BARNET COMMUNITY SAFETY PARTNERSHIP

SAFER COMMUNITIES
PARTNERSHIP

Keeping Barnet Safe

DOMESTIC HOMICIDE REVIEW

into the murder of two victims at the hands of
a family member

KEY ISSUES & LESSONS LEARNT

Report Author

Gaynor Mears OBE, MA, BA (Hons), AASW, Dip SW

The Domestic Homicide Review Panel and the members of the Barnet Safer Communities Partnership would like to offer their sincere condolences to the family and friends of the two victims whose tragic deaths have brought about this Review. They have lost two important pillars of their family who were much loved.

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Key Issues, Learning & Recommendations Arising from a Domestic Homicide Review in the London Borough of Barnet

1. Brief Background Concerning the Case:

1.1 This Domestic Homicide Review concerned the death of two family members who were brutally stabbed to death by the youngest adult child who had a long history of cannabis use from a young age (i.e.14 years) who then developed paranoid schizophrenia aged 19 years. He had 5 admissions to hospital under the Mental Health Act, some under Section and as a voluntary patient. The perpetrator was a patient of the Mental Health Trust at the time of the murders. The perpetrator had low literacy skills and relied on family members in this context. When at school he had a Statement of Special Education Need.

1.2 The perpetrator frequently refused to take his medication, the exception to this was a period of a year when he had a Treatment Order in place, but this was then removed with the agreement of two older male family members as he had complied. Compliance was short lived after this. In addition to cannabis the perpetrator also used other illicit drugs such as cocaine and to the concern of his family he became involved with drug dealers and those engaging in anti-social behaviour who often took advantage of him by staying in his living accommodation. Police would visit at the request of his family, and he was cautioned for possession of drugs.

1.3 The perpetrator's behaviour was volatile; he would regularly cause disruption within the family and also carry out assaults against them. There were 16 incidents which would be defined as domestic abuse not all of which were recognised as such. During one mental health assessment he made explicit threats towards one of his victims and was judged a risk to the family and to that family member in particular. This risk did not appear to be carried forward into assessments in the community as part of his Care Programme Approach. He also made threats of violence towards a psychiatrist who was trying to assess him on another occasion. A year before the killings his mental health care coordinator changed. The new coordinator was told by the departing coordinator that that the perpetrator's mental health was stable; the new coordinator did not read the perpetrator's history and case notes.

1.4 Callouts to the Police and Ambulance Service were frequently made by the family and on occasions by the perpetrator, but no coordinated approach with Mental Health Services was taken. At one point a Mental Health social worker was going to make a referral to a Community MARAC concerning his anti-social behaviour and drug use, but there appeared to be confusion between the Domestic Abuse MARAC which is understood nationally to be for managing and safety planning for high risk victims of domestic abuse and a Community MARAC set up in the area to deal with cases of anti-social behaviour locally. No referral was made.

1.5 The perpetrator made a serious assault on one of the victims which resulted in his arrest. Assessments as a vulnerable adult in custody by Approved Mental Health Professionals failed to identify his full mental health history due to IT problems and his long standing mental health diagnosis and any risk was missed. A referral was made to MARAC for the victim. The MARAC was poorly attended, and the mental health representative did not disclose his mental health diagnosis and history only that 'drugs were the problem'. The MARAC and its outcomes were not recorded on the perpetrator's Mental Health Service notes and no actions were offered by Mental Health. The only actions were for an Independent Domestic Violence Advocate (IDVA) to follow up contact; however, IDVA support was declined. Police action was to seek a Treatment Order from the court.

1.6 After a period in on remand in custody he was released on bail with conditions to stay away from the family home. This he did not do, and his family allowed him to remain. The perpetrator was arrested a short time later for racially aggravated anti-social behaviour. The prosecution for this was withdrawn as witnesses refused to attend court. A few weeks later he assaulted an elderly member of the family and made threats with a knife. No MARAC referral was made on this occasion. He was arrested and held in custody once more to stand trial. Despite the Mental Health Trust also being providers of prison health care via the In-reach Team, liaison between Community Mental Health and the prison In-reach Team was inadequate. This was compounded by the care coordinator informing the Team that they were about to discharge the perpetrator as he was not engaging with the service.

1.7 The court requested a psychiatric assessment rather than a mental health report from the Mental Health Service who had already had a history of assessments on record as part of the perpetrator's Care Programme Approach. As a consequence, Probation requested a psychiatric assessment from the Mental Health Service. No formal pathway existed for this process, and after some weeks delay due to annual leave, the Mental Health Service recommended that a prison psychiatrist undertaken the assessment. Verbal information passed to a Probation court administrator was not recorded in the appropriate case note section and was not seen by the Probation court officer to inform the court. After a number of adjournments, the court made a sentencing decision without a mental health report and without a sentencing recommendation from Probation. The court found the perpetrator guilty of the assaults and he was released that day due to time served without a restraining order and without any Treatment Order. No pre-release plan was in place as his release date was not known by the prison.

1.8 His Probation risk assessment at the court was inadequate and his risk to his family not considered, he was therefore referred at that time to the Community Rehabilitation Company (now National Probation) for supervision and given instructions to attend their office the next day. This he failed to do. It was not until a Probation officer called at his home to remind him that he had signed the supervision agreement that he was eventually taken to the office by a family member. He was late for his next appointment, again taken by another family member, which resulted in a planned continuation of his Probation officer's assessment being unable to be completed. The Probation officer made routine checks of the Police but was told the IT system was down and only a manual check was made which was incomplete; it did not include his history of domestic abuse to family members. A short time later the brutal killings of two family members took place. The perpetrator fled the scene but was arrested next day. He admitted the murders. Psychiatric assessments found him unfit to stand trial and a trial of the issues was heard where he was judged to have committed the killings. He was sentenced to an indefinite Hospital Order with Restriction under Section 37/41 of the Mental Health Act 1983[1]. If he becomes fit to stand trial in the future a trail will be held at that stage.

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[1] A Section 37 Hospital Order made by the Court requires a person's detention in hospital. Section 41 is a Court Order preventing a person's transfer to a different hospital, granted leave or discharged without consultation with the Secretary of State for Justice, it is made if the Court considers it necessary to protect the public from serious harm. Anyone convicted of an imprisonable offence and the Judge considers the most suitable option is for the person to go to hospital can receive a Section 37/41. Section 41 is usually made without a time limit meaning that neither the hospital order nor the restriction order is renewed but continues indefinitely. Where there is a Section 41 order without a time limit, it is not possible to have the restriction removed from the order.

2. Key Issues:

Support for Family & Lack of Think Family Approach

2.1 In the one meeting held with two members of the victims' family at the start of the Review they expressed how they felt let down by Mental Health Services. The number of calls made by the family to the Police and Ambulance Service is indicative of the pressure they were under trying to manage the perpetrator's behaviour, and from the chronology for the Review community based crisis interventions were not always available or viewed as satisfactory at such times.

2.2 It is striking that the Community Mental Health Service contact with the family was primarily with the male members of the family, notably the perpetrator's elder brother and his father when he was alive, both of whom did not live in the family home. The victims who lived at the same venue as the perpetrator are conspicuous by their absence in their records. The impact of neither the perpetrator's mental ill-health nor substance misuse on the whole family appeared to be considered. One reference to a carer's assessment being offered was made to the elder brother who did not live at the family home.

2.3 The family appear unaware of the risk associated with perpetrator's mental illness when he relapsed, which suggests that they had never been fully 'educated' about his condition. There is no record that risks identified in assessments were shared with them. Support for the family as a whole was needed but was absent. A change to a 'Think Family' approach is needed by Community Mental Health Services to support families more effectively where their family member has a mental illness.

Information Sharing and Accurate Recording

2.4 Information sharing at various levels was not effective or did not take place. This was due in part to systems breakdown such as lack of clear process to achieve a psychiatric assessment for the court, and the failure of the Police to provide an accurate intelligence report to CRC to assist their assessment due to an IT failure. There were failures to share information between the Community Mental Health Team and the prison In-reach Team to accurately portray perpetrator's history.

2.5 The failure to share information even affected the MARAC which is designed to achieve this within agreed procedures. The Mental Health representative at the MARAC failed to share information on the perpetrator's mental health implying that his problem was 'just drugs', and Mental Health offered no actions to support a safety plan for the victim he assaulted. This does not appear to have been challenged.

2.6 Recording in Mental Health notes was not up to date or inaccurate, for example recording minimised the assaults on the victims, and the perpetrator was often presented as stable when events involving the Police and Ambulance Service suggest the opposite. Disappointingly record keeping and the need for management scrutiny to ensure policies are being adhered to have been a recommendation for the Mental Health Trust in a previous Barnet DHR. It is essential that this issue is addressed at the highest level in the Trust.

2.7 The MERLIN system to raise awareness within agencies when the Police are involved with a vulnerable adult should have resulted in actions by Mental Health, but there is no evidence that any intervention took place as a result. Unfortunately, the Police did not complete a MERLIN following the perpetrator's assault on one of the victims which resulted in his arrest, but a MERLIN was forwarded to Mental Health regarding the knife threat and assault on his other victim.

Releasing Remand Offenders from Custody Without Plans

2.8 The perpetrator was released straight from prison custody after his sentencing hearing due to time served. There was no time to put in place a plan for his release; no alternative accommodation was arranged meaning he returned home, and no medication was arranged, although it is understood that despite exhibiting signs of mental illness he was not put on medication in prison by the In-reach Team.

2.9 The court also failed to put in place a Restraining Order to protect the victims and to try and prevent the perpetrator from return home. The lack of pre-sentence report also meant no recommendation was made for any Treatment Orders which could have seen the perpetrator comply with drug or mental health treatment; he had successfully complied with a Community Treatment Order a few years previously. Sufficient information was available to inform the Court.

Risk Assessment

2.10 Apart from the Police undertaking DASH risk assessments, and risk assessment during hospital admission under section or voluntary arrangements there was an absence of risk assessment concerning the perpetrator's risk to others. A phone report by one of the victims to the Community Mental Health Team 2 years before the murders informing them of an assault and attempted strangulation and an attack on their car the following year by the perpetrator, plus a care coordinator witnessing an unprovoked attack by the perpetrator on a family member, did not register that the perpetrator was an increasing risk to his family and one of the victims in particular. Surprisingly, these reports did not trigger a new risk assessment by Mental Health.

2.11 There was an lack of recognition among Community Mental Health Service practitioners of risk associated with adult family abuse, and particularly the additional risk posed by the presence of substance misuse and mental illness. The perpetrator used cannabis and its more potent form skunk; medical notes first reference this when he was 14years old. Longitudinal research such as the Dunedin 2002 research[2], which followed a large cohort from birth and which supports the findings of an earlier large cohort historical study[3], found there is an association between cannabis use and an increased risk of experiencing schizophrenia symptoms. The research suggests that younger cannabis users may be most at risk as their cannabis use becomes longstanding, as the perpetrators did. In the Dunedin research of those using cannabis by age 15 a tenth developed schizophreniform disorder by the age of 26 compared with 3% of the remaining cohort. The risks identified were specific to cannabis use. The research also found that young male cannabis users were nearly 4 times more likely to be violent than non-users. The Dunedin study found parents and siblings may be injured and homicides were not uncommon. The perpetrator said he used skunk in the days after he came out of prison before killing his mother and sister. The co-morbidity of psychosis and drug use such as cannabis must be taken seriously and be recognised as an addition risk factor in assessments, especially in connection with risk to others.

3. Conclusions:

3. 1 Looking back on the chronology in this review it is clear that perpetrator's behaviour due to his mental ill-health and drug use was extremely resource intensive for the agencies

[2] Arseneault L, Cannon M, Poulton R, Murray R, Caspi A, Moffit T E, "Cannabis use in adolescence and risk for adult psychosis: longitudinal prospective study" BMJ. 2002 Nov 23; 325(7374): 1212–1213. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC135493/#B4. Accessed 19.01.19

[3] Zammit S, Allebeck P, Andreasson S, Lundberg I, Lewis G "Self reported cannabis use as a risk factor for schizophrenia in Swedish conscripts of 1969: historical cohort study" BMJ. 2002 Nov 23; 325(7374): 1199. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC135490/ Accessed 19.01.19

with whom he came into contact, and it could have been more so had Community Mental Health been more proactive following the change in care coordinator in the 2 years before the murders. That being the case we should ask what was it like for his victims and the rest of his family living day to day, year on year, with such significant emotional, physical, and time demands on them?

3. 2 There was a sense that some agencies thought the family down-played the perpetrator's mental illness and his behaviour at times, but living with the ups and downs of his actions in the years since his diagnosis probably meant that in the context of his more volatile periods where he was sectioned, by comparison his behaviour at other times was viewed as relatively tolerable and stable. There is also the question how much knowledge and understanding did all the family members have about the perpetrator's diagnosis and were any consequential risks shared with them?

3. 3 Over time the seriousness and impact of the perpetrator's mental health diagnosis and his drug use appeared to have been lost, threats made towards one victim in particular were not taken seriously, and the additional risks caused by his drug use were not taken into account. Risk to his other victim within the family was never considered. His involvement with others involved with drugs was a cause of concern for his family and these individuals brought with them additional problems and risks. An initiative to use a multi-agency community response to the perpetrator's drug use and involvement with others using illicit drugs went nowhere and was not followed up.

3. 4 Timely sharing of information played a major part in agencies' lack of sufficient information to process the perpetrator through the criminal justice process effectively and safely shortly before the killings. The Review revealed a lack of clear processes for communication between services. The perpetrator was released from prison due to time served without the court being given the report they had requested and without sentencing advice. The opportunity to restart the perpetrator on his medication in prison appeared not to have been taken, and he was released so quickly that any release plan had not had time to be put in place. The court did not use its power to put in place a Restraining Order to protect the victims from the perpetrator even though he had been found guilty of their assault. No other supervision or community orders were put in place in an attempt to regulate his behaviour and assist with his compliance with treatment and medication.

4. Lessons to be Learnt:

Information Sharing:

4.1 A failure to share relevant information is a constant finding in DHRs and Serious Case Reviews and this review is no exception. On occasions this was due to individual oversight or failure to follow procedures, such as in the Court process where the Court Probation Service did not gather the information which was available to inform the magistrates. On other occasions information was not shared or provided due to a failure in systems such as the lack of clarity as to who provided a psychiatric report for the court, or diverse data systems which impeded information sharing between Community Mental Health and Prison In-reach Team, and an inaccurate intelligence report provided by the Police to Probation to inform the perpetrator's assessment. There were also times when safeguarding concerns should have been recognised as high enough to override patient confidentiality and warrant sharing information on the threats made by the perpetrator in Mental Health Assessments against his family member.

4.2 Information was not fully shared by the Mental Health representative at the MARAC. They only reported the problem was the perpetrator's drug use, no mental health history nor his diagnosis of schizophrenia was given, and no MARAC actions offered for Mental

Health's contribution to the safety plan, nor did it appear that this was this challenged. The MARAC representative did not inform the perpetrator's care coordinator of the MARAC following the meeting, and linked to the learning below, nor was this recorded on the RiO notes for the MARAC to be visible when the care coordinator accessed the notes. Those referred to MARAC are necessarily viewed as high risk victims. There is no room for complacency as the threshold for MARAC is high; anyone referred must be recognised as high risk, and by association their perpetrator poses a high risk. At the very least this should have result in the care coordinator discussing the case with their manager and/or the holding of a strategy meeting and revising the perpetrator's risk assessment.

4.3 Disturbingly, care coordinator 2 had not read the perpetrator's case notes when they took over responsibility for his case. They relied on the information from care coordinator 1 who told them that the perpetrator was stable. Thus, care coordinator 2 was unaware of the perpetrator's past history, the periods of volatility which existed, or the aggression towards his family members. It is vital that new staff are given protected time to familiarise themselves with their service users histories to ensure they are fully informed to enable them to manage risk.

4.4 Overall, the DHR Panel felt the most overriding problem in this case was a lack of information sharing. This is true regarding information sharing between professionals, and with all members of the family. This omission in practice has relevance for, and impact on, the other lessons to be learnt arising from this review below.

Record Keeping

4.5 Accurate and up to date record keeping is a further issue which appears in many reviews. Good record keeping goes hand in hand with efficient information sharing, for example where information is needed when the case-holder is on leave or unable to be contacted. Poor record keeping can involve unnecessary gaps in information to inform risk assessment leading to an underestimation of risk. It can also cause expensive delays in assessments and providing care. An example of this was the non-recording of the perpetrator's temporary address when a warrant for his mental health assessment could not be executed because the incorrect address was on the warrant. This not only delayed assessing the perpetrator, it took the Police and Ambulance Service personnel away from their roles as emergency responders along with the mental health professionals at a time when resources are stretched.

4.6 The accuracy of record keeping is also vital. For example, a recording of an assault on one of the victims was inaccurate and it was overlaid with the perpetrator's arrest for a racially aggravated incident in the street which caused confusion and an underestimation of the seriousness of the assault. Disappointingly record keeping and the need for management scrutiny to ensure policies are being adhered to have been a recommendation for the Mental Health Trust in a previous Barnet DHR. It is essential that this issue is addressed at the highest level in the Trust.

4.7 The Panel recognise the pressure practitioners are under where available resources mean that caseloads are high and data recording systems are cumbersome to complete. Management need to take steps to alleviate these issues and to ensure that recording policies are followed.

Risk Assessment:

4.8 Risk assessment outside of incidents involving the Police was lacking in any understanding of risk associated with domestic abuse, and the additional risk factors that research shows come with substance misuse and mental illness. The lack of understanding and consideration of adult family violence was notable; the perpetrator's

care coordinator once describe assaults between the perpetrator and his brothers as 'men fights' in the context of 'rough and tumble'. This shows an absence of analysis of the whole picture, awareness of the number of Police callouts, the building tensions in the family, and the perpetrator's growing propensity for violence which was increasing risk.

4.9 The fact that the perpetrator had made threats of violence towards one particular family member during assessments appears not to have been carried forward to inform any ongoing assessment of risk to others. An assault of this particular family member the year before the killings should have rung alarm bells at that time, in addition the assault on his other family member who was later killed, should have rung yet more and resulted in another referral to MARAC. The frequency and level of the perpetrator's violence was increasing. The care coordinator would have been ideally placed to make this referral as it should have been clear to them that the perpetrator was the perpetrator of abuse to both victims.

4.10 A review of the literature by Onwumere et al[4] observed "that carers, particularly those who are female and living with the patient (e.g., typically mothers), are more likely to be the identified target of violent acts compared to other family members and the general population"(p3). The Onwumere research acknowledged that although most adults living with psychotic disorders are not violent, they recommend that domestic violence in psychosis cases should be an issue of public health and concern, and information on this patient sub group who are violent toward their caregivers might help the development of preventative and targeted interventions, which would have the potential to improve outcomes for all.

4.11 The family were often reluctant to take formal action as they did not wish to criminalise the perpetrator. This is frequently a wish by family members in cases of both intimate partner and family abuse cases; one family member said they did not want him going to prison to mix with 'undesirables'. However, there are times when professionals need to take responsibility for identify the risk and take the decision away from those at risk and act to protect them. As one practitioner said:

"His mother didn't want him to be reported to the police and I was sympathetic towards that. I decided we'd do it her way, and that was a mistake, it was a mistake that she paid for". (Ferriter & Huband, 2003, p555)[5]

4.12 The Mental Health Trust had introduced the LINKS pilot project IDVA into the Mental Health Team the year before the homicides. This innovative approach was to educate staff about domestic abuse including risk assessment. Despite the availability of the IDVA to give advice to practitioners it appears that the perpetrator's care coordinator did not absorb the training and did not seek support with risk assessment when the first victim was assaulted and then the other was assaulted and threatened with a knife. It is vital that practitioners recognise risk, when they need to seek expert advice, keep the risk assessment under review as circumstances change, and adjust risk when new incidents occur which indicate escalation or an increase in frequency. Management needs to

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[4] Onwumere J, Zhou Z and Kuipers E (2018) *Informal Caregiving Relationships in Psychosis: Reviewing the Impact of Patient Violence on Caregivers.* Front. Psychol. 9:1530. doi: 10.3389/fpsyg.2018.01530. https://www.researchgate.net/publication/327397274_Informal_Caregiving_Relationships_in_Psychosis_Reviewing_the_Impact_of_Patient_Violence_on_Caregivers

[5] Ferriter,M.,andHuband,N.(2003).Experiencesofparentswithasonordaughter suffering from schizophrenia. J. Psychiatr. Ment. Health Nurs. 10, 552–560. doi: 10.1046/j.1365-2850.2003.00624.x cited in Onwumere J, Zhou Z and Kuipers E (2018) Informal Caregiving Relationships in Psychosis: Reviewing the Impact of Patient Violence on Caregivers. Front. Psychol. 9:1530. doi: 10.3389/fpsyg.2018.01530 https://www.researchgate.net/publication/327397274_Informal_Caregiving_Relationships_in_Psychosis_Reviewing_the_Impact_of_Patient_Violence_on_Caregivers

assure itself that learning from domestic abuse training results in the implementation of that learning in case management.

Family Support & the Think Family Approach

4.13 Some professionals appeared to think that the family members with whom they had contact were minimising the perpetrator's mental health condition and/or not always informing the case holding care coordinators of the whole picture. However, the male family member with whom they had most contact did not live in the family home where the perpetrator resided, and he worked long hours. As a consequence, this family member may not have had the most detailed up to date information. There was also a question regarding how much the family understood about the perpetrator's diagnosis, the risks during relapse, and the additional support which might be available including through specialist voluntary services. For example, the victims were not referred to a specific Women's Aid relevant to their faith which may have improved the chances of their acceptance of support.

4.14 The person who was offered and turned down a carer's assessment was the perpetrator's elder brother who did not live at the family home which seems counter intuitive. Nothing further was offered. Other family members, particularly the women, are absent from offers of support, raising the question of conscious or unconscious gender bias on the part of the care coordinators. Family members who are carers or informal carers may not consider themselves as such, but research shows that the adverse health effects on informal carers (predominantly women) in managing their relative's psychosis can not only affect the carers health, but also impact on outcomes for the patient resulting in higher admissions to hospital[6]. Whilst it is impossible to say whether such a private family would have accepted support, it should nevertheless be offered as a positive option outside of statutory agency services, especially as there are specialist agencies locally offering services to their specific faith community.

4.15 The impact of the perpetrator's mental illness on the whole family appears not to have been considered. Practitioners working in the field of mental health need the help and support of family members to provide information when devising care plans and ongoing monitoring of a service users progress. It is essential that this is a two-way process undertaken in partnership as described by the Carer's Trust research and guidance Triangle of Care[7]. Family members need to be supported with education about their relative's diagnosis, managing symptoms and relapse, identification of risk, and who to contact about any difficulties or concerns. Whilst the ethos of patient confidentiality is understood, where a patient is living within the family home, it seems only reasonable that the family should have all the knowledge they not only need to support their relative, but also to be realistic and able to recognise risk to themselves. If the patient does not consent to information sharing it can still be achieved if the information shared does not contain personalised data, for example explaining the diagnosis, providing information already in the public sphere, and the use of a carer's plan.

4.16 As previously mentioned, families frequently prefer not to prosecute their family member as they do not wish to criminalise them. One of the perpetrator's family members was clear that they did not want him to go to prison. However, sometimes this can prove a helpful step to take. The perpetrator had complied with a Community Treatment Order

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[6] Onwumere J, Zhou Z and Kuipers E (2018) Informal Caregiving Relationships in Psychosis: Reviewing the Impact of Patient Violence on Caregivers. Front. Psychol. 9:1530. doi: 10.3389/fpsyg.2018.01530 https://www.researchgate.net/publication/327397274_Informal_Caregiving_Relationships_in_Psychosis_Reviewing_the_Impact_of_Patient_Violence_on_Caregivers

[7] The Triangle of Care Carers Included: A Guide to Best Practice in Mental Health Care in England. 2nd Edition 2013. The Carer's Trust. https://professionals.carers.org/sites/default/files/thetriangleofcare_guidetobestpracticeinmentalhealthcare_england.pdf

and had he been put before a court earlier a recommendation could have been made to the Court for a Drug Treatment Order and a further Community Treatment Order with which he may have complied once more. It is useful if family members have this explained and are supported to see this as a helpful option.

Working with Challenging Service Users

4.17 There is no doubt that the perpetrator presented a challenge to the services with whom he came into contact, particularly the Community Mental Health Service. When his illness was at its worst he lacked capacity and could therefore legally be admitted to hospital regardless of his views. There were occasions when he recognised he needed hospital treatment and he accepted voluntary admission. However, once at home in the community he stopped taking his medication and there was little success in keeping him engaged apart from the one time he was under a Community Treatment Order; this proved to be the most stable and 'quietest' year for his family and the emergency services. There appears to have been little effective practice to keep him engaged; no use of the assertive approach[8] seems to have been considered which can prove effective.

4.18 The perpetrator's behaviour needed a multi-agency coordinated assertive approach. The MARAC failed to provide this through an effective safety plan, and the referral to the local Community MARAC for his involvement with other drug users and risk of being drawn into gangs, was not actually made. His care coordinator could usefully have called a multi-agency strategy meeting to plan a joined up approach to managing his behaviour and the increasing risk he and others posed to his family.

4.19 From the transfer of the case by care coordinator 1 to care coordinator 2 it feels as though an air of resignation had descended that the perpetrator would not engage meaningfully with support or take his medication. Care coordinator 2 accepted his former colleague’s assessment of the perpetrator instead of bringing a fresh pair of eyes and professional curiosity to the case. Case notes had not been read, and other cases took over. Management supervision did not pick this up. Trying to work with the perpetrator was beset with difficulties around avoidance and racial abuse by the perpetrator at times. Practitioners working with intractable long term cases need effective individual and group supervision to overcome the barriers to becoming stuck as to how to progress with such cases.

Barriers to Safe Planned Release of Offenders

4.20 The fact that the perpetrator was released from remand in prison without pre-planning for where he should live, or consideration for the safety of his assault victims, and without any community orders or Restraining Order in place, was significant to the terrible events which unfolded. Given the nature of the crime for which the perpetrator was on trial, and the information at Magistrate’s disposal from the earlier hearing, it is concerning that they failed to make a Restraining Order before he was released.

4.21 Whilst fully appreciating that an offender cannot be held beyond their sentence tariff, a way needs to be found to avoid them being released straight from Court or prison without a pre-release plan in place. A Court hearing date is usually pre-arranged; therefore, pre-planning for release could aim to be in place for that date. However, the problems arise if, like the perpetrator, there are a number of hearings and finally the Court makes the decision to release immediately due to time served on remand. This presents prison staff with a very challenging problem particularly in relation to accommodation. The review

[8] The assertive approach entails frequent and repeated contacts with the service user, both via telephone and visits in person in the home or away from the home. The approach was developed in the United States of America. Initially used in a team for those difficult to engage, the approach has now been assimilated into individual practitioner's practise. Practitioners may have a lower case load to enable them to accommodate this intensity of work.

author is aware of a similar DHR where the offender was release straight from Court without services and anti-psychotic medication in place, and the Panel were concerned about the ramifications of this process of release immediately following Court for vulnerable offenders with additional needs, and victims who may be at risk following their release.

5. Recommendations from the Review:

5.1 The following recommendations arise from information provided to the Review, Panel discussions, from the lessons learnt and agency Individual Management Reviews (IMRs).

National Level:

Ministry of Justice:

Recommendation 1:
It is recommended that the Ministry of Justice review the current Prison release process and include the implementation of a Prison Release Risk Assessment which would be completed prior to every prisoner's release from the Courthouse (including video link court proceedings) thus ensuring notification and referral to appropriate agencies is in place to establish continuity of care, welfare, and the safeguarding of others prior to release.

Ministry of Justice & Her Majesty's Courts & Tribunal Service

Recommendation 2:
There should be an agreed process between the Ministry of Justice and Mental Health Services as to how Psychiatric/Psychological reports are commissioned by the Courts with Terms of Reference and timings agreed within which the report will be produced.

Ministry of Justice & Her Majesty's Courts & Tribunal Service - Magistrates Courts:

Recommendation 3:
It is recommended that the Magistrates Bench and Justices Clerks are provided with information and/or training clarifying the difference between a mental health assessment and a psychiatric report, thus assisting them with determining which type of mental health report will provide the most appropriate and timely assessment to inform sentencing when considering a case in which mental ill-health is a component.

Department of Health & Social Care:

Recommendation 4:
In order to facilitate an improved response to the risks associated with domestic abuse and mental ill health for victims and perpetrators, it is recommended that the DOH provide funding so that IDVA's can be placed in NHS mental health provider settings.

Home Office:

Recommendation 5:
The Home Office should forward copies of all DHRs involving a mental health component to the Secretary of State for Health & Social Care and the lead minister for mental health, for their consideration and to inform policy and decision making concerning community mental health and primary care service delivery.

Local:

Multi-Agency

Recommendation 6:
All provider agencies working in the community involved with service users and their families should take a Think Family approach and (in line with data sharing requirements), when assessing risk practitioners and their managers should ensure that assessments are fully informed by information from the family or carer living with the service user, in addition to research into psychosis, schizophrenia, coexisting substance misuse and domestic abuse. Any change in circumstances should trigger a review of the case.

Barnet, Enfield & Haringey Mental Health NHS Trust:

Recommendation 7:
The Mental Health Trust should review its process for disseminating MERLIN notifications from the Police to ensure that they are inserted and easily visible on patient case notes (via a flag if possible), the case holder is informed directly, and that risk is reviewed following their receipt. Where 5 MERLINs are received in a 12 month period the care coordinator should be responsible for reviewing the risks with partner agencies and amending the risk management plan accordingly. Family members or carers should be consulted as appropriate. If there is an act of violence reported in the MERLINs management of the case should be escalated promptly. Professionals should be mindful of viewing the whole historical picture to identify escalation.

Recommendation 8:
All staff involved in assessments, CPA care planning, and risk assessments should receive dedicated domestic abuse training which includes adult family violence and abuse, risk assessment, and MARAC referral process. The training should include lessons and case studies from adult family violence DHRs. Refresher training should be built into annual professional development plans at 3 yearly intervals.

Recommendation 9:
Mental Health Trust management supervision sessions with practitioners should routinely include evaluation of domestic abuse training when it has been undertaken, check the practitioner's levels of understanding against training outcomes, and assess evidence within review of cases to ensure that domestic abuse is recognised and learning is being acted upon.

Recommendation 10:
Newly appointed mental health practitioners should be given protected time to read through their new caseload case notes to ensure they are fully informed of their service users history and able to assess their needs using their experience.

Recommendation 11:
BEH should develop a MARAC protocol to ensure there is a clear understanding of process, attendance, and recording requirements on the patient record. Management, the MARAC representative, and their deputy should see advice for Mental Health MARAC representatives at:
http://www.safelives.org.uk/practice_blog/role-mental-health-representative-marac
(IMR Recommendation). *This recommendation was acted upon by the Mental Health Trust Safeguarding Committee before the DHR was completed.*

Recommendation 12:
BEH clinical supervision should ensure that it includes the active exploration of assessment of needs, formulation of care plans, risk assessment, and risk management using data from caseload records and information from all available sources. (IMR Recommendation).

Recommendation 13:
BEH should engage with the Court and Prison mental health schemes with which it has regular contact to ensure that pathways of care and contact details are clear to all staff involved. (IMR Recommendation). *Action complete before review was completed.*

Recommendation 14:
BEH should review the use and operation of the Risk and CPA facilities on RiO and develop systems that provide easy and direct access to information necessary for risk assessment and management. (IMR Recommendation). *Completed before DHR was completed. Simplified Risk assessments are in place on RiO.*

Recommendation 15:
Following a Mental Health Act Assessment at least one of the medical assessors should make written entry of their findings that is transferred to the RiO record as soon as practicable whether or not the patient has been detained. If the patient is not detained, the reasons for the decision should be included. (IMR Recommendation)

Barnet Adult Social Care

Recommendation 16:
The Local Authority Approved Mental Health Professional should ensure they always inform the GP that an assessment has taken place and particularly if a decision has been made not to detain the patient under the Mental Health Act.

Barnet MARAC - Hestia & MARAC Chair

Recommendation 17:
Review the structure, governance, and working of the MARAC and its Steering Group including updating the Terms of Reference to ensure that:

(a) the MARAC chair role is sustainable to maintain continuity to ensure that previous meeting actions are fully achieved and where outstanding agencies are challenged.

(b) Agencies must submit updates on actions to the MARAC Co-ordinator by the given deadline, and the chair and MARAC coordinator should review minutes and actions before the start of subsequent MARAC meetings to ensure actions are reported completed and the plan remains fit for purpose to minimise the risk to the victim/s. The Domestic Abuse MARAC coordinator to assist in bringing these items to the attention of the chair.

(c) Revisions to MARAC should include a process for carrying forward a case for future MARAC review where a perpetrator is in custody to ensure that a safety plan is drawn up ready to be put in place to protect the victim/s prior to the offender's release. Where applicable this should include requesting a Restraining Order from the Court and any other relevant order i.e. Drug Treatment Order, Mental Health Treatment Order, or suitable Order available under legislation at the time.

Recommendation 18:
Where a MARAC case includes consideration of specific cultural, ethnicity or religious interests, the MARAC coordinator should ensure that the relevant MARAC member organisation is invited for that case discussion either in person or through secure telephone conference facilities. The MARAC should keep under review the agency membership to ensure that it is up to date and that the required information and confidentiality agreements have been agreed and signed by the agencies called upon.

Recommendation 19:
When gathering pre-MARAC information to assess risk to a victim of domestic abuse all agencies and the MARAC chair must ensure that others in the household, including adults as well as children, are identified and if found to be vulnerable and at potential risk include them in the safety plan. The MARAC Operating Protocol and MARAC Research Form should be amended to include this process.

Recommendation 20:
The MARAC Steering Group to undertake a regular dip sample review of MARAC cases involving domestic abuse, substance misuse and mental ill-health, to ensure that information from all agencies has been shared, safety plans are appropriate, and all relevant services have offered actions to mitigate the heightened risk posed by the three combined issues.

Community Safety Team

Recommendation 21:
There needs to be a clear distinction between community MARAC and Domestic Abuse MARAC. This recommendation was acted upon by early learning. (IMR Recommendation)

Recommendation 22:
That the Barnet Safer Communities Board ensure they receive confirmation from the agencies involved in this Review that the learning in this DHR has been disseminated to all staff within their service once the DHR has received approval by the Home Office and the date that dissemination is completed. Also that the issues raised and learning has been built into their future training on domestic abuse. Confirmation should be required that relevant lessons for Domestic Abuse MARAC are being included in Domestic Abuse MARAC training.

Metropolitan Police

Recommendation 23:
SX BOCU Level: - (IMR Recommendation)
It is recommended that SX BOCU SLT dip sample domestic abuse reports to: -

- Ensure five year intelligence checks are being completed as per toolkit.
- Ensure compliance with current MARAC referral threshold and that rationale is being recorded within report.

Recommendation 24:
SX BOCU Level: - (IMR Recommendation)
It is recommended that SX BOCU SLT reinforce the requirement for all staff: -

- to understand the Vulnerability and protection of adults at risk policy
- to understand the Vulnerable Adult Framework
- to complete ACN MERLIN reports where they have identified vulnerability whether they are a victim, witness, suspect or member of the public they have encountered using VAF.

Recommendation 25:
That the Metropolitan Police review the use of the name MARAC for the Multi-Agency Anti -Social Behaviour group to avoid the confusion which arose in this DRH between the MARAC which is understood nationally for managing high risk victims of domestic abuse, and the MARAC in London for dealing with vulnerable anti-social behaviour victims.

National Probation Service

Recommendation 26:
Probation officers should use their best efforts to consult with local IDVA services to inform pre-sentence reports in domestic abuse case in order to understand current risk factors, concerns, and wishes of the victim(s). Where IDVA provision exists within the Court the probation officer to liaise with them to quickly identify risks and concerns for the victim. Whilst recognising Court time constraints may impact on the practicality of this It is recommended that this is adopted as best practice.

Recommendation 27:
The NPS have introduced Performance Improvement Tools (PIT tools),. The NPS to seek assurance from all line managers of Court staff that this has been integrated into the supervision process of Court based Offender Managers to ensure that assessments are of sufficient quality and there is a consistency of standards and compliance with procedures. (IMR Recommendation)

Recommendation 28:
The National Probation Service as part of its Effective Practice review should undertake a review of all training in the use of risk assessment tools to Court staff and in particular the use of the RoSH/CAS tool to ensure sufficient and consistent practice by all Probation Court Staff. (IMR Recommendation)

Recommendation 29:
That NPS Court Probation processes are reviewed and best practice implemented regarding those offenders who are released directly from the Court, including those appearing by video link, to ensure that Licence requirements are appropriate to manage the risk of harm that the offender may present. (IMR Recommendation)

Recommendation 30:
That Sentencers are briefed to ask for a report if it is not provided, even if the Probation Court Officers are unable to propose an appropriate sentence. (IMR Recommendation)

Royal Free London NHS Foundation Trust

Recommendation 31:
Commence monthly Frequent Attender Meetings to consider the management of complex, vulnerable ED attendees, how they are monitored, reviewed, referred and supported with multi-agency attendance. (IMR Recommendation)

Recommendation 32:
Review of how information is shared within the Emergency Department with contracted Mental Health support staff so that a consistent method is adapted to ensure that within the Trusts medical files all assessments are available. (IMR Recommendation)

Recommendation 33:
To review the training provided to trust staff to raise awareness of abuse in all age groups and how to ask about domestic abuse. (IMR Recommendation)

Victim Support:

Recommendation 34:
It is recommend that the existing searching of the case management system process is enhanced to ensure that upon receiving a referral, a thorough search of the case management system is conducted on the address for the referral subject to check whether there are related cases to ensure all known risk information is available to enable appropriate allocation of cases. (IMR Recommendation)

Recommendation 35:
Ensure that all Victim Support staff are aware of the timeframes stipulated in the DA Operating Procedure and provide training in areas where this practice has not been adopted. Managers to continue to address this with their teams, through team meetings and one to one supervision. (IMR Recommendation)

Recommendation 36:
Ensure that present day Victim Support procedure and practice is adhered to through continued use of dip-sampling and case review and feedback to staff. This is already being actioned through the introduction of an improved case review and auditing process throughout the organisation on a national level. The Victim Assessment and Referral Centre staff should be included in this explicitly. (IMR Recommendation)

Recommendation 37:
When changes are made to policy and procedure to bring them up to date, this needs to be accompanied by a “briefing note” circulated throughout the organisation and feature on team meeting agendas within a month of launching revised policy/procedure to identify any further training need. (IMR Recommendation)

Westminster Drug Project:

Recommendation 38:
All non-attendance or poor engagement in elements of care plan (e.g. group, counselling, ETE or other recovery-based activity) to be reported to lead worker and canvassed in key work and care plan reviews and MDT. (IMR Recommendation)

Recommendation 39:
Workers to seek consent to liaise with service user’s family and offer invite to Family & Carers group. Outcome of both consent and family’s response to invitation to be clearly recorded in case notes. (IMR Recommendation)

Recommendation 40:
Ensure staff are updating risk assessments and the respective risk management plans by checking in supervision and through local and central audit processes. (IMR Recommendation)

Recommendation 41:
Workers to seek consent from service users to liaise with their GP and/or other relevant services i.e. Mental Health Services, with whom they also have involvement.