Domestic Homicide Review Overview Report

Report into the death of John T in October 2013

Report produced by Patrick Watson
Independent DHR Chairman & Author

Contents Page 2

Introduction

1. This Domestic Homicide Review was conducted following the tragic homicide of John T in October 2013. This was the fourth domestic homicide review to be carried out under the auspices of the Wandsworth Community Safety Partnership. It was carried out in accordance with the Home Office guidance and section 9 (3) of the Domestic Violence Crime and Victims Act 2004.

2. There was originally some doubt by the police as to whether this case met the criteria for a domestic homicide review and Home Office advice was sought and obtained by the Metropolitan Police Service. The case was then referred by the police to the Community Safety Partnership on 15th May 2014 with a recommendation that they consider carrying out a Domestic Homicide Review. It was agreed in June 2014 that a DHR be established.

3. The review of John T's homicide began with an initial panel meeting on 18th September 2014.

4. This report outlines the circumstances of the case and the findings of the review. This review was undertaken to examine the role of the agencies involved with a view to learning lessons from the case and, where needed, to alter practice in order to improve outcomes for victims and their families involved in future similar cases. The report: -

   a) summarises the key facts of the case and the sequence of events;
   b) summarises the key issues, key decisions and whether with hindsight different decisions or actions could have been taken;
   c) identifies examples of good practice and notes where systems need to improve;
   d) carries out an analysis on the Terms of Reference;
   e) outlines the conclusions and lessons learned from the review; and
   f) details both recommendations from individual agencies and from the Review Panel.

John T Family input

5. The Home Office guidance sets out the benefits of friends and family involvement as follows:- "The benefits include assisting the family with the healing process which links in with the objectives of the new National Homicide Service - supporting victims for as long as they need after homicide. For example, a review may allow them to disclose information in private, which may not be published. A family would not be able to achieve this in an inquest, which is in the public domain. Participation by the family also humanises the deceased helping the process to focus on the victim's and perpetrator's perspectives rather than agency views".

6. Other benefits are:

   - helping families satisfy the often-expressed need to contribute to the prevention of other domestic homicides

   - enabling families to inform the review constructively, by allowing the Review Panel to get a more complete view of the lives of the victim and/or perpetrator in order to see the homicide through the eyes of the victim and/or perpetrator. This approach

can help the panel understand the decisions and choices the victim and/or perpetrator made.

- obtaining relevant information held by family members, friends and colleagues which is not recorded in official records

- revealing different perspectives of the case, enabling agencies to improve service design and processes

- allowing the review panel to get a more complete view of the victim's life and see the homicide through the eyes of the victim and those left behind - this approach can help the panel understand the decisions and choices the victim made

7. We were aware that the family of John T were traumatised by the loss of a much loved son and brother. The panel sent their condolences to the family. We were anxious to obtain and include the perspective of the family as they were closest to the events leading up the tragedy and were best placed to provide an accurate insight into the actions that followed. Without this perspective we were aware that we would have to rely solely on the views of the service providers and that would have lacked the vital insight that could otherwise have been provided by those more intimately associated with the victim and the perpetrator.

8. Unfortunately, we did not have direct access to the friends and family and had to route all our requests and correspondence through the police Family Liaison Officers (FLO). We were informed by the FLOs, for both the victim's and the perpetrator's family, that both the families declined the invitation to participate. The friends of the victim and the perpetrator also declined to participate. Therefore, regrettably, there is no direct involvement in this review from the family or friends of John T or Mr Brian N

9. It was difficult having to use the police FLOs as the only gateway to the family and friends but we understood why this was the preferred route for initiating engagement. This method of facilitating contact has many benefits and we accept that initial contact can be more effective if made by a familiar face who has built up a degree of confidence among the family members and who can introduce the concept of the review sensitively and can answer questions about the process. This is a very delicate task entrusted to the FLOs and to the best of our knowledge we are not aware that they receive any specific training to increase their understanding of domestic homicide reviews which would strengthen their ability to explain the process and help families understand why engagement can be beneficial for them. This is not meant as any form of criticism of the FLOs who worked with us on this case as we have no reservations about the professionalism and commitment they applied to their role. Engagement was not successful in this case and we took the view that this highlights the need for FLOs to be given specific training regarding DHRs and specifically on the benefits of the insight that can be provided by those outside the statutory framework.

10. Given the minimal involvement of statutory bodies and the absence of family and friends participation, this DHR could have been forced to end before it had even begun because of a lack of input. Participation in a review of the killing of a family member may mean reliving traumatic events and some family members may feel unable to endure this emotional process. We fully accept that family and friends have choices and can decide whether or not to participate and that these decisions must be accepted sensitively and graciously. Given

the importance of family and friend involvement in reviews we took the view that we should make recommendations that would ensure that they had good quality impartial and knowledgeable advice available to them when deciding on participating.

11. While training for FLOs in the benefits of involving family, friends and colleagues in DHRs forms part of our recommendation we also looked at the role the voluntary sector could play in this process. We are aware that a registered charity already exists specifically to help and inform the families of victims of domestic homicides and in our view they would be ideally placed to play a more supportive role in helping people with the DHR process. The charity is Advocacy After Fatal Domestic Abuse (AAFDA) and to quote from their website they "specialise in guiding families through Domestic Homicide Reviews". There may be other voluntary sector groups that could be considered for this role but we could only identity one organisation with the necessary skill sets despite extensive searching. We therefore recommend that it becomes standard practice for FLOs to refer victim's families to this charity for specialist support in much the same way they refer the families to Victim Support.

12. In our particular case all approaches to the family and friends were through the FLOs and we had no direct contact. The killing of John T was a dreadful event which left those involved traumatised and we tread very carefully given the sensitivities involved. We, and the FLO, were initially led to believe that the family and friends would contribute but this changed diametrically within a short period of time. The input of the three females with whom Mr Brian N had significant relationships with was considered crucial but all three did not want to get involved although one, Mary W, allowed us to have a copy of her police statement (after some redaction by her) for use in the review. The perpetrator's mother was also feeling the strain and the FLO feedback was that she appeared to be in a state of some distress. She also told the FLO that she could not endure the stress and strain of going through another process. She also allowed us a copy of her police statement for use in the review. The perpetrator's brother was also distressed by the tragedy and informed the FLO that he felt unable to talk about it.

13. The family of John T offered their daughter, Nora T, as the family spokesman and representative and as the person best placed to fill in any details needed. She had also been the girlfriend of the perpetrator and could also offer valuable insight from this perspective. After we were given her contact details it proved very difficult to establish contact with her and we made no progress in initiating participation. We then decided to make direct contact with the father (KT) of John T and wrote to him asking him if he would be willing to engage. The letter was written with sensitivity setting out many of the benefits included in the Home Office guidance. The FLO then contacted us to say that KT was initially willing to engage but he (FLO) had just met with the family and the mother (ET) and daughter (Nora T) did not feel they wanted to relive the events leading up to that fateful day. It was agreed among them that they would stand together on this and show family solidarity and as a result the father (KT) also decided he would not participate.

14. We contacted the perpetrator in prison to ask for him to engage with the DHR process and this is dealt with in more detail later in this report. We also contacted the employers of both the victim and perpetrator to attempt to gain background insight through the eyes of colleagues and friends at work and our findings are set out later in this report.

15. The decisions by family and friends not to participate in the review was of concern to the

panel members and as previously stated this issue is the subject of a recommendation.

Process

16. In October 2013 the Metropolitan Police discovered John T had been killed at his home address by his flatmate, Mr Brian N. As mentioned earlier there was some doubt as to whether this case, involving two flatmates, met the DHR criteria and as a result it was not until May 2014, after advice from the Home Office, that the Metropolitan Police subsequently made a request that a Domestic Homicide Review be considered, as it met the criteria of a review, set out below:

17. A review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by¬

    (a) a person to whom he/she was related or with whom he/she was or had been in an intimate personal relationship;

    (b) a member of the same household as himself,

18. The victim and perpetrator, as flatmates, were living together in the same household. The advice from the Home Office was that the death of John T appeared to have resulted from violence by a member of the same household as the victim and that the criteria for the statutory definition of a DHR was met.

19. The Wandsworth Partnership took responsibility for this review as prescribed by relevant legislation and guidance. They appointed Patrick Watson as independent chair and author of this report. He is fully independent of all the agencies involved in the review.

20. Patrick Watson is a retired local government chief officer with management experience in both the private and public sector. His responsibility portfolio was extremely wide and included the governance of the local authority and oversight of its human resources function. He was an advisor to the Local Government Association and Home Office in his specialist areas. His background is as a business analyst and management information specialist. He has over 35 years' management experience. He has wide experience of carrying out reviews, writing complex reports and acting as an independent adjudicator.

21. A panel was formed of the following members:

    Patrick Watson - Independent Chairman and Overview Report Author

    Stewart Low - Head of Community Safety, Wandsworth Borough Council

    Stewart Low, in addition to his role as a panel member, also worked in partnership with the chairman of the review panel on managing the significant associated organisational work involved.

    Susan Murray minuted the meetings of the review panel and carried out much appreciated secretarial support.

    Jenny Iliff, Domestic Violence Co-ordinator, acted as domestic abuse advisor to the panel.

Clive Simmons - WBC, Safeguarding Policy & Development Manager

Chris Brown - Metropolitan Police, Critical Incidents Advisory Team

Jeremy Walsh - SW London & St. George's Mental Health Team NHS Trust

David Flood - St. George's Hospital, Lead Nurse, Adult Safeguarding

Anna Twomlow – Divisional Manager Victim Support

We invited the Samaritans to contribute to this DHR because of their expertise in suicide prevention and counselling but despite a number of requests they declined the offer to participate in this review.

22. We followed the Home Office guidance in cases where there has been a criminal prosecution and obtained a transcript of the judge's summing-up and comments on sentencing. Although expensive to obtain, this provided a valuable supply of information not available from other sources and very importantly a summary overview of the legal proceedings.

23. The panel met on the following dates

18th September 2014
10th June 2015
24th June 2015

24. The final version of the report was approved by the Home Office Quality Assurance Panel on 23rd March 2016. It would have been our normal practice during this time to make regular contact with the victim's family to keep them fully briefed on the outcome and to answer any questions emanating from the report but no members of the family wanted to engage or to be contacted.

Terms of Reference

25. The key terms of reference for the review were to:

a) Review the involvement of each individual agency, statutory and non-statutory, with John T and Mr Brian N between 2007 and 2013.
b) Summarise the involvement of agencies on and prior to October 2013.

26. In terms of timescale the panel agreed on a proportionate approach in order to focus on more recent events. While a decision was taken to focus on the period from October 2007, each contributor to the review was nevertheless asked to examine their records prior to this period and report on any information that appeared to have significance to this case. As the review progressed further information did come to light that was considered significant and this is acknowledged and reflected in the narrative chronology of events.

27. The agencies responsible for providing details of their involvement, through chronologies of contact and individual management reviews were as follows:

St George's Healthcare NHS Trust
Metropolitan Police Service
Hertfordshire & Cambridge Police Services
SW London & St. George's Mental Health Team NHS Trust
GP of Mr Brian N
Employer of John T
Employer of Brian N
Victim Support

28. We asked Wandsworth Borough Council to examine their records for any contact with the victim or perpetrator and their response was that neither person was known to them. We asked the Children's Social Services Department to check their records again as St George's Hospital had confirmed to us that they had sent them a paper referral in September 2013 following his attendance for self-harming. They sent this referral as part of normal procedure when "there is a parent who has self-harmed and they have access to their child as they may be a child in need/at risk". Of course we have no evidence that the referral was ever received by Wandsworth Council; ever posted; or even sent to the correct address. It is of concern that Children's Social Services Department has no record of this referral. The loss of this document has no detrimental effect in this case but it helps identify a potential weakness either in despatch procedures or in record systems and should be addressed by St George's and Wandsworth Council.

29. Where relevant each of the contributing agencies were required to:

a) Provide a chronology of their involvement with John T and Brian N during the time period.
b) Search all their records outside the identified time periods to ensure no relevant information was omitted.
c) Provide an individual management review if necessary: identifying the facts of their involvement with John T and/or Mr Brian N, critically analysing the service they provided in line with the specific terms of reference; identifying any recommendations for practice or policy in relation to their agency.

30. In order to critically analyse the background to the incident, the terms of reference required specific points to be addressed:

a) Communication and co-operation between different agencies involved with John T and/or Brian N

b) The identification of lessons to be learnt from the case about the way in which local professionals and agencies worked together to safeguard the victim and his family.

c) Identify what those lessons are, how they will be acted upon and what is expected to change as a result.

d) Whether the agencies or inter agency responses were appropriate leading up to and at the time of the incident on Thursday 17th October 2013.

and specifically to:

e) Examine whether information sharing and communication within and between agencies regarding the families of John T and/or Brian N was effective and comprehensive; did it enable joint understanding and working between agencies; were all appropriate agencies involved in the information sharing.

f) Examine whether the sharing of information was sufficient to facilitate "joined up working".

g) Examine whether previous "learning" from local or national cases had been acted upon.

h) Examine whether data protection issues or client confidentiality concerns impeded the sharing or dissemination of information.

i) Examine whether there were any early warning signs of aggression or violent behaviour and what actions followed.

j) Examine whether the level of risk posed by the perpetrator was assessed and addressed properly; whether there was an appropriate intervention plan.

k) Examine whether equality and diversity issues were considered appropriately by all the agencies involved with the families of John T and/or Brian N

l) Establish whether agencies have appropriate policies and procedures and associated monitoring procedures to respond to domestic abuse and to recommend any changes as a result of the review process.

m) Review the care and treatment, including risk assessment and risk management of Brian N in relation to his primary and secondary mental health care if he was found to have a mental health background.

n) Seek the involvement of the family, employers, neighbours & friends to provide a robust analysis of the events.

o) Seek to establish whether the events of Thursday 17th October 2013 could have been predicted, prevented or the likelihood of it happening could have been reduced. The evidential standards applied being on the balance of probabilities. For example if an event 'probably' would have been avoided had certain steps taken place then the balance of probability test is satisfied. If an event 'possibly' would have been avoided had certain steps taken place then the test of the balance of probability is not satisfied.

John T Family Composition

31. The family relationships of John T are set out below.

Name	Gender	Relationship	Location
Mr K T	Male	Father	England
Mrs E T	Female	Mother	England
Ms Nora T	Female	Sister	England

Profile of Agencies involved in the review

32. St Georges Healthcare NHS Trust serves a population of 1.3 million across south west London. It provides this service over a number of sites which include St Georges Hospital Tooting and Queen Mary's Hospital Roehampton. The trust merged with Wandsworth Community Services in 2010 and therefore it provides acute and community services for its local Wandsworth residents.

33. The Metropolitan Police Service provides the police service for London. It employs around 31,000 officers together with about 13,000 police staff and 2,600 Police Community Support Officers (PCSOs). The MPS is also being supported by more than 5,100 volunteer police officers in the Metropolitan Special Constabulary (MSC). The Metropolitan Police Services covers an area of 620 square miles and a population of 7.2 million.

34. South West London and St George's Mental Health NHS Trust (SWLSTG) is the main provider of integrated mental health and social care services in South West London. It serves just over one million people of all ages across the London boroughs of Kingston, Merton, Richmond, Sutton and Wandsworth. It also provides a range of specialist regional and national services. Over the last 175 years the Trust has been a leading innovator and provider of mental health care. The Trust employs over 2,000 people who operate from multiple locations, including three main inpatient sites. The Trust's role involves providing care and treatment to approximately 20,000 people from South West London and beyond at any given moment. Trust income in 2014/15 is forecast to be c£157m.

35. The GP of the perpetrator was interviewed as part of this review. The surgery is based in South London and is split over two sites.

36. The Samaritans were invited to participate in this review because of their expertise of suicides but did not take up the offer.

37. Victim Support - South West London Division. Victim Support is the independent charity for victims and witnesses of crime in England and Wales. Last year they offered support to more than one million victims of crime. They offer a broad range of services delivered by compassionate, professional staff and volunteers that are tailored to meet the individual needs of anyone who has been affected by crime. Victim Support provides the Homicide Service supporting people bereaved through murder and manslaughter and runs more than 100 local projects which tackle domestic violence, antisocial behaviour and hate crime, help children and young people and deliver restorative justice. Nationwide the charity has around 1,100 staff and more than 3,000 volunteers.

38. In the interest of conciseness the full names of the agencies involved in this case will be

truncated in this report as follows:-

St Georges Healthcare NHS Trust – St George's Hospital
The Metropolitan Police Service – MPS
South West London and St George's Mental Health NHS Trust (SWLSTG) - The Mental Health Trust
Victim Support, South West London Division - Victim Support

Information Sources

39. The details included in this report were sourced from the IMRs and briefings from the agencies listed above; interviews with the GP of Brian N, his employer and the employer and colleagues of John T; the police statements that were made available to us; transcript of the judge's summing up and sentencing remarks.

Terminology

40. This report refers to various terms and abbreviations. To clarify these issues and help to understand the flow of this report better we have provided below a brief explanations

a) CSA – Child Support Agency
b) MISPER – Missing Persons
c) Met CC – Met Command and Control
d) Grip and Pace Centre – Local police control centres
e) CAD – Computer Aided Dispatch
f) NCRS – National Crime Reporting Standards
g) DV – Domestic Violence
h) DASH – Domestic Abuse Stalking and Honour Based Violence
i) CRIS – Crime Reporting Information System
j) SPECSS – Separation Pregnancy Escalation Community Stalking Sexual
k) MERLIN - database run by the Metropolitan Police that stores information on children who have become known to the police for any reason
l) MASH – Multi Agency Safeguarding Hub
m) ACN – Adult Coming to Notice
n) VAF – Vulnerability Assessment Framework
o) PVP – Protecting Vulnerable People
p) MOPAC – Mayor's Office for Policing And Crime
q) CSU – Community Safety Unit
r) PNC – Police National Computer
s) PND – Police National Database
t) CCC - Central Communications Command
u) BOCU - Borough Operational Command Unit

Details of the homicide

41. In October 2013 police were contacted by John T's father, KT. He raised concern as John T had failed to turn up at work that day and despite numerous attempts to contact him, the family had not been able to reach him. Officers went to John T's home address in South

London. They were met by his elder sister, Nora T, who was waiting outside the flat. At 20:57 hours police forced entry to the flat. The flat had power but no lighting. Officers searched the flat and found John T lying on the bed in his room. There was a significant amount of blood, a knife and a hammer on the floor. Officers checked John T for signs of life, but found no pulse and noted that rigor mortis had set in.

42. The officers then tried to gain entry to the bathroom but the door was blocked. They were able to observe that Brian N was lying collapsed behind the door. He had lacerations to his wrists and a metal pole through his jaw. The blood on the wounds was drying and his pulse was very weak. The officers also found a long barrelled spear gun in the bathroom

43. The London Ambulance Service (LAS), Helicopter Emergency Medical Services (HEMS) and London Fire Brigade (LFB) were also in attendance and Brian N was transported to St. George's Hospital. Following treatment at St. George's Hospital, Brian N was arrested for murder the following day at 10:45 hours. He made no reply and was transferred to Sutton Police Station following his discharge from hospital three days later.

44. Brian N was interviewed in October 2013 with his solicitor present and he provided a prepared statement, which read: "I have been drinking very heavily over a long period of time and have been taking drugs. I can remember hugging Nora T on my doorstep and the next thing I remember is being in the hospital with a terrible pain in my head. I remember nothing in between. I now wish to make no comment". Brian N was interviewed on two further occasions on 22nd October 2013 and made no comment on either occasion.

45. John T was examined at the murder scene by a force medical examiner (FME) who pronounced his life extinct at 01:53 hours.

46. A special post mortem on John T was carried out that same day by Home Office Pathologist Dr PJ at St George's Hospital. He gave the cause of death as haemorrhage and a stab wound to the lung and heart. There was a second significant injury which was a stab wound to John T's left temple, approximately 6 cm in depth towards the rear of his left eye socket.

47. The murder trial commenced in April 2014 at the Central Criminal Court and it lasted for seven weeks. In May 2014 Brian N was unanimously found guilty of murder and sentenced to a mandatory life sentence with a minimum of a 23 year term of imprisonment. He appealed his sentence in November 2014 and the appeal was dismissed. The original sentence stood.

The Crime Scene

48. The address is a mid-terraced townhouse that has been converted into two flats. Flat A (where Brian N and John T lived) is a two bedroom split level ground floor flat with access at front and rear garden. On the lower floor is the victim's bedroom, kitchen, bathroom and living room. There are stairs that go to a second floor where Brian N had a bedroom. The property also has a cellar where the murder weapon was stored.

An unusual Domestic Homicide

49. This Domestic Homicide was unusual and significantly different from most of the cases reviewed under the terms of Domestic Violence Crime and Victims Act 2004.

50. Firstly, it involved two men who were not in a familial, sexual or intimate relationship. They met the criteria for review under the legislation because they were part of the same household. We define a household as consisting of one or more people who live in the same dwelling and also share at meals or living accommodation, and may consist of a single family or some other grouping of people.

51. Secondly, the victim in this case was not the person that the perpetrator ultimately wanted to hurt as his motive appeared to be to hurt his sister.

52. This is not to say that this case did not involve domestic abuse because it did. The perpetrator exercised emotional and psychological domestic abuse on his female partners. This case sets out his relationship with three different female partners. It was apparent that he wanted to control and hurt them emotionally and psychologically and achieved this initially by indirect means. He broke and damaged possessions that were precious to them. Possessions that had emotional and/or sentimental value to them were damaged as a way of hurting them. He did not admit or accept responsibility for the loss or damage to the possessions. His last girlfriend had moved out of his flat and taken all her belongings with her. We do know that one thing she held dear – his flatmate - her younger brother and only sibling was subsequently killed by Brian N.

53. The prosecution claimed that the evidence presented to the court pointed to an elaborate plan to hurt her by killing her brother. They contended that Nora T effectively rejected him and he set about hurting what she valued above anything else, her brother. The judge in his sentencing remarks reinforced these points - “As to your culpability, I sentence you on the basis that this was a deliberate planned killing, planned well in advance, amounting almost to an execution”…….. “It seems to me that the only motive raised by the totality of the evidence, including yours, is that you set out to kill John T because he was the dearly beloved brother of Nora T who had left you”.

54. Revenge appeared to be the motivation for this killing. Nora T had walked away and ended their relationship. She was not prepared to continue to accept his erratic negative behaviour. We were unable to identify that she had ever acknowledged his behaviour as domestic abuse.

Displaced Aggression – Explanatory Note

55. One of the main themes to emerge from the homicide of John T is about abuser damage of treasured possessions and how its effect can be greatly underestimated. Displaced aggression in this review is an explanatory term used to explain the method that the perpetrator used to inflict emotional and psychological abuse as a form of control on his victims.

56. Damage to possessions and property is a well recorded form of emotional and psychological domestic abuse and is typically listed in the types of controlling behaviour that victim are advised to look out for and/or as indicators of potential abusers. There is a general tendency for inexperienced people to see it as “low level” or “mild” abuse because the violence is not direct. Its seriousness can be underestimated as demonstrated by this case.

57. Displacement of aggression involves taking out frustrations, feelings, and impulses on people or objects that are less threatening. Rather than express anger in ways that could lead to negative consequences (for them), instead expressed anger is directed towards a person or object that poses no threat (such as objects, spouse, children, or pets). Indirect aggression of this kind reduces the need to confront the victim directly. It diminishes the risk of a counterattack. Taking out anger on possessions may seem less frightening than a physical attack to someone outside the relationship but the abuser is being very selective in their violence. They are in control and this is one more weapon in the abuser's arsenal of control and manipulation.

58. The damage to possessions that occurred here would not automatically trigger alarm bells about domestic abuse to non-professionals. Often this type of behaviour would be erroneously seen as indicating a need for anger management.

59. With both Susan M and Nora T, after a long period of indirect aggression he crossed the line between the two forms of abuse. He became increasingly verbally aggressive and on one occasion physically abused his partner. Both women quickly made it clear this was not acceptable and ended the relationship. With Nora T, he subsequently killed her only brother.

Victim (John T) background

60. John T was born in April 1992 and was 21 years old at the time of his murder in October 2013. He grew up in a large historic village and attended a co-educational independent school in that area. Cooking was his passion and he was trained at an internationally acclaimed academy.

61. We learnt that he was part of a very close and loving family. His relationship with his older sister was described as an extremely close and loving relationship. They were devoted to each other, they were proud of each other.

62. His parents still lived in the village but his only sister had moved to London. In September 2012 she moved in with Brian N in a flat in South London.

63. John T moved to London to further his career. He did casual work for a number of catering staff agencies before being taken on full time as a trainee chef by a famous and much sought after central London restaurant in January 2013. He had taken the first steps in fulfilling his dream of becoming a great chef.

64. One friend described John T as a good and shining person who thought of everyone but himself. He was seen as humble and hard working in his chosen profession. This was a view shared by his colleagues at his workplace.

65. He was highly regarded at his place of work where he regularly worked 16 hour shifts. The owner of the restaurant, on hearing of his death, had this to say - "It is a big loss to the industry and to us to lose someone with such passion at such a young age. He had a great skill set and would have been able to make whatever he wanted of himself. JOHN T was very passionate about food, was a hard worker, very reliable and always trustworthy. Our head chef had been very happy with his performance at such a young age. He will be deeply

missed and it is a huge shock to all who knew and loved him here. He always had a huge smile on his face and would bend over backwards to help his colleagues."

66. At the trial even the perpetrator, Brian N, described him in glowing terms and said that he - "thought very highly" of John T and had bought him gifts including a pasta maker, a sushi knife and a watch. "He was kind and had a remarkable talent for cooking. Despite being a number of years younger than me, we had a lot of common ground. He was a friendly guy."

67. Another example of their good relationship in the days before the murder was illustrated by an exchange of text messages three days before the murder. Brian N texted John T to ask him to get some nitrous oxide on his way home from work. John T had some in his room and texted back saying 'you're welcome to mine at home'. Nitrous oxide is what is colloquially termed as a 'legal high'.

68. Despite these generous words he nevertheless brutally murdered John T. He entered a plea of self-defence and told how he had goaded John T by referring to an incident related to his past. It is therefore appropriate at this stage to mention a road traffic accident that John T was involved in when he was 19 years old. It is mentioned at this stage to explain events and not to imply any character faults or weaknesses.

69. In 2011, John T was involved in a road accident which resulted in the death of another young man from the same area. The police investigation concluded that "the collision was unavoidable for the driver and the results were tragically inevitable".

70. During the period leading up to the murder there was nothing to suggest that the relationship between John T and Brian N was anything but good. There was no indication of any bad feelings, arguments or aggression between them. They were friends. As previously mentioned John T was considered to be 'a kind good hearted and friendly guy'. This good heartedness can be illustrated by the statement made by his mother that 'John T stayed in the flat because he thought that Brian N needed the support after his sister, Nora T, moved out'.

71. The caring and friendly side of John T can also be seen from comments by his friends when Brian N's behaviour continued to decline. The John T family did care about Brian N but they were also worried about their son remaining in the flat. They all decided that it would be best if John T moved out and went to stay with another friend, HX, who had available accommodation. The court heard from HX that John T was quite reluctant to leave Brian N in the state he was because he thought that he needed help. This comment from his friend, apart from demonstrating the caring nature of this young man also makes clear that he was on good terms with the perpetrator who killed him and that, as far as anyone could see, their relationship was positive.

Perpetrator (Brian N) background

72. This part of the report sets out Brian N's background in order to put many of the issues highlighted in this case into context. A large part of the trial proceedings dealt with the way he lived his life before he met any of the family of John T going right back to his childhood. This material was put before the jury with the consent of his counsel in order for him to run

not only his primary defence of self-defence but also his alternative partial defence of diminished responsibility because of a mental abnormality.

73. Brian N was born in August 1983. When he was seven, he, his younger brother and older sister moved with their parents from the south coast to Cambridgeshire. His father worked there as an aerospace engineer but was made redundant when Brian N was nearly 13. The family could not sustain their usual lifestyle after the father lost his job and they had to move to a council estate. Money was very tight for the family. Brian N acknowledged that his father tried very hard to find work but could not get the same sort of job as before and in their reduced circumstances there were many arguments about money between his parents. He said he had a very difficult childhood. He said his father kept them short of money and his mother struggled to bring them up. He blamed his father for having to live on a council estate which he deeply resented.

74. In 2001 when he was about 18 he went off to university with his mother assisting him with money and his father helping him academically. He said that with his father's help, with hard work and with his own natural ability, he did well. At 21 he obtained a place at Cambridge on a MA course with a view to progressing on to doing a PHD but he gave it all up after a few months because his father left home in acrimonious circumstances which will be related later in this report. He said he missed his father very much.

75. His mother confirmed to the court that she brought up the children with the help of her parents after her husband left the family home in 2004.

76. He told the court that it was difficult without his father's income to meet the financial gap when at Cambridge and he was encouraged to pursue a career. He abandoned his MA and the possibility of a PHD and began to study to be an actuary.

77. In the world of work he appears to have done extraordinarily well financially for someone so young. In 2005, at age 22, he took a job which paid him £55,000 a year. He began his exams at this time to qualify as an actuary. After two years he was head hunted by a leading pension company and went up to a salary of £70,000. He said he spent the money on material things for himself and he put that down to spending seven years, as he put it, in council accommodation with little money. His money was spent as quickly as he earned it.

78. He completed his exams in late 2009. He appeared to have completed the qualification course in three and a half years whereas most people take seven. He was by all accounts a very intelligent and clever person and this point was made on numerous occasions by him and others throughout the trial.

79. The court heard that in September 2011 he was head hunted by a leading accountancy firm and the salary then went up to £120,000. Unfortunately, he was a victim of the financial crisis that occurred around this time and he was one of the many financial sector workers made redundant. He sent his CV around a number of high profile companies and managed to secure new employment. Unfortunately this meant a significant drop in earnings. He had lost the job where he was getting £120,000 and was taking on new employment where he was getting £70,000.

80. His relationship with his mother declined over unpaid loans she made to him to the extent that they were not on speaking terms from 2011. The relationship was not a good one. She claimed that when she asked for the money to be repaid he sent her abusive texts. She describes him as having a volatile temper – 'when he's angry he stares directly into your eyes and is very threatening. If you stand up to him though he will try and manipulate you into feeling sorry for him. If he thinks he has the upper hand or any power over you he will be completely dominant and threatening…. Brian N has always been very manipulative and controlling..… I had already decided that I was going to cut ties with him. I had given up believing anything Brian N told me and I don't trust him at all'.

81. He would often make promises that in the future he would be rich and would look after his mother in her old age. This seemingly altruistic gesture also included barbed negative comments which hurt his mother. He used to say that he would put her in a home and if she was good it might even have a window. He would make frequent flippant comments which she found quite hurtful such as he would get her membership to EXIT which is an organisation which helps members to commit suicide.

82. She instructed a solicitor to recover the money for her and recalled that when the letter was received by Brian N she received a text out of the blue saying 'I love you Mum. I'm really sorry x'. She did not reply as she 'knew I would get a whole diatribe of self-pity which meant nothing'. His mother revealed that she tried mediation with solicitors in 2012 and how they had sat in different rooms as she did not want to see him as she said she knew he would try and manipulate her.

83. When she heard that he was suspected of killing John T she recalled his behaviour as a child and young adult as always been manipulative and narcissistic. Everything was always about him and how he could benefit from a situation. She recalled a recurring theme whereby he would try and make people feel sorry for him and would even say he was going to commit suicide. She researched narcissism and felt that many of the traits (but not all) could be found in Brian N. She produced a list of the 18 personality/behaviour traits that she recognised in Brian N which matched those of psychopaths and submitted this to the Metropolitan Police to help them with their investigation.

84. His mother, as indicated above, had a very negative opinion of him and she finished her police statement with the following comment – 'My greatest fear is that Brian N will blame his actions of killing John T on anybody but himself. He is very skilled at lying and manipulation. He projects his own bad behaviour and selfishness onto others. I am worried that he will act as the victim so well in any forthcoming trial that people will believe that he isn't responsible for his actions……. He cheats, lies and manipulates but never thought he would be this person that murders someone'

85. The court heard from him (Brian N) about other disturbing aspects of his early life relating to his relationship with his father. He told how his father was away from the family home for a few days and during this period he (Brian N) and his mother were clearing out his father's shed. They found nearly 1,000 drawings by his father depicting a man with an iron bar or bat having sex with a woman. She and Brian N took the pictures to their GP who sent them to the police who in turn said no crime was committed but nevertheless shredded them. When his father returned home the family would have nothing more to do with him.

86. Brian N appeared to be fond of his father but the nature of the relationship is far from clear. He said that from the age of seven his father hit him on occasion and behaved inappropriately to him. He said it has still affected him and his mother knew and had not protected him. He claimed that his mother could not have failed to notice his injuries. His mother told the court that she never saw her husband sexually or physically abuse him and that he had never complained of it. She said he was never punished.

87. When Brian N was testifying he refuted his mother's recollections and said 'You know that she told you that there were not any, or she did not see any - she is lying to you when she says that, and she is lying when she says I never complained." He then incongruously added, "My father was a caring man with whom I liked to spend time."

88. His girlfriend, Nora T, knew about his relationship with his mother, his grandmother and his sister and she knew that these relationships had all broken down. She also knew that he had not seen his father for many years. He told her his father was physically abusive to him as a child and later she believed he was telling her that his father sexually abused him.

89. This issue of sexual abuse and whether he had ever said his father sexually abused him was a subject that occupied part of his trial. In a text to Nora T he said "My Dad did more than just beat me. That is why therapy is so hard." She asked, "What did he do?" And Brian N replied, "Sexual. Now you know something I never told anyone." At the trial he retreated from this claim - "That is not what I meant. What I meant when I was asked what did he do, and I said sexual, I was actually referring to the pornographic images that he had created".

90. He was a regular user of cocaine. The usage started off as recreational after a night out but his dependency escalated as he became stressed. His alcohol intake increased quite dramatically and when he was depressed in 2013 it was in the range of 200 units a week. He was also a user of nitrous oxide which, as previously mentioned, is a 'legal high'. Nitrous oxide is a gas with several legitimate uses (it is used in the catering industry for whipping cream), but when inhaled it can make people feel euphoric and relaxed. This happy feeling has led to it being nicknamed 'laughing gas'. Some people also experience hallucinations.

Relationship Background

91. Brian N left behind him a string of failed relationships. There were four main females in his life and at one time or another they had all loved him. They had one main thing in common. They were all frightened of him because of his unpredictable behaviour which the judge described as "reprehensible". None of them would live with him because he made them feel vulnerable and unsafe. The four females consisted of his mother and three girlfriends. They were all women who cared for him but who were not willing to continue being treated badly. These four relationships are crucial in terms of understanding how this tragedy occurred.

92. The relationship with his mother was described in detail above in the paragraphs 80 to 87 onwards. She gave her insight into what she saw as her son's flawed personality. Below the relationships with the three girlfriends are explored in chronological order.

Susan M - ex-partner of perpetrator

93. When Brian N finished University in 2005 he, at age 22, took a job which required him to leave home. He shared a house and one of his housemates was Susan M. After about six months, the end of February 2006, they began what he described as a deep intense relationship. He said they were in love. He was however intensely jealous of her ex-boyfriend and it became obsessional. The court heard how on one occasion he arranged for her to sing in a pub so that he could destroy pictures of the ex-couple displayed on her wall at home. He also destroyed a necklace her ex-boyfriend (KL) gave her when they split up. When JK managed to get her some singing work, he (Brian N) got jealous and broke her hair straighteners, smashed her CD player, turned the room upside down and ripped her clothes in a fit of anger. He denied that these actions were part of a pattern of consistent bad behaviour and explaining them as isolated incidents which he described as shameful and regrettable behaviour that he later tried to address.

94. Susan M spoke of how he told her stories about his ex-girlfriends and how they made her feel uncomfortable yet he was jealous if she mentioned her ex-boyfriend.

95. While he was living with Susan M he spent a great deal of time studying for his actuarial exams which he completed in three and a half years compared to the normal seven. He was totally focused on exams to the exclusion of everything else and things between them began to break down. His relationship with Susan M was changing. He told the court that they were spending less time together. When he was not studying he went out with other friends. He neglected her. He told the court that he told her that she was not worthy of his time. She was unhappy and confided in a senior work colleague and began some sort of relationship with him. Brian N suspected something was going on and tricked her into revealing her password, read her emails and discovered she was having a relationship with someone at work. He was very upset and angry.

96. There was a big row during which she told him everything. They talked through the night while he flicked, as she put it, between anger and upset. In the night he kicked her out of the house without any money but eventually he let her back in. They fought verbally and physically. He spat in her face. He held her against the wall and punched her in the stomach. He urinated in a glass and threw it in her face. Next morning he apologised but she said he always did. He wanted to be comforted. He was affectionate but then he got angry again and destroyed the things he knew were precious to her. A picture painted by her best friend for her 21st birthday was destroyed and he took her Grandmother's ring from her and threw it in the river.

97. The following weekend he kicked the wing mirror off her car because she was blocking him in when he wanted to leave to go and see his sister.

98. Asked why he damaged things precious to a partner, he said it was because he was upset and out of frustration but it was not meant to make her suffer. He said – "it was my way of letting her know how much she hurt me".

99. She said afterwards he was always very remorseful. She told how she swept things under the carpet because she wanted the relationship to survive. They had been happy. They had good holidays and he bought her presents but there had always been ups and downs because of his jealously. She decided that she could not live like this any longer and they

broke up in December 2009. She got her own flat. He went to his mother and then to London.

100. We made enquiries of both Cambridgeshire and Hertfordshire police and asked them to scrutinise their records for involvement with Brian N as he had lived in their area during his relationship with Susan M. We were informed of an incident recorded as Domestic Violence – Non Crime report in December 2009. A neighbour telephoned the police that he and Susan M had been arguing for two days after he found out she had been cheating on him with another male. When the police arrived the scene was calm and both seemed well presented and no offences were disclosed to police. The risk assessment by the duty inspector was graded as low. They were both sent Domestic Violence letters which was routine in the circumstances. This incident was not mentioned in the IMR prepared by the MPS and this omission will be addressed later in this report.

101. She said when they were together he did not take illegal drugs, he drank no more than anyone else in the group, he did not self-harm but she was aware of his behaviour and problems. She wanted him to talk to a professional but he saw it as a weakness and wanted to deal with it himself.

102. Even when they broke up they kept in touch. She said that not long after they broke up he got a primary school teacher pregnant, or at least that's what he told her, but later he said it was a lie he told to hurt her. One time after they broke up there was an occasion when he told her he had leukaemia. He said the doctor told him the cause of it was stress and that it was related to his failed relationship with Susan M.

103. It was about this time, she said, that she wrote a long email, headed, "No more lies" dated July 2010. In the email she says that she wants to support him and to start again with him and describes their relationship as magical. But she told the court that this positive outpouring emerged because he made her do it and the way she put it was this: "I wrote it at his instigation. He put pressure on me to describe only the positive things and leaving out the negatives." She complied, she said, because he was in a bad way and she wanted to help him because he was in a bad way. "I was distressed and panicked to mend something that couldn't be mended. My father said after we broke up there is nothing that he could do that you wouldn't forgive him for, and she said, that seemed to be true." Later on, because she got into such a state over him having leukaemia, he told her he was in remission.

104. In 2013, when he became depressed, he claimed that the panic attacks were so severe he believed he was going to die. He wanted to talk to Susan M to say goodbye to her because he wanted them to part on good terms. He phoned Susan M in May 2013 and told her that he had a tumour in his back and that he had to make a big decision as to whether or not to have an operation. At the trial he accepted that this was a total lie.

Mary W – ex-partner of perpetrator

105. His next main relationship was with Mary W who he had first met when he was at college studying for his A levels. The judge referred to this period of his life as particularly important. "I have taken the trouble to spell out this part of the evidence because it is your

dealing with the W family that came back to haunt you subsequently. Perhaps she and her father were made of sterner stuff than you expected".

106. In March 2010 after years of no communication Mary W got in touch through Facebook. He saw her in Leeds over five weekends and then in Cambridge. They did not date because she had a boyfriend, but he had a sexual relationship with her which ended in late May, possibly early June. In June or July 2010 he parted company with both Mary W and his current girlfriend. In July, after he had stopped seeing Mary W he discovered she was pregnant.

107. She wanted to keep the child and wanted to attempt a relationship. Although he claimed he was still very much in love with Susan M he said he had no objection in trying to have a relationship with Mary W, even though he had been barely seeing her. Her father encouraged him to buy a house and he had no objection to that either although he told the court he thought it was unlikely that there would be any long term relationship with Mary W.

108. He found a house in another town and completed the purchase in November 2010. He said, "I had no money for the deposit so Mary W's father provided £15,000 for the deposit and £7,000 for furniture. The reason I agreed to buy the house was for my son, not for Mary W. My name alone was on the deeds. I didn't tell Mary W or her family that I though it unlikely there would be a long term relationship but I decided that I had a duty to look after her and our child". He went on to tell the court that his sexual relationship with Mary W "was just a fling."

109. Around the time he was completing on the property was just about the time he began to have an intimate relationship with Nora T. She was the receptionist at his new place of employment. They had resolved it would be a one off and to stop but they did not and it happened increasingly often and we learnt that they went to a hotel together over Christmas and they also went skiing in January.

110. In February 2011, Mary W, then eight months pregnant found out. He said that he played it down but Mary W was very unhappy and her parents who were very keen to protect her and the as yet unborn baby, consulted solicitors. In March 2011 his son, TU, was born.

111. This is a very important stage in this case as Brian N attributes his mental health problems to two main sources a) the stress of the legal battle with the family of Mary W and b) the fact that not seeing his son regularly was unbearable for him. His mental condition was key to his defence of diminished responsibility.

112. He claimed to be very supportive of Mary W because he was present at the moment of birth and then cutting the umbilical cord. The court heard that after about one hour he was on the phone to Nora T and then left to go and see her. Mary W said that "after the baby was born he left and showed no interest in seeing the baby that day." He did take two weeks paternity leave but spent a large proportion of that time on the internet. He said, "I was there as often as I could be. I only spent two nights a week with Nora T. I was there with Mary W because I absolutely adored TU (his son) and had very strong feelings for Mary W as his mother."

113. Brian N's mother visited a number of times and painted a completely different picture of the relationship between father and son. She said she was struck how unnatural and how indifferent the defendant was to TU. How he did not even hold him. Round about May she and her sister had lunch with Mary W, the defendant and the baby. It was in a pub, and again she noted he did not hold the baby. Later she went to see Mary W when the defendant was not there to warn her about him.

114. By May he was only there with Mary W on 4 days a week arriving at 10pm and leaving by 8am and never at weekends. She had found his phone and discovered he was having an affair which he dismissed as a fantasy relationship. Mary W was quite clear that at this time he did not have mental health problems. She added that on the second occasion that she tackled him about Nora T he did behave peculiarly. He took a kitchen knife and went around the house pretending to stab himself. She said it was pathetic and she said to him, "Do what you want."

115. Mary W said during their relationship he was mentally cruel but he was not physically violent to her. He did however break things, for example, her computer, and he cut her off from others. He controlled her. He manipulated her to try and cut her off from her family. She told that she never saw drugs in their house but she said Brian N would arrive in an unusual mood, either really buzzing or itching his nose or sleeping depressed in a corner on the sofa.

116. Around September 2011 he told Mary W that they would have to move to a smaller house or they would be bankrupt. He said there was a place in another nearby town where they would start a new life and he sent her to her parents while he made final arrangements. He said it was supposed to be for only two weeks. She claimed that he tricked her into signing a document telling her that if she did not sign it they could not move to the new location. She said having gone to her parents she never did go to the new town and she never was able to go back into their existing house. He changed the locks on the door. She said all her possessions were left there under lock and key until the end of November.

117. Mary W's father was determined to get justice for his daughter and to recover the money lent at various stages and started legal action. She still wanted her son to have a relationship with his father and was prepared to give unlimited access. They met for lunch just before Christmas and she claimed it was clear that he had no interest in his son and only used him as a pawn. She made arrangements for visits but claimed that time after time he was either very late, did not show or only stayed for 30 minutes.

118. He was erratic in making payments for the upkeep of and she made a CSA claim. He wanted to see her and TU to try and sort things out. By the time he got there TU was almost asleep and she claimed that it was clear he just did not want to see him. She said he only wanted to see him when he could use TU as a pawn, and on that occasion it was to try and stop the CSA claim (£610 per month).

119. The court case, legal fees, child maintenance, repaying his mother, rent in London, mortgage, etc. all had a significant negative effect on the finances of Brian N.

120. As the court case initiated by Mary W's father got closer the text messages pleading to be able to see his son increased in volume. Mary W responded by saying that all contact

should be made through the solicitors. He replied saying he was really depressed and that it was all his fault and he had just tried to slit his wrists. At the trial the pleadings for access to his son was countered by Mary W's claim that Brian N had not seen his son by choice.

121. Mary W's final comments on Brian N were as follows and unsurprising hostile:- "Brian N is charming on the surface as far as I knew him, when you look closer on the surface he is not a nice man. He is selfish. It is about his feelings. He is a poor little boy who tells tall tales. I couldn't believe what he would tell me. He tells lies to everyone, with slightly different stories. When he gets caught out he panics and cries. He then tells you what you want to hear. He can be manipulative. He was very controlling, specifically when it comes to financial matters. In reality he never had the guts to follow through with any threats or harming anyone. I don't know what happened to him since we split to lead towards what he ended up doing. The court case has been very cautious from our side so not to cause him any further stress. As far as I know Brian N did not have any mental health issues, depression or treatment in the time I knew him".

Nora T – sister of victim

122. Nora T first met Brian N in March 2010 when she went to work in the same company as a receptionist. The relationship started towards the end of 2010. At the time he was in a relationship with Mary W who was 6 months pregnant with his child. Nora T said her impression of Brian N when she joined the company was that he seemed very intelligent, confident, professional, competent with good prospects and a good salary.

123. By the end of that first year they had gone on holiday together, spent Christmas together and the relationship was moving at a fast pace. He was well regarded by her family and all four went on holiday together in July 2013. He described that holiday as him being quite relaxed and enjoying it but that he had to spend a couple of days in their room alone because he was upset, and the reason that he was upset was that NT had told her friends that he had cut his wrists.

124. This was quite a strong intense relationship and the couple were very close. The judge made this observation - "I am, however, quite satisfied that when you became infatuated with Nora T you left baby TU with as little thought as you left Mary W".

125. In August 2012 they rented a property in South London and moved in together. He had been made redundant the month before but had quickly found new employment but it came with a salary drop from £120,000 to £70,000 and this added to his financial worries. She described them as liking to socialise but he never as much as her. They were part of a set of friends that occasionally took cocaine recreationally.

126. From his perspective he was not entirely comfortable with her friends but he made the effort. When he went out he had fun and he was not depressed. But he said he was becoming more anxious and he found that drinking alcohol helped. He ended up increasing his alcohol intake and snorting a couple of grams of cocaine each week. She agreed that from December 2012 she thought Brian N was becoming depressed. She said he was still confident around other people, always very sure of himself but he said by this time, December 2012, he was losing some of his energy. He did not want to go out so much. He

did not want to mix. He was sometimes in a low mood, sometimes anxious, for example, about going to work. She said that he could be verbally very aggressive and abusive to her.

127. He called this behaviour panic attacks but this was something they never agreed on. He described himself as being in a bad way, struggling to breathe and very nervous. He said that the panic attacks were life threatening. He said he thought that he would die. He described two or three episodes when he had sweaty palms, a racing heart, difficulty in breathing and pains in his arms. He thought he was having a heart attack and he hid in the toilet at work for between 10 and 30 minutes. He was by then having thoughts of self-harm and suicide.

128. She said she would not describe them as what she thought of as panic attacks, but she said there were incidents of self-harm and talking about self-harm and she kept on saying that he needed help. Her account was that he was just grumpy and in a bad mood and that he made her cry. Her view was that he acted like this when he just did not want to do something and was in a bad mood. She said that when he was in a bad mood it was hard to get him out of it. He would argue, he would sulk and if she did manage to get him out of his mood, it was usually due to a couple of glasses of wine because then he would be fine.

129. They discussed this behaviour on a number of occasions and he initially refused her advice to go and see a psychotherapist. He insisted that it was something they could sort out between the two of them but in her view they plainly could not. In December 2012 he sought help from his local GP complaining of anxiety and low mood, giving an account of redundancy, loss of friends, loss of family, worry about work, loss of confidence, excessive sleep, describing Nora T as a protective factor.

130. Nora T told of an incident at a friend's wedding they attend as an example of his self-absorbed behaviour. She said he did not want to socialise and towards the end of the evening when a social event was taking place, he stormed off leaving her with no way to get back to the hotel. When she got back the following morning she found that he had destroyed the sunglasses that he had given her. She said this type of consequence had become a pattern. He blamed her saying she had abandoned him. She said his behaviour was just not normal.

131. She told the court that she felt that if she said the wrong thing he broke her belongings, particularly those which were valuable to her and she was ultimately to cite a list of them which he claimed (with one exception) were all accidents.

132. He said as far as the incident at the wedding was concerned, she knew perfectly well that he needed her to hold his hand. He had a panic attack during the evening. He asked her to come outside and she would not, so he walked back to the hotel. He called her and sent texts but she did not respond. He accepts that he deliberately broke the sunglasses that he knew were special to her. He said he did it because he was frustrated, because he did not get the hand holding that he needed.

133. On 26th August the plan was that she would go with the defendant to the Notting Hill Carnival but he refused to go so John T took her instead. Brian N claimed that he had refused to go because of the crowds and she said it was nothing to do with crowds it was because they had had an argument.

134. During the day she cut her foot on broken glass and John T took her to hospital where she was given crutches. She had been texting the defendant during the day but he had not responded to her messages, even when she said she was going to hospital. Eventually she got home and she said that after a couple of drinks the defendant seemed to be okay but when she woke up in the morning she found that he had broken her crutches and she could not use them. He said it was her fault for going out without him. She was only able to hop around the house and was effectively in difficulties getting out.

135. Shortly after that it was her birthday on the 28th. Her parents visited. He gave her a card and at her request drove her to the doctor to get the dressing changed, but he spent the rest of the day in his bedroom. Nora T said he showed no interest in her apart from having driven her to the doctors.

136. Next morning (29th) she came downstairs and found that he had passed out in the lounge after heavy drinking. She managed to hop into the kitchen and made herself some tea and breakfast. He came in and she asked him to carry the breakfast for her into the lounge. He did. He asked where his breakfast was. She said, "I haven't made you any because you were asleep." She told him how upset she had been that he had not come to bed and he grabbed her breakfast and went to the kitchen where he threw the plate and the cup at the wall. He closed the kitchen door. She hopped after him and pushed the door open and it hit him on the head. She had not realised that he was behind it but he was.

137. She said it was an accident and that he was very melodramatic about it. He went into the living room and he closed the curtains. She followed asking what the problem was. He threw her across the room pushing her on to the sofa so that she hit her head and neck. She said, "He pinned me down." He put his both hands over her nose and mouth obstructing her breathing. He was glaring at her and it made her scared. She tried to wriggle free. She got to the front door and he shoved her into the hallway and closed the door behind her. She was in her pyjamas and she sat on the stairs for some 15 minutes until he opened the door. She said she did not want to see him anymore. She told him to get out and he did.

138. He left with his car keys but he also left with her house keys, her bank card and a large kitchen knife. He drove off at speed and later she reported it to police. She then went to a friend's house and she said she never stayed at the flat again. She did not go back to the flat because she did not want to be alone with him and she was scared.

139. The next day, the defendant's brother, DN, contacted to her say that Brian N had cut his wrists and was in hospital. She did not go to see him. On the 1st September he phoned her from hospital. He was repeatedly saying, "I'm sorry, I'm so sorry I'll never do it again." He wanted them to get back together but she said, "You need to get better. You need to see a psychiatrist and take medication. Stop taking cocaine and get back to work." She told the court that he said he would do anything to have her back.

140. Despite the ending of the relationship she continued to show him affection. She continued to help him sort himself out and get medical help. She encouraged him to return to work and acted as an intermediator with his employer. She said she just did not want to hurt him more in his fragile situation, but she said, he could be incredibly aggressive towards her, he lied and he ran away from things, and in her view they could only be friends. She did not

want to keep wondering every time that they argued which of her things would be broken next. She was there for him but she said she was not going back.

141. They exchanged a plethora of texts over the following weeks. Many of them were pleas for forgiveness, expressions of regret and attempts to gain sympathy and pity but Nora T stood firm. Text from Nora T - “I have been unhappy for a long time. It is not just the incident on the morning that I left. I have been unhappy for a long time.” Text from Brian N - “I was completely out of order. I shocked myself and I am ashamed. I was my father.”

142. In one of her texts she said "I helped you every step of the way, banging my head against a brick wall." She used the expression that he had ‘blown the chance’ and that she was scared of him, "wouldn't want to be alone with you because I am frightened about what you would do’, but she was still saying that she really loved him, she was encouraging him to go back to work and pick up the pieces. His consistent response was, "Give me a chance." And she was saying to him "Go back to your work; see a psychiatrist and then maybe." She had texted that he had tried to kill her but adjusted this under cross examination to being overstated and an emotional response.

143. It was during these exchanges that he introduced the prospect that his father had sexually abused him which retrospectively increasingly looks like an attempt to generate sympathy or pity from an ex-girlfriend. “My Dad did more than just beat me. That is why therapy is so hard.” She asks, “What did he do?” and he replied, “Sexual. Now you know something I never told anyone.” At the trial he retreated from this claim - “That is not what I meant”.

144. On 29 September Nora T and her parents came to collect her belongings from the flat. He begged her to stay and he said things that she took to be a threat to kill himself, but she told the court that he had raised this many times as a blackmail tactic and so she just left.

145. During his psychiatric assessment after the event, Brian N sought to put the stress factors he was experiencing in context. He told the psychiatrist that the top most of all the stresses in his life was not seeing his son which he said was 100 times more stressful than ending his relationship with Nora T. The continued use of his son as a pawn in his contrived sense of emotional hurt underlined his propensity to lie and his manipulativeness.

146. Brian N had made a will and it throws some light both on the strength of the relationship with Nora T and on his oft repeated claim that his son was his main preoccupation and the centre of his world. He said – "She had been the sole beneficiary of my pension and my life insurance policy, worth £30,000 and £480,000 respectively. I made no changes in that.” The judge commented “So that everything he had effectively he was saying was, perhaps not everything, but certainly his pension and his live assurance policy were to go not to his mother, they were to go not to Mary W, not to go to baby T, they were to go to Nora T”

Narrative Chronology

147. Much of the background to the victim and perpetrator have been described in some detail earlier in this report and this narrative chronology will focus on the events leading up to the murder of John T.

148. July 2012. Brian N was made redundant from his £120,000 per year job. He was simply another victim of the recession and the need to 'slim down' in the financial sector. He found new employment within two months but the change of job meant a £50,000 fall in salary and this happened at a time his personal finances were coming under heavy pressure from a number of different directions while maintaining an expensive alcohol and cocaine habit. His new contract of employment was not permanent and he was subject to satisfactory probationary review in six months.

149. August 2012. Brian N and Nora T set up home together in a flat in South London. They were joined by her young 21 year old brother, John T, in January 2013. John T occupied the ground floor bedroom while Brian N and his sister (Nora T) had the first floor bedroom.

150. He was feeling under a great deal of pressure. He said he was having frequent panic attacks but his girlfriend felt that he was being somewhat melodramatic in the description of his symptoms. He certainly appeared to be depressed. He attended his GP surgery on 20th December 2012 with symptoms of mixed anxiety and low mood.

151. He put these symptoms down to life events such as redundancy, family breakup. He added that he was in a new job in the financial sector and he was worried about his work as he had made a few mistakes. He reported loss of confidence, avoidance of social contact and excessive sleep. He reported thinking that if anything went wrong then at least dying is a way out. He stressed however that this was not something he would contemplate as it would be alien to him. He was concerned about any mental health diagnosis going on his record. He was also going to check if work offered confidential help. He decided to explore self-help options rather than medication.

152. March 2013. Nora T took him on a spa holiday to Marrakech. He said he had a panic attack on the bus in Marrakech and another near the market in the centre. He described himself as being in a bad way, struggling to breathe and very nervous. Her account was that he was just grumpy, in a bad mood and he made her cry. He was uncommunicative, told her to go away and he would then read for hours.

153. His probation period at his new job expired but he did not get a full time job and instead his probation period was extended. He was very disappointed claiming he worked very long hours with great responsibility, had made the firm a lot of money and they were still not prepared to give him the full time job – only another probation. It should be noted that no full time job actually existed. They liked his CV which was sent in on spec and they created a new temporary position for him to see how it could work out for the firm. At the end of the probation period they were still unsure about making the new job a permanent position.

154. Personal finance pressure was ongoing and his legal bills for the dispute with the family of Mary W were mounting. In terms of his cocaine habit he was using about 3 grams per week equivalent to about 30 lines of cocaine.

155. In May 2013 he got in touch with the Samaritans. We do not know what course of action they advised as they would not tell us quoting client confidentiality. We do know however that the court was given a copy of the response and it was used in the trial proceedings. We did note the judge's comment that Brian N having got that response from the Samaritans did not in fact pursue it.

156. He saw his GP again on 2nd May and this time was prescribed anti-depressants. He returned again on the 4th June. He was tearful and reported that there were lots of things going on in his personal life – stressful work and difficulty accessing his son and the legal battle he was involved in. He reported having thoughts of ending his life as a solution to all his problems. He identified his girlfriend as a protective factor. He did not reveal any plans or actions of self-harm but the doctor noticed a bandage on his right wrist and Brian N said they were superficial cuts and that he had never done this before. The doctor changed his medication, issued him with a medical certificate to cover his sickness absence from work and also referred him to The Community Mental Health Team on the same day.

157. During his evidence at the trial he elaborated on the anxiety he was experiencing and told how one of the overriding factors in his anxiety was not seeing his son. He said it made him feel like the whole world was ending. This theme of not seeing his son featured continuously throughout the trial as the main reason for him being depressed.

158. Nora T said he would not take the medication unless she made him and even when he did take them it did not seem to make any difference.

159. Brian N subsequently failed to attend two Outpatient appointments offered by the Mental Health Team. He was uncontactable by telephone and he was therefore discharged from the service by them. He returned to the surgery on 18th for a backdated certificate. On 16th July he informed his doctor he would be returning to work on 1st August. He was re-referred back to the Mental Health Team but failed to attend any of the appointments offered. They were unable to make contact with him either by telephone or letter despite a number of attempts.

160. He attended the surgery on one occasion with his girlfriend and requested a private referral to see a Regent Street psychologist. He attended one session with this psychologist and failed to keep any subsequent appointments.

161. He had been certified as sick from 25th May and on 31st July he stopped being on half pay and went on to statutory sick pay and a weekly figure of £86 was mentioned.

162. 29th August 2013. Brian N breaks Nora T's crutches. He said it was her fault for going to Notting Hill Carnival without him. He went into the living room and closed the curtains. Earlier in this report we told how he threw her across the room pushing her on to the sofa so that she hit her head and neck and pinned her down. She did not want to see him anymore and told him to get out and he did.

163. 29th August 2013. He left with his car keys and a large kitchen knife. He drove off at speed and later we know she reported this incident and his suicidal tendencies to the police.

164. Despite several attempts to arrange an appointment to see Nora T (she repeatedly said she was unavailable), the police were only able to speak to her on 4th September 2013. They also saw Brian N on his own on the same day and a risk assessment was carried out with "no" responses entered throughout. The reporting officer recorded that there was no indication that any party had access to weapons. The IMR from the police recognised that

the risk assessment was flawed and there were missed opportunities and these will be reviewed in more detail later in this report.

165. On the day following the breakup with Nora T, Brian N was found at home with his wrists slit by his brother, DN, who called an ambulance which took him to A&E at St George's Hospital. His brother contacted her to say that he had cut his wrists and was in hospital. If this was intended to make her remorseful for leaving him it did not work. She did not go to see him.

166. The cuts did not need stitches. At the hospital he rang Nora T to say sorry about how he had behaved on her birthday but he was beginning to feel that she did not want to be with him. He was repeatedly saying, "I'm sorry, I'm so sorry I'll never do it again. She kept saying that he had to make changes first. He had to sort himself out, go back to work, get help with the depression issues, stop using cocaine and try to drink less. He said he would do anything to have her back.

167. He told the court about this incident as follows. "So on Sunday morning to draw my brother's attention to the fact that I was in a bad way and needed help I cut my wrists. I filled the bath with water and got in clothed. I used a razor on my wrists. It wasn't a serious attempt, it didn't bleed a huge amount and after a while I got out and went downstairs and woke up DN. I said that I had done something stupid and they called an ambulance."

168. The hospital recorded the attendance as an attempt at self-harm although initially it was seen by the ambulance crew as an attempted suicide. He was moved to the mental health assessment room where a mental health risk matrix was completed and he was overall given a risk category of 'low'. The plan was for him to be evaluated medically for his wrist injuries and for psychiatric evaluation by the liaison psychiatry team (part of the Mental Health Trust and based at St George's Hospital). He was referred to the liaison psychiatry team who agreed to come and see him. This psychiatric evaluation did not take place.

169. The records of the Emergency Department and the on call psychiatry team differ on the reasons why Brian N did not have the psychiatric assessment. St George's stated that the liaison psychiatry team instead conferred with the A&E doctor about Brian N by telephone and reached a decision about whether he would be seen. As Brian N had told the A&E doctor that he would not harm himself again, he was judged to be 'no risk, low risk'. Brian N was discharged home by A&E and his GP was sent standard notification.

170. The records of the liaison psychiatry team, held on their patient electronic clinical record (RIO), show that the referral was made at 11.45am and that that they did attend A&E 20 minutes later at 12.05pm to see Brian N but he had self-discharged and left the building. They subsequently telephoned Brian N that same day but he said he was not able to continue with the call at the time and the conversation was terminated. Repeated attempts by the Consultant Psychiatrist to make contact with Brian N from 2nd to 13th September were unsuccessful.

171. The attendance at A&E was a missed opportunity for Brian N to consult medical professionals about his mental health and this is regrettable. It however needs to be noted that the Mental Health Trust overall tried repeatedly to engage with Brian N but he was not responsive. From June 2013, when his GP referred him, to the time of the St George's attendance, the Mental Health Trust wrote to him on six occasions and telephoned him

seven times but only made contact once when he said it was not a good time to talk. In addition, the Trust found it difficult to made contact with the GP surgery despite repeated attempts over this same period.

172. 19th September 2013 was the day that Brian N was due to return to work part time on a phased basis. Full time return was planned for 7th October. He did not return to work.

173. 29th September 2013, Nora T and her parents called at the flat to pick up her belongings. He pleaded for her to stay and threatened to kill himself but he had raised this too many times as a blackmail tactic and she just left. He sent her a text saying – "Goodbye, on your head be it".

174. During this time the family of Nora T had been offering Brian N help and support as they were concerned about him. On 7th October 2013, the father of Nora T telephoned Brian N's GP and expressed concerns about his mental health. He mentioned Brian N's previous self-harm and requested for a doctor to call him and to try to get him to come and see them. He spoke to one of the administrative staff and the message was conveyed to a doctor when she became available. The doctor telephoned Brian N the next day but was unable to make direct contact and the call went to voicemail.

175. 8th October 2013, as he had failed to return to work as agreed, he was notified by his workplace that there would be a disciplinary hearing on 14th October.

176. Since about 9th October 2013 there seems to have been a problem with the power supply to the flat. Brian N described this as an 'outage' on everything to do with power in the flat except the lights. The lights functioned but nothing else did. He swapped the fuses over so that they had no lights but everything else functioned. A couple of days later he said he fixed it himself. When the police entered the flat on the day of the murder the lights were not working and it was in darkness. The fuse cartridge for the lights had been removed. When a police electrician replaced the fuse the lights worked perfectly. The Prosecution drew out the significance of this lack of lights at the murder scene as demonstrating a further level of premeditation and as a way of reducing John T's ability to defend himself.

177. 14th October 2013 – this was the day scheduled for the disciplinary hearing. Nora T sent him a WhatsApp message to wish him good luck. He told her in reply he was going but was very nervous. At lunchtime she asked him how he was getting on. He lied and said he had to go back for a further meeting. He did not attend the disciplinary hearing. He was due to meet Nora T for lunch. He cancelled it.

178. He was due to have dinner with Nora T and John T that evening but he did not turn up. John T told his sister that he had left Brian N asleep on the sofa. Brian N sent her a text telling her he did not feel well and was throwing up. However, before they got to dinner time and in the course of the afternoon she discovered that there had been alterations to her email account, and she messaged him, asking what he was doing changing her passwords. He messaged back denying doing that, but she was aware that the recovery had been reset to his email and his mobile number

179. He sent further messages and the content of them effectively was him begging for her to go to the flat and she was saying things in response like, one at 7.15pm in the evening, she did

not want to go because it frightened her. The messages that were being sent that evening left her feeling uncomfortable. She told the court that she felt unsafe around him after what had happened in August and she did not want to go into the flat, but he just would not leave it and she said in the end she was persuaded to go to the flat but only to the doorstep and she was not going to go inside, and that is just what she did.

180. He did not look well, he was shaking and he said he had been sick; there was blood around his nose. He said that was because he had been sick through his nose but she suspected it was because she had been taking cocaine. She hugged him goodbye and they parted. She was asked whether this was a panic attack, and she replied that it had looked like a panic attack to her and it was unlike what he had previously referred to as a panic attack. This hug on the doorstep was the very last thing that Brian N claimed to be able to remember following the amnesia that had set in following the murder of John T.

181. She texted him shortly afterwards, saying she would get him a GP's appointment, but she did not and the reason she did not was because she later discovered that he had changed her password on her Gmail account so that he could read her emails. He had been trying to hack into her social networking sites but he had not been able to get access. She was very worried about this and she did not therefore make the GP's appointment for him.

182. Four days before the murder, his solicitors wrote to him saying that if he did not pay the £3,000-plus he owed them for acting for him in the various legal actions he was involved in, they would take proceedings against him. Meanwhile, the estate agents were trying to gain entry to repossess the flat as the rent was overdue and notice had been served. They were unable to get access to Brian N but they were in contact with Nora T who was aware that he would not let them in and would turn off all the lights in the flat and hide.

183. By now Nora T and her parents had decided, in conjunction with John T, that he should move out as Brian N was steadily getting worse. The arrangement was that he was going to go to HX's place. HX told the court he thought that John T was actually quite reluctant to leave Brian N in the state that he was, because he thought Brian N needed help. When asked about this during his defence testimony Brian N said "I didn't feel abandoned because I was not aware that John T was going to move out the following weekend".

184. We know that at five to six in the evening before the murder he was researching pay-day loans. We know that on this day his application for a loan from Wonga was turned down and he made many investigations that day relating to pay-day loan companies.

185. On one of the days (exact date not known) the estate agents tried to get into the premises. Brian N said that he "had locked the door and had hidden in the basement to avoid them and while I was there in the basement I saw a spear gun, I took it up to my room to kill myself with it." He was asked why, and he said "Well I wanted to have it there in my room to kill myself."

186. On the day before the murder he texted Nora T to check to see if she had made a doctor's appointment for him and she replied: 'No. You have changed my details, you have sent e mails as if you were me'" and she made it clear that she was not happy.

187. In the few days earlier he had been researching a number of issues on the internet. One search was whether the police could retrieve deleted numbers and texts and his reason that was given was that he wanted this explanation for an employment tribunal. His attention turned to researching the subject of how long it would take to bleed to death. He moved on to accessing web pages relating to spear guns, spear gun accidents and many articles such as 'woman survives harpoon shot through the mouth' and 'spear gun in heart'. His explanation for all these spear gun searches was he had seen someone on the television using a spear gun and he wanted to know if he could kill himself with it. It was pointed out to him that he was not researching how to kill someone, he was researching accidents and survival of spear gun accidents, and he said putting in 'accidents' and 'survival' was the best way to find out how to commit suicide.

188. His searches progressed to 'How to knock someone out', then he was accessing web pages in relation to 'Knock someone out with one hit', 'How to knock someone out with drugs', 'Best chemical agent to knock someone out', and other examples of how to knock someone out, and he said that was all because they had watched this film 'Snatch' and they did not believe that you could knock someone out with a single punch.

189. Then he said he and John T also talked about another matter which led him to do some further researches related to diminished responsibility. 'Murder by Mental Illness', and then web pages concerning a triple homicide suspect's long struggle with mental illness. 'Not guilty of murder by reason of mental illness', 'Murder by mental illness', he looked at a national confidential inquiry into suicide and homicide by people with mental illness. Into the early hours of the night at just before 1.15 in the morning: 'Sentencing for murder in the UK', 'Murder in English law', Murder and mental illness, sentencing', 'Murder and mental illness sentencing UK', a whole series of researches there. His explanation was that he had watched a television programme and just wanted to find out if was factual.

190. His internet research also covered 'How you bypass the security questions to access Hotmail passwords', and he said what he was trying to do was to find Nora T. What he wanted to do was to work out by researching how he could bypass her security questions and get into her Hotmail, find out where she actually was and then go to meet her. He said there was nothing sinister in this at all; he was just copying a character in 'Fifty Shades of Grey'.

191. On the eve of the murder - Nora T's father, aware that the estate agents were pressing to take possession, texted Brian N about his moving out arrangements. At 2.30pm Brian N thanked him and said he would have a clearer idea of things within the next week.

192. Within two minutes of this text exchange Brian N was googling "killing with a hammer". His explanation formed part of his plea of self-defence. "I had gone into John T's room to get cigarette papers, the doors have no locks and we often went in and out of each other's rooms. Nothing I had seen in his room before had ever made me anxious", not even though he had seen knives in there before because he said knifes were part of John T's kit. There was nothing surprising about it, but this time he said: "I went in and I saw a hammer by his laptop on the floor, I had been using his laptop and I saw that he put this weapon there, so he had put this hammer there as a weapon, warning me to stop. This made me anxious. I picked the hammer up. I held it for some time. I crouched in the lounge we had. I had a panic attack, I was sweating and struggling to breath, but I quickly calmed myself. I thought

I had better put it back. This is why I was still extremely anxious at 14.32 and I made a Google search."

193. At 15.56 he was accessing an article about men who have committed a string of murders with a hammer. His reasoning for the searches was that he had found the stab marks to the bed near Nora T's laptop and he thought that John T had made the stab marks in frustration because he had used his sister's laptop and because of how he had treated Nora T. "So thinking that I might be harmed in my sleep I Googled what I did". Then at 16.36 he accessed how to 'Kill someone sleeping?'

194. Of course, he was cross examined about that and asked whether that was in fact what was to happen hours later, that he was to kill John T sleeping, and he said it had nothing to do with that. "I was doing all of this because I was worried that John T would kill me in my sleep." He agreed that at this stage he was lucid, articulate and able to control his actions.

195. Just before 6pm he was trying to replenish his supply of cocaine and telephoned for a home delivery. The supplier took the offered cash but it was money that he had already owed for cocaine he had had before and the supplier did not give him any cocaine on this occasion, so he did not have any drugs. He then went to Tesco's at the end of the road and got two bottles of white wine, some Whisky and some cigarettes. From 6.30 or 7 o'clock onwards he was drinking the wine and he had drunk most of it before John T got home that evening.

196. At 8.30am that morning John T started a double shift at work. This ended about 11.30pm and as was the usual practice he went for a quick beer with the team. He walked to the underground where he said goodbye to his colleague and headed home. His workmate described John T as being normal and happy when they parted. The time was about quarter past midnight. He sent some texts on his way home and they were cheerful and planning for his day off on Saturday. He texted Nora T and said he was on his way back from work.

197. Within four minutes of John T leaving the station on his way home, Brian N was Googling John T and accessing the report in the Gazette about the fatal road accident incident. Asked at the trial why he was accessing this incident he replied "I did it to challenge my anxiety". He then accessed the Facebook page of John T and also the previous boyfriend of Nora T.

198. At 2.30am, MI, who lived next door to the flat woke up and made herself a cup of tea and a sandwich. She returned to her bedroom which adjoins the flat and heard about three or four thumps and then shouts like a woman's voice crying out "ah, ah, ah". There were no voices and no shouting. She got up and looked out and could see there were no lights on in the flat. She was quite clear that the flat was in darkness. The time had just gone 3am. She went back to bed. There was no more noise.

199. At 06.51 on the day of the murder, Nora T sent her brother a text. There was no reply. John T was due to arrive at work at 08.30 but he did not turn up. This was very unusual. John T was in the habit of texting his mother between 8 to 8.30am to make sure she did not worry about him but there was no text message that morning. Nor was there any text at about 16.00, the other time of day when he would usually text his mother. The family started to get concerned. At 13.10 the father of John T sent a text to Brian N as estate agents were due to visit that morning but there was no response.

200. The father of John T called the surgery of Brian N to enquire whether the GP had made contact with him. He reported that Brian N's mental health had deteriorated and that he was erratic in his behaviour and suicidal. The call was taken around 2pm by the administrative staff and one of the doctors was informed later that afternoon when he became available. Administrative staff tried to contact Brian N to offer an urgent on the day appointment for the evening surgery but were unable to speak to him. The plan was to try and contact him again the next day.

201. The family discovered that John T had not been to work and called the police. At about 8.45pm Nora T went to the flat. She tried calling Brian N but there was no response from him. While she was there waiting outside the emergency services arrived.

202. The flat was locked and secure and in complete darkness. The keys were in the locks of the front door (in the inside) and the police had to force entry. The front room was empty and the television was flickering. The officers tried to turn the lights on but there was no electricity. Police found the lifeless body of John T on his bed.

Failed Plea of Lawful Self defence

203. Brian N put forward a not guilty plea based on self-defence. Unusually he asked for a secondary plea to be considered if the first was not successful. This was a plea of manslaughter with diminished responsibility due to a mental abnormality which he had at the time of the incident. Neither plea was successful.

204. Brian N claimed to have suffered from amnesia due to the trauma of this horrific incident and his excessive alcohol intake. He had no memory from the time of the hug with Nora T on the doorstep of the flat on a few days earlier until he woke up in hospital following the murder. Expert witnesses did not accept that the trauma of an event could cause amnesia that is then backdated by three or four days. When asked about amnesia triggered by alcohol they replied that you only get amnesia around alcohol for the period when you are drunk, not for the period before you were drunk. They were sceptical about the regaining of nearly all memory during the period in prison.

205. The claim of the onset of amnesia meant that Brian N was not in a position to say anything that would incriminate him because he could not remember any details of the incident. Virtually all of his memory returned for the start of the trial and he gave consistent responses to the questions put to him in cross examination although many answers were less plausible than others. The judge in his sentencing remarks make the following comments – "I am quite satisfied from your evidence and seeing you at length in the witness box that you have studied over and over again the papers in this case just as you studied and prepared for your exams in the past, that you have prepared a defence that has sought to account for and explain away every facet of the Crown's case right down to a bloodied sock print".

206. Brian N claimed that when John T returned from work about 12.30am they sat chatting amiably and talked about Nora T and her brother suggested that he was stalking her and wanted to hurt her. John T returned to the living room about 20 minutes later and said that he did not accept the explanation given. "He was not aggressive or intimidating or threatening, but he wanted answers. He accused me of trying to ruin her life as I had ruined

my own life and he stormed out of the room". Brian N passed his door on his way to the kitchen for another whisky and said that it was not he who ruined lives, it was him (JOHN T) – referring to the road traffic accident. As he turned into the kitchen he claimed that John T hit him over the head with a hammer. He blacked out. When he came round he went back to challenge John T as to what he was doing. John T took a knife out of his bedside drawer and started lunging at Brian N cutting him several times.

207. Brian N told the court that he ran to his room and while there picked up the harpoon gun which he had brought up from the basement some days earlier and went downstairs with it to threaten John T and make him phone for help.

208. He went down to John T's room and he was sitting on the bed with a large cook's knife in his hand. "I pointed the gun at him and I screamed that I would shoot if he did not drop the knife. He tossed it underarm onto the floor between us. I told him to dial '999'….. "We were both screaming and our voices were raised". John T keyed some numbers into the phone then lunged for the harpoon gun and pulled it towards himself. It went off and the spear entered his head. Brian N said he was not even holding the harpoon gun at the time.

209. He claimed that John T had picked up a silver knife and started lashing out cutting him several times. Brian N reached out for something to stop him – whatever was to hand – and as he reached down by his side his hand felt the large brown handled chef's knife. "I held it in front of me and pushed it at him as he lunged". He alleged that the knife unintentionally entered John T's chest.

210. He then claimed to have picked up John T's mobile to phone for help but it was locked. He had his own phone by this stage but did not want to use it to call for help. Instead he started Googling how to unlock John T's phone to use it to call for help. When asked why he had not used his own phone, he replied - "I was fixated on calling the same person that JOHN T had called." He felt he would get the same person in emergency services by using the same phone. He did manage to unlock the phone but in any event he did not call for help. He sat on the bed for 20 minutes, then went to the bathroom, filled the bath and got into it fully clothed and cut his wrists. The bath eventually got cold despite being regularly topped up using his toes on the hot water tap and he got out. At 7am he was woken by John T's alarm and went to his bedroom to turn it off and he retrieved the harpoon gun while he was there. He changed out of his wet clothes. He took the bottle of whiskey and a book and went to the living room where he drank half the bottle. He went back to the bathroom with the whiskey and harpoon gun. He loaded the gun and put it under his chin and fired it with his big toe. This was how he was found many hours later by the police.

211. When Brian N regained his memory after his total amnesia he recalled every move in minute detail and could account for every cut and scratch he had endured in the ordeal that he had been put through.

212. The prosecution argued successfully that this whole scenario was implausible and too extraordinary to be believed. Their case was that this was a planned execution and an act of revenge for being jilted by Nora T. His internet searches showed that he had researched the killing options and even his own defence options. The picture they painted was that John T came home from work late after a double shift (15 hours) and went to bed as he had an early start the next day. Brian N had brought the harpoon gun up from the basement

some days before in preparation. The killing had happened when John T was asleep. The fuse had been removed from the consumer unit so that the flat was in darkness when the killing was carried out. Brian N had used the light from his mobile to carry out the killing. When John T did not die from the harpoon spear he stabbed him to death with the cook's knife. The forensic evidence helped build up a scenario whereby Brian N had cut himself strategically to produce plenty of blood all around the flat and to help with the fiction that he himself had been attacked by someone yielding a knife.

213. The suicide attempts in the bathroom appeared stage managed. The cutting of the wrists was not deep or severe enough to cause death despite many hours of bleeding. The blade had gone through skin and subcutaneous fat - no veins or tendons had been cut. The shooting of the harpoon gun into his head was also unconvincing as the entry wound was into soft tissue and the spear came out very easily and with minimal effort when the paramedics moved him. This form of non-fatal wounding had been the result of extensive research by Brian N some days earlier.

214. The neighbour who was awake at the time confirmed that there was no shouting or voices at the time just a series of agonising screams. John T was in his bed clothes and on his bed when killed confirming that he was most likely asleep at the time he was attacked. Brian N phone was used at 2.50am and the Crown suggested this was to provide some light for the killing.

215. The claim of being hit over the head with a hammer by John T was similarly not felt to be feasible. Brian N had been examined a number of times during his first few days in hospital and in custody and no head wound was identified. Indeed Brian N himself did not discover the wound until he was in prison and having his hair cut.

216. The supposed frenzied attack by John T would have been completely out of character by the young man who was remembered as a gentle and kind person.

Plea of Mental Abnormality

217. Although the secondary plea of diminished responsibility was also dismissed it is examined here as it gives some very useful insight into his character and mental state. Two psychiatrists and a psychologist gave evidence. The defence sought to show that on a balance of probabilities (the balance of probabilities means more likely than not) that at the time the defendant struck the blow with the necessary intent for murder his responsibility for his action was diminished because of his mental condition. There are two conditions that need to be satisfied for this plea to be accepted.

    a. At the time he killed John T, the defendant was suffering from an abnormality of mental functioning which arose from a recognised mental condition.
    b. In addition, the mental condition or combination of conditions must have substantially impaired his ability to understand the nature of his conduct and/or to form a rational judgement and/or to exercise self-control.

218. All three doctors did agree that at the time he killed John T he was suffering from an abnormality of mental functioning which arose from a recognised medical condition. They all agreed that he was suffering from a medical disorder that involved moderate to severe

depression and marked anxiety. In addition one of the three thought he was suffering from alcohol dependence.

219. Two of the doctors concluded that the depression was likely to impair his ability to form a rational judgement and to exercise self-control but would go no further than that. The other doctor was much more forthright. He also agreed that Brian N suffered from recognisable mental disorders, namely, anxiety and depression, but in his view neither of them were of such severity that it would have impaired his ability to understand the nature of his conduct, or to form rational judgements, or to exercise self-control as is required for the defence of diminished responsibility. The judge, in his sentencing remarks, stressed that this psychiatrist was not saying his illnesses impaired but not substantially. He went much further than this and was saying it would not have even impaired those abilities. He explained that the reason for his view was that the conditions from which Brian N suffered do not make him aggressive, rather the reverse and they could not therefore explain his conduct. His illnesses could not explain what he had done.

220. The psychiatric evidence pointed to various aspects of Brian N's personality such as lying, aggression, deceiving and manipulation, but they did not think that they had reached such a level as to warrant a diagnosis of personality disorder. When discussing his negative personality traits one of the psychiatrists noted that "when he is hurt he responds by wanting to hurt his hurter even at times before he had depression and anxiety". Another of the psychiatrists when asked to comment on whether this amounted to a personality disorder responded "Whether at the time of the killing he was acting in revenge for what he thought Nora T had done to him is not a matter for me, it's a matter for the jury."

221. The judge in sentencing drew attention to concerning character traits which had formed a continuous thread through the testimony of his mother and his three ex-girlfriends and the independent psychiatric evidence. Each of the ex-girlfriends stressed that at the times he treated them badly he had no mental health problems. "I accept you were suffering from depression and anxiety and that whilst you do not have a diagnosable personality disorder, you do have character traits which give significant cause for concern, those traits including manipulativeness, dishonesty, vengefulness and a desire to hurt those whom you believed hurt you, particularly by destroying objects they loved".

222. The psychiatric insight into his character was quite revealing and reinforced the accuracy of the views and opinions of the women in his four failed relationships. "In times of stress, this defendant exhibits two main antisocial behaviours. Firstly, a tendency to lie and deceive and secondly, an aggressive destruction on his partner's property. For example, he described breaking Nora T's sunglasses as an expression of his frustration."

223. Brian N tried to explain why he was destructive of property, "A retaliation against her because she had not helped me on the day". A demonstration to her that she had let him down. He rationalised this even further by suggesting that when his father had hit him as a youngster it was because his father was frustrated and that he avoided doing the same to others by using techniques like destroying property or by leaving the scene.

224. His ex-girlfriends and his mother portrayed him as a highly intelligent arrogant man who felt superior and this was a feature of his character that the psychiatric assessments considered and the view was that his self-satisfaction and self-confidence overlays a tendency to

pessimism and self-doubt. Despite intelligence, academic achievements and a high salary, it was suggested he feels a sense of fragile vulnerability, leading for example to jealousy. His failure to shape his world as he felt it should be led to feelings of depression and in turn to panic, leading to substance misuse to alleviate the feelings. "I think he avoids and tries to repress negative aspects of himself but there are times when he finds it difficult to constrain his emotions."

225. In quite simple terms the case for the prosecution and the defence were based on two diametrically opposed views – "Bad or Mad". The emerged conclusion from the psychiatric assessment was that his behaviour was not due to a psychiatric condition. "I concluded on the basis of all the material available to me that he tries to present himself in a consistently favourable light, has a high opinion of himself, and believes he is extremely intelligent. This suggests a degree of arrogance and possible narcissism leading him to think he is superior to others. There are antisocial features of aggression, deception, lying and manipulation probably compensating for underlying feelings of insecurity. When he feels rejected or jealous or his emotional needs are not met, he can respond with petulant, immature, aggressive behaviour both verbal and physical. He is unable to deal with such feelings and responds inappropriately with anger and a desire to hurt the person who hurt him. This was demonstrated in his behaviour before there was any psychiatric condition. This is not a reflection of a psychiatric condition; it is a reflection of his personality. His alcohol and cocaine use also predates any psychiatric history."

226. "It is his personality which I think is the driving force in his behaviour. Enraged by Nora T's rejection by killing her brother he has caused her the hurt he was feeling. This is not a mental disorder; this is part of his makeup. His actions may have also been influenced by the disinhibiting effect of substance misuse but none of this can amount to diminished responsibility."

Issues arising from the Narrative

227. The DHR panel considered the chronology and narrative carefully and identified a number of issues that required further deliberation as it progressed. The main issues that stood out were the three missed opportunities by statutory agencies to engage with Brian N. Our observations on these three missed opportunities are explored in the analysis of the IMRs.

Engaging Family and friends

228. A domestic homicide of this nature can take a terrible toll on family members and friends and they can often feel side-lined and ill informed. With this in mind the DHR panel sought to make every effort to ensure that the needs of family and friends were at the forefront of our deliberations and sensitively handled.

229. As previously stated we sought to ensure that family and friends were given every opportunity to be fully involved in this review and felt able to make a positive contribution. We were fully aware that family and friends could critically inform the review and provide insight into how John T and Brian N saw their choices and fill in information gaps about the effectiveness or appropriateness of services or lack of them. The information set out below has been derived from points discussed during the court proceedings and from police statements and information pieced together from the IMRs.

Father of the victim John T

230. Mr KT, the father of the victim John T, declined the invitation to participate in this review. The information set out below is from the police statement made by KT and has also been derived from the IMR compiled by the MPS. It demonstrates that the family of John T wanted to think positively about Brian N and to help and support him right up to the day he killed their son.

231. Mr KT described Brian N's behaviour as impeccable. However there were times where his behaviour was described as 'not normal'. They went on a family holiday together in July 2013 and he sensed there was something amiss. Shortly afterwards Nora T and Brian N separated after a quarrel. She left their flat and moved in with a friend. John T remained in the flat as he was very good friends with Brian N. Both KT and his wife had concerns for their son.

232. KT met with Brian N, where he disclosed financial problems and issues around access to his son. He said to KT that he wanted to get back with Nora T. KT had concerns for Brian N and so contacted the Samaritans for guidance. He was advised to speak to Brian N's GP and so made contact with the GP's receptionist. The receptionist said that they would alert his GP and make contact with Brian N. KT did not know whether the GP ever made this contact.

233. At the beginning of October 2013, KT went to his daughter's flat to collect some of her belongings. He took Brian N to a local pub and was subsequently joined by John T, his wife and daughter. KT described Brian N as looking unwell and depressed at the time. The family had discussed moving John T out of the flat on his next day off. He made further contact with Brian N's GP on the day of the murder (unaware that his son was already dead) to urge them to provide help to him and find out what progress had been made further to the previous call. The surgery staff could not confirm whether Brian N had been spoken to by his GP.

Perpetrator Involvement in the DHR process

234. We contacted the perpetrator in prison to ask for him to engage with the DHR process given his defence that this killing was not an intentional act. We sent our request by recorded delivery but did not receive any response. We then contacted the prison governor asking him to make contact with Brian N to ensure he did receive our request and secondly to ask him (the governor) to ascertain from Brian N whether he wished to engage with the review. We received a response from a senior probation officer at the prison who met with Brian N and suggested that he seemed ambivalent about engaging with the review. We were told that Brian N would consider some written questions and these were to be sent to him via the probation officer. The questions we posed related to his contact with the statutory agencies as we wanted to ascertain from his perspective how well they interacted with him, how his needs were addressed and whether there were any warning signs or cries for help that went unnoticed. Our aim was to identify any constructive learning that could be adopted using his insight.

235. We received his response after the report had been drafted. The points he made had already been incorporated and well examined in the report and he had nothing new to add

that warranted inclusion.

Individual Management Reviews (IMR)

236. IMRs and written responses were received from the list of agencies and bodies below and have been summarised for the purpose of this report.
St George's Healthcare NHS Trust
SW London & St. George's Mental Health Team NHS Trust Metropolitan Police Service
Wandsworth Council (Education and Social Services Department - WESSD)
Brian N Doctor
Brian N Employer
John T Employer

IMR - St George's Healthcare NHS Trust

237. St George's Healthcare NHS Trust searched their records and found no registered involvement with John T anywhere on their systems.

238. There were two only recorded involvements with Brian N and these were 1st September 2013 (attempted suicide/self-harm) and on the day of the murden (taken to hospital from the murder scene).

239. On 1st September 2013, Brian N was brought to the Emergency Department (ED) at St George's Hospital by ambulance at 10.03am following an attempt at self-harm at 7am earlier that morning.

240. 10.05am: The ambulance crew handed him over to the nursing staff in the emergency department. They indicated that he had cut his wrists at 7.00am and had wanted to kill himself. He was triaged as 'urgent' (to be seen within 1 hour), and was moved to cubicle 9 (the mental health assessment room) in the Majors area of the emergency department.

241. 10.20am: A mental health risk matrix was completed and Brian N was given an overall risk category of 'low'. The plan was for him to be evaluated medically for his wrist injuries and for psychiatric evaluation.

242. 11.00am: Brian N was seen by Dr MG, Emergency Medicine Doctor. His wrist wounds were treated and he was referred to the liaison psychiatry team on call who agreed they would come and see Brian N. St George's Hospital recorded that at some point later the liaison psychiatry team spoke to Dr MG by telephone and advised that they would only see Brian N if he was a risk to himself. As Brian N had said to Dr MG that he would not harm himself again, he was judged to be 'no risk, low risk'. The liaison psychiatry team advised that to access psychiatric services again, Brian N would have to see his GP the following week. Dr MG therefore confirmed that Brian N would see his GP the following week and he was then discharged home.

243. St George's Hospital recorded that following his discharge, the liaison psychiatry team came down to the emergency department. After reviewing their records, they had found out that he had missed his last appointment. Therefore the liaison psychiatry nurse stated that she

would contact Brian N at home to say that he could come and make an appointment to see his psychiatrist as an outpatient rather than go through his GP.

244. Following his discharge further attempts were made by the liaison psychiatry team to contact Brian N from 2nd September 2014 – 13 September 2014 but these attempts were unsuccessful.

245. Paper referrals were made by Dr NH to Wandsworth Children's Social Services and also to the St George's Alcohol Liaison service. A letter was also sent to the patient's GP to provide details of the discharge and advised that the GP needed to review the patient.

Analysis

246. Analysis by St George's was as follows : - Having made due reference to the relevant patient records and having reviewed the patient's assessment during his short time within the Emergency Department, we are satisfied that he was appropriately assessed and treated, subject to review by psychiatric services – to be accessed via his GP. Having said this, the result from the mental health risk scoring matrix did not seem to be truly reflective of the patient's level of distress and how it is used appears to require review.

247. Following the patient's discharge several attempts were made by the liaison psychiatry team to contact Brian N from 2nd September 2014 – 13 September 2014 but these attempts were unsuccessful. Paper referrals were made by Dr NH to Children's Social Services and also to the St George's Alcohol Liaison service.

Lessons Learned

248. Lessons learned by St George's was as follows:- NICE guidance on self-harm (CG16 July 2004, as updated by CG133, November 2011) states: (at 1.4.1.5) "All people who have self-harmed should be offered a preliminary psychosocial assessment at triage (or at the initial assessment in primary or community settings) following an act of self-harm. Assessment should determine a person's mental capacity, their willingness to remain for further (psychosocial) assessment, their level of distress and the possible presence of mental illness." In light of the above, it is considered that the patient should have been seen by the liaison psychiatry team, rather than the team relying on information relayed via telephone.

249. In terms of the other questions: ED would normally/automatically refer to social services if there is a parent who has self-harmed and they have access to their child as they may be a child in need /at risk.

250. Having discussed this with the psychiatry liaison team and regarding the follow up issue: ED would not normally have access to this info. In terms of responsibility, liaison psychiatry advised that they would take responsibility to make follow up contact with the patient.

Recommendations

251. Recommendations by St George's were as follows:- There is an identified need to review the way the mental health risk scoring matrix is used, in conjunction with the psychiatry liaison service and it would be advisable to devise and implement a policy that states referrals from the ED or GPs to specialist teams cannot be refused and that such specialist teams must review patients before making such judgements.

Comment (DHR Panel)

252. When reviewing the Narrative, we identified the failure to talk directly to Brian N as a missed opportunity as it would have been the first and only time that he was seen by a mental health professional before the killing. Although Brian N was conveyed to the hospital by ambulance his wounds were quite superficial and the initial diagnosis by the LAS paramedics of attempted suicide was downgraded upon examination. It is important to note that the hospital records show that Brian N spent less than two hours in St George's Hospital as this may help put the extent of his injuries and concerns at the time into some sort of context. St George's has told us that lessons have been learnt and recommendations made which from their perspective should help prevent similar patients slipping through the net.

253. The conclusion and subsequent recommendation by the St George's Emergency Department regarding the lack of success in carrying out a psychiatric interview with Brian N is different from the explanation offered by the Mental Health Trust in their IMR. We have information from the records of both agencies and neither are able to add any additional information to clarify the matter.

SW London & St. George's Mental Health Team NHS Trust

254. The Trust had minimal direct involvement with Brian N and the only occasion when he was directly seen by a member of Trust staff was in October 2013 following his arrest on suspicion of murder.

255. The involvement of the Mental Health Trust dates back to the first referral by his GP on 4th June 2013. Brian N was referred to the Central Wandsworth & West Battersea CMHT on the 4th June 2013 by his GP. The referral letter from the GP stated that Brian N believed that he had suffered a breakdown. He reported low mood, anhedonia and long term social isolation. Brian N said he was feeling suicidal and tearful and had been making cuts to his wrists, although he stated that his girlfriend was a protective factor. He was signed off work. The referral recorded that Brian N had a high pressure job; had no close family and his best friend had recently died. He had a difficult relationship with his ex-partner and problems with the access arrangements for his young son.

256. The referral was received by fax and an appointment letter was sent out by the CMHT on the 6th June 2013 offering Brian N an assessment appointment with a Consultant Psychiatrist and a CPN on the 20th June 2013. Brian N did not attend his assessment appointment with the Consultant Psychiatrist. Staff attempted to make contact with Brian N but there was no answer on his mobile number. A further appointment was then offered to him by post. Brian N did not attend the second offered appointment for assessment on the 8th July 2013. Staff again tried to call his mobile number but there was no response. The CMHT then agreed it would be appropriate to discharge him from the service. A letter was sent to the GP on 8th July informing him of this and inviting him to re-refer Brian N if there were any further concerns. A copy of this letter was also sent to Brian N.

257. A letter of re-referral from the GP was received in the CMHT on the 26th July 2013. This letter was dated the 16th July 2013. The letter from the GP stated; 'Please see the above patient for an assessment & further management. He describes a long standing history of low mood, anxiety & having problems at work. He feels tired & is finding it difficult to sleep.

Has suicidal ideas but no actions & no past medical history of deliberate self-harm. Patient is currently taking anti-depressants'. There was no level of urgency stated on the referral. Following receipt of the referral a letter was sent to Brian N on the 29th July 2013 offering him an appointment on the 15th August 2013 with a Consultant Psychiatrist from the CMHT. He did not attend the appointment on the 15th August 2013. Despite sending letters and leaving messages on his phone the CMHT did not hear anything from Brian N.

258. On the 1st September 2013 he presented at A&E at St George's Hospital with superficial lacerations. He had been drinking but was not assessed as suicidal. He asked for help and told staff he was taking Sertraline although was not compliant. A&E staff felt he was at low risk of self-harm. Staff in A&E requested that Liaison Psychiatry carry out an assessment but Brian N self-discharged and did not wait to be seen by staff from the Trust. A Liaison Psychiatry Nurse tried to ring Brian N to speak to him about arranging an appointment with Central Wandsworth & West Battersea CMHT but he said it was not a good time to talk and he terminated the call.

259. The extract from the RIO record system was as follows:- "Brian N presented with his partner with superficial laceration to wrists and he reported having used alcohol. The referring A&E doctor said he was not suicidal and regrets his self-harm and wished help via services. He said his G.P. has started him on Sertraline but has not been compliant. I agreed that will see him for risk assessment. He was referred at 11.45 hours. I went to see him at 12.05 hours. Patient had self-discharged with his partner and had agreed that he would be seeing his G.P. The referring A&E doctor said he was at low risk to self at the time of discharge".

260. The Consultant from Central Wandsworth & West Battersea CMHT tried to call him the following day, 2nd September 2013, but she got a message that stated 'the other person has hung up'. On the 5th September 2013 Brian N did not attend his scheduled appointment with the CMHT Consultant. The Consultant rang him and left a message for him and also tried to contact the GP surgery, she had to leave a message there also.

261. On the 10th September 2013 the Consultant again left a telephone message for the patient and also attempted to speak to the GP. He was not in the surgery and there were no other GP's available at this time. On the 13th September 2013 the Consultant again tried to speak to the GP but was not able to do so. A letter was sent to Brian N, and copied to the GP, asking Brian N to make contact with the CMHT before the 27th September 2013 in order to avoid being discharged. On the 17th September 2013 the CMHT Consultant wrote to the GP surgery to let them know she had been unable to see the patient and that he had not responded to telephone messages. She also informed the GP that she had been unable to speak to anyone at the surgery despite leaving messages, and she invited the GP to contact her if he had any concerns. There was no further contact from the GP surgery.

262. There was no further contact noted until the Consultant Psychiatrist from Liaison Psychiatry at St George's hospital was asked to review Brian N after his arrest on suspicion of murder on the day following the murder in October 2013. Brian N reported he had been drinking heavily for the last 2 months, sometimes up to 200 units a week. In the days prior to the incident, he reported that he had been drinking even more than usual. He stated that the last few days had been a blur, he had split from his girlfriend. Had been hallucinating and had possibly experienced possible delirium tremors. Was also taking cocaine on occasion & abusing nitrous oxide. Brian N reported he had been depressed for about the last year

although the Consultant was unclear whether this was related to excessive alcohol use or an underlying depressive illness. There was no evidence of psychosis. There were indications of deliberate self-harm on the patients' arms. The Consultant felt Brian N was at high risk of suicide due to ongoing suicidal thoughts, estrangement from family and he reported that he did not feel he had much to live for.

Analysis

263. Analysis by the Mental Health Trust was as follows:- The Operational Policy for Community Mental Health Teams referrals fall into three categories:
Routine: All initial assessments should be offered an appointment within four weeks.
Urgent: Referrals specifically designated as urgent will be seen within one week of receipt of the referral. Emergency: Referrals that require assessment within 24 hours or assessments under the Mental Health Act. If a referral is received within office hours the person will be seen by the CMHT or in conjunction with the local Crisis and Home Treatment Team. As this was a routine referral the CMHT was obliged to offer an appointment to Brian N within 4 weeks and they complied with this requirement in each case. They also complied with their "DNA (Did Not Attend) policy and went further by offering a second appointment each time which was not required by their policy.

264. Following Brian N's presentation at St George's Hospital A&E on the 1st September 2013 a further appointment was made for him to meet with the CMHT Consultant on the 5th September. It is not clear who made this appointment for him but he did not attend. In the period between the 5th and 17th September 2013 the CMHT Consultant made 3 attempts to contact the GP by telephone but was unable to speak directly to a GP and had to leave messages. On the 17th September 2013 she wrote to the GP to inform him that the CMHT had not been able to speak to Brian N and that she had been trying to contact the surgery. This action was not required under the Trust DNA policy so should be considered as good practice on the part of the CMHT Consultant. It is not recorded that any response was received from the GP and no further contact with Brian N is recorded.

Conclusion

265. Conclusion by the Mental Health Trust was as follows:- The Mental Health Trust's conclusion was that the action of the CMHT Consultant adhered to and exceeded policy expectations and the services that were offered to Brian N were appropriate. Both Brian N and the GP were aware of how to contact the CMHT in order to prevent discharge or to raise any escalating concerns. The Mental Health Trust did not include any lessons learned from this incident and did not make any recommendations.

Comment (DHR Panel)

266. We remain unclear as to why Brian N did not have a psychiatric assessment during his attendance at A&E on 1st September 2013 because the records held by the Emergency Department (St George's Hospital) and the liaison psychiatry team (Mental Health Trust) offer different explanations. Neither agency can offer any further information on the subject over and above their records compiled at the time.

267. We addressed this discrepancy in some detail not to apportion blame but to ensure that the review process fulfils the requirement that it is seen as a learning exercise providing reassurance that services have improved across all agencies. The discrepancy between the two sets of records is of concern.

268. Nevertheless, we are clear on a number of very positive related points regarding Brian N's limited involvement with the Mental Health Trust which make it quite clear that he was not neglected by them. According to their records he self-discharged and left the building before they had an opportunity to see him. Even though the psychiatric assessment did not take place they attended A&E to see him within 20 minutes of receiving the referral. Similar fast action was noted in respect of the referral from his GP and he was offered an appointment for 16 calendar days from the receipt of the referral. In a period when the media publish details of staggeringly long NHS waiting periods this is impressive. They exceeded their normal procedures and offered him four appointments, none of which he kept. They persisted in trying to contact Brian N to offer help despite his repeated failure to answer their calls or respond to messages left on his voicemail. Finally, they also persisted unsuccessfully with attempts to engage with his GP In order to work together to get him the psychiatric help that he needed.

IMR – Metropolitan Police

269. The IMR from the Metropolitan Police Service was compiled by the Critical Incident Advisory Team SC&O 21(2) of the Specialist Crime and Operations section. The IMR contained a great deal of detail about events leading up to the tragic death of John T and this was extremely useful to us given the reluctance of the key individuals involved to cooperate with the review. The IMR provided a significant amount of background detail for this crime and this was greatly appreciated. The IMR and the analysis was thorough and comprehensive. Much of the factual content of the IMR has already been used in this report and there is nothing to be gained by repeating it.

270. The police had very minimal involvement with any of the principal figures in this case. With the exception of a dangerous driving conviction by John T none of them had any criminal record or cautions recorded on the PNC (Police National Computer).

271. Following treatment at St. George's hospital, Brian N was arrested for murder on the day following the murder at 10:45 hours. He was interviewed on two further occasions four days later and made no comment.

272. Following these two second interviews he was charged at 3:30pm at Sutton Police Station. He made no reply to caution and was remanded in custody to appear to Croydon Magistrates Court. The murder trial commenced in April 2014 at the Central Criminal Court and lasted for seven weeks. At the conclusion of the trial Brian N was unanimously found guilty of murder and sentenced to a mandatory life sentence with a minimum of a 23 year term of imprisonment. He appealed his sentence in November 2014 and the appeal was dismissed. The original sentence stood.

273. On 29th August 2013, Nora T called police at 12:28 hours stating that earlier that morning she had had an argument with her partner, Brian N. He had driven off in his car taking with him a large kitchen knife. She said he had self-harmed before and raised concerns that he may do something to himself. She had left the flat and gone to a friend's address. She did not want police to attend her friend's house. She said she would return home the following day and asked that police make contact then to arrange an appointment. When re-contacted by police Nora T said she was going to her parent's home and asked to re-arrange

the appointment for 2nd September 2013.

274. **MPS Comment:** The Wandsworth controller made comment that Nora T was to be seen sooner than the arranged 02/09/2013 as the male (Brian N) was not accounted for, neither was the knife. It appears that the risk surrounding Brian N was not fully considered, nor was the concerns raised by Nora T that he had previously self-harmed, was depressed and in possession of a knife. He should have been reported as missing, a MISPER report should have been created and enquiries progressed to locate him. When the Met Command and Control (Met CC) Supervisor tasked the Met CC operator to make further enquiries regarding Brian N, the operator followed the reporting of Domestic Abuse path but did not consider concerns that he had not been located or spoken to.

275. These issues are essentially individual learning. This has been identified as learning for the staff involved and will be dealt with locally by Met CC. There is no indication that current policies or processes are inadequate. However, the concerns have been raised with Met CC to ensure that feedback is given when training staff, to make certain that instructions are passed on clearly.

276. **MPS Recommendation 1** - BOCU CCC/Wandsworth - Missing Persons
It is recommended that staff/supervisors from Met CC and Wandsworth Grip and Pace Centre are reminded of their responsibilities and the correct processes when dealing with a potential missing or vulnerable person.

277. Despite several attempts to arrange an appointment to see Nora T, she said she was unable to speak to police until the 4th September 2013. Due to the delay a skeleton crime report was created on 4th September 2013 for a Non-Crime Domestic Incident. Note: A skeleton crime report provides limited details (from the CAD) around the incident reported. These are created to ensure that National Crime Reporting Standards (NCRS) are adhered to.

278. Primary Investigation: The initial investigation was satisfactory in terms of the information available for a skeleton report. It was created as a Non-Crime Domestic Incident - specified investigation and passed to the Community Safety Unit (CSU).

279. Secondary Investigation: The report was allocated to a Supervisor in the CSU. The issue around Brian N not being reported missing was raised with the Grip and Pace Centre. The Supervisor created a CAD for officers to attend the address and speak with both parties. Officers attended and spoke with Brian N. Nora T was not present. A Book 124D and DASH risk assessment was completed on the information provided by him.

280. Risk Assessment: The responses to the DASH risk assessment were 'no' throughout. A further 'H.A.V.E' assessment was conducted which provided information on History, Aggravating factors, Violence and Escalation. The risk was assessed as 'standard'.

281. **MPS Comment**: Of note the reporting officer made an entry stating there was no indication that any party had access to weapons. This was despite information on both CAD and CRIS that Brian N had left the address with a kitchen knife.

282. The officer noted that Brian N 'takes prescription medicine for depression and has previously had thoughts about self-harm and suicide. He is currently receiving support from

his employer. There are no SPECSS questions of note'. This is despite a specific question within the risk assessment around 'suicide' and that Brian N had slit his wrists and been admitted to hospital on 01/09/2014.

MPS Comment: The officer's assessment did not detail Nora T's perception of risk and therefore the assessment was flawed. A risk assessment should be based on the full facts of the incident. The informant/victim should always be spoken to and given the opportunity to provide responses to the DASH risk assessment. However, it must be noted that efforts were made on several occasions to speak with Nora T, but she repeatedly said she was not available. In addition there appears to have been no consideration around Brian N's vulnerability. An 'Adult Coming to Notice' report should have been created on the MERLIN system and consideration given as to whether it would have been appropriate to share the report with other services within the Multi Agency Safeguarding Hub (MASH). The omissions fall to individuals, the DASH risk assessment, if followed correctly provides an adequate and accurate assessment of risk. A MPS Explanatory Note is attached as Appendix One.:

Recommendation 2 - Wandsworth Borough - Vulnerable Adults

283. It is recommended that Wandsworth Borough officers and supervisors are reminded of the requirement to complete an 'Adult Coming to Notice' report when dealing with any incident involving a vulnerable adult.

284. Supervision: The report was supervised on two occasions, firstly by a frontline supervisor as a skeleton report at 19:05 hours on 04/09/2014. It was supervised again later that day by the CSU supervisor at 20:51 hours and an action plan created, which highlighted that there was no reference to creation of a MISPER report being created (see secondary investigation).

285. Outcome: Brian N was spoken to in person by police. Nora T did not respond to police despite repeated attempts to contact her. No further action was taken. This was the last interaction police had with any of the individuals involved in the domestic homicide, prior to John T's murder.

MPS Conclusion and Recommendations

286. The MPS only had one contact with two of the three key individuals prior to the murder and no contact with the victim, John T. The significant contact with Brian N and Nora T took place in August/September 2013. There were missed opportunities around identifying the risk Brian N posed to himself and/or others. Met CC operators and initial investigating officers focussed on reporting the domestic abuse and did not consider that he was a vulnerable missing person. In addition there was a misunderstanding on 30/08/2013 when the Met CC Supervisor tasked a Met CC Operator to make further enquiries into the boyfriend (Brian N). The Operator followed the reporting of domestic abuse path, rather than identifying the vulnerabilities surrounding Brian N being missing. This does not highlight any significant issue in the embedded processes. It has been addressed by local management / supervision and the recommendation made in paragraph 276. There was no indication from the information provided to police that Brian N posed any risk to Nora T or John T or indeed to anyone. There were no threats made, nor any suggestion that he had ever been or intended to be violent to either of them. There were clear indications of the potential for him to self-harm. Brian N should have been reported missing following initial police contact on 29/08/2014. This would have informed a holistic risk assessment. His

vulnerability should have assessed and an Adult Coming to Notice (ACN) report should have been created on MERLIN for the dissemination with the MASH. This may have led to a multi-agency response to his needs. This has been addressed in the recommendation at paragraph 283.

287. Prior to submission, this IMR was quality assured by members of the Senior Leadership Team (SLT) within the separate business groups within this organisation. It has written and agreed on behalf of the lead officer for Domestic Homicide within the MPS (Association of Chief Police Officers' (ACPO) rank), Territorial Policing SLT (responsible for Pan London Borough policing) and SCD21 (2) SCRG SLT, (responsible for the conduct of this review). The SLT for these groups are also responsible for ensuring that when recommendations are made they are acted upon and that appropriate learning and feedback is given to those involved. The responsibility for updating the outcome of any recommendations rests with the MPS ACPO lead for Domestic Abuse. In accordance with current MPS policy, this report is signed by the author on behalf of the senior managers responsible for the individual business groups above.

288. In terms of diversity issues the MPS stated that all persons mentioned in this report are of white British background. There is no information or inference in police records to indicate that any incident mentioned in this report was motivated or aggravated by, ethnicity, faith, sexual orientation, gender, linguistic or other diversity factors. Where this family had contact with police, or in any of the joint working that took place, there appears to be nothing to suggest that any diversity factors were relevant in the decision-making or how they were treated.

Comment (DHR Panel)

289. This was a very thorough management review and problems with the application of procedures were identified in an open and transparent fashion. Procedures were already in place and the weaknesses were attributable to individual performance which can be corrected by training and supervision.

290. We did have one minor concern regarding the organisation and management of national police records which we set out below. There is a tendency to assume that the PND (Police National Database) is comprehensive and a genuine complete 'national' source of information throughout the UK. We were aware that the perpetrator lived in a variety of locations over his adult life and wanted to ensure that the police information we had about him was complete. We were informed that MPS officers responding to incidents in London would not have known information in relation to any domestic incidents that did not result in a conviction (or caution) outside their force's area and would not have had the ability to search for this information. There was no trace of Brian N for any other domestic abuse incidents on the PND.

291. The MPS made contact information available to us for a number of police forces throughout the UK and we wrote to them asking for details of any involvement with Brian N. Hertfordshire Police carried out a very comprehensive search of their records and informed us that one incident of domestic abuse was recorded in relation to Brian N and his girlfriend at the time (Susan M). A neighbour complained that a row had broken out between Brian N and Susan M following him discovering her infidelity and that this was still ongoing after two days. Both parties were calm and presentable on police arrival. The incident was

categorised as low risk by the Duty Inspector. DV letters were sent to both parties.

292. We were initially surprised that this 'history' was not picked up at the time of the incident on 1st September when Brian N left the flat after an argument with his girlfriend in possession of a large kitchen knife. However, we accepted that details of this earlier domestic incident was only held by the Hertfordshire Police on their local systems and not on any system available to the MPS. If the PND had been more comprehensive and more of this "soft intelligence" held then it may have been seen as of no significance but on the other hand it may well have heightened awareness and led to greater involvement at the time. From our examination of the material made available to us there was no indication that those enquiries were made of other police authorities during the actual murder investigation to see if the perpetrator had any relevant history.

293. Because of the escalating nature of this crime we accordingly have made a recommendation that intelligence about domestic abuse and persons of interest be routinely held on the PND so that information on suspected abusers is not geographically restricted by police force boundaries.

294. Finally. Earlier in this report we commented on the decision by the families of both the victim and perpetrator no to engage in the DHR process. . This emphasised to us the need to ensure that FLOs are given specific training about DHRs and in particular how engagement by families can be beneficial both personally and organisationally. In addition, we were of the view that the families of victims of domestic abuse should be automatically referred by the police to the specialist charity AAFDA for support and guidance in much the same way as they are referred to Victim Support.

Brian N's Doctor

295. We made an appointment to interview the GP of Brian N in order to get a better understanding of his state of mental health in the six months before the murder of John T. In addition we were of the view that there were a number of unanswered questions about the doctor's perception of the seriousness and urgency of his illness.

296. Brian N was registered in a small but busy GP surgery in South London stretched across two sites. It was not practicable for him to see the same doctor on each visit and our review of his appointments showed that he had been seen by five different doctors between the time when he attended with anxiety symptoms in late Dec 2012 and the homicide of John T in October 2013. We noted that while he was seen by five different doctors in a ten month period two of these were locums. Consistency in care was therefore not available. Anecdotally we were told that this is becoming the norm across London fuelled to some degree by computerisation and the view that it doesn't matter who you see because all medical history is on the computer. This could lead to a fragmented approach but that is another topic far wider than this review.

297. Much of the detail of his consultations with the GP and the treatment have already been described a number of times in this report and there is no value in repeating it all again. We know that he sought treatment but did not always use it when it was offered. We know from the evidence of his girlfriend, Nora T, that he did not take his medication until she pressed him to do so. We know that he mixed his medication with a cocktail of cocaine,

nitrous oxide and alcohol. He was offered psychiatric help on four occasions but failed to keep any of the appointments. Under pressure from his girlfriend he did attend one session with a private psychologist but failed to attend any subsequent appointments. He had private insurance from his employer but did not take advantage of it. His employer offered consultations with a Harley Street psychiatrist but he declined the offer. The doctors at the surgery referred him for psychiatric help and he did not keep any of the appointments and this seems to have been accepted without any intervention by the GPs and we questioned the doctor about this. We had noted the comment in the Mental Health Trust IMR that there was no sense of urgency in the referral letters and raised this with the GP and were satisfied with their answers. We were also concerned about the action which followed his admission to A&E on 1st September following what was described as a failed suicide attempt. Our most worrying area of concern related to the action that was taken following the telephone call from the father of John T who expressed his concerns about Brian N's mental health and suicide tendencies.

298. In retrospect we could see that many of our concerns were based on hindsight and awareness of the terrible tragedy that followed and we accepted in many cases the rationale offered by the doctor for their approach. They saw Brian N as a patient suffering from anxiety and depression. He showed signs of self-harm and of wanting attention but suicide was seen as something he spoke of but did not give any real signs of taking it any further. Given the demands on the health service he was not seen as coming under the heading of needing urgent treatment given the response time for psychiatric amounts was relatively short – within a few weeks.

299. We asked the doctor about the admission to A&E on 1st September 2013 and the failed suicide attempt and were referred to the observation of the doctor who treated him there. The wounds were superficial and did not require serious treatment. There was little loss of blood and it was of note that Brian N was admitted to A&E three hours after he had cut himself. Brian N had admitted to the treating doctor that it was not a suicide attempt. He was discharged as not being a risk to himself. The doctor also emphasised the difficulty there was in making contact with Brian N both by the surgery staff and other medical professionals.

300. We accept that the surgery was always busy but felt that a more proactive approach to issues would increase the efficiency and effectiveness of the surgery. We noted that the Mental Health Trust had remarked on the poor level of responsiveness from the surgery whenever they tried to make contact. In the period between 5th and 17th September 2013 the CMHT consultant made three attempts to contact the surgery by telephone and was unable to speak to a GP and had to leave messages. The consultant also wrote to the surgery explaining her attempts to make contact with them. There is no record of any response being made to the messages left or letters sent. This does not seem like a satisfactory way to work with other medical professionals. Not following up missed appointment also does not seem a good use of scarce medical resources.

301. Finally, we addressed the way the telephone call from John T's father was dealt with. It appeared to us that it should have been given a greater level of priority and sense of urgency. Brian N last visited the surgery on 12th September and John T's father telephoned on 7th October to report a serious deterioration in his mental health but no action was taken until the next day when one of the doctors tried to call him unsuccessfully. A message

was left on his phone voicemail. Only one attempt was made and no further action was taken. Our impression was that they felt they had done their duty with the one attempted phone call. We questioned why it had taken so long to take any action and were told that the surgery had been very busy. This was not a satisfactory response.

302. We asked about whether anyone within the surgery had considered seeking assistance of the police and we were told that there was insufficient detail of risk to human life to warrant involving the police. They took the view that given the limited information available the police would have been reluctant to get involved.

303. It appeared to us that there was little appreciation of Brian N's potential vulnerability and insufficient sensitivity about the needs of a depressed young man who had voiced suicidal thoughts. We were also of the view that the MPS could have supported the surgery in making contact with their patient but no approach was made because the surgery had already held the assumption that the police would not have been interested without more concrete evidence that Brian N was at risk. There was no understanding that the MPS have a well thought out "vulnerability" policy designed to deal with situations like this. The patient was known to the MPS because of the concerns expressed by Nora T about his propensity to self-harm only a month earlier. We considered it highly unlikely that the MPS would not have been receptive to a request for assistance in getting help to a vulnerable patient.

304. The request for intervention by KT was not treated with the seriousness that such a request deserved. The second telephone call from John T regarding Mr MA's deterioration was given a higher level of priority and attempts were made to make contact that same day and offer an urgent same day appointment. Of course by this time it was too late and John T was already dead.

305. Guidelines on the issue of self-harm from the National Institute for Clinical Excellence (NICE) are not particularly relevant to GPs as they focus on Accident and Emergency Department procedures. The Royal College of General Practitioners recognises the need to seek out and share examples of good practice across the GP community to help fill this current gap in knowledge about self-harming.

Victim Support

306. Victim Support (VS) provides emotional support, information and practical help, over the phone or face-to-face, to help victims and witnesses of crime get the information they need to make informed choices to deal with the effects of crime.

307. In London Victim Support (VS) has a central Victim Care Unit (VCU) which handles referrals received by automatic data transfer from the Metropolitan Police Crime Reporting Information System and other police force systems. Victims can self-refer to local support offices and outreach sites, and Victim Support also accepts referrals from other agencies.

308. All cases dealt with by VS are recorded on the Case Management System (CMS) which has security clearance to impact level 3 (similar to that of CRIS used by the Metropolitan Police Service).

309. Searches were carried out of the Victim Support's Case Management Systems dating back to 2008. This system holds all cases for Victim Support in London for clients that have either been referred via automated data transfer from the Metropolitan Police, City of London Police or British Transport Police, self-referrals and referrals by other agencies. No records were found for the victim, his sister or the convicted.

310. A second search of Victim Support systems nationally was carried out on an ex-partner of the convicted – Susan M. Again no records were found fitting the criteria given for this person.

311. A further question was asked by the DHR Chair concerning written communications (a domestic violence letter) sent to both the ex-partner and the perpetrator while living in Hertfordshire querying whether this had been sent by the local police or by Victim Support. Victim Support policy nationally is currently and has always been that letters are never sent to victim of domestic violence. This does not preclude the police giving information sheets or leaflets about support in their area to victims of all crime.

312. It would appear that Victim Support had no knowledge of this victim or other parties prior to his murder. No records were found.

John T's employer

313. We made arrangements to interview the general manager of the restaurant where John T worked and his immediate line manager who was more familiar with the details of the tragedy.

314. Most of the information about John T's employment has been set out earlier in this report in support of the sections on his background and also in the Narrative. There was very little of relevance that could be derived from this information given the assumption that John T was used as a way of hurting his sister, Nora T. His behaviour or actions were not in question. We attempted to speak to his work friend that he regularly walked to the station with at the end of the working day but we were told that he had emigrated and now worked in Germany. John T was well liked in his workplace and he was seen as a keen helpful young man who was always anxious to please. He had mentioned that he was living with his sister and her boyfriend but never mentioned anything negative about the relationship or the atmosphere in the house. He never expressed any misgivings or concerns about Brian N and gave the general feeling that he got on well with him.

315. The colleagues in the workplace were very shocked by this incident and like most people involved never had the slightest inclination that anything was even faintly not right.

Brian N's Employer

316. Given the limited sources of input to this review we explored all opportunities in order to gather background information on the perpetrator, Brian N. We requested and were granted an interview with his employer which was a large London pensions company. We interviewed the Human Resources Manager and the Head of Pensions.

317. Brian N began employment with the company on 11th September 2012 as an Actuary in the

Pensions Department which was his speciality. There was no recruitment campaign and no job vacant. He had just been made redundant and sent in his CV on spec. They felt they could use someone with his background and took him on to see how it would work out. He was initially on six month probation just to monitor his work and to ensure he was suitable for the job. In March 2013 his probation was extended for a further six months as certain aspects of his work required further assessment. His attendance at work was good to begin with taking three days off in October 2012 and one further day on 17th May 2013 with what he said was Tonsillitis. He returned to work for a few days then did not come back to work from the 22nd May 2013. They received no doctor's certificates and after eight days according to their procedures they were obliged to contact the absent person.

318. They made repeated phone calls and sent emails to Brian N but received nothing back. They then began communicating with a female known as Nora T who they believed to be Brian N's girlfriend. They received letters from Nora T in relation to Brian N suffering from depression and anxiety. She also informed them that he had tried to take his own life. In view of his situation they were trying to manage it as best they could whilst being sensitive to his needs. They offered medical help, employer support service and other assistance but none of this was taken up by Brian N. They also extended this offer of support to Nora T. The company offered employees health insurance and they tried to get Brian N to take up the offer of a Harley Street psychiatrist which would have been subject to the normal medical rules of confidentiality. He did not accept the offer.

319. Brian N would often listen in when they had telephone conversations with Nora T and they were aware of this.

320. All the contact was through Nora T until, on one occasion, they had a telecom meeting with Brian N and discussed matters over the phone. He seemed keen to come back and a phased return was agreed subject to the agreement of his doctor. The meeting was initiated by Nora T informing them that Brian N should be good to come back around the end of August 2013 and a date of Monday 23rd September was agreed for him to return to work. This was initially going to be for 2 days in the first week and increasing as he settled back in.

321. He failed to turn up on the 23rd September and made no contact to inform his employer. He did turn up on the 26th September and apologised saying that he had "bottled it". It was agreed he would work the 1st, 2nd and 3rd of October the following week but again failed to turn up. During this time there was frequent contact with Nora T who was also seeking to find out if he had turned up for work. After his failure to attend in October they sent him letters informing him that they were commencing disciplinary procedures. He failed to turn up to either of the two meetings organised. In our discussions with the employer they informed us that the offer of help and support was always open to him even at this late stage. To some extent the disciplinary hearing was a catalyst to bring him to the meeting table to discuss how they could move forward but his reluctance to meet was a continual barrier to any progress.

322. Throughout his trial Brian N constantly spoke of the long hours he had to work and how his employer wanted more and more from him. We were concerned about this and raised it at our meeting with the employer. They agreed that the work could be stressful and the hours long at times but that was why the salary (even at the probationary stage) was over £80k per year. It was that type of industry. They added that Brian N did not work longer hours

than others in the company and that it was not continuous as it depended on the particularly piece of work being done at the time. We asked the employer for a copy of his timesheets so that we could see for ourselves the workload pressure that he was under. We were provided with a spreadsheet and we carried out our own analysis and this showed that on average he worked 8.27 hours per day which we did not consider to be excessive.

323. At this time Brian N was under increased financial pressure as his income was declining quite rapidly. He was earning approximately £80,000 per year and received a £2,500 bonus. From 6th July to 31st July he received half pay and from 1st August he went down to Statutory Sick Pay which was £86 per week. He received full pay for longer than he was entitled as a probationary member of staff because his employer did not want to reduce his pay and exacerbate his anxiety and depression.

324. He was not part of a regular team at work but was friendly and sociable. He mainly kept himself to himself. His work colleagues were not aware of any issues, comments or unusual behaviour in relation to him. There was a general feeling that he was a very intelligent and able young man. He completed a medical questionnaire when he started this employment and nothing of any concern was revealed. He had revealed in his court hearing that he had gone to the toilet to conceal a panic attack while at work and none of his work colleagues were aware of any of these episodes.

325. Overall we were of the opinion that Brian N was treated well by his employer. He was dealt with compassionately and nothing was done by them to exacerbate his depression or anxiety. He was offered a wide variety of support opportunities but declined these in their entirety. They maintained a dialogue with him during his absence using Nora T as an intermediary given his reluctance to engage. The company praised the high level of support she gave him during his illness which continued even when their relationship had ended.

The Samaritans

326. The Samaritans were invited to join the panel because of their expertise regarding suicide. It was felt that they could assist the panel to have a fuller understanding of the frequent references about suicidal thoughts made by the perpetrator Brian N. In addition we are aware that Brian N contacted the Samaritans direct to ask for support and was offered advice which he did not follow. This was reported at the trial and the Judge made reference to a response the court received from the Samaritans on this matter.

327. In addition we know that KT, the father of the victim got so worried about Brian N's mental state and suicidal tendencies that he phoned the Samaritans for advice. They advised him to contact Brian N's GP and make them aware of his concerns.

328. The Samaritan's response to our request to join the panel was that as confidentiality was the cornerstone of their relationship with clients they could not see what contribution their participation would achieve. They ended by saying that the Samaritans are unable to participate in this or any subsequent review of a similar nature. We replied back to them to make the point that we are interested in the expertise about suicide they could bring to the review rather than confidential information about any of their clients. We asked them to reconsider their participation and invited them to attend the DHR panel meeting but they were unable to put forward a representative.

329. We raise this issue in this review because this is not the first time we have encountered this reluctance to get involved in domestic homicide reviews and feel that a nationally acclaimed organisation such as the Samaritans should revise their approach and participate in order to increase understanding and help play a part in preventing similar tragedies happening in the future.

Analysis of the terms of reference

330. In this part of the report the terms of reference (ToR) are analysed to confirm that they have been addressed and met. The terms of reference were set at the first meeting of the panel when we had quite sparse information about the nature of the crime and the relationships involved. It was agreed that the ToRs would be evolving and would adapt as information was obtained. Initially the ToRs focused on the victim and it was agreed that where appropriate they would also encompass the perpetrator, Brian N.

331. **ToR** Examine whether information sharing and communication within and between agencies was effective and comprehensive; did it enable joint understanding and working between agencies; were all appropriate agencies including GPs and health authorities involved in the information sharing. The review will also examine the extent to which voluntary agencies were involved in supporting or advising John T and the level of information and communication between them and the public sector bodies.

332. **Analysis** There was very little involvement with the victim or perpetrator by statutory or voluntary agencies prior to the murder of John T. Neither the victim or perpetrator was known to Victim Support and therefore they had little input into this case. The police involvement with the victim was limited to a road traffic accident some years previously which had no relevance to his murder. None of the other statutory agencies had any record of involvement with the victim.

333. The only significant involvement with the perpetrator by the police related to a domestic incident in December 2009 details of which were held in the local records of the Hertfordshire police and not available to the MPS. There was no charges or cautions made following this incident but DV letters were sent to Brian N and his girlfriend at the time. Each individual police force, as the data owner, will decide what information is stored on the PND which commenced in 2010. They also individually decide the criteria for the loading of backdated records. The MPS leads, in volume terms, with the sharing of routine intelligence information with other forces via the PND.

334. The 2009 DV incident preceded the commencement of the PND and was not included on that database. If this information had been held on the PND it may have prompted a greater interest in Brian N when Nora T contacted the police regarding her concerns about his vulnerability. Given the escalating nature of this crime, the lesson that emerges here is the need to ensure that intelligence about domestic abuse is always loaded onto the PND where it can be available to police forces nationwide.

335. This case highlights certain communication weaknesses within the health agencies supporting Brian N. The GP surgery did not engage with the Mental Health Trust after it asked them to provide services to Brian N. We gained the impression that it felt their part

was done after the referral was made as no responsibility was accepted for assisting with steps to ensure Brian N kept his psychiatric appointments. There were no responses to the letters or telephone calls from the Trust.

336. We became aware that there had been monthly liaison meetings between GPs and the Mental Health Trust but these had stopped and we were unable to find out why. There is a need to explore why these monthly liaison meetings have been stopped. We accordingly have made a recommendation that they be restarted as this mechanism could, in the future, be a valuable platform where high risk patients, issues of mutual concern, training and the problem of DNAs are discussed or escalated.

337. The communication between the two health agencies based at St George's Hospital is normally of high quality but not on this occasion which appears to be an isolated deviation from the norm. Despite being based in the same building and treating the same patients they used two separate and independent record systems. Neither had access to the records of the other and this opens the way to potential confusion. One such confusion is the two different interpretations as to why Brian N was not given a psychiatric assessment. This issue of access to records needs to be addressed by the Emergency Department of St George's and the Mental Health Trust. We have no solution for them other than to make the point that incompatibility of records reduces efficiency and effectiveness.

338. **ToR** Examine whether the sharing of information was sufficient to facilitate "joined up working".

339. **Analysis** The opportunities for joint working were limited as there was limited involvement of statutory or voluntary agencies. There were some limited opportunities for joint working on a multi-agency basis but it was not always done very well. We have already mentioned the approach of the GP surgery and felt that a more proactive and inclusive approach is needed there. The steps taken by the Mental Health Trust to engage and work with the GP surgery were appropriate and constructive. The sharing of information at St George's Hospital between the Emergency Department and the Mental Health Trust did not, on this one occasion, lead to joined up working and an opportunity to engage with Brian N was lost. Early intervention by a health care professional could have been beneficial and may have halted his slide into more profound depression and anxiety.

340. The GP surgery did not share information with the MPS following the concerns expressed by the father of the victim's about Brian N's mental health because of their view that the police would not have been interested without more evidence that someone was at risk. This was over cautious and we are of the view that the concerns about vulnerable patients should have been passed to the MPS and it would have been up to them to decide whether to get involved or not.

341. **ToR** Examine whether previous "learning" from local or national cases had been acted upon.

342. **Analysis** We are not aware of any previous learning from local or national cases that are directly relevant to this case. We consulted all the voluntary and statutory agencies involved but they were unable to identify any specific learning that had been followed or missed. As learning gets embedded into policies and procedures it becomes

mainstream and loses its unique identification.

343. All the agencies involved have mechanisms in place to take on board new learning from case reviews etc. and we did not identify any weaknesses in their general aptitude or resolve to improve their service delivery.

344. **ToR** Examine the quality of the information sharing with and assistance given to John T regarding his personal safety, the options available to him and sources of support both in the statutory and voluntary sector.

345. **Analysis** Given the unique nature of this case there were no instances where there were concerns about the safety of the victim, John T. Although he was killed by his flatmate all the concerns that were raised related to self-harm by Brian N on himself and his mental condition. In this review we have highlighted the two instances where Brian N attacked his girlfriends, Susan M and Nora T. Neither of these two victims took any action regarding these assaults and the statutory agencies were not aware of them and therefore not in a position to do anything about them. The general view therefore was that Brian N was not a risk to the public but only to himself.

346. **ToR** Examine whether data protection issues or client confidentiality concerns impeded the sharing or dissemination of information.

347. **Analysis** We could not identify any instances whereby the flow of information between agencies was impeded because of concerns about data protection or client confidentiality.

348. **ToR** Examine whether there were any early warning signs of aggression, violent behaviour, homicidal or suicidal intentions and what actions followed.

349. **Analysis** None of the statutory or voluntary agencies were aware of any signs of aggression, or homicidal intentions within the relationship between Brian N and John T or between Brian N and Nora T. As already mentioned earlier he was not seen as a risk to the public.

350. He regularly voiced suicidal tendencies or intentions but often softened this with comments that he would not actually do it. One such example was when he was taken to A&E at St George's after cutting his wrists and convinced the doctor that he would not do it again and was classified as low risk. His suicidal comments were often seen as attention seeking and not taken very seriously. There is a common misconception that people who talk about suicide won't really do it and at times it seems that he was labelled in this way. Initially he was seen as a 'self harmer' but as his depression and anxiety intensified, the threat of suicide started to be taken more seriously. Viewing the evidence retrospectively it would appear that he never made any serious attempt to end his life. Even the final cutting of his wrists and the harpoon incident following the murder of John T seemed contrived.

351. We can form views about the seriousness of his intentions with hindsight but at the time he should have been seen as a person at risk. The MPS identified in their IMR that the risk surrounding Brian N was not fully considered and that the incident when he left his flat with a large kitchen knife was not handled appropriately. The correct policies and procedures

were in place but they were not followed by the officers dealing with the case in September 2013. He should have been classified as a missing and vulnerable person given his depression and previous self-harming.

352. **ToR** Examine whether the level of risk posed by the perpetrator was assessed and addressed properly; whether there was an appropriate intervention plan.

353. **Analysis** In the previous ToR above we concluded that there were no significant warning signs available to any of the agencies involved in this case regarding Brian N being a risk to others.

354. The police officers dealing with the case carried out a risk assessment which the MPS in their IMR have identified as flawed. The reporting officer made an entry on the risk assessment that there was no indication that any party had access to weapons despite the CAD and CRIS stating clearly that Brian N left his property with a large kitchen knife. In addition the risk assessment contains a specific question about suicide and this was not addressed correctly. There was no consideration of his vulnerability and this was the most significant failure of the risk assessment as it should have led to an 'Adult Coming to Notice' (ACN) report being created on the Merlin system. This in turn would have been the prompt for consideration as to sharing the report with other agencies with the MASH (Multi Agency Safeguarding Hub) facility. This could have been the trigger for full sharing of information and for a multi-agency response to his needs and it is very regrettable that this did not happen.

355. **ToR** Examine the efficacy of the risk assessment guidance of those agencies involved to evaluate whether there is a consistent and reasonably coordinated approach to risk assessment.

356. **Analysis** This was an area that we felt required further work by the agencies involved in this case as we were not completely convinced that sufficient guidance was available. The major agencies had risk assessment strategies in place and the MPS system (DASH) is particularly impressive and comprehensive but like all complex systems it is dependent on the competency of the people implementing it. The MPS has identified the need for further individual learning among some officers. The use of the risk assessment system in place in the Emergency Department at St George's Hospital for mental health risk scoring has been recommended for review. It did not seem to be truly reflective of Brian N's level of distress at the time the risk matrix was applied. The Mental Health Trust did not have the opportunity to use their risk assessment tools as Brian N was not assessed until after the killing of John T. Other than assessing Brian N for psychiatric help we are not aware that the GP had any risk tools in place to determine his vulnerability when concerns were voiced.

357. There are no apparent safeguarding adults concerns and there is evidence that individual agencies made attempts to engage with and respond to Brian N's presenting needs.

358. However, the presence of a range of needs were known to varying degrees by a number of agencies in the months preceding the incident; including self-harm and possibly suicidal behaviours, clinical depression, and disengagement with services. We did not identify anything that would give cause to suspect potential harm to others or to uncover the potential domestic abuse which remained under the radar. Communication between

agencies appeared to be fragmented and, if more coordinated, may have triggered a multi-agency risk assessment and management meeting and plan. There is no indication, however, that this would have led to prediction or prevention of the incident.

359. **ToR** Examine whether equality and diversity issues were considered appropriately by all the agencies involved in this case.

360. **Analysis** The DHR panel had diversity considerations as an integral part of their scrutiny and deliberations at all times throughout the course of this review. We had in mind all equality and diversity issues to see if they had any bearing on how any of the main figures in this case were treated by any of the agencies (statutory or voluntary) that they had contacted with. We also had these considerations in mind in terms of how the review was explained and conducted and the outcomes disseminated.

361. All persons mentioned in this report are of white British background and there were no communication factors that impacted on the ability to communicate or understand events. There was no information or inference in agency records to indicate that any incident mentioned in this report was motivated or aggravated by, ethnicity, faith, sexual orientation, gender, linguistic or other diversity factors. From our perspective there appeared to be nothing to suggest that any diversity factors were relevant in the decision-making or how they were treated.

362. Brian N was identified as having mental health problems and we were satisfied that these needs were addressed professionally and with consideration and that it was his decision not to take up the many offers of help.

363. **ToR** Examine whether all the agencies involved had policies, procedures and training relating to domestic abuse that were publicised and fit for purpose.

364. **Analysis** Domestic Abuse was a significant factor in this case but it was not evident to any of the statutory or voluntary agencies involved with the victim or perpetrator. We have identified this abuse earlier in the report as emotional and psychological starting as displaced aggression which then developing to direct physical and verbal assault. The two victims of the abuse both terminated the relationship when it became physical abuse but did not bring this to the attention of any statutory or voluntary agencies. We did not identify any warning signs that these agencies overlooked or may have missed. There were therefore no instances where domestic abuse procedures would have been triggered. All the agencies did confirm that domestic abuse policies and procedures were in place should they be needed.

365. **ToR** Review the care and treatment, including risk assessment and risk management of Brian N in relation to his primary and secondary mental health care if he was found to have a mental health background.

366. **Analysis** Brian N did have mental health needs and while these were initially identified and help offered this never evolved into the provision of care because of his unwillingness to engage. Earlier in this report we set out the many offers of help that were made to him from the Mental Health Trust and his employer and how he did not accept these offers or provide any explanation for his reluctance to cooperate.

367. He tried initially to deal with his mental health needs without medication but later requested prescription drugs from his GP. We learnt from his girlfriend that he neglected to take this medication that he had requested unless she was there to pressurise him to do so. We also learnt that when he did take the medication he also mixed it with a cocktail of cocaine, alcohol and nitrous oxide. He did attend one session with a private psychologist but did not keep any of the further appointments that had been arranged.

368. His mental health needs remained untreated and grew increasingly worse with time. We did feel that his GP could have been more proactive in trying to get him to keep the appointments with the consultant from the Mental Health Trust. Contact with the GP surgery by the Mental Health Trust appeared to be ignored and we considered this to be very regrettable as this interaction could have led to a concerted joint plan to get the appropriate treatment to Brian N.

369. We made contact with a number of local surgeries in the Wandsworth area to try and get a feel for the response that should or would typically be given in this type of scenario. The feedback was that there was no specific training for GPs on mental health related issues and no agreed approach for assessing vulnerability. Many GPs feel ill prepared. With cases that are more clearly high risk the escalation process to get help from the police or mental health specialists is relatively straightforward. With low to medium risk cases the way forward is less clear and approaches will vary. We felt that this may, if an accurate reflection of the situation, highlight a learning need and a gap that needs to be closed with further training for GPs.

370. In terms of the lack of response to the letters from the consultant psychiatrist to the Brian N's surgery the GPs consulted were sympathetic but making the point that they have a huge daily postbag that time constraints means that there is currently little scope for re-evaluating cases of this nature. Earlier, we set out our intention to make a recommendation to reinstate the regular liaison meetings between GPs and the Mental Health Trust and this is in our view the suitable vehicle to establish an effective and resilient communication system between these two agencies.

371. **ToR** Examine whether professionals working with the victim (or perpetrator) had proper supervision and control.

372. **Analysis** We found that policies and procedures were in place but they were not always followed correctly by the individuals implementing them. In this context, the issue of supervision is seen as important. We asked all the agencies involved in this case to provide information regarding the supervision and control mechanisms in place when they dealt with the victim or perpetrator. The feedback from the agencies was that they were satisfied that adequate and appropriate supervision was in place at the relevant times and that no weaknesses were identified in this area. There was some identified deviation from procedures which can be addressed by individual learning. Training was seen as the appropriate solution rather than a level of micromanagement that would be impractical.

373. **ToR** Examine whether the publicity on the availability of domestic abuse support services (statutory and voluntary) was satisfactory.

374. **Analysis** Domestic abuse was relevant in this case but it was not evident. All the

agencies involved had domestic abuse publicity available. Generally, there appears to be a need for greater awareness of coercive control and all its manifestations. We identified the initial method of perpetrating domestic abuse in this case as indirect or displaced aggression which is not so widely known or publicised. Where it is seen it is often misrepresented as a need for anger management. We took the view that this manifestation of domestic abuse needs more prominence in order to be properly recognised and its detrimental effect on victims to be properly appreciated. It is a form of manipulation and control and needs to be seen as such. This case demonstrates how easily a perpetrator can move from indirect to direct aggression and the fatal consequences that can follow.

375. **ToR** Seek the involvement of the family, employers, neighbours & friends to provide a robust analysis of the events.

376. **Analysis** We have explained at great length in this report the steps we took to engage with the family and friends. We were unsuccessful. They all wanted to move on and put the past behind them. We fully respected their wishes and ended all contact. We do feel that there are benefits from friends and family involvement and engagement can be quite therapeutic particularly in ensuring that a similar tragedy does not happen to another innocent victim. With this in mind we have recommended that victim's families be put in contact with the charity Advocacy After Fatal Domestic Abuse (AAFDA) which has a great deal of expertise in helping bereaved families with the DHR process. We also recommended that FLOs, as our first point of contact with the families of victims, should have specific training about DHRs and how families can help the reviewers see the tragedy through the eyes of the victim, their family and friends and therefore help them to make the best recommendations.

377. **ToR** Take account of any criminal proceedings and coroners' inquest in terms of timing and contact with the family and/or the family of the alleged perpetrator.

378. **Analysis** This review was initially delayed because it was not seen to meet the criteria for a domestic homicide review. After clarification from the Home Office it was passed to the Community Safety Partnership with a recommendation that a DHR should be carried out. We paused the timing of the review at the request of MPS in order not to compromise the appeal proceedings. There was further delay because of the lack of engagement by family and friends.

379. **ToR** Produce a report which summarises the chronology of the events, including the actions of involved agencies, analyses and comments on the actions taken and makes any required recommendations regarding safeguarding of families and children where domestic abuse is a feature.

380. **Analysis** This report setting out the events that led to this terrible tragedy together with background information on the relationships involved and an analysis of the involvement of statutory and voluntary agencies. Recommendations from the individual agencies are set out within together with the DHR panel's recommendations.

381. **ToR** Seek to establish whether the events in October 2013 could have been predicted, prevented or the likelihood of it happening could have been reduced.

382. **Analysis** After reviewing all the evidence in this case the panel reached the conclusion that the tragic death of John T in October 2013 could neither have been predicted nor prevented nor could the likelihood of it happening been reduced.

383. We established that there were no warning signs which would have indicated to the agencies what was going to transpire and the agencies could not have predicted nor prevented what happened. We did not identify any responses by the agencies that if done differently would have prevented this tragedy.

Conclusions and key learning

384. The tragic events of October 2013, could not have been predicted or prevented. We could also not identify any actions or inventions that if done differently could have prevented or predicted this tragedy. The MPS, NHS, Mental Health Trust and the GP surgery were the agencies involved in this case and we found that they followed their policies and procedures (with the exception of some minor deviations and the need for some individual re-learning) and behaved appropriately.

385. The DHR reviewed and analysed the information available and drew a number of conclusions and identified key learning which is set out below.

386. The perpetrator, Brian N was controlling and manipulative. When he could not get his own way in his relationships he hurt those who he perceived had hurt him. We learnt of many instances where he broke or destroyed items of value belonging to his victims. We described this method of perpetuating this abuse as displaced aggression which involves taking out frustrations, feelings, and impulses on people or objects that are less threatening. Two of his significant girlfriends related how this damage to their personal possessions was the general pattern when they lived with him. With each girlfriend he moved from this indirect aggression to verbal aggression and then to a physical attack and they both ended the relationship at this point. In the case of the last girlfriend he hurt her by killing her only brother that she had a close and loving relationship with.

387. He had mental health problems but psychiatrists, post incident, concluded that these did not lead to the killing of John T. They instead pointed to his negative personality traits as a more appropriate cause.

388. Domestic abuse of the kind explained early was at the heart of this case. The significance of damage or destruction of personal possessions can be dangerously underestimated and often trivialised as bullying or as requiring anger management. The fact that it can escalate to full blown violence can be overlooked. It is controlling and manipulative behaviour and our conclusion was that its profile as a dangerous form of domestic abuse needs to be raised. This heightened awareness needs to be publicised in a sophisticated and convincing way so that does not give the impression that the significance of a pair of broken sunglasses is drastically overstated. The emphasis needs to be on the importance of it when it becomes a pattern of abuse.

389. Brian N did not attend the psychiatric appointments following referral and apart from this being a serious waste of expensive resources the GP surgery do not appear to have seen it as an indirect responsibility of theirs to try and encourage him to attend. The telephone call

to the surgery by the victim's father asking for help because of Brian N's deteriorating condition was not treated with the seriousness it deserved. Both these examples show a shortfall in the quality of patient care.

390. The quality of police records held on the PND were a cause for concern and we were of the view that domestic abuse intelligence where it has not reached the stage of caution or conviction should routinely be loaded on to the PND for access by police forces nationwide rather than just held locally. This would seem a sensible approach given the escalating nature of this crime.

391. The MPS systems and procedures stand out as high quality and comprehensive but as they themselves have pointed out that these are only as good as their application and the level of supervision applied. The flawed risk assessment they identified highlighted the need for effective training and checks that the procedures are being implemented as intended. If this assessment had been carried out correctly it could potentially have triggered a need for a multi-agency case review and the sharing of information which may have had consequences for the future course of events.

392. During the course of this review we identified that within the same hospital two services dealing with the same patients using different computer systems and neither service had access to the records of the other. Earlier in this report we set out that Brian N did not have a psychiatric assessment at the hospital and we were presented with two different accounts of why that happened. This was a missed opportunity to determine his mental capacity, his willingness to remain for further (psychosocial) assessment, his level of distress and the possible presence of mental illness. With hindsight, had it occurred, it may potentially have altered the future pattern of events. Leaving hindsight aside we know that there was nothing at the time to indicate that Brian N was a serious risk either to himself or to others. It simply seemed to us that co-ordinated accessible patient records would be more efficient and effective than two separate records and we ask the two services concerned to explore this issue with a view to improved record keeping.

Recommendations

393. Recommendations relating to specific service issues are detailed within each contributing organisation's individual management review and will be included in the action plan for these services. Where appropriate contributing organisations and agencies have accepted identified shortfalls and have made recommendations to correct and improve their service provision or organisational behaviour.

394. **Recommendation One** The College of Policing to issue guidance to ensure that intelligence about domestic abuse is routinely held on the PND so that information on suspected abusers is not geographically restricted by police force boundaries.

395. **Recommendation Two** The Home Office to consider that the profile of controlling behaviour expressed through displaced aggression be raised to increase the understanding and awareness of the methods and forms of control and manipulation used by domestic abusers.

396. **Recommendation Three** Regular bipartite meetings between GPs and the

Mental Health Trust in Wandsworth be reinstated. We ask that GP awareness of mental health issues is addressed.

397. **Recommendation Four** St George's Hospital Emergency Department and the SW London & St. George's Mental Health Team NHS Trust based at St George's Hospital to explore sharing of records and/or common access to records.

398. **Recommendation Five** Police Family Liaison Officers be given training on Domestic Homicide Reviews and on victim and perpetrator family engagement with the process.

399. **Recommendation Six** Families of victims of domestic homicides to be routinely referred to AAFDA (Advocacy After Fatal Domestic Abuse) or other similar suitably qualified service for help and support.

400. **Recommendation Seven** Wandsworth Children's Services Department in conjunction with St George's Emergency Department to review why a self-harm referral is not held on their record systems and to take appropriate steps to ensure that self-harm referrals are properly recorded.

Appendix One

MPS Explanatory Note: The ACN (Adult Coming to Notice) framework was rolled out in the MPS in April 2013. The MPS Vulnerability Assessment Framework (VAF) is a simple investigative approach to assessing vulnerability. In all interactions the police have with the public it should be applied, regardless of whether someone is a victim, witness or suspect. Its principles provide an ongoing process that should be repeatedly used throughout the period of time the individual is interacting with police. Increasingly cases have come to the attention of the MPS where the vulnerability of an individual has not been identified and appropriately responded to by the MPS and police are now being held accountable for inaction, inappropriate action or being asked to account for action that has been taken. The VAF will enable information to be recorded in a formalised process, and as a narrative on the appropriate database, allowing risk identification, providing accountability and ensuring appropriate referral pathways to partners at the earliest opportunity.

The VAF (Vulnerability Assessment Framework) is developing a methodology that enables the police to identify, record and react quickly to vulnerability, identify immediate police action that is required and appropriately refer on to other agencies when they have responsibility. It provides a narrative of how the police are interacting and enables data to be collated as to how much time is spent dealing with such incidents and enables patterns to be picked up.

Early identification and referral will reduce crime, reduce repeat victimisation and the amount of time officers spend dealing with those that are vulnerable as appropriate referrals will enable earlier intervention from partners preventing matters reaching crisis point.

MPS Definition of vulnerability:- Vulnerability may result from an environmental or individual's circumstance or behaviour indicating there may be a risk to that person or another. Those who come to notice of police as vulnerable will require an appropriate protective safeguarding response. Additional factors to vulnerability may include mental health, disability, age or illness and should include appropriate multi-agency intervention especially in cases of repeat victimisation.' The definition captures the concept of the overarching need to properly identify vulnerability as a starting point, whether as victim, witness, suspect or another member of the public, and the identification of risk. It supports recommendations by the Independent Commission for Mental Health and Policing, recommendations outlined in the MOPAC Policing Plan, as well as the move towards 'Protecting Vulnerable People (PVP) strand of business in MetChange. It enables appropriate investigative and referral pathways to be identified and enhances existing partnership procedures to protect both children and adults. Use of this definition will encourage officers to utilise updated MERLIN systems to record and share concerns appropriately, timely and more effectively. On 11/11/2014 the MPS Vulnerability and Protection of Adults at Risk Toolkit was introduced. This covers Initial Investigation, Initial Supervision, Secondary Investigation and Secondary Supervision. They are accompanied by a Questions and Answers section that expands on details within the toolkits. These are all available via the intranet within Policy Pages. The toolkits are easy to follow, contain clear direction about what are mandatory requirements and are easier to adapt/respond to Organisational Learning recommendations.