Executive Summary

Domestic Homicide Review

Safer Ealing Partnership

Case of Rose

Independent Chair: Victoria Hill

November 2015

Introduction

1.1 This executive summary outlines the process and findings of a domestic homicide review (DHR) undertaken by the Safer Ealing Partnership (SEP) into the death of Rose. The identity of those involved has been anonymised for the purposes of confidentiality. Pseudonyms have been used in this report for all individuals mentioned in the review.

The facts – Rose's death

2.1 At 01:15hrs, on 13/03/2012, a neighbour of Peter heard a loud disturbance and a woman scream three times. They heard what they believed to be crockery smashing and looked out of their window to see where the noise was coming from.

2.2 The same neighbour then heard banging and saw Peter in his property. He was holding a large black handled knife in his right hand and was banging the handle on the frame of his window. He looked directly up at the neighbour and said "Call me an ambulance, someone has died here".

2.3 At 01:32hrs, Police were also called to Peter's address. The caller (Rose) told the operator that her boyfriend had stabbed her; that his name was Peter, and that she was on the floor in the kitchen. The London Ambulance Service (LAS) were also requested.

2.4 On Police arrival, four Police Officers went up the stairs to the third floor flat and knocked on the door, which was closed, stating 'Police, open the door'. A few seconds later the door was opened by about an inch. Police pushed the door open where they saw Peter standing at the end of the hall next to the kitchen holding a large black handled knife in his hand. They saw Rose who was in a dressing gown lying on the kitchen floor on her back, with her head propped up on a cupboard door near the sink and her feet pointing towards the front door. She was obviously wounded, bleeding heavily and she told the Police Officers 'Help me I need an ambulance'. She was still talking on the phone to the Police Operator when the Police arrived.

2.5 The Police instructed Peter to put the knife down on a number of occasions, but he refused. He walked backwards and forwards from the sitting room, bedroom and back to the hall. At one stage he had put the knife down in another room[1]; however, when Police

[1] The officer's statements were re-reviewed to clarify what rooms Peter moved between. Events unfolded very quickly and none of the officer's statements clarify which room he was walking in and out of. On examination of the map of Peter's property (Appendix Four) alongside the officer's statements it would seem that the Police Officers were at the front door/just into the hallway of the flat, and were about six or seven feet away from Peter, who was facing them but down along the corridor more towards the door of the lounge and kitchen. Although none of the officers say which room this was, it would either be the bedroom or lounge/sitting room.

approached Peter he quickly ran to the room and re-armed himself. The officers sprayed Peter with CS gas twice, and this appeared to have no effect. Peter then ran into the kitchen and in front of the officers, leant over Rose and stabbed her once more in the side of her stomach. After a struggle using batons, the officers were able to disarm Peter and tried to assist Rose who was bleeding badly from several knife wounds.

(*To assist the reader a map of Peter's address is included in Appendix Four of the overview report).*

2.6 On the arrival of the LAS, Rose was taken to St Mary's Hospital, Paddington. Her life was pronounced extinct at 03:08 hrs.

2.7 Peter was arrested for Attempted Murder whilst at the scene. He told officers that 'the BBC made him do it' and 'it's the BBC's fault'. He was further arrested for Murder when in custody at Acton Police Station. Peter made no comment to the charge.

2.8 A special post mortem was held on 13/03/2012. Rose's cause of death was multiple stab wounds to the chest. Rose had sustained several stab wounds to her shoulder, abdomen, chest, legs and side but the main chest wound had pierced her aorta. She had very few defensive injuries but had a black eye and various bruises on her arms.

The review

3.1 These circumstances led to the commencement of this domestic homicide review (DHR) at the instigation of the SEP. The SEP is the Community Safety Partnership (CSP) in the London Borough of Ealing.

3.2 Following the death, the SEP requested the review to commence in April 2012 and an independent chair was appointed in May 2012. The first panel meeting took place on 03/07/2012. Due to delays experienced in convening the panel, the original independent chair then decided to resign from the review on 08/02/2013.

3.3 Following this, the SEP had to restart the review again and approached Standing Together Against Domestic Violence to chair the review in March 2013. Please refer to the section *Delays with the DHR* for more detail about this.

3.4 Standing Together were then subsequently commissioned to chair the review and the initial meeting of the reconvened review was held on 15/05/2013. There have been six subsequent meetings of the DHR panel to consider the circumstances of this death.

3.5 The DHR was established under Section 9(3), Domestic Violence, Crime and Victims Act 2004.

3.6 The purpose of these reviews is to:

3.6.1 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.

3.6.2 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.

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

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

3.6.5 This review process does not take the place of the criminal or coroners courts nor does it take the form of a disciplinary process.

Terms of reference for the DHR

4.1 The full terms of reference are included in Appendix One of the overview report. The essence of this review is to establish how well the agencies worked both independently and together and to examine what lessons can be learnt for the future. The review used the original terms of reference agreed for the original review commenced in 2012.

Review methodology (including family contact)

5.1 The approach adopted was to seek Individual Management Reviews (IMRs) for all organisations and agencies that had contact with Rose or Peter. IMRs included chronologies for contact in the period agreed by the panel for the terms of reference.

5.2 The time period subject to the review was 01/01/1993 – 13/03/2012. 1993 was chosen as the start date for the chronology as this is when Peter's mental health concerns are first recorded.

5.3 It was also considered helpful to involve agencies that could have had a bearing on the circumstances of this case, such as local domestic violence services, even though they were not previously aware of the individuals involved.

5.4 Once the IMRs and chronologies had been provided, panel members were invited to review them all individually and debate the contents at subsequent panel meetings. This became an iterative process where further questions and issues were then explored. This report is the product of that process.

5.5 No other parallel reviews have been conducted.[2]

5.6 Rose and Peter between them had four adult children. They were all contacted by the chair to see if they would like to be involved in the review. The chair has had brief contact with one of Rose's sons, who subsequently decided not to engage further with the review. One of Peter's daughter's, (Tina) has spoken frequently with the chair and has engaged in the review. The other children have not responded to approaches made by the chair.

5.7 Agencies and services participating in the review:

- Metropolitan Police – Ealing borough and Critical Incident Advisory Team
- Ealing Council – Safer Communities Team
- Ealing Council – Noise Nuisance Team
- Ealing Council – Public Health[3]
- Ealing Council – Tenancy Management and Landlord Services (including Housing Repairs Service)[4]
- NHS England (representing General Practice Ealing)
- NHS Ealing Clinical Commissioning Group (CCG)
- West London Mental Health NHS Trust
- Ealing Hospital NHS Trust
- Imperial College Healthcare NHS Trust (St Mary's Hospital)
- Southall Black Sisters
- Hestia Housing
- Victim Support
- Housing for Women

[2] The circumstances of Rose's death were not referred to the Independent Police Complaints Commission

[3] Ealing Council Public Health did not attend any panel meetings but were included in the distribution of all the papers.

[4] This was previously Ealing Homes, an Arms Length Management organisation, responsible for social housing.

- RISE (drug and alcohol service)
- Standing Together Against Domestic Violence (chair and administration).

A full list of panel members is contained in Appendix Two of the overview report.

5.8 The independent chair of the DHR is Victoria Hill, an associate consultant working for Standing Together Against Domestic Violence, an organisation dedicated to developing effective, coordinated responses to domestic violence.

5.9 Victoria Hill has fifteen years' experience of working in the domestic violence sector and has no connection to the London Borough of Ealing or with any agency involved in this case.

Individual Management Reviews

6.1 Agencies were asked to give chronological accounts of their contact with the victim prior to the deaths. Each agency's report covers the following:

- Chronology of interaction with the victim and/or their family
- What was done or agreed
- Whether internal procedures were followed
- Conclusions and recommendations from the agency's point of view.

6.2 The following agencies involved in the panel responded as having contact with the individuals concerned. These agencies were:

- Metropolitan Police
- Ealing Council – Noise Nuisance Team
- Ealing Council – Tenancy Management and Landlord Services (including Housing Repairs Service)[5]
- NHS England (representing General Practice Ealing)
- West London Mental Health NHS Trust
- Ealing Hospital NHS Trust
- Imperial College Healthcare NHS Trust (St Mary's Hospital)
- Victim Support.

[5] This was previously Ealing Homes, an Arms Length Management organisation, responsible for social housing.

6.3 In addition, the following services confirmed that they had no contact with either Rose or Peter during the time period set out by the review (01/01/1993 – 13/03/2012):

- Southall Black Sisters
- Hestia
- Housing for Women
- Central and North West London NHS Foundation Trust (including Gatehouse Services and CRI Treatment Services)
- RISE - Recovery Interventions Service Ealing[6].

Delays with the DHR

7.1 This review has encountered unacceptable significant delays which has potentially compromised the purpose and the integrity of the review (particularly with the families of Rose and Peter). It is concerning that the delays have no doubt impacted on the review's ability to expedite learning and ensure that improvements to the response to domestic violence are implemented as soon as possible so to help prevent similar events from happening to others.

7.2 The first review was convened by the Safer Ealing Partnership, who selected an independent chair to guide them through the process of the DHR. This review failed to achieve momentum, and there is acceptance from the Council's lead department (Safer Communities) that with this being their first review they had under estimated the time and resources necessary to support such a process. The chair of the review tendered their resignation and arrangements were made for the appointment of a new independent chair.

7.3 Standing Together were commissioned in May 2013 to chair the review, and based on their experience of other similar reviews recommended and offered to provide the coordination and administrative function to support the process. Standing Together commenced the review (and coordination/support of the same) immediately following their commission.

7.4 The reconvened review has unfortunately experienced on-going difficulties in identifying the appropriate agencies and representatives to engage with the review, and there have been delays by some agencies in the production of their IMRS.

[6] RISE have confirmed that Peter was never referred to the in house alcohol service which was operating at his GP surgery.

7.5 Further delays were encountered in obtaining the IMRs, notably from Rose's and Peter's GPs. Changes to the NHS in April 2013 meant that it was unclear who was formally responsible for commissioning the IMR from the GP. The Home Office DHR Statutory Guidance makes it clear that the IMR must be provided by someone who has not provided care to the individuals concerned (or supervised those that have). This added a delay of over two months to the review. The depth of information included in the two GP IMRs has also unfortunately limited the rigour of analysis of the review in regard to the victim's and perpetrators contact with their GP. The issue of securing GP IMRs has been included as this is a fundamental block for all DHRs.

7.6 Following review of the IMR submitted by Peter's GP, an additional IMR was then required from Imperial College Healthcare NHS Trust (St Mary's Hospital) to obtain information on his Hepatitis C treatment. Submission of the IMR was then subject to further delays due to their internal quality assurance process.

The perpetrator - Peter

8.1 Peter admitted to stabbing Rose five times before Police arrived and then further admitted stabbing her in front of the Police Officers. Peter stated that he had stopped taking medication for his Hepatitis C condition about one week before the incident as it made him feel strange. He stated that he did not know why he attacked Rose, that he could not remember Rose arriving at the flat or what they did prior to the incident (despite having said he thought that they had watched television). He stated he heard abusive voices in his head; although, they did not tell him to do anything specific.

8.2 Peter has not had any convictions prior to this incident since 1994. Peter had an alleged history of domestic violence. He also had a recorded history of violence offences of varying degrees of severity (including a stabbing) dating back to 1978.

8.3 Although it is not within the time frame subject to this review, in 1989 Peter was sentenced to three years imprisonment for Grievous Bodily Harm with intent, after he used a kitchen carving knife to attack a man (to whom he owed money to). The victim was stabbed twice in the left arm, once in the chest and was slashed across the face causing injuries requiring thirty stitches.

8.4 There were allegations of previous violent conduct towards Rose, his own children and also towards Rose's children.

8.5 Peter had a previous history of Class A drug use (intravenous use of heroin), alcohol use and fluctuating mental health.

8.6 Peter declined to engage in the review.

Sentencing Peter

9.1 Peter pleaded guilty to the manslaughter of Rose under diminished responsibility in December 2012. On 10/07/2013, he was sentenced at the Central Criminal Court to a Hospital Order with restrictions, to be detained indefinitely under Section 37/41 of the Mental Health Act (1983) for purposes of public protection.

9.2 At the sentencing hearing, the Judge said that the behaviour of the Police Officers at the scene was exemplary and commended the officers for their bravery, skill and courage in tackling Peter and attempting to save Rose's life.

Peter's mental health diagnosis

10.1 Peter had a documented history of experiencing periods of poor mental health in the 1990s and his last contact with West London Mental Health Trust (WLMHT) was in 1998. This history was not evident in his GP record, and appears not to have been a factor or consideration in his contact with them since registering with his GP in 2007.

10.2 Peter's historical contact with mental health services show some diagnostic uncertainty, but a working diagnosis of paranoid schizophrenia complicated by substance use was originally made by WLMHT.

10.3 It would appear that Peter has had episodes of drug induced psychosis over the years.

10.4 Peter's history of mental health concerns was not sufficiently captured in the transfer between his GPs. This resulted in the detail of his history being lost (no mental health diagnosis marker added to his record), and this impacting on the health care and support he subsequently received, notably from the Hepatology Clinic. The clinic conducts a detailed mental health assessment, and if Peter's mental health history had been known there may have been a discussion as to whether anti-viral treatment was in fact possible as no other alternative drug is available and he would have had contact with the psychiatric liaison team.

10.5 Following Rose's death, Peter was diagnosed with Dissocial Personality Disorder (otherwise known as antisocial personality disorder) complicated by a history of drug induced psychosis. An explanation of Peter's diagnosis from WLMHT is provided below:

10.5.1 "Individuals with Dissocial Personality Disorder have enduring problems with impulsive, conflict seeking behaviour. They fail to profit from experience and have a persistent disregard for rules, laws and the rights of others. It is not uncommon for such individuals to be involved in criminal activity. Those with dissocial personality disorder have significant problems tolerating frustration and delaying gratification. This often leads to angry or violent outbursts. People with dissocial PD often have relationship difficulties. They are able to form relationships but these are often characterised by conflict, and usually end after running a turbulent and short course."

10.6 Drug induced psychosis describes periods of psychotic symptoms in the context of drug use; most commonly cannabis, cocaine or amphetamines. Such symptoms might be very similar to schizophrenia and include hallucinations (abnormal false perceptions) and delusions (abnormal false fixed beliefs). Individuals with drug induced psychosis might have psychotic symptoms for several weeks or even months, but there is a clear link to drug use at the same time and after time. Symptoms respond to treatment or pass with time.

10.7 At Peter's sentencing hearing, it was stated that a long term prognosis could not be made of his progress, and that since he had been detained there had been little progress in his mental health improving.

Peter and Rose's relationship

11.1 The Police information states that the couple were in a relationship for about nineteen years. At Peter's sentencing hearing it was stated that they were together for fourteen years. The Police IMR stated (which was confirmed by Peter's eldest child Tina) that about sixteen years ago, Rose and Peter had previously lived together with all of their four respective children. They had never married.

11.2 Prior to Rose's death, they were living at separate addresses and this arrangement appears to have suited them both. It has been described by one of Peter's children (Tina) that Peter's relationship with Rose had changed to where she had become more of a carer to her father than being his girlfriend. In October 2010, Rose described Peter to her GP as her ex-partner.

Contact with family, friends and other people who knew Peter and Rose

12.1 The guidance for conducting DHRs is very clear that families and friends should be a part of the DHR process. Engagement with friends and family members is important so that the review can be accurately informed about the nature of the relationship, attempts that may have been made to seek help, and any contact with services. Family and friends are also invited to share their thoughts on what happened and what can be changed to prevent future deaths.

12.2 As part of this review, the chair has had brief contact with one of Rose's sons - Matthew. The chair has spoken in detail with one of Peter's children - Tina. The panel were unable to engage with any friends of Rose or Peter. A family genogram is included in Appendix Five of the overview report.

Findings from the review

13.1 **Reported history of domestic violence and police contact**

13.1.1 There was a history of reported domestic violence between Rose and Peter (three incidents over a twelve year period).

- 04/01/1998 – Criminal Damage to Rose's property
- 16/06/2003 – Peter was drunk and would not leave Rose's property
- 11/02/2010 – Neighbour reported hearing a woman screaming.

The three incidents were all classed as non-crime domestics. These were not referred to Victim Support.

13.1.2 There is also a documented history of domestic violence involving Peter with other partners. There are Police records of domestic violence between Peter and an ex-partner in 1993 (assault with a table leg), and also in 1999 (threats to assault). In 1998 an ex-partner of Peter disclosed an incident of domestic violence to mental health professionals. There were also reports of violence between Peter and Rose's sons and also between Peter and with his daughters.

13.1.3 The three incidents reported to the Police between Rose and Peter would not have met the threshold for referral to the Ealing Multi Agency Risk Assessment Conference (MARAC). Although the MARAC implemented in the borough in 2010 (and after the last Police report) the non-crime domestic could have been referred to Victim Support and Peter could have been risk assessed as they

were already using the CAADA DASH RIC[7] at this time. This process would have supported discussions with Rose about her relationship with Peter and concerns she may have had.

13.1.4 The non-crime domestic incident in 2010 (when a neighbour reported that they heard a woman screaming) was not progressed appropriately by the Police. As the Police Officers were unable to locate and speak with Rose that evening, they opened a Computer Aided Dispatch for this to be followed up later. This was an appropriate course of action; however, the Police Officers who then went to deal with this only spoke with Rose's lodger and not with Rose personally. This contact with her lodger was then followed up again several days later, and again Rose was not spoken to or seen face-to-face by the officers. They took the account of a neighbour that Rose had been seen and there was no concern for her welfare.

13.1.5 Rose should have definitely been seen and spoken to by the Police following this incident to establish how she was and if she had any concerns as this would have been an opportunity to offer her specialist domestic violence support. The Police should not have closed the call until Rose had been directly spoken to about the incident.

13.1.6 The review has established that not every non-crime domestic incident is automatically referred to Victim Support. The individual Police Officer who attends the scene assesses and uses their professional discretion to decide whether to refer a non-crime domestic to Victim Support (when the victim's consent has been obtained). Due to funding issues, only domestic violence crimes are automatically referred to Victim Support as part of the daily automatic data transfer (once the victim's consent has been obtained).

13.1.7 For non-crime domestic incidents, the Police Officer would make an assessment as to whether a referral would be helpful given information gathered from intelligence checks (such as the history of any previous reports) and the nature of the incident. The issue concerning referral practices from non-crime domestics

[7] The CAADA DASH Risk Indicator Checklist (RIC) helps practitioners identify high risk cases of domestic abuse, stalking and 'honour'-based violence and decide if the case needs to be referred to a MARAC and what other support might be required. A completed form becomes an active record that can be referred to in future for case management. The tool enables agencies to make defensible decisions based on the evidence from extensive research of cases, including domestic homicides and 'near misses', which underpins most recognised models of risk assessment.

and the lack of funding for these incidents to be referred to Victim Support is a national issue and not just specific to the London Borough of Ealing.

13.2 **Family functioning and relationships**

13.2.1 The review noted that there were also other reports of interfamily violence and also reports of domestic violence in some of the children's own intimate relationships. It seems as though that when the families lived together there was conflict between Peter and Rose's sons, and that this was a stressful domestic living arrangement.

13.2.2 Rose and Peter had been together in a long term relationship before they agreed to live separately. Rose referred to Peter as being her ex-partner in her contact with the hospital in 2010. Rose may have experienced a conflicting struggle about wanting and needing to care for Peter and not wanting to be in a relationship with him. This may have prevented her from being able to seek help regarding his behaviour.

13.3 **Domestic violence enquiry and risk assessment**

13.3.1 There was no detailed enquiry with Rose or Peter by professionals about their relationships or support networks. When partners were mentioned, this did not trigger enquiries to be made about the nature of their relationships. There was a lack of appropriate curiosity about their family lives and support networks. This seems a significant omission given Rose's serious health concerns and Peter's presentation. There are several incidents (other than the three reported domestic incidents with the Police) in the chronology where domestic violence enquiry would have been opportune, relevant and possibly beneficial:

a. 29/12/2008 – Rose attends Ealing Hospital for injury to right side rib.

b. From November 2008 when Rose was being treated for a serious health condition (questions should have been asked in relation to what support she had at home). Rose was seen by her GP and the hospital regularly about this and it is surprising she was not asked about her relationships or her home life given the nature of her health concerns and that she may have needed emotional and practical support.

c. 21/07/2009 – Rose attends Accident and Emergency following a fall. She was seen also by the GP about this. On both consultations the cause of the

injury was accepted; however, later on 28/07/2010 she presented at Accident and Emergency again reporting another fall. The cause of the injury and the fact this was similar to her attendance in 2009 was not questioned.

d. 04/08/2010 – Rose seen by GP regarding the second fall.

e. 07/12/2012 – Rose has a routine smear test.

13.3.2 Despite a partner being referred to in Peter's consultations, there is no evidence of consideration of the risks presented to Rose and what safeguarding actions may need to be considered. There are several incidents in the chronology where consideration of domestic violence and exploration of domestic violence risk assessment with Peter should have been made:

a. 26/03/2008 – Peter given standard generic information on sexually transmitted infections.

b. 26/01/2000 – Peter seen at Ealing Hospital for a sexually transmitted infection and stated in triage that he "may have got it from his girlfriend".

c. 03/09/2010 – Peter diagnosed as Hepatitis C positive. GP provided generic safe sex advice (to use condoms to protect his partner).

13.3.3 In 1998 during Peter's admission in Torbay Hospital, it is stated that Peter's girlfriend (not Rose) disclosed concerning behaviour by him towards her on one occasion when he was unwell and under the influence of drugs (this incident was Peter driving on the wrong side of the road at high-speed to test if she was being unfaithful, holding a knife to her throat). This did not trigger a risk assessment about the issues identified.

13.3.4 Due to the date of this disclosure and the length of time of Rose's and Peter relationship, this information was rechecked to confirm whether the girlfriend mentioned was actually Rose. Peter's daughter (Tina) thought it could have been Rose; however, the WLMHT records (a report dated 27/03/1998) states that Peter's partner leading up to and including 1998 was a different woman (not Rose). It is also stated that he had a previous partner but is unclear in the report when the relationship with her ended and the relationship with the new partner (not Rose) started. The review is therefore unclear if this is a new partner disclosing domestic violence to a professional concerning Peter was in fact

Rose. Regardless there is a reported disclosed history of domestic violence involving Peter which was not properly considered.

13.3.5 The comment included in the records that there was disclosure of domestic violence on one occasion but in interview (it is now assumed to be Rose) it stated that there were not *"any other incidents of regular domestic violence"* highlights a lack of understanding and awareness of the dynamics and nature domestic violence. The comment raises the question of what was meant by the phrase "regular domestic violence" and that a disclosure of violence had been made and that was not taken seriously.

13.3.6 In both of the GP IMRs it is stated that their records showed no signs of domestic violence. There was no evidence of the indicators of domestic violence, any direct self-disclosure of domestic violence from Rose or that the prospect of domestic violence was ever considered. It is noted that Rose was known personally at her GP practice. The panel discussed whether this may have influenced the nature of enquiry for domestic violence by clinical staff.

13.3.7 As part of the GP IMR process, both Rose's and Peter's attendances at hospital and other critical dates were cross referenced with their GP records and no issues concerning the risk of domestic violence were identified.

13.3.8 The GP practices concerned in this review have confirmed that they do not have a domestic violence policy or had ever received specific training on domestic violence awareness and conducting clinical screening and enquiry for domestic violence. The lack of a domestic violence policy for GPs and ensuring staff receive specific domestic violence training for GP practice staff is recognised as a borough wide issue and not specifically isolated to the two GP practices concerned in this review.

13.3.9 The review found that one of the GP surgery's (due to its close proximity to the borough's domestic violence refuge) was previously offered domestic violence training but that take up was limited and engagement by the domestic violence service with the practice has been difficult. The review has made efforts through the panel representatives for NHS England and Ealing CCGC to expedite the provision of domestic violence training and publicity materials to the two GP practices concerned.

13.3.10 One of the GP practices concerned in the review stated that domestic violence training is now planned. This is a welcomed development; however, a borough wide GP domestic violence training initiative is needed in order to help support improvements across the board.

13.3.11 The Borough should therefore consider commissioning the IRIS Project[8] to improve primary care's response to domestic violence. It is also hoped that the NICE Guidance (PH50) Domestic Violence and Abuse – how services can respond effectively[9] will help to improve the health service's response to domestic violence (particularly from general practice).

13.4 Caring responsibilities and support

13.4.1 Peter's daughter (Tina) said that her father and Rose had decided to live apart. This could be an indicator that life together was difficult or stressful. There is no evidence of any support provided to Peter for his historical mental health issues or to Rose for her serious health concerns.

13.4.2 It was stated that Rose was providing care for one of her sons and that she was also a carer to Peter. There was no evidence of a carer's assessment being requested or conducted.

13.4.3 When Rose was discharged from hospital following surgery for her serious health condition on 16/11/2006, her caring role was not explored nor was Peter's own support requirements documented. This would appear to be a gap in the care planning for Rose given the seriousness of her condition.

13.4.4 Rose had on-going frequent contact with her GP due to treatment and care for her serious health condition, compared with Peter who was visiting his GP less frequently and his contact was considered as being more episodic. During Peter's contact with clinicians, it seems that Rose is invisible. This may have been reinforced by the fact that they were registered at different practices and the limits of sharing information due to patient confidentiality.

[8] IRIS Project is a general practice-based domestic violence and abuse (DVA) training support and referral programme. Core areas of the programme are training and education, clinical enquiry, care pathways and an enhanced referral pathway to specialist domestic violence services. It is aimed at women who are experiencing domestic violence and abuse from a current partner, ex-partner or adult family member. IRIS also provides information and signposting for male victims and for perpetrators http://www.irisdomesticviolence.org.uk/iris/

[9] http://www.nice.org.uk/guidance/index.jsp?action=byID&o=14384

13.5 **Vulnerable adults and Peter's presentation**

13.5.1 The complaint sent to the Noise Nuisance Team concerning Peter (October 2004) appeared to indicate that there may have been wider problems beyond that of simply noise nuisance. The flooding issue in Peter's flat would not, in normal circumstances, be sufficient to warrant a safeguarding concern. The complainant's references to throwing empty beer cans out of a window and reference to Peter as 'a menace' may have indicated wider anti-social behaviour issues. No follow up about these other matters was recorded and direct contact and questioning of the complainant may have yielded wider concerns.

13.5.2 It was noteworthy that the Noise Nuisance Officer who attended Peter's address on 21/09/2005 (following a noise nuisance complaint from a neighbour) in their notes stated (Peter) "looked unwell" and that "he looked terrible". This contact with Peter would not necessarily raise significant safeguarding concerns but may have been an indication of safeguarding vulnerable adult issues. This should have warranted a consideration of vulnerable adult and liaison with the Safeguarding Adults Team.

13.5.3 At the second direct contact the Noise Nuisance Team had with Peter on 14/10/2005, Peter again appeared intoxicated but it is recorded that he was compliant. The Noise Nuisance Team informed the panel that it is not unusual for them to find that the subject of a noise complaint is intoxicated, as complaints of loud music are often associated with parties and celebrations when alcohol is consumed, especially late at night.

13.5.4 Despite Peter being described by one of his neighbours to the Noise Nuisance Team as a "menace" in their contact with the team on 07/01/2004. It is unlikely that Peter's presentation to the noise nuisance officer that he "looked terrible" and his noted alcohol use would have met the threshold for statutory safeguarding adults intervention concerning the possibility of him a posing a risk of harm to himself and others.

13.5.5 Peter's daughter Tina contacted the Noise Nuisance Team on 23/07/2007 following receipt of the warning letter concerning amplified music. The notes of this conversation raised no direct concern.

13.5.6 The Noise and Nuisance Officers and Response Officers have now received training to identify indicators of domestic violence, child safeguarding concerns

and wider vulnerabilities when dealing with their routine contacts with members of the public.

13.5.7 When a noise nuisance complaint is received the procedure now is that questions are asked of the complainant to help identify any vulnerabilities. The Council's Noise and Nuisance Officers and Community Safety Officers (whose responsibilities include dealing with tenancy enforcement with regard to anti-social behaviour) now work together in clusters which promote information sharing between the Noise Nuisance and Community Safety Team. Officers can directly liaise with the Risk Coordinator in the Safer Communities Team, who co-ordinates the response to high risk cases of vulnerability and repeat victimisation, ensuring that the response to high risk cases is in line with national/local policy and legislation in relation to Safeguarding vulnerable adults and children.

13.5.8 The Housing Repairs Service now has a different system when responding to a repair request. The tenant is asked about the nature of the repair and how the damage was caused. Appropriate referrals for support are then made. The tenant is asked to supply a crime number from the Police, and if the incident had not been reported to the Police they are asked to do this. The council's Community Safety Team and Housing Officers would also be advised of the incident. Contractors who do the repairs have received safeguarding adults training and understand that they must report back any concerns if they identify any safeguarding concerns. It was confirmed that such safeguarding reports from repair contractors are rare.

13.5.9 It is good practice that all reports to the Housing Repairs Centre are now all screened regarding the possibility of domestic violence. However, as it is noted that such reports are rare, this would indicate that more work is needed with housing providers and repair contractors to improve their response to domestic violence. Housing providers need to be included in the Borough's coordinated community response to domestic violence so that domestic violence reports are increased and that tenants are appropriately supported.

13.6 **Ealing Hospital's response to domestic violence**

13.6.1 The review has recognised the welcomed and positive developments undertaken by Ealing Hospital concerning its response to domestic violence. The Trust's

Domestic Violence Policy (2012) is comprehensive and detailed. The policy provides guidance and advice for managers to support employees who are currently suffering or have suffered as a result of domestic violence. The policy also provides evidence based information for professionals to escalate concerns using risk assessment tools.

13.6.2 Training around domestic violence awareness, MARAC processes and risk assessment tools is embedded within Ealing Hospital's Level 3 Child Protection training study days. It is a mandatory requirement for staff working frontline with children and families to attend Level 3 training. This would capture staff working in Accident and Emergency who would often work frontline when victims of domestic abuse assess services.

13.6.3 This training does not always reach staff working in other areas of Ealing Hospital, such as those working on wards or in community based settings. When Rose was being treated for her serious health condition, it was not recorded whether she was asked about her relationships or the support she had. Given her serious health concerns, it would seem appropriate and necessary to establish what support Rose had around her. Whilst it is recognised that domestic violence enquiry at such appointments may be extraordinarily difficult, a discussion about Rose's home life and support may have prompted an exploration of her relationships and eventually a sensitive domestic violence enquiry could have possibly been made.

13.7 **Peter's contact with mental health services**

13.7.1 The panel questioned the seemingly informal nature of Peter's discharge in 1998 from Mental Health Services when his GP told Mental Health Services that Peter was seeing a doctor 'down the coast' which resulted in him being discharged from WLMHT.

13.7.2 WLMHT discharge practices have since changed. A "Notice to GP of intention to discharge" is sent to the patient's GP. If the GP is in agreement with the plan to discharge, the GP must confirm this by returning a slip.

13.7.3 In addition to the discharge notice sent to GPs, WLMHT clinicians receive a training package on 'Safe Discharge Methodology'. In the event of relapse after discharge, the GP contacts the discharging team for advice or contacts the single point of referral for assessment as per details of the Discharge

Template/Care Plan.

13.7.4 WLMHT have also given assurances that GPs are now routinely contacted when they have concerns about a patient and that patients are provided with out-of-hours contact details for further support. WLMHT would contact the individual directly by telephone as well as writing to them if they had not attended an appointment. In addition, the GP would be contacted and written to.

13.7.5 Since Peter's last contact with Mental Health Services, there have been a number of changes on how safeguarding concerns are dealt with and managed. All WLMHT staff participate in mandatory safeguarding training and there are named professionals that provide guidance to those staff who identify concerns relating to domestic violence and abuse.

13.7.6 It is good practice that WLMHT's induction and mandatory safeguarding training (both children and vulnerable adults) does reference domestic violence. The Trust is in the process of finalising the recruitment of two additional posts to join the corporate safeguarding team. These posts will help further improve the safeguarding response to vulnerable adults (including developing the response to domestic violence) through access to expertise and increased training capacity.

13.7.7 In comparison, GP responses to domestic violence are located within the vulnerable adults framework. It is important, given the complexity of domestic violence, that the issue is highlighted as a specific separate safeguarding agenda and is not lost by being incorporated within the safeguarding response to children or adults.

13.7.8 The review recognises that WLMHT is actively working to ensure domestic violence is visible in safeguarding responses to patients. Their newly updated safeguarding adults policy has been subject to expert review by the AVA Project[10] to ensure it appropriately covers domestic violence. There are robust systems in place to audit workforce take up of safeguarding training and updates, which is done through a score being scrutinised on a monthly basis looking at each team's take up of compliance to ensure training compliance rates are achieved.

[10] AVA Project – Against Violence and Abuse Project www.avaproject.org.uk

13.7.9 WLMHT's organisation intranet site includes comprehensive information on domestic violence as well as the relevant forms concerning the MARAC (including the CAADA DASH RIC). Efforts have been made to help ensure that the information is easily accessible for staff to support and inform their practice.

13.7.10 During the course of the reconvened review, WLMHT have been developing a dual diagnosis strategy which is currently awaiting corporate sign off.

13.7.11 The Ealing Multi Agency Safeguarding Hub (MASH) is still in its infancy and is children focused. The MASH provides an integrated safeguarding response service; however, it is noted that currently the arrangement does not include representatives from Adult Social Care or Adult Mental Health Services. There is a named contact within WLMHT when information and checks are needed. Having these services in MASH, as well as ensuring that there is domestic violence expertise within the arrangement, would help to provide a more timely and coordinated response to cases which would not meet the threshold for statutory safeguarding intervention, such as in this case and the concerns identified respectively with Peter deteriorating mental health.

13.7.12 Although Mental Health Services are not part of the Ealing MASH, there is a Mental Health and Drug and Alcohol link and provision of twenty-four hour psychiatric liaison across the trust. There are now two full-time drug and alcohol assessment workers located within Accident and Emergency, and as a result of a serious case review now hold a safety net meeting once a week.

13.8 **Treatment of Peter's Hepatitis C**

13.8.1 Peter's treatment by the Hepatology Clinic was not informed by his full medical history due to the lack of a diagnosis marker being included in his GP records concerning his previous mental health concerns.

13.8.2 The Hepatology Clinic is informed by GP information but also heavily relies on patient disclosure as part of the clinical relationship. The referral to the Hepatology Clinic from Peter's GP did not include information about his previous mental health concerns and contact with Mental Health Services. This gap in information about Peter is significant given the likely side effects of his anti-viral medication may have had on his mental health.

13.8.3 The Hepatology Clinic does not have a formalised system in place to independently verify information from patients, which means there is an over reliance on patient full and accurate disclosure, which may have a negative impact on their care and treatment.

13.8.4 The Hepatology Clinic assesses approximately five hundred to six hundred patients a year. Given the volume of patients they see, assessment is very much informed by GP information and patient disclosure, which they need to take at face value which is supplemented by their own clinical assessment. The clinical relationship is informed by a detailed assessment process due to the long lead in time into treatment and that the sharing of information from patients is a fine balancing exercise. Whilst it is acknowledged that this is important for building trust, rapport and not further stigmatising patients, the process of gathering information as part of assessment process needs to be more accurately informed and verified by other sources of information.

13.8.5 Given the known side effects of Peter's anti-viral medication and Peter's own concerns about the side effects of his medication on his mental health, there should have been a formal liaison with his GP about his history to fully establish any mental health concerns.

13.8.6 Whilst recognising Peter received a good standard of care from the Hepatology Clinic (and the timely response offered to Peter on the day before Rose's death), the reliance on his self-disclosure of his mental health concerns influenced his treatment plan. There was a gap in what information was verified with the GP and also what was shared by the GP in the original referral concerning Peter's mental health history. This lack of information impacted on the safeguards put in place in an attempt to monitor any deterioration in his mental health as a result of possible Peginterferon-induced psychosis.

13.8.7 On the day before her death, Rose reported her concerns about Peter's mental state deteriorating to his nurse. This shows the rapport that Rose had developed with Peter's nurse but could also be an indicator that Rose may have not had any other source of support to approach for help.

13.8.8 It is noted that the response offered to Peter that day was swift with an appointment offered that same day; however, he later cancelled the appointment which was made for him at the hospital. As there were no known active present

issues concerning Peter's mental health or any concerns about his alcohol or substance use, he did not have a key worker in the community and there was not a coordinated care package in place. His GP was not engaged in his care plan. This meant that there was not an opportunity or ability to arrange a multi disciplinary approach to the concerns Rose had raised about Peter's behaviour and mood – which could have included a home visit being made to him that afternoon.

13.8.9 Had Peter's past history been known, the clinic would have taken a different approach to his treatment – such as a referral to the in-house liaison psychiatric team which could have led to a different response to the concerns raised on the day before Rose's death.

13.9 **Information sharing between health services**

13.9.1 The information exchange between Peter's GP and WLMHT in 1998 was brief and his discharge to his GP at the time was informal. On his transfer to his current GP (the GP involved in the review) there was no mention of his previous contact with Mental Health Services. This information became historical, as demonstrated by its lack of reference in the IMR submitted to the review by Peter's GP. Peter's history was not reviewed and did not inform the care from his GP or from the Hepatology Clinic.

13.9.2 The review welcomes the move by Ealing CCG, in association with the other CCGs within the CWHHE Collaborative, to SystmOne electronic records. The CCGs are encouraging local NHS providers to use the system or a compatible system, which it is hoped will help improve effective information sharing with patient consent.

Preventability

14.1 The panel have carefully considered the events that unfolded in Peter's flat leading to Rose's death and him stabbing her in the presence of the Police Officers.

14.2 Tina is of the view that if the call for the ambulance (before Peter assaulted and stabbed Rose) had not been cancelled, Rose may well have not died that night. This view was also also expressed by the Judge at Peter's sentencing hearing. Tina has informed the chair that this is her father's view too. Rose may have survived if this had happened and if the ambulance reached them before Peter commenced the attack on Rose.

14.3 It has been confirmed that the Police Officers who attended the scene were wearing standard issue kit (equipped with a stab vest, CS spray and asps). The CS spray used twice on Peter was ineffective. It was thought by Police representatives at the panel that had a Taser been available, the attending officers would have been able to demobilise Peter and this could have prevented him from stabbing Rose again. At the time of the incident, uniformed response Police Officers within the Metropolitan Police Service (MPS) were not deployed with Taser. This has since changed.

14.4 As part of this review, the Metropolitan Police Service have confirmed that the use of Taser by Specialist Trained Unit Officers (STU's) only commenced across MPS Boroughs in April 2013. Each borough now has a compliment of forty STU officers. This provides for each borough team to have four STU officers on duty per shift, ideally working in pairs. The rationale for this arrangement is to ensure there is support should the Taser deployed by one officer be ineffective.

14.5 In deciding the preventability of Rose's death, the panel are not able to absolutely state that had the call to the LAS not been cancelled whether it would have arrived in time to prevent (or even intervene earlier) Peter from attacking Rose and possibly avoiding her death.

14.6 Upon the arrival of the Police and the LAS, Rose had already sustained serious injuries and we do not know whether her life would have been saved regardless of their intervention and medical care given at the scene.

14.7 Finally, the panel were of the view that given the injuries Rose had already sustained by the time the LAS and the Police arrived, it is unlikely that the final blow inflicted on Rose in the presence of the Police was in fact fatal[11].

14.8 The panel noted the Judge's comments that the response of the officers at the scene was noteworthy of praise.

14.9 The anti-viral medication Peter was prescribed is documented to induce a number of psychiatric disorders. Peter was subject to the standard assessment for patients on Peginterferon. His treatment for Hepatitis C was only informed by his own self-disclosure of his mental health. His mental health history was not verified with his GP, nor was his mental health history included in the referral made by the GP to the Hepatology Clinic. The lack of information about Peter's previous mental health, his assessment and the

[11] *This was not view was a general consensus of the panel and was not of specific expert medical opinion.*

safeguards put in place to manage the side effects of his anti-viral medication, were factors that contributed to the deterioration of his mental health in the days before Rose's death.

14.10 The report has shown the various missed opportunities to engage with Rose and enquire about her relationship, support networks and also the prospect of domestic violence in her relationship with Peter.

14.11 Due to the uncertainty of the impact and relevance of all of the above factors, the panel have been unable to definitely confirm the exact chain of causation leading to Rose's death.

14.12 The panel are therefore of the view that there was not a single identifiable point of contact with a service or a significant incident that could have been a defining moment where different intervention could have prevented Rose's death.

Diversity

15.1 All the protected characteristics as outlined in the Equality Act 2010 have been considered in relation to this case. All of the characteristics were need not relevant with the exception of disability:

15.1.1 There is reference to Rose's caring responsibilities towards Peter and her youngest son. There is no record of a caring assessment being conducted.

15.1.2 Peter's historical mental health issues as well as having Hepatitis C could be considered as a vulnerability and being somewhat disabling. Hepatitis C is a chronic condition which is often stigmatised which may have made accessing help difficult.

15.1.3 It would appear that Rose received little support in her care towards Peter. There may have been feelings of responsibility towards Peter which may have made it difficult for Rose to seek help. It is likely that Peter's mental health concerns and his Hepatitis C would have an impact on his (and Rose's) daily life. This is supported by comments made by Peter's daughter that Rose would return to her own flat when she needed a break from Peter's behaviour.

Conclusion

16.1 Peter is described by a neighbour who made a noise nuisance complaint as a “menace”. We know that he had a history of violence towards others including a mental health worker and previous partners. There are also reports of incidents of violence and abuse towards Rose (and her children) and towards his own children. Although the noise nuisance reports state Peter was cooperative and compliant when they had contact with him, it is difficult to understand how he generally presented to professionals and whether staff were hesitant about questioning and challenging him about his behaviour and lifestyle. Peter’s Personality Disorder may have impacted on his relationships with both Rose and the children. Given the complexities of Personality Disorders it is likely that his mental health would have at points, had a negative impact on family relationships and that Rose may have had to modify her behavior to “manage” him.

16.2 It is noted that there is a break in Peter’s offending history and this may have coincided with him reporting that he was no longer taking drugs.

16.3 A significant gap identified is how Peter’s mental health concerns faded with time and that there was no recognition of his mental health history (particularly in the GP records), and an absence of considering the potential of safeguarding adults issues. The lack of a diagnostic code being added to Peter’s GP records concerning his mental health meant that information about his historical contact with Mental Health Services became lost in the passage of time.

16.4 There was a very prompt follow up by the Hepatology Clinic offered to Peter on the day before Rose’s death following concerns raised by Rose about Peter’s mood, and there were measures in place to help monitor any deterioration in Peter’s mental health as a result of possible Peginterferon-induced psychosis. However, the lack of formal verification of Peter’s mental health highlights a gap in the assessment and safeguarding response to patients subject to anti-viral medication who may have previous mental health concerns.

16.5 Given that the information about Peter’s mental health was historical, the panel are unable to state whether this information had been shared with the clinic by his GP, if this would have changed his course of treatment if this may have possibly contributed to the events that resulted in Rose’s death.

16.6 The review has found that professionals (particularly clinicians across all health services involved in this review), were ill equipped and unskilled to consider and respond to the

potential of domestic violence. This is due to a lack of training, policies and procedures to understand domestic violence and staff being confident to conduct appropriate clinical domestic violence enquiry with both Rose and Peter.

16.7 A number of recommendations of this review focus on general practice's response to domestic violence. The recommendations reflect the NICE Guidance (PH50) Domestic Violence and Abuse – how services can respond effectively. It is hoped that the implementation of the NICE domestic violence guidance, combined with the completion of the review's recommendations will help to improve the health element of the local community coordinated response to domestic violence.

16.8 The review of the IMRs and chronologies showed no documented evidence of domestic violence enquiry with either Rose or Peter. Despite mention of a partner in both Rose's and Peter's health records, domestic violence is invisible and there was no consideration of the potential risks Peter posed to Rose.

16.9 Support systems for families affected by fatal domestic violence should be strengthened. Family structures, dynamics and relationships vary significantly and a uniform approach to the provision of support can mean that certain family members can be isolated from information and support following fatal domestic violence. The potential issue of conflict of interest needs to be sensitively and carefully managed. This is particularly relevant for step or blended families when the biological parent is the perpetrator.

Recommendations

17.1 The recommendations made by this review reflect the consistent lack of awareness of the prospect of domestic violence and the overlap with mental health by the services in contact with Rose and Peter. The recommendations also address the safeguarding concerns posed by Peter, both to himself and others. The recommendations are particularly themed on the issue of training staff on awareness of domestic violence and conducting enquiry.

17.2 There were missed opportunities to find out more about Rose's and Peter's relationship. There was no evidence of domestic violence enquiry being conducted with either Rose or Peter or an exploration of their relationships and support networks. If enquiry is not conducted, the prospect of direct self-disclosure of domestic violence (direct for the person experiencing the abuse) will be minimal.

17.3 This review has generated a large number of recommendations. The panel has made several regional and national recommendations to help inform strategic policy development. The panel has not identified a single point of contact which would have prevented Rose's death but have identified missed opportunities when Rose and Peter could have been asked about their relationships and where domestic violence enquiry would have been relevant and helpful.

17.4 The review's recommendations are numerous in order to help support the Safer Ealing Partnership understand what parts of the coordinated community response to domestic violence need to be strengthened and improved.

17.5 The recommendations are wide ranging and attempt to address direct themes identified in the review as well as associated issues that have an impact on the response to domestic violence by services in Ealing.

17.6 All of the agencies involved in this review should audit their practice, policies and procedures and where gaps are identified, ensure that they put in place provision to address staff awareness of domestic violence and their ability to respond appropriately to concerns and disclosures of domestic violence.

17.7 An internal action for the West London Mental Health Trust has already been promulgated to allow learning to occur alongside swift change to organisational change. This is shown below:

17.7.1 Add to the domestic violence page of the organisation's intranet site, a new section titled Risk Assessment to include the CAADA DASH RIC form.

17.7.2 The WLMHT intranet site has now been updated and changed to ensure that the borough domestic violence risk assessment tools are easily accessible and visible for staff to locate and use.

17.7.3 Recommendations made concerning Ealing Hospital's Accident and Emergency Department have been amended to apply to the new Urgent Care Centre.

17.7.4 All recommendations will be overseen by the Safer Ealing Partnership, and will be delivered by the Ealing Violence Against Women and Girls Strategic Group. The recommendations have also been translated into an action plan (Appendix Three) which is included at the rear of this report.

17.8 The panel recommendations are shown below:

17.8.1 **Safer Ealing Partnership**

Recommendation 1

Widely disseminate learning to services mentioned in this review. This should be in the form of a written briefing to all relevant staff and dissemination session(s).

Recommendation 2

Ensure that the circumstances and findings of this review are incorporated into any commissioned domestic violence training delivered in the borough.

Recommendation 3

Produce a multi-agency domestic violence referral pathway/protocol in consultation with the Police and specialist domestic violence services and ensure partnership staff are aware of the document through training and publicity.

Recommendation 4

Commission a borough domestic violence publicity campaign to include provision of an awareness poster and a palm size/Z card which should be distributed across the partnership to outline to victims the domestic violence support available locally.

17.8.2 **Safer Ealing Partnership (also addressed as a national recommendation for the Home office)**

Recommendation 5

Review and address the funding provision to domestic violence support services concerning the support offered to cases that are classed as Police non-crime domestic incidents.

17.8.3 **Safer Ealing Partnership and Ealing Safeguarding Adults Board**

Recommendation 6

Work to secure inclusion of vulnerable adults within the evolving borough's Multi Agency Safeguarding Hub.

Recommendation 7

Audit adult safeguarding links and information sharing processes between GPs, the Police and mental health services.

Recommendation 8

Work with services in the borough who support domestic violence victims, vulnerable adults and carers so that there is an understanding of these agendas and ensure that this is addressed in training.

Recommendation 9

Audit referral processes so that agencies working with domestic violence victims, vulnerable adults and carers have effective referral and safeguarding systems to respond to concerns raised by their client groups (such as Multi Agency Risk Assessment Conference, and safeguarding adult alerts).

Recommendation 10

Ensure that the circumstances and findings of this review are incorporated into any commissioned safeguarding and domestic violence training delivered in the borough as well as into any routine audits of safeguarding adults practice. The training should have a specific focus on carer abuse and the dynamics of domestic violence that may feature and also the connection between the use of alcohol, substances, mental health and the incidence of domestic violence.

17.8.4 **Ealing Safeguarding Adults Board**

Recommendation 11

Review the process of carer assessments and include domestic violence screening enquiry questions into the process.

17.8.5 **Ealing Housing Providers and Registered Social Landlords**

Recommendation 12

Produce a specific housing and domestic violence policy and procedure, to especially detail responding to repairs, noise nuisance reports and making referrals to specialist services.

Recommendation 13

Ensure all staff are trained on the domestic violence policy and procedure.

Recommendation 14

Ensure staff and residents have access to up to date domestic violence information, highlighting services and support available.

17.8.6 **Metropolitan Police:**

Recommendation 15

Pilot an assessment criteria, to support and improve consistent decision making and practice when officers are considering making a referral to a specialist domestic violence support service for victims involved in a non-crime domestic.

Recommendation 16

Ensure that there is a follow up for every domestic violence victim where they are seen/contacted and are provided with information on local domestic violence support services (linked to recommendation 4) and that this action is then recorded on CRIS.

17.8.7 **Ealing Noise Nuisance Team**

Recommendation 17

Ensure that officers responding to noise nuisance or housing related anti-social behaviour complaints are trained on safeguarding vulnerable adults and understand how to identify concerns and make a safeguarding adult alert.

17.8.8 **Ealing Hospital NHS Trust**

Recommendation 18

Conduct a domestic violence needs analysis to identify and understanding staff training requirements.

Recommendation 19

Create a Level 2 and 3 safeguarding training package that includes domestic violence so that staff understand their roles and responsibilities.

Recommendation 20

Raise awareness of the MARAC processes risk assessment tools and referral processes.

Recommendation 21

Identify and audit DV attendances in the urgent care centre to establish if cases have been managed appropriately, including if they have been provided with information and advice and if the case has been subject to a domestic violence risk assessment.

Recommendation 22

Explore options of commissioning independent domestic violence advocacy service provision to be located with the urgent care centre.

Recommendation 23

Implement clinical domestic violence enquiry within the triage system for the urgent care centre.

Recommendation 24

Scope the opportunity to devise a liaison meeting (reflecting the weekly safety net meeting held to discuss child safeguarding concerns) to share vulnerable adults concerns.

17.8.9 **Ealing's commissioned specialist domestic violence services**[12]

Recommendation 25

Provide specific training to the Met Police Community Safety Team to include information on the domestic violence referral pathway.

Recommendation 26

Create and distribute a domestic violence card to be provided to all uniformed Police officers to give to all callers at all non-crime domestics.

Recommendation 27

Engage in a jointly delivered programme of community engagement activities to raise the profile and promote the domestic violence services available in the borough.

17.8.10 **RISE**

Recommendation 28

Commission and deliver domestic violence dynamics and domestic violence risk assessment training for all clinical staff.

Recommendation 29

Implement enquiry for domestic violence as part of intake assessment for all clients (both as victims and perpetrators) and ensure there is a referral pathway

[12] Southall Black Sisters and Hestia Advocacy Service (commissioned by Safer Communities) and Housing for Women and Hestia (Supporting People).

in place to specialist domestic violence services for both victims and perpetrators.

17.8.11 **Ealing CCG**

Recommendation 30

Ensure that the learning points from this review are shared across the CCG partner practices.

Recommendation 31

CCG Safeguarding Team to work with the GP practice in close proximity to the domestic violence refuge to support their immediate take up of the offer from the refuge service provider of domestic violence training.

Recommendation 32

Consider how mental health diagnosis and domestic violence issues are coded or flagged within GP records.

17.8.12 **NHS England (London Area)**

Recommendation 33

Review the use and effectiveness of the IRIS Project across London GP practices to consider potential for wider commissioning of the project.

17.8.13 **Ealing CCG and General Practice Ealing**

Recommendation 34

Via the Named GP audit GP compliance with LSCB safeguarding training in Ealing.

Recommendation 35

To advise Practices to use the Royal College of General Practitioners toolkit which include a domestic violence audit.

Recommendation 36

Consider ways to commission domestic violence training for GP staff relevant to their roles and responsibilities (doctors, practice nurses and reception staff).

Recommendation 37

Encourage all GP locations to display and have available up to date information on domestic violence and support services.

17.8.14 **Imperial College Healthcare NHS Trust (St Mary's Hospital)**

Recommendation 38

When prescribing antiviral medication (such as Peginterferon) which has documented side effects of inducing psychiatric disorders, a specific verification from the patients GP concerning any mental health concerns should be obtained.

Recommendation 39

Hospital Safeguarding Team to link to Ealing Safeguarding Adults Board and ensure that the Hepatology Clinic has access to information on safeguarding adult process and support services.

Recommendation 40

Amend the notification letter sent to the GP concerning commencing antiviral treatment to specifically request that if they have any information which may have an impact on the patient to notify the Hepatology Clinic without delay.

17.8.15 **Ealing CCG and Imperial College Healthcare NHS Trust (St Mary's Hospital)**

Recommendation 41

Arrange a meeting between borough safeguarding GPs and Safeguarding Vulnerable Adults Leads with the Hepatology Clinic to improve partnership working and support offered to patients who are considered vulnerable.

Recommendation 42

Share information with all Ealing GP's about the Hepatology care pathway so that they are aware and understand their role in the care plan for patients being treated by the Hepatology Clinic.

National recommendations

17.9 The panel has made a number of national recommendations to address concerns identified through the review process. It was agreed that although these could not be monitored by the Safer Ealing Partnership it was important to include these so that could provide helpful feedback to the Home Office Quality Assurance Panel to highlight broader strategic and policy issues considered relevant to the review.

17.9.1 **Home Office and Department of Health (national recommendation)**

Recommendation 1A

Work with NHS England to clarify responsibilities and requirements of commissioning GP IMRs to help resolve issues with delays and quality of GP IMRs submitted to DHRs.

17.9.2 **Department of Health (national recommendation)**

Recommendation 2A

Seek to rectify the patient information systems used across all clinical settings so that attendances at health care settings can be linked and viewed in their entirety.

17.9.3 **Home Office (national recommendations)**

Recommendation 3A

Review and address the funding provision to domestic violence support services concerning the support offered to cases that are classed as Police non-crime domestic incidents.

Recommendation 3B

Review and improve access to specialist support provision for families affected by domestic homicide, (this should cover step or blended families when the biological parent is the perpetrator).