the Panel.

Media and communication

5.22 The management of all media and communication matters will be through the Review Panel, supported by the Strategic Partnerships Team.

Roles and Responsibilities

Chair of Strategic Partnerships Team

5.23 To commission the DHR and seek assurance that the Terms of Reference have been met for the DHR before sending onto Home Office to be quality assured.

Independent Chair

5.24 To convene (with administrative support from the Partnership) and Chair the Review Panel meetings.

5.25 To liaise with the family/friends of Arthur and Jeremy, using the relevant family advocates or Family Liaison Officer.

5.26 To determine the brief of, coordinate and request Individual Management Reviews (IMRs)

5.27 To review IMRs ensuring that they meet the satisfactory criteria of the Home Office

5.28 To write the Overview Report and Executive Summary

5.29 To present the findings of the Overview Report to the Strategic Partnerships Team.

6. Methodology

6.1 Thirteen agencies/multi-agency partnerships/departments were contacted about this review initially in the Hertfordshire area and these are listed in Appendix D. The decision to undertake this review is referred to in Section 3.

6.2 The following agencies confirmed that they had had relevant contact with either Arthur or Jeremy, and therefore were asked to undertake an IMR or Helpful Statement (if their contact was minimal). These were:

- Hertfordshire Partnership University NHS Foundation Trust
- Hertfordshire and West Essex Integrated Care Board- representing GP Practices
- Paradigm Housing
- Hertfordshire Constabulary
- Hertfordshire County Council- Adult Social Care
- Probation

6.3 Independent Management Reviews (IMRs) were commissioned by the Independent Chair in November 2024. The above-mentioned agencies Four agencies undertook an IMR/Helpful Statement and presented this back to the Panel in February 2025. The purpose of an IMR is for the individual organisation to scrutinise their involvement in the case and establish whether policies and practices were adhered to or not. Following this review, the organisation may make recommendations to improve their response to domestic abuse as a result of this case.

6.4 IMRs were written by separate individuals to those who represented the organisations on the Panel in order to best support the independent scrutiny element of this choice of methodology and in line with best practice from the Statutory Guidance. Helpfully, Arthur's GP Practice were able to present their Helpful Statement to the DHR Panel alongside their Panel representative from the Integrated Care Board. The Chair praised the GP Practice for their dedication and interest to support the review.

6.5 This Report has been compiled using information and facts from the following:

- Individual Management Review (IMRs) presentations and Helpful Statements as above

- A chronology of events leading to the death of Arthur, coordinated and produced by Strategic Partnerships Team.

- Discussions during the Review Panel Meetings.

7. Involvement of family, friends and wider community

7.1 As per the Home Office guidance a letter together with the Leaflet on 'Domestic Homicide Reviews', was sent to Arthur's two other adult children, Benjamin and Sophie, inviting them to contribute and engage in this review, this was sent by the Independent Chair. Another letter was sent to Arthur's ex-wife and another to Jeremy. These letters were shared with Hertfordshire Constabulary colleagues who had built a rapport with these individuals during the Police investigation, therefore the Independent Chair has assurance that the invitation letter was received and confidence that the process will have been explained.

8. Contributors to the Review

8.1 Whilst there is a statutory duty that bodies including, the Police, local Authority, probation and health authorities must participate in a DHR; in this case twelve organisations voluntarily contributed to the review from the Hertfordshire Domestic Abuse Partnership. These were the following.

- Hertfordshire Constabulary
- Welwyn Hatfield Borough Council
- Hertfordshire County Council
- Refuge
- Hertfordshire Partnership University NHS Foundation Trust
- Hertfordshire and West Essex Integrated Care Board
- Burnvill House GP Practice
- Priory Gardens GP Practice
- Baldwin GP Practice
- Probation
- Paradigm Housing
- Carers for Herts
- Turning Point

9. Multi Agency Review Panel

9.1 The Review Panel consisted of senior managers, from both the statutory and voluntary sector, listed below. All of the organisations that have been part of the Review have assisted in the identification of lessons and committed to implementing action plans to address the lessons. All Panel members have also undertaken the Home Office DHR Panel training and signed confidentiality statements.

9.2 The membership of the Multi Agency Review Panel included the following.

Organisation	**Job title**
FJK DHR Consultancy	Independent Chair/Report Author
Hertfordshire County Council	Development Officer (Strategic Partnerships) Administrator Head of Safeguarding (Adult Social Care)
Welwyn Hatfield Council	Anti-Social Behaviour and Community Safety Manager
Refuge	Service Manager
Hertfordshire Constabulary	Detective Inspector
Paradigm Housing	Neighbourhood Manager
Hertfordshire Partnership University NHS Foundation Trust	Specialist Safeguarding Practitioner
Burvill House GP Practice	GP
Carers in Herts	Michele Stokes

Hertfordshire and West Essex Integrated Care Board	Head of Safeguarding/Designated Nurse

9.3 The Panel sought the expertise of the specialist domestic abuse support service within the Hertfordshire County to support DHR Panel discussions on what further work could be undertaken where there is an informal carer's arrangement between two family members. Expertise was also sought from Carers in Herts for their check and challenge on what carers are and should be offered and most importantly how agencies should approach this.

9.4 The Independent Chair and the Review Panel members offer their deepest sympathy and condolences to Arthur's family. The Chair would also like to thank the Review Panel who have contributed to the deliberations of the Review, for their time, honesty, transparency and cooperation.

10. Author of the Overview Report

10.1 The Chair of the Panel possesses the qualifications and experience required of an Independent DHR Chair, as set out in section 5.10 of the Home Office Multi- Agency Statutory Guidance. She has worked as a practitioner, commissioner of services for survivors and a consultant in the domestic abuse sector. She dedicated her Master of Science to 'What works when working with domestic abuse perpetrators of domestic abuse'. She is not associated with any of the agencies involved in the Review nor had she had any dealings with ARTHUR, and she is totally independent. She has undertaken the AAFDA (Advocacy after Fatal Domestic Abuse) DHR Chair Training, is an experienced DHR Independent Chair/Report Author and is passionate about improving the responses to domestic abuse both locally and nationally.

11. Parallel Reviews

11.1 The Coroner's Inquest is still outstanding. It is intended that the Overview Report will be shared with the Coroner's Office on completion of a final version.

12. Equality and Diversity

12.1 The Panel have been committed to the Review, within the spirit of the Equalities Act 2010, and have demonstrated an ethos of fairness, equality, openness and transparency. The Panel have worked as a partnership in ensuring that the Review has been conducted in line with the Terms of Reference. The Review has been cognisant of Arthur's family and their privacy. Arthur's family members and Jeremy were contacted as part of this Review to ascertain their views about Arthur's lifestyle, interaction with agencies and his relationships.

12.2 The practices of agencies were carefully considered to ascertain if they were sensitive to the nine protected characteristics of the Equality Act 2010 ie. Age, disability, gender reassignment, marriage and civil partnerships, pregnancy and maternity, race and religion and belief, sex or sexual orientation. In line with the Terms of Reference, the Panel

considered these protected characteristics and concluded that given Arthur's mental health diagnosis this was a factor relevant to the review. Section 6 of the Equality Act defines disability as when a person has a physical or mental impairment which has a substantial and long-term adverse effect on their ability to carry out normal day-to-day activities. As reported by Jeremy to agencies in the latter part of the timeframe of this review, Arthur did require support with his day-to-day activities. To that end Hertfordshire Partnership University NHS Foundation Trust were aware of Arthur and there was evidence as part of this review that they did offer support and services to him. There was no evidence in the records held by agencies that there was ever any question of Arthur's mental capacity, therefore no formal assessment of capacity was ever required.

12.3 Arthur was a white British male with English as his first language. He had been married and had 3 children. He had a good relationship with all three of his adult children; this was evident in witness statement gathered by the Police as part of the criminal investigation which was undertaken following Arthur's death.

12.4 Jeremy is also a white British male with English as his first language. We understand from this review that he also had periods of time when he suffered from anxiety and low mood. No agency held information that indicated that he lacked capacity to make decisions and there was no indication from the resources analysed as part of this review that a formal assessment of capacity was ever required for him. It was understood from information known by agencies that his marriage broke down and a short while later he was living with Arthur and then assumed what we now have identified was a caring role. It was unclear what other changes may have occurred during this time for Jeremy, for example employment or impact on his social life when he moved in with Arthur in 2022. The Panel paid due regard to these lifestyle changes that happened for Jeremy during this time.

12.5 The above factors were all considered as part of this review. It was also reported in various studies, in particular by University of Oxford and Professor Rachel Condry that during Covid 19 pandemic saw an increase in child on parent violence owing to pressure and tension building in households/families. The Panel were cognisant of this information when considering the intersectionality of Arthur and Jeremy.

13. Dissemination

13.1 Actions to be taken after presentation of the Overview Report to the Welwyn and Hatfield Community Safety Partnership.

13.2 The partnership should:

- Provide a copy of the Overview Report and supporting documents to the Home Office Quality Assurance Group. This should be via email to DHRENQUIRIES@homeoffice.gsi.gov.uk

- The document should not be published until the partnership has received confirmation from the Home Office that the report has passed the Quality Assurance process.
- In preparation of publication, the Partnership should agree and sign off the content of the Overview Report for publication, ensuring that they are fully anonymised, apart from the names of the Review Panel Chair and members.

13.3 On receiving clearance from the Home Office Quality Assurance Group, the Welwyn and Hatfield Community Safety Partnership with Hertfordshire Domestic Abuse Partnership should:

- Provide a copy of the Overview Report and supporting documents to the senior manager of each participating agency listed in Section 8, including individually each of the Panel members listed in Section 9. As well as Domestic Abuse Commissioner.
- Decide whether an electronic copy of the Overview Report (this must be carefully redacted) and Executive summary should be published on the Hertfordshire County Council website. Only where necessary and for safeguarding reasons or wishes of the families involved in the review will the Report not be published.
- Monitor the implementation of the specific, measurable, achievable, realistic and timely (SMART) Action Plan.
- Formally conclude the review when the Action Plan has been implemented and consider an audit process.
- Make arrangements to provide feedback and debriefing to staff, family members and the media as appropriate.

14. The Facts

14.1 Arthur was a father to three adult children and originally lived in Harrow, however it is understood he moved to Hertfordshire in 2007 following a court order where he was convicted of a criminal offence of Actual Bodily Harm believed to be against his wife. It is recorded on agency records that during 2007, ARTHUR and his ex-wife were discussed at a Multi-Agency Risk Assessment Conference (MARAC) meeting owing to the nature of this incident and Arthur's mental health. A MARAC meeting is where agencies share information, assess risk and safety plan high risk cases of domestic abuse. It was also shared at this meeting that Arthur had 'profound mental health issues and a history of self-harming behaviour'. In particular it was shared that following the incident with his ex-wife, Arthur self-harmed causing significant injury by cutting his body from his throat to his stomach and had previously slashed his wrists.

14.2 Arthur was treated under Hertfordshire Partnership University NHS Foundation Trust from 2008 following concerns for his suicidal ideation and ADHD (attention deficit hyperactivity disorder). It is reported as part of this review that his engagement was varied, and it is unclear what the reasons were for this. In November 2009 an assessment was undertaken by this Trust which found that he did not have an Asperger's diagnosis. Arthur disputed this outcome on several occasions requesting re-assessments.

14.3 In 2010, Arthur contacted Hertfordshire County Council seeking support from Adult Social Care, advising that he had a diagnosis of Autism and Aspergers and that this was impacting on this daily life and ability to work. Therefore, he wanted to understand what support could be offered to him. Arthur was contacted by a social worker the following day where he added that he stays active by running, dancing and martial arts and sees his children, however his main problem is paying bills and not being able to get an Autism and Aspergers diagnosis. Arthur confirmed to the social worker that the mental health practitioners and his GP have advised that there was no positive diagnosis. During the following week, various calls were made by the social worker to other colleagues to establish any diagnosis, the assessments undertaken and next steps. The social worker was advised that Arthur had a Care Coordinator who had been helping him manage stress for the last year. The social worker was also informed that it was possible that Arthur wished for a positive diagnosis of Aspergers to support his employment position because he had been signed off work for some months at this point. The occupational health process that Arthur was working through with his employer were also advocating that if he had a disability for example Aspergers then the employer would need to make specific adjustments.

14.4 In 2011, it was recorded on Hertfordshire Partnership University NHS Foundation Trust system that Arthur registered with the Autistic Association despite a previous assessment by Hertfordshire Partnership University NHS Foundation Trust in 2009 finding that he did not have an Aspergers diagnosis. In 2012 Arthur was assessed privately by the Maudsley Hospital and Hertfordshire Partnership University NHS Foundation Trust received a letter in October 2012 which confirmed an Asperger's diagnosis by this private organisation.

14.5 No other records held between 2012-2016 which were reviewed as part of this statutory process because the focus of agency information was set from January 2017 to August 2022. However, in 2016, with the positive diagnosis of Aspergers now being noted by all agencies further attempts were being made by Hertfordshire Partnership University NHS Foundation Trust and Turning Point to engage with Arthur in order to undertake a social care needs assessment. An Assistant Therapy Practitioner (ATP) and a Turning Point Worker (TPW) were both assigned to Arthur, and both made attempts to contact him in October 2016. A referral had also been made to the Asperger's team in October 2016. Some of the support offered was in relation to Arthur's finances and to manage his financial debt. There was a reflection in the agency notes that Arthur often did not answer his phone, however, would engage well upon visits. The support offered by both the ATP and TPW both ended in November 2016 following a few visits to support Arthur with his financial debt and other practical areas. Instead, a Care Coordinator had now been reallocated to Arthur, although it was noted in the records that they struggled to make contact with him via phone.

14.6 At the start of 2017, further attempts were made by the Care Coordinator to make contact with Arthur, through an unannounced visit, appointment letters and texts. Conversations took place via phone and emails between the Hertfordshire Partnership University NHS Foundation Trust and the Council (Asperger's team) to establish who was engaging with Arthur and what his needs were. At the end of February 2017, the Care

Coordinator received a call from the job centre who was due to see Arthur for an interview and he did not attend. It was reported to the Care Coordinator that there were concerns by colleagues at the job centre who had also attempted to make contact with Arthur by visiting his home address. The Care Coordinator confirmed that they had also not been able to meet with or speak with Arthur and therefore a Police welfare check was requested. A welfare concern was logged with Hertfordshire Constabulary by the Community Mental Health Team. The Police visited Arthur and were satisfied that he was safe and well. He confirmed that he would contact Hertfordshire Partnership University NHS Foundation Trust. Arthur did respond to the Care Coordinator via text advising 'sorry I can't talk right now'.

14.7 The following month a social care referral was raised by the Community Mental Health Team at Cygnet House in relation to Arthur and he was also added to the waiting list for the Aspergers team in order that he could have some specialist support. Further attempts were made in April to engage with Arthur with a phone call and a home visit however to no avail. In May 2017, an internal multi-disciplinary team discussion took place in relation to how the Trust could best engage with Arthur. The outcome of this discussion was to discharge Arthur back to the care of his GP and to inform both Arthur and the GP of this action.

14.8 Further concerns in relation to how Arthur was coping with daily life were made again by the job centre in July 2017 when they visited Arthur at home, and he confirmed that he had not opened any of his post. There were concerns that not engaging in services would impact on his benefit entitlement also. The Job centre re-referred Arthur back to mental health services (Hertfordshire Partnership University NHS Foundation Trust).

14.9 In early August 2017, Arthur's son Jeremy made contact with Hertfordshire Partnership University NHS Foundation Trust requesting a medication review for his father. An outpatient appointment was offered for mid-September the following month and was sent out to Arthur via post. A Care Coordinator was allocated to Arthur and attempts were made via phone and a home visit in early September 2017. Arthur attended his outpatient appointment on 19th September 2017. Arthur's records were updated with a risk assessment following this appointment. Also, at the end of September, Hertfordshire County Council wrote to Arthur asking him to get in contact regarding offers of support and advice.

14.10 Following Arthur's outpatient appointment, his Care Coordinator from the Mental Health Trust (Hertfordshire Partnership University NHS Foundation Trust) continued to make attempts to contact and engage with Arthur to offer support, including an unannounced home visit where he didn't respond to the knock on the door but did to the window knock. It was reported as part of this visit that Arthur's flat was clean and tidy. Arthur advised the Care Coordinator that he was getting a lot of support from his children and enjoyed exercising but needed help registering with a new GP, who would understand autism and help with his benefits. During October, the Care Coordinator allocation changed, a handover was done following an unsuccessful visit to see Arthur together. The new Care coordinator visited Arthur at the end of October, Arthur informed the professional that Jeremy had been supporting him to achieve a habitable house as he was having difficulty with the condition of the accommodation. Arthur also advised that he had been unable to

open his post, the two undertook this together and Arthur had an invitation to an assessment offered by the Aspergers society which the Care Coordinator agreed to follow up on.

14.11 The Review Panel also had sight of records relating to Jeremy, and at this similar time it was noted that he was also accessing mental health services during this time owing to low mood and requesting cognitive behaviour therapy at Hertfordshire Partnership University NHS Foundation Trust. It is recorded that Jeremy had a car accident in 2015 which has left him feeling dependent on others, with increased difficulty in social situations, difficulty focussing, anxiety and spending a lot of time thinking about the past. Attempts were made on various occasions during November and December 2017 to offer support to Jeremy, however there was no response to these phone calls and voicemails. This was discussed in supervision, and it was agreed that a discharge letter would be sent. Following receipt of this letter, Jeremy made contact requesting an appointment, however it is unclear what happened after this.

14.12 Further attempts were made at the start of 2018 to engage with Arthur by the Care Coordinator however to no avail. In April 2018, contact was made by the Care Coordinator to Jeremy regarding Arthur's care and Jeremy confirmed that Arthur did need support. Further multi-disciplinary meetings were held to discuss and critique how services could best engage with Arthur, a decision was made at the end of April to discharge him with a 7 day opt in letter as a result of the Trust's engagement 'not bettering his present mental health'. In mid-May, it was found that Arthur had not engaged following receipt of the letter, and therefore Jeremy and Arthur's GP would be informed that he had been discharged from services, and that should Arthur become unwell and require services he would need to be referred to the service and undergo assessment.

14.13 In September 2018, Hertfordshire Partnership University NHS Foundation Trust heard from Arthur directly. It was recorded that he appeared anxious on the phone and that he had not been contactable because he was not feeling very well owing to depression, ADHD and Autism. He also added that he had received forms in the post possibly relating to assessments for his benefits which he needed help with, and he had subsidence in his property.

14.14 The next month the GP completed a number of forms to support Arthur with his claim for benefits and to manage his medication. There was no other contact had with Arthur until May 2019 when he attended the GP Practice for a face-to-face appointment advising that he had been discharged from mental health services (Hertfordshire Partnership University NHS Foundation Trust) and wanted to re-engage. A referral letter was sent by the GP to Hertfordshire Partnership University NHS Foundation Trust the next day. The Trust received and screened for routine triage noting that 'the patient is taking melatonin bought over the internet, seeking cannabis oil'. Successful contact was also made with Arthur via phone who advised that he was unable to engage before owing to not opening his post or answering his door or phone. Arthur specifically advised that he is struggling because of his poor sleep hence the self-medicating. Arthur's records were updated, and an initial assessment appointment letter was sent for later the same month.

14.15 The day before his appointment he called Hertfordshire Partnership University NHS Foundation Trust to cancel it advising that he was not in the right headspace to see anybody due to lack of sleep. An appointment the following month (June 2019) was offered which he declined. The Trust informed him that he would need to be seen within 28 days of cancellation so he asked to be discharged from the service and that he would be re-referred when he felt more up to it.

14.16 From late 2019 to February 2022, there was no contact had by any agency with Arthur apart from communication relating to immunisations against the Covid 19 pandemic. The next significant contact had by Arthur with services was in early 2022 when the GP Practice made contact with Arthur regarding an emergency appointment in relation to his weight loss which was noted to be mental health related, this was triggered by Jeremy making contact with the GP Practice with concerns regarding Arthur's weight loss. The following day, a text message was sent to Arthur confirming that he should book blood tests at the hospital. The same day Arthur was also seen at the GP Practice with Jeremy regarding his ongoing weight loss. It was noted that he was severely underweight, therefore shakes were prescribed, and he was referred to the Eating Disorder Team with bloods to be taken and a follow up appointment was organised for the following week.

14.17 The referral was received by the Community Eating Disorder Service provided by Hertfordshire Partnership University NHS Foundation Trust later that week and triaged as urgent. The referral also stated that there were potential physical health concerns and a history of severe mental health issues, patient's son was supportive, and that Arthur may be difficult to engage. An appointment was offered for two days later, this was followed up by a call to Jeremy who confirmed that he could bring his father to the appointment.

14.18 At the appointment, Arthur was assessed, the outcome of this was that he had a Disordered Eating Disorder and should be referred to Adult Community Mental Health Services and referred by his GP to a community dietitian. During this assessment Arthur reported that he feared eating too much and wasting his son's time and effort in preparing food for him. It was also recorded that Jeremy shared that Arthur refused to use a cooker or a hob therefore meal options were very limited. Arthur added that he sometimes would get caught up with something else and then when food goes cold, he no longer finds it appealing. Notes from the assessment also shared that Arthur reported having a lot of self-critical thoughts which occupied his mind and kept him distracted from eating. Arthur admitted that he sometimes binges on biscuits and pastries and then felt guilty for wasting resources. It was also recorded that despite others sharing with him how the digestive system works he would chew food for a long time, sometimes taking it would take him 3 hours to eat one meal. Arthur shared during this assessment that he did not like how he looked. It was recorded that Jeremy shared that he had bought his father some weighing scales to show how underweight he was to prompt him to eat better but that it hadn't worked.

14.19 Later the same month, the details shared at the assessment together with the plan following this assessment was shared with Arthur via letter and with the GP. It was noted within this that upon referral to the Adult Community Mental Health Services team that Arthur would benefit from some psychological intervention and review of his social care

needs. It was also recommended that Jeremy was supportive and may benefit from a carers assessment.

14.20 An appointment letter to see the Adult Community Mental Health Services, provided by Hertfordshire Partnership University NHS Foundation Trust, in late April 2022 was received by Arthur in late March. Nevertheless, this was cancelled the day before the appointment and a new date was set via phone with Jeremy for mid-May 2022.

14.21 Arthur attended his first appointment (assessment) with the Adult Community Mental Health Services, and it was reported by Jeremy that Arthur's eating pattern was highly erratic, and that he constantly engaged in 'delay tactics' in order to avoid doing things he did not want to do. It was noted that Jeremy was trying to help his father but was becoming increasingly frustrated. There was a discussion in relation to the impact of Covid, where Arthur shared that it caused him to become more isolated and now, he felt anxious and didn't want to go out. It was recorded in the notes that he lived alone and that his son Jeremy did most of the talking during the assessment and was supportive. It was noted within this plan following the assessment that there would be an offer made to Arthur and a carer's assessment for Jeremy. This offer to Jeremy, of a carer's assessment, was made within a few days following Arthur's appointment via phone however there was no answer and therefore a message was left. A welcome letter was also sent to him via post.

14.22 Arthur had another appointment with the Adult Community Mental Health Services for early July 2022, however it was recorded that this was cancelled by him and rearranged for early September 2022. The carer's referral was also closed for Jeremy in early July following no response to the letter or call which were made.

14.23 Between early August and late August Arthur was in touch with his GP Practice on numerous occasions, with his son's support, in relation to concerns for his ears which were infected, vaccines and blood tests.

14.24 At the end of August a letter was sent to Arthur and his GP to advise that the Adult Community Mental Health Services appointment which was scheduled for September 2022 was now to be October 2022.

14.25 The last contact Arthur had with agencies involved in this review was in late August regarding Arthur's blood test results.

14.26 On the evening of a night in August 2022, paramedics were called to the local hotel to reports of a male in cardiac arrest, the call having been made by Jeremy. Upon arrival of Police and ambulance staff, Arthur was declared deceased in the room at midnight and had a notable bruise to his neck. There was also evidence of a disturbance in the room, with some blood and a damaged shower hose.

15. Overview

15.1 The agencies listed in Section 8 were invited to attend the Panel meeting to discuss their involvement:

15.1.1 Hertfordshire Partnership University NHS Foundation Trust is the main provider of mental health services in Hertfordshire, and both Arthur and Jeremy accessed these services. They also provide some of the requirements relating to Social Care and Safeguarding under the Care Act 2014 following a formal delegation from the County Council. The (Adult Community Mental Health Service) ACMHS offers a multi-disciplinary service to adults experiencing severe and enduring mental illness. This service is comprised of a range of professions: specialist medical professionals, nursing, social work, occupational therapy, psychological therapy, art psychotherapy, drama therapy, psychology, support workers and administrative staff. At the time of his death, Arthur was due to have his second appointment with the Adult Mental Health Service several weeks later.

15.1.2 Hertfordshire and West Essex Integrated Care Board is the main commissioner of health services within the Hertfordshire area including Primary Care services, GP. Arthur and Jeremy were registered at different GP Practices which was not unusual given they were Father and Son and hadn't long lived together. Arthur had some contact with his GP Practice during the timeframe of this review.

15.1.3 Hertfordshire Constabulary provide the Police service to the county of Hertfordshire. Neither Arthur nor Jeremy were known to this agency, however from the Police National Computer they were able to provide the Review with information relating to these parties which was held by the Metropolitan Police. This related to Arthur's assault on his ex-wife and Jeremy's car accident in 2007 when it is believed he further suffered with post-traumatic stress disorder as a result. There was only one relevant agency contact with Arthur in 2017 which was reported by the Community Mental Health Trust at the time with concerns for Arthur's welfare.

15.1.4 Paradigm Housing is a charitable organisation which provides affordable homes across the Southeast. Arthur was housed in a Paradigm Housing property in 2009. His property had an issue with subsidence and therefore in 2022 he had to decant the property urgently owing to concerns over a fractured gas pipe resulting in no hot water and heating. Although Jeremy was living at the property he was not on the tenancy, and it was not clear to Paradigm that Jeremy was living there consistently and permanently.

15.1.5 The Probation Service is a statutory criminal justice service that supervises offenders serving community sentences or release into the community from prison. Arthur was known to this service owing to the assault he was convicted of in 2007 against his ex-wife. However, their involvement was very limited during the timeframe of this review and previous systems were used to record information when Arthur was accessing these services.

15.1.6 Turning Point is a community outreach support service for adults with mental health needs and other complex health and social care issues. This organisation did not provide information directly to the Review as their involvement with Arthur was outside of the timeframe of the review (October2016). However, there was some useful information held

within the Hertfordshire Partnership University NHS Foundation Trust information system which related to this organisation.

15.2 A chronology was compiled as part of this review given the number of contacts that Arthur and Jeremy had had with these agencies. A brief summary of this is captured in 'The facts' section of this report.

15.3 As previously advised, other agencies also attended the Panel in order to provide expertise to discussions in relation to the area of Hertfordshire (local authority), domestic abuse (Refuge- specialist domestic abuse service- providing IDVA service across Hertfordshire), and Carers in Herts (a voluntary sector organisation supporting carers and their families across Hertfordshire)

16. Analysis

16.1 The Panel has considered the individual management reviews (IMRs), through the viewpoints of both Arthur and Jeremy, to ascertain if the agencies' contacts were appropriate and whether they acted in accordance with their set procedures and guidelines. Where they have not done so, the panel has discussed whether the lessons have been identified and appropriately actioned.

16.2 The authors of the IMRs have followed the Review's Terms of Reference and addressed the points within it. The agencies undertook the IMRs or Helpful Statements (where the contact was very limited) in an honest, thorough and transparent fashion, ascertaining information from a number of sources. The following is the Review Panel's view on the appropriateness of the intervention undertaken by each agency.

Hertfordshire Constabulary

16.3 As previously advised above, this organisation had very limited contact with Arthur and Jeremy. In 2017 when the welfare concern was received by Hertfordshire Partnership University NHS Foundation Trust, proactive actions were taken to check that Arthur was well. It was the second visit to Arthur's property when Police Officers were able to locate and speak with Arthur. The Panel were assured by these positive actions taken.

16.4 Following receipt of information provided by the Police and Coroner during criminal investigation, it came to light that Jeremy had used methods of restraint on Arthur to manage his behaviour. The Panel discussed 'use of restraint' by carers, and this is further explored in the next chapter. Arthur's family also reported in witness statements, as part of the criminal investigation, that they had concerns in relation to Arthur's unexplained injuries and Jeremy's controlling behaviour however this information came after Arthur's death.

16.5 The Panel were provided with the following assurance from the Helpful Statement provided by the Police for this review. *'Policing responsibilities under the Care Act 2014 created a legal framework to ensure that key organisations with responsibilities for adult safeguarding work together. Adult safeguarding means protecting an adult's right to live in safety, free from abuse and neglect. When it is appropriate for policing to take steps to*

support the care needs of an adult, interventions should be in line with their wishes as far as possible. This approach is in line with the Care Act 2014 overarching principle of Making Safeguarding Personal (MSP). 'Wellbeing' principles are linked to the MSP when carrying out any care and support, or safeguarding actions, in respect of an adult with care and support needs. Safety and wellbeing will always be the priority and on receipt of a referral from any agency the local authority has a duty to gather information to evaluate any immediate risk to the adult. They should use this to decide as to whether a care needs assessment or an enquiry under section 42 of the Care Act 2014 is required'. This was followed by a clear rationale that in Arthur's case, the caring relationship between him and Jeremy was not known to this organisation nor the details of Arthur's complex physical and mental health needs. Therefore, there were limitations in learning for Hertfordshire Constabulary.

Hertfordshire and West Essex Integrated Care Board

16.6 This organisation worked closely with both GP Practices where Arthur and Jeremy were registered to collate the information required for this review. Owing to lack of contact from Jeremy to engage with this process there was limited information to explore or analyse from his GP Practice owing to factual information available and consent. However, Arthur's GP Practice were thoroughly engaged in the Review Process, and this was recognised as excellent practice by the Panel. The GP Practice presented their own findings of their Individual Management Review to the Panel at the second Panel meeting and were able to contribute to valuable discussions.

16.7 It was reported within the Individual Management Review that Arthur engaged quite well with the GP Practice to improve his physical health and that there were several contacts with the GP Practice in the few weeks leading to his death in 2022. The GP Practice spoke with his son regularly with his father's permission however they also did not identify or recognise him as a carer as recorded in Arthur's notes. Jeremy was not registered at the same GP Practice and therefore they did not know anything about him other than the support he offered to his father Arthur. The Panel were provided with assurances from the GP Practice that they hold a carer's register on their system of all patients who identify as an unpaid carer. Those patients are then regularly reviewed, and support is offered to them with the coordination of a dedicated carer's champion in the Practice. It was noted that had Jeremy been registered at this Practice then he would have been offered support.

16.8 Within the Individual Management Review it was reported that there are posters and leaflets in the waiting room and reception area aimed at carers. It was highlighted that this is to ensure that those carers not registered with the GP Practice but are bringing a patient they care for can access this information. The Panel acknowledged this as good practice.

16.9 The GP Practice reflected to the Panel that they have a process in place to review as a wider clinical team any unexplained deaths, however that previous practice was not to discuss these at a 'significant event' meeting until the postmortem and coroner's report had been received. Following this incident, recognising the value of discussing circumstances and identifying early learning this process has now changed and the overview of the death

will still be discussed in a timely manner with a more detailed discussion following the postmortem report but with patients rolled over to every meeting to avoid any patients not being thoroughly reviewed.

16.10 The Panel explored with the Integrate Care Board how GP Practices are supported with Domestic Abuse training and learning from reviews and assurances were provided on what is offered. The Panel reflected on the challenges when family members or couples in a caring relationship are both not registered at the same GP Practice and the difficulties in information sharing and understanding the bigger picture, risks and situation. The Panel recognised that with no one single GP Practice system that holds all of the information then there are limitations for what each GP Practice can do, hence the good practice of the posters and leaflets for all individuals to read and view in the reception and waiting room areas. It was confirmed by the GP Practice that had there been safeguarding concerns then there would have been conversations between the GP Practices with Adult Social Care.

16.11 Lastly it was also noted by the Panel that when clinically indicated and appropriate follow ups were undertaken with Arthur, or Jeremy if on behalf of Arthur to establish how Arthur was and how his health needs were both face to face or through telephone consultations. There also was not an over-reliance on Jeremy or other agencies to make referrals to Hertfordshire Partnership University NHS Foundation Trust where it was required, and proactive action was taken by the GP Practice which was good practice. The GP practice did also acknowledge that Arthur's ability to engage with mental health services at Hertfordshire Partnership University NHS Foundation Trust were challenging owing to his own neurodiverse needs but also the structure of what the Trust required from him.

Hertfordshire Partnership University NHS Foundation Trust

16.12 This organisation had sporadic contact with Arthur from 2007. The Panel recognised that this was most probably a mixture of Arthur struggling to access these services owing to his own physical and mental health issues as well as the Trust's challenges in trying to engage with Arthur as a patient.

16.13 It was explored in the Individual Management Review and the Panel the cumulation of information known by this organisation over a period of years and how it was used to inform next steps, particularly when patients are neurodiverse. It was unfortunate that a 7 day opt in process was sent to Arthur in relation to his engagement with services in 2018 when they were already aware that he struggled to open post. The Trust reflected that there should be reasonable adjustments made for patients who do not maintain contact through these routine means so that any barriers to engagement are mitigated.

16.14 There was a missed opportunity in 2018 to identify Jeremy as a carer for his father Arthur when contact was made with Jeremy following a home visit verifying that his father needed support. As a result of not identifying Jeremy as a carer meant that Jeremy was not offered a carers assessment to support him and reduce any carer's stress at this time. Further to identifying any individual with a caring role, it was highlighted in the Individual Management Review for this organisation that when Arthur was accompanied by Jeremy at appointment there was no evidence of Arthur being asked whether there was any objection

to Jeremy presence. Therefore, there was a potential missed opportunity to explore with Arthur alone, what Jeremy's role was and how he felt he was being cared for if indeed that was how Arthur foresaw his son. Furthermore, it was reported in the Individual Management Review that staff had recorded that children were supporting Arthur and therefore there were several missed opportunities to offer a Carer's assessment or record any of his adult children as having a caring role.

16.15 Another area identified by this organisation in their Individual Management Review was whether a social care assessment should have been undertaken during 2022 when Arthur was assessed by the Adult Community Mental Health Services owing to his weight loss and other health concerns. During the assessment it was recorded that Arthur said he had housing and was being looked after by his son, however during the same assessment it was also shared that he had become socially isolated since Covid and was having difficulty in engaging with social activities and daily tasks like collecting prescriptions and eating. The Panel supported this finding that the Care Act 2014 is clear Section 6.15; *'local authorities must consider all of the adult's care and support needs, regardless of any support being provided by a carer. Where the adult has a carer, information on the care that they are providing can be captured during assessment, but it must not influence the eligibility determination.'* As such, the Panel supported the Trust's finding that further education was needed to highlight that social care assessments should not be ruled out on the basis that informal support is in place. As a result of this the Trust assured the Panel that since 2022, Connected Lives/ Care Act training has been reviewed and is now offered as a 'one-stop shop' training by the HPFT social care team. This training articulates clearly that all Connected Lives assessments should be 'carer blind' in line with Care Act 2014 guidance. In addition, the Trust noted that the Social Care Pathway in Adult Community Mental Health Services was currently being addressed within the Community Services strategy/transformation programme. One key improvement within this was to embed better screening tools for social care need within the Initial Assessment and Personalised Care and Support planning processes. Linked to this analysis, the Trust also recognised how these learning points should be reflected in the Adult Social Care Services and Hertfordshire Partnership University NHS Foundation Trust Cross Service Protocol and then implemented by both organisations, ensuring that it is clear to each organisation where responsibilities for social care assessments and care's assessment lie. This is so that there can be improved handover between teams or joint working to support complex patients and/or carers when appropriate.

16.16 The Panel did support the Trust's assessment within their Individual Management Review that when they did formally recognise Jeremy as a Carer which was at the Initial Assessment for Arthur in May 2022 that he was offered a carer's assessment in a timely manner which was good practice. It was unfortunate that Jeremy did not take up this offer, which is not mandatory, because it was recorded that Jeremy appeared frustrated and stressed with Arthur's presentation. The Trust advised that the carer pathway was currently under review during 2024 in order to ensure that there was clearer guidance for all staff with regards to carer identification and support offered. The Panel felt assured that there was a plan to role out associated training in line with this during 2024/25 specifically around carer assessments for carer's of individual with a functional mental health need.

16.17 Lastly, the Panel felt assured by the comprehensive and robust Individual management Review provided to the Review which provided evidence of domestic abuse training alongside safeguarding adults, use of domestic abuse champions across the Trust, and 3 yearly reviewed policies to underpin the expectations of practitioners working for this organisation.

Hertfordshire Council- Adult Social Care

16.18 The Panel were provided with a short Helpful Statement from Hertfordshire Council Adult Social Care Services owing to their minimal involvement in 2010 and 2017. However, the team was connected with the Community Mental Health Team in Hertfordshire Partnership University NHS Foundation Trust, and it was deemed that they were the right service to support Arthur at that time. Owing to Arthur's Aspergers diagnosis which he ascertained privately, then there may have been a role for the Community Learning Disability Team within Hertfordshire Council Adult Social Care team however it was agreed between the two organisations to maintain contact and share if there was a need. It should be acknowledged here that during this period the specialist Asperger's service was provided by Hertfordshire County Council. Nevertheless, there was nothing recorded to indicate that the Trust felt that there was a need for this service. As highlighted above, learning was identified in the Trust's Individual Management Review where these two services through the Cross Service Protocol might be reviewed and strengthened for both workforce teams.

16.19 Furthermore, see Lessons Learnt for the Panel discussion in relation to use of restraint. However, as the local authority has a duty to undertake Carer's assessments to support carers the Panel sought assurances from this organisation on how carers are supported to understand what is reasonable in relation to use of restraint. It was following this discussion that it was highlighted that the Carers strategy should reflect more information in relation to domestic abuse and use of physical force, restraint versus abuse and neglect.

Paradigm Housing

16.20 The Panel were pleased to have the engagement of Arthur's housing provider as part of this review owing to the emergency decant of his property to a local hotel for temporary accommodation. As previously noted, the urgent change of accommodation was owing to subsidence in the property and a leaking gas pipe nearby. The Panel were assured to note that Arthur was moved speedily and with his support, Jeremy. Similarly to other agencies, Jeremy was not identified as a having a caring role by Paradigm despite speaking with him with Arthur's consent to do so. It was reported as part of this review that they were not aware that Jeremy was living and had been living with Arthur as his carer for some time. Paradigm advised the Panel that during the urgent decant there wasn't the opportunity to explore the details of Jeremy's living arrangements, however, was noted to have been something to return to because his property was a one-bedroom house. On further reflection Paradigm recognised the importance of ensuring that all relevant health and social care factors are ascertained from their residents including any other persons occupying a property, particularly where an emergency decant process is underway.

16.21 It was also recorded in this organisation's Individual Management Review that there were complexities for Arthur which were not known to them, some of which would not be relevant noting Human Rights- Right to Private Life etc. However, as a Panel, this organisation reflected that there should be some infrastructure within the service that enables meetings to take place to discuss any residents who may have complex needs, and that the role of a housing provider might be within this.

16.22 Assurances were provided to the Panel on how staff are trained to identify and respond to signs of domestic abuse and their policy was provided for review by the Independent Cahir as part of this process.

The Probation Service

16.23 This organisation had contact with Arthur sometime before the timeframe of this review. However, it felt necessary to include this information owing to the offence that Arthur was convicted of and the impact this had on Jeremy as a child. It was reported by this organisation that within their records it states that Jeremy as a child 'apparently has nightmares about being killed by father'. Jeremy was 11 years old at the time and therefore suggested that what he witnessed of his father possibly towards his mother was significant enough for him to have these concerns. However, the Panel were clear not to make assumptions and owing to the lack of engagement with Jeremy we could not be sure as to why he felt like this and how long for. There was no further information provided by this organisation in relation to the review.

17. Conclusions

17.1 In reaching their conclusions the Review Panel have focussed on the following questions.

- Has the Panel fulfilled the Terms of Reference for this review by undertaking a variety of lines of enquiry, including discussing the identification of caring responsibilities and working with couples who both present with mental health concerns?
- Will the actions and suggestions for improvement improve the response domestic abuse victims have in the future?
- What are the key themes or learning points from this review?

17.2 The Review Panel are satisfied that the Terms of Reference have been fulfilled and that discussions did take place at the Panel meeting to consider what was known prior to Arthur's death in September 2022.

17.3 The Panel is of the opinion that the agreed recommendations as listed in Section 19 below appropriately address the points raised throughout the review, particularly in relation to key areas identified in the IMRs and described in the Analysis and Lessons to be learnt sections of this report.

17.4 The main issues identified as part of this review process were;

17.4.1 The identification of unpaid carers for Arthur noting that all of his adult children during various points were mentioned in agency records and they were not recognised in by agencies performing a 'caring role', as a result of this there were missed opportunities to offer support and reduce any carer's stress that may have been present and to better understand the relationships. As a result of unpaid carer's not being identified then support by valuable organisations like Carers in Herts cannot be offered or referred to, likewise carer's assessments are not undertaken.

17.4.2 In addition to the above, the use of restraint was questioned during this review owing to some of the injuries Arthur experienced. The Panel recognised that unpaid carers also are probably unaware what use of restraint can be safely used and that no training or literature is provided by any of the agencies about this which is potentially a gap.

17.4.3 Lastly, the Panel concluded that the Covid pandemic also had an impact on Arthur and his confidence and ability to access and engage with services when he found times challenging, as services had changed, he had become more reliant on unpaid carers and his confidence had decreased. This was recognised as a moment in time and learning has been extrapolated more widely on how services might recognise the impact on those with similar learning needs to Arthur if anything were to happen of a similar nature in the future.

18. Lessons to be learnt

Carers identification, use of Carers in Herts and importance of Carer's Assessments

18.1 The Panel discussed this theme several times during the course of the IMR presentations and review. The identification of Jeremy as a 'carer' or whom had a caring role for his father Arthur was not identified at the earliest point. There were missed opportunities where Hertfordshire Partnership University NHS Foundation Trust, Paradigm Housing or the GP Practice could have sought clarity on Jeremy's role. Had this occurred Jeremy may have been offered adequate support and a carer's assessment sooner, although it was recognised by the Panel that when Jeremy was invited for a carer's assessment he did not engage with this supportive offer.

18.2 The term 'carer' is defined by NHS England as 'anyone, including children and adults who look after a family member, partner or friend who needs help because of their illness, frailty, disability, a mental health problem or an addiction and cannot cope without their support. The care they give is unpaid. Many carers don't see themselves as carers and it can take an average of two years to acknowledge their role as a carer' (NHS England, 2023).

18.3 Carers in Herts provided some excellent reflection to the Panel as a subject matter expert based on what they had observed and heard from the Panel discussions. It was highlighted that to fulfil a caring role for another person, it is critical that a carer's own level of stress is managed. This was relevant for this review because Jeremy showed signs to agencies that he was frustrated by Arthur's behaviour and set of circumstances. George et al (2000) supports this view, where they found that between one third and a half of carers have been estimated to experience significant psychological distress which in turn has

shown to have an impact on a caregiver's mental health more often than the general population. They added that the level of stress associated with caregiving varies but it can be influenced by level of care required, physical or cognitive impairment experienced by the care recipient or the duration of the caring relationship.

18.4 To this end, Carers in Herts emphasised the importance of referrals into specialist services like theirs for carers rather than a reliance on individuals to self-refer. The Panel supported the acknowledgement that more should be done to raise awareness of how individuals can access support if they have a caring role and how family or friends who are concerned about how a loved one is being cared for can also access support. Further to the research findings above by George et al (2000) this research also suggested that public health campaigns should recognise the burden that psychological stress can have on caregivers.

18.5 The Panel also reflected that based on the information known for this review there may well be stigma that still exists in relation to caring roles and accessing help and support. However, it is vital that agencies challenge this owing to the stark statistics that we know about carers and their own health and wellbeing. Carers in Herts shared that a local statistic about their own population was that before support 47% of carers reported low wellbeing[1].

18.6 Lastly, as has been previously mentioned above it was also highlighted by Hertfordshire Council that domestic abuse as a factor in carer's stress should also be referenced and described in the local authority Carer's strategy. This will affirm the principle that domestic abuse can feature in a caring relationship and should be distinguished from carer's stress. Refuge, Hertfordshire's specialist domestic abuse service provider, also supported this recommendation highlighting that collaboration between Refuge and Carers in Herts should be stronger.

Use of restraint

18.7 The second learning point discussed at length was Jeremy's use of restraint of Arthur during this time whilst caring for him. As part of the criminal investigation that took place after Arthur's death, it came to light that Jeremy would restrain Arthur when he struggled to manage his behaviour. This was not shared with any agencies prior to Arthur's death. Some of Arthur's injuries found during the postmortem could have been caused by Jeremy's use of restraint however this was inconclusive. The Panel therefore discussed the use of restraint by carers and how carers are educated on this topic. The Panel described collectively that the use of restraint should only be used proportionately, time-limited and in a person's best interests. Carers in Herts were clear that they will talk about this with their service users. The Panel did not confirm that there is any specific training for carers on use of restraint or any literature. However, they did provide assurances that if practitioners found that use of restraint by a carer to be unreasonable then this would meet the criteria for a safeguarding concern into Adult Social Care and/or Police concern.

[1] https://www.carersinherts.org.uk/our-impact/

18.8 Andres et al (2024) found in their research that the pervasiveness of restraint is concerning and suggests a lack of evidence-based guidance and support for caregivers to prevent use of restraint. Following a small-scale review of research, 'Understanding restraint: A guide for unpaid carers'[2] written and published by Lambeth Safeguarding Adults Board was found. This is a short two-sided page document that describes restraint and when it should be used. It would appear that something like this could be created in Hertfordshire with the support of Carers in Herts which could act as an education tool and resource for unpaid carers on use of restraint.

18.9 The Panel lastly reflected that this review created an opportunity to explore this theme and learning point owing to information that became known after Arthur's death. As has previously been mentioned, although there was evidence of various injuries from Arthur's postmortem, owing to his own health needs and concerns, it could not be ascertained that these had occurred as a direct result of Jeremy's use of restraint on his father. Therefore, the learning point was more broadly discussed in terms of use of restraint by carers both paid and unpaid, what it is and when it is acceptable or not, and most importantly what organisations might do to assure themselves further that the appropriate use of restraint is used by all carers.

Impact of Covid-19 pandemic on individuals and couples experiencing mental health issues

18.10 The Covid-19 pandemic began in 2019 and was the transmission of a virus which sadly had deadly results for many people from all walks of life. Patients were first admitted with Covid into acute hospital beds in England during 2020 and the first lockdown came in March 2020, followed by further lockdowns over the rest of that year and into early 2021. These restrictions had a huge impact on all members of society, but the Panel identified by discussion and reflection that this was also significant for Arthur. As previously articulated in section 14, Arthur shared himself that he changed as a result of the pandemic and that this impacted his confidence and mental health to socialise and leave the house.

18.11 Services, in particular health services, which were relevant to this review also were affected in terms of their delivery to patients like Arthur. The Panel reflected that Arthur's rescheduling of appointments during 2022 may also have been as a result of health services recovering from the Covid-19 pandemic. Consistency of care-coordinators that may or may not have been able to build a rapport with Arthur would have also been impacted by the pandemic and the way services operated and delivered services to patients.

18.12 The Panel explored the impact of the pandemic on Arthur and as organisations they shared their reflections of how services were delivered during this time and what changes or improvements could be made next time. Changes felt limited owing to Arthur's needs and asks of services that changed. At times, Arthur was proactive in reaching out to organisations for support or intervention and other times Arthur felt unable to access or engage with services.

[2] https://www.lambethsab.org.uk/sites/default/files/2020-10/Understanding%20restraint%20-%20info%20for%20unpaid%20carers%20v2.pdf

19. Recommendations

Hertfordshire County Council

19.1 To ensure that domestic abuse features in the local authority and partnership Carer's strategy, making note of the importance of carer's stress versus domestic abuse, and how carer's assessments can be helpful tools to ascertain further information that will determine risk, actions and relevant agency support.

19.2 To remind and encourage practitioners working across Hertfordshire who identify an individual with a caring role to refer to Carer's in Herts rather than signpost to this service. This should improve the accuracy in terms of numbers of carers there are living within the county and improve engagement.

Hertfordshire Integrated Care Board – GP Practice

19.3 Discussion of unexplained deaths to be had at Practice's Significant Event Meeting routinely.

Hertfordshire Partnership University NHS Foundation Trust

19.4 Learning from this review to be circulated to divisional leads and Social Care Team through appropriate forums such as Quality and Risk Management Group for consideration alongside existing workstreams.

19.5 Hertfordshire Partnership University NHS Foundation Trust/ Hertfordshire County Council Adult Social Care Cross service protocol to be recirculated to all relevant teams through practice governance meetings.

19.6 Hertfordshire Partnership University NHS Foundation Trust Adult Community Division First Contact Task and Finish Group to consider how to capture when social care support may be responsibility of Local Authority to ensure that this is explored and actioned appropriately.

19.7 Did not attend/Not brought in policy to be reviewed in line with learning regarding use of opt-in letters

Paradigm Housing

19.8 To review the 'Emergency Decant Process' to ensure that all relevant information including health and social care factors are ascertained from residents including any other persons occupying the property.

19.9 To hold monthly meetings to discuss any residents who have complex needs and what Paradigm Housing's role is within this.

Hertfordshire Domestic Abuse Partnership

19.10 The Partnership should add the following learning points to their communications plan in relation to learning from Domestic Homicide Reviews:

- Educate professionals, including domestic abuse specialist support services, and citizens of Hertfordshire to refer and access specialist services like Carers in Herts which aims to support carers and reduce their stress and to report concerns to relevant agencies; Police or adult social care when there are concerns for how individuals are being cared for by paid or unpaid carers.

19.11 Hertfordshire Safeguarding Adults Board should create a similar document to Lambeth on use of restraint by unpaid carers, which could be used as an educational resource to ensure that unpaid carers known what proportionate use of restraint is.

Appendix A

Bibliography

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Pieces of legislation

Crime and Disorder Act 1998

Domestic Violence, Crime and Victims Act 2004

Equalities Act 2010

Serious Crime Act 2015

Care Act 2014

Protection from Harassment Act 1997

Appendix B

Confidentiality Statement

DOMESTIC HOMICIDE REVIEWS - Confidentiality Declaration

Domestic Homicide Reviews are conducted in accordance with Section 9 of the Domestic Violence, Crime and Victims Act 2004. The duty to undertake Domestic Homicide Reviews came into force on 13 April 2011.

The purpose of a DHR Panel is for agencies to share historical and current agency information known about the victim/perpetrator/family household members or known significant others; to share information about the events preceding the death of the victim; and to determine whether the statutory criteria for undertaking a Domestic Homicide Review has been met.

The purpose of a Domestic Homicide Review is to:

1. 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.

2. 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

3. Apply those lessons to service responses including changes to policies and procedures as appropriate

4. Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

Information discussed by the agency representatives within the Domestic Homicide Review Panel is strictly confidential and must not be disclosed to third parties without the agreement of the partners of this meeting and in any case within accordance with Data Protection and relevant Information Sharing Agreements.

All agencies should ensure that the minutes are retained in a confidential and appropriately restricted manner. These minutes will aim to reflect that all individuals who are discussed at these meetings should be treated fairly, with respect and without improper discrimination. The responsibility to take appropriate actions rests with individual agencies; it is not transferred to the DHR Panel. The role of the Panel is to facilitate, monitor and evaluate effective information sharing to enable appropriate actions to be taken to increase public safety. It is the responsibility of that agency to complete their actions within the agreed time constraints.
In the event of a Serious Case Review or a Criminal Investigation the minutes from the Panel may be released to support that process. In signing this confidentially declaration you agree, with prior notification, for full disclosure of the minutes taken at this Panel.
The Chair of the Domestic Homicide Review Panel must adhere to the data protection clauses of their contract with Hertfordshire County Council.

Signed……

Date …….

Appendix C- Action Plan

Domestic Homicide Reviews in Hertfordshire: SMART Recommendation and Action Plan Template for the case of Arthur

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
Single agency recommendations						
Discussion of unexplained deaths at Practice's Significant Event Meeting	Local	Correspondence to all clinical staff to add unexplained deaths onto our Significant Event meetings even if no postmortem	Burvill House, Practice Manager	Significant Event meetings have been regular in the Practice since 2021. Since June 2022 the template for the meetings was amended to ensure that all pre-meeting information is gathered, summary of discussion had, and the meeting is documented for any outcome/learning points. Actions are clearly assigned to staff too. From January 2025 we	January 2025	This is now our process moving forwards.

				have included patients with an unexplained death, but no postmortem following this IMR.		
Learning from this review to be circulated to divisional leads and Social Care Team through appropriate forums such as Quality and Risk Management Group for consideration alongside existing workstreams.	Local	Learning summary to be produced from IMR and circulated via QRMs Copy of IMR and learning summary to be sent to Social Care Team And Divisional Director to support existing workstreams	HPFT	Learning summary produced. Learning summary presented at Divisional QRM Learning summary sent to social care team and divisional director	January 2026 February 2026 January 2025	IMR was shared and Learning has been discussed verbally with relevant parties but learning note not yet produced.
HPFT/ HCC ACS Cross service protocol to be recirculated to all relevant teams through practice governance meetings.	Local	Cross-Service protocol re-circulated to relevant teams for discussion in Practice Governance meetings	HPFT	Cross service protocol recirculated via email. Cross service protocol included	January 2025 February 2025	Completed Completed

				on agenda for Social Care Leads meeting		
HPFT Adult Community Division First Contact Task and Finish Group to consider how to capture when social care support may be responsibility of Local Authority to ensure that this is explored and actioned appropriately.	Local	Consideration at Task and Finish Group.	HPFT	Learning shared with Adult Community division and Social Care lead for consideration as part of Task and Finish Group Discussion at Task and Finish group	January 2025 July 2025	Completed Identification of social care need and responsibility has been routinely discussed at this forum however the first contact assessment T&F Group has evolved over time to adapt to the community transformations changing direction. It is likely that this action will now be picked up for

						follow up via the Trust's review of it's social care delivery model.
Did not attend/Not brought in policy to be reviewed in line with learning regarding use of opt-in letters	Local	DNA/ NBI policy to be reviewed in line with learning from review	HPFT	Learning shared with DNA/ NBI policy owners for consideration of amendment to policy.	January 2026	Policy was reviewed and there is already relevant guidance in there so may not need amending.
Multi agency recommendations						
To ensure that domestic abuse features in the local authority and partnership Carer's strategy, making note of the importance of carer's stress versus domestic abuse, and how carer's assessments can be helpful tools to ascertain further information that will determine risk, actions and relevant agency support.	Local	To include domestic abuse and the heightened risk of this to both carer and the person being cared for as part of the carer's strategy.	Hertfordshire County Council	May-August – completed Strategy drafting – August-Sept		Consultation on draft – Sept-Oct TBC Governance – Nov-Feb TBC

To remind and encourage practitioners working across Hertfordshire who identify an individual with a caring role to refer to Carer's in Herts rather than signpost to this service. This should improve the accuracy in terms of numbers of carers there are living within the county and improve engagement.	Local	To encourage professionals to actively refer to Carers in Herts rather than signpost.	Hertfordshire County Council	Hertfordshire County Council commission Carers in Hertfordshire to provide carer awareness training to professionals, to better understand the needs of carers. Within Adult Social Care there are things like the Listening to the Carers Perspective training for staff and various written resources, and Children's Services have recently launched a young carers ilearn which is also available to external organisations.	Completed	Completed.
To review the 'Emergency Decant Process' to ensure that all relevant information including	Local	We have already indicated during the review that our process has changed. We now capture all the requirements of a resident, including vulnerabilities and	Paradigm Housing			This has been the process since the decant policy was reviewed.

health and social care factors are ascertained from residents including any other persons occupying the property.		household composition in a decant process pro-forma which helps us to understanding their health and social factors. We also have a tenancy sustainment team who will work with multi-agencies, if required.				
To hold monthly meetings to discuss any residents who have complex needs and what Paradigm Housing's role is within this.	Local	We have complex and operational case meetings where cases are discussed and any issues and actions required, which would include a multi-agency approach.	Paradigm Housing			This has been the process for some time now.
The Partnership should add the following learning points to their communications plan in relation to learning from Domestic Homicide Reviews: Educate professionals, including domestic abuse specialist support services, and citizens of	Local	To conduct a thematic review into recommendations from previous DHRs by Hertfordshire.	Hertfordshire Domestic Abuse Partnership	Ildiko Cseri is work on a library of themes that are emerging from Hertfordshire DHRs, considering 4 major research papers that were published by the Domestic Abuse Commissioner and Manchester Metropolitan University on the types of recommendations	May 2026	Thematic reviews to be published based on themes.

Hertfordshire to refer and access specialist services like Carers in Herts which aims to support carers and reduce their stress and to report concerns to relevant agencies; police or adult social care when there are concerns for how individuals are being cared for by paid or unpaid carers.				made for Adult Social Care, Children's Services, Criminal Justice System and Health Services. These will be considered as a basis to see how Herts recommendations fit into the national picture.		
Hertfordshire Safeguarding Adults Board should create a similar document to Lambeth on use of restraint by unpaid carers, which could be used as an educational resource to ensure that unpaid carers know what proportionate use of restraint is.	Local	To create a document on use of restraint by unpaid carers, which could be used as an educational resource to ensure that unpaid carers know what proportionate use of restraint is.	Hertfordshire Domestic Abuse Partnership	For the domestic abuse partnership to ascertain whether a similar document already exists as a result of SARs. This will be discussed at the Domestic Abuse Partnership Board's procedures meeting.	March 2026	TBC

Appendix D

List of agencies approached about this Domestic Homicide Review

- Hertfordshire Constabulary
- Welwyn and Hatfield Borough Council
- East and North Hertfordshire NHS Trust
- Refuge
- Hertfordshire Partnership University NHS Foundation Trust
- Hertfordshire and West Essex Integrated Care Board
- Welwyn Hatfield Borough Council
- Hertfordshire Probation
- Paradigm Housing
- Carers in Herts