DOMESTIC HOMICIDE REVIEW

Birmingham Community Safety Partnership

Anthony Wills
August 2013

Domestic Homicide Review – GH
Birmingham Community Safety Partnership

Executive Summary

Outline of the incident

1. EF is a man in his early 30s, who had known and significant mental health issues at the time of the murder of his father, GH (aged 56), which took place at his father's residence in Small Heath, Birmingham.

2. EF's main residence until February 2011 was in Hammersmith and Fulham. Thereafter short periods were spent in a bail hostel in Lewisham, in custody, in temporary accommodation provided by LBHF Council, then finally with EF's sister until two weeks before GH's death. During this period, EF was the subject of various interventions including mental health assessments.

3. In September 2011, EF was giving his family cause for concern and his father, who was separated from his mother, came to Hammersmith and Fulham to collect EF and bring him to Birmingham where EF was living for two weeks before he assaulted his father on 25.9.11 to the extent that GH died of his injuries in hospital on 6.10.11.

4. A murder investigation was initiated in Birmingham and EF pleaded guilty to manslaughter by virtue of diminished responsibility and on 15.11.12 EF was sentenced to a Hospital Order and a Restriction Order to be 'detained without limit of time.'

The review process

5. After the death, Birmingham Community Safety Partnership (BCSP) was notified and conducted a thorough scoping of local agencies, which revealed that neither the victim nor perpetrator had any contact with Birmingham agencies. However, further scoping by the Metropolitan Police revealed that the perpetrator had significant contact in London and the London Borough of Hammersmith and Fulham (LBHF) in particular.

6. On 7.2.12, BCSP questioned the Home Office about the requirement to undertake a DHR in such circumstances as there appeared to be no potential for learning specific lessons locally.

Discussions concluded on 20.07.12 with BCSP being encouraged to undertake the DHR in liaison with the Borough that had had the significant involvement.

7. Hammersmith and Fulham Community Safety Unit were contacted and Standing Together Against Domestic Violence (STADV) assisted in the local scoping of agencies in that Borough. This scoping concluded with no response from local agencies, beyond that which the Metropolitan Police had previously provided. West London Mental Health Trust (WLMHT) advised BCSP on 27.9.12 that they were conducting a separate serious incident review (SIR) (homicide) and that this had been led by an independent chair and was multi-agency in nature. Some months elapsed whilst permissions were sought from WLMHT to share the review with BCSP who delayed in proceeding with a DHR in anticipation that this review may satisfy the requirements of the DHR process.

8. This Review was shared with BCSP, with the permission of all organisations participating in the review, on 27.11.12 and considered at the meeting of Birmingham DHR Steering Group (DHRSG) on 18.12.12. The Steering Group concluded that the SIR did not satisfy the requirements of a DHR and that a DHR would need to be undertaken, albeit that much groundwork had been done and some key recommendations for WLMHT had been agreed and were being implemented through an Action Plan.

9. The DHR was therefore commenced outside of the timeframe normally required within the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews [2011] and the Home Office have been advised accordingly.

10. As EF was living in London with connections to LBHF and there was no contact with any agencies in Birmingham in the months and years before GH's death, BCSP requested a Domestic Violence Homicide Review (DHR) be conducted and appointed Anthony Wills from Standing Together Against Domestic Violence to chair a DHR based in LBHF. The initial meeting was held on 2nd April 2013 to consider the circumstances leading up to this death.

11. The DHRSG in Birmingham specifically sought greater clarity and analysis of the involvement of other agencies; of wider agencies' knowledge and involvement with the family and of opportunities for the future in strengthening multi-agency working. The DHRSG considered much of the work of reviewing had already been done through WLMHT SIR. However, additional analysis was required in order to meet the DHR requirements particularly:

- a formal analysis of involvement from wider agencies;

- a feeding in of other agencies service reviews, such as CNWL Prison In-Reach Service;
- an attempt to view the world through the eyes of the victim and other family members;
- a monitorable multi-agency action plan; and
- lessons to be learnt for other areas, particularly where persons of risk are known to move across service area boundaries.

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

13. The purpose of these reviews is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result
- Apply those lessons to service responses including changes to policies and procedures as appropriate
- Prevent domestic homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working

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

Terms of Reference

15. The full terms of reference are included at Appendix 1. The essence of this review is to establish how well the agencies worked both independently and together and to examine what lessons can be learnt for the future.

Methodology

16. The approach adopted was to seek Individual Management Reviews (IMRs) for all organisations and agencies that had contact with EF or GH. It was also considered helpful to involve those agencies that could have had a bearing on the circumstances of this case, even if they had not been previously aware of the individuals involved.

17. Contact with family and friends has been attempted and is discussed further below.

18. Once the IMRs had been provided, panel members were invited to review them all individually and debate the contents at three subsequent panel meetings (on 2nd July, 5th August and 20th September 2013). This became an iterative process where further questions and issues were then explored. This report is the product of that process. It would be fair to say that due to the fact that much previous work had been competed in this case, and because of subsequent complexities within agency activity, the process of discovering the facts and their subsequent analysis has proven challenging. The panel believe, however, that this report is now more complete for that effort.

Independence

19. The independent chair of the DHR is Anthony Wills, an ex-Borough Commander in the Metropolitan Police, and Chief Executive of Standing Together Against Domestic Violence (STADV) an organisation dedicated to developing and delivering a coordinated response to domestic violence through multi-agency partnerships. He has no connection with the city of Birmingham. BCSP are confident that despite STADV's links with LBHF, Anthony Wills is not involved in the management of the local strategic partnership or practice and is able to maintain independence throughout this review process.

Parallel Reviews

20. The WLMHT Serious Incident Review undertaken in this case liaised with the GP, Probation Service, Police, Housing, SLaM and CNWL In-Reach prison services and is understood to have shared their findings with the Strategic Health Authority. It is not a publishable report. The family had spoken with the Panel Chair during Review and the family were considering a meeting with the Panel but this had been delayed whilst criminal proceedings concluded. As time has elapsed, this may now have changed. The Panel Chair made arrangements to share the report with the family.

21. A service review was undertaken by CNWL Prison In-Reach Service.

Contact with family and friends

22. GH has a number of surviving family members, including his ex-wife, daughter and sons. Despite many and varied attempts to contact GH's family, the chair of the panel was not able to speak to any of his family as part of this review. Efforts through Victim Support, local police, West Midlands Police, LBHF Family Services and via letters have all proved fruitless. This is potentially due to time passed since GH's death and additional issues within the

family dynamic which are not necessary for inclusion in this report. It was not possible to identify any friends who could have added value to this review.

23. The perpetrator has not been interviewed to date and is unlikely to be due to the nature of his incarceration and significant mental health issues.

Summary of the case

24. GH was Somalian and moved to the UK in 1990, shortly before the civil war broke out. He was joined in the UK by his family three years later. The family lived in Hammersmith and it is reported that GH separated from his wife two years following their reunion. His son described his father regularly using khat.[1]

25. The date of GH's move to Birmingham is unknown but he is thought to have worked as a community support officer in the city. He was a private tenant in that city and his only contact with agencies was in respect of housing benefit claims and routine health appointments.

26. EF was born in Southern Somalia and came to the UK with his family to join his father in 1992. He attended primary and secondary schools in Hammersmith and started study at Middlesex University, which he did not conclude. He lived in the family home until aged 23 when he moved to Southampton, working in casual jobs for a period of five years. He continued to be registered with the GP in Southampton until the homicide subject to this review.

27. In respect of previous known incidents of violence, EF was convicted of actual bodily harm in 1998 at the age of 14 and suspected of a serious incident against a female in 2003. On 19.02.11 he was arrested for causing a disturbance at the family home, released without charge and on 20.02.11 (the next day) he was arrested and charged following additional assaults on his mother and younger brother with whom he had been living in Hammersmith.

[1] Khat is a leafy green plant containing 2 main stimulants. Their main effects are similar to, but less powerful than, amphetamine (Speed). Stimulants speed up your mind and body. Khat is mostly used in Africa, but it is becoming more common in Europe. Khat has recently been made a Class C drug and is now illegal in the UK. Khat can make pre-existing mental health problems worse and can cause paranoid and psychotic reactions (which may be associated with irritability, anxiety and losing touch with reality). Information taken from www.talktofrank.com.

28. After this series of charges EF was provided with accommodation at a Lewisham Bail Hostel and in May 2011, the Probation Officer referred him to secondary mental health services where he was treated for depression.

29. On 30.05.11, EF was charged and held in custody at Wormwood Scrubs for criminal damage at the bail hostel where he had set alight to the kitchen and barricaded himself in the building, trapping other residents. On 29.06.11 EF was convicted of all outstanding charges and sentenced to four months imprisonment with an anticipated release date of 29.07.11 which became, in time, his actual release date. While at Wormwood Scrubs, EF was seen by the Prison InReach Team[2] for two months.

30. Between May and September 2011, EF had two Mental Health Act assessments, on 31.05.11 and 05.09.11. On both occasions he was found not to be detainable under the Mental Health Act. Following the second assessment he was waiting further follow up by the assessment service in Hammersmith and Fulham but failed to attend a follow up appointment on 16.09.11. From May through to September, the Serious Incident Review chronology details a heightened intensity of agency involvement between West London Mental Health Trust (WLMHT), South London and Maudsley NHS Foundation Trust (SLaM), London Borough of Hammersmith and Fulham Housing, the Metropolitan Police, the Probation Service and the Prison In-Reach Service whilst he was in Wormwood Scrubs.

31. EF was released from custody on 29.07.11 and placed in temporary accommodation by LBHF Council, where he remained until moving in with his sister on or about 30.08.11. His mental health care was transferred to WLMHT but he was taken to live with his father in Birmingham at some point in early to mid-September 2011 as his family in London were no longer able to care for EF due to fears for their safety.

32. Two weeks later, Ambulance and Police responded to a call from EF on 25.09.11 and discovered his father, GH, with stab wounds to his abdomen and severe injury to his ear. GH died in hospital from injuries sustained on 6.10.11. EF was charged with murder following a

[2] HMP Wormwood Scrubs is a category B male prison which has an operational capacity of 1,281 male prisoners and is usually considered to be at full capacity. The throughput of prisoners passing through the prison is very high, with approximately 400 new prisoners per month. The Mental Health Inreach Team provides a service for men with acute, severe and enduring mental health needs and aims to provide a service of the same standard and quality as is provided to the general public in any other NHS setting. The team provide prompt and specialised assessments of patients. Routine referrals are seen within 5 working days unless urgent when they are seen within 24 hours. Emergency referrals are seen as soon as possible but within a maximum timeframe of 4 hours. The multidisciplinary team is led by a full-time Consultant Psychiatrist. There is also a speciality doctor, psychologist, team leader and 5 community psychiatric nurses. There is administrative support for the team.

mental health assessment which found him fit to plead, convicted of manslaughter and sentenced on 15.11.12 when he was made subject to a hospital order and 'detained without limit of time'

33. The terms of reference specifically seek information about EF and GH from 1st January 2004 but to assist this DHR some earlier information is included, particularly about EF's criminal record (see Metropolitan Police section below) and Family Services' involvement with the wider family (See section below).

Key issues arising from the review

34. EF is a 33 year old man with significant mental health and moderate substance misuse issues, which were known to a variety of organisations at the time he killed his father, GH.

35. In the last 6 months of GH's life, EF had significant contact from a variety of agencies including the Police, WLMHT, SLaM, CNWL Prison InReach, Probation and LBHF Housing Options, due to a series of criminal incidents including criminal damage, common assault and breach of the peace. The assault on his mother and brother in February 2011 instigated a series of events that led to EF becoming homeless, incarcerated and in receipt of two Mental Health Assessments.

Areas of Practice to Highlight in relation to the above:

1. **Missed opportunities (or delays) to share information**
2. **Missed opportunities to offer support to EF and his family regarding EF's mental health and substance misuse needs**
3. **Missed opportunities for multi-agency coordination and referral to MAPPA**
4. **Missed opportunities to demonstrate full understanding of the dynamics of domestic violence including:**
    - **Lack of robust risk assessment procedures and referrals to MARAC**
    - **Lack of adherence to policies/procedures**
5. **General procedural issues and failure to effectively manage risk to the public**

Missed opportunities (or delays) to share information and for multi-agency coordination

36. Lack of full Information sharing between London Probation Trust and LBHF Housing Options: This review process recognised that had EF's probation officer disclosed full information to LBHF Housing regarding the incident of fire starting in the bail hostel on

31.05.11, they may not have not accommodated EF due to the potential risk he posed to other residents in a multi-occupancy dwelling.

37. Upon receipt of this information had Housing decided not to accommodate EF, there would have been sufficient time prior to his release in July for alternative housing arrangements to have been considered. Linked to this is the wider issue about a lack of suitable accommodation for people who pose a high risk of harm to others. There are no specialist resources for such individuals available to housing. This review questions whether EF's specific needs could have been met in more suitable provision and who has access to such provision, if it exists.

38. It is worth noting that there are potential issues around over-reliance on email communication between agencies throughout this case, but in particular between Probation and Housing. At times, language used in emails did not reflect the severity of the case and could be considered inappropriate.

39. Lack of information regarding who was responsible for EF's care within the NHS: The fact that EF was still registered at the Nicholstown Surgery in Southampton, proved to be problematic during the period from February – August 2011 in terms of understanding which NHS trust had responsibility for his care and treatment, including financial accountability. EF's GP records would have only been required to be forwarded once he registered at a new local practice, which he did not do.

40. Because EF was last registered with a GP in Southampton, had lived for several years with his mother in Hammersmith and Fulham and had been bailed to a temporary address in Lewisham, during the period 04.05 -29.06.11, the Probation Officer spent a considerable amount of time liaising with three separate Mental Health Trusts in order to identify a doctor to take responsibility for EF's treatment in the community. In order to expedite matters, the Probation Officer went over and beyond his role by securing a verbal agreement from Hampshire Mental Health Trust on 23.06.11 to take interim responsibility for EF so that he could be sentenced.

41. It should also be noted that EF's case had to be adjourned by the Court on three separate occasions on 12th May, 2nd June, 23rd June 2011 because a section 12 doctor had not been identified to take responsibility for his treatment.

42. Housing and hostel failure to understand and mitigate the risk posed by EF and share information with mental health services: A few days before the second fire setting incident, there was an altercation between EF and another resident at the hotel in which EF threatened to throw boiling water over a resident and in turn he was threatened with a hammer. Police were not called as the hotel manager diffused the situation. Housing were informed of this incident the following day and housing staff were asked to issue warning letters to both residents, in line with normal practice. Mental health services should have been informed bearing in mind EF's growing mental problems.

43. General issue with requests to Police regarding EF's criminal history: This review has highlighted that there are procedural issues about how organisations including SLaM, Family Services and Housing request information regarding criminal history from the Police.

Missed opportunities for multi-agency coordination and referral to MAPPA

44. Lack of referral to MAPPA: EF's profile indicated a number of Static and Dynamic Risk Factors, which were known to Police and should have formed the basis of a referral to MAPPA. Police and Probation are two of the three Responsible Authorities and could have referred EF to MAPPA. The responsibility for referral rested with the 'lead' agency, which changed throughout EF's timeline of incidents.

45. Had a referral been made to MAPPA, information held by all responsible agencies including National Health Service, HandF Mental Health, HandF Adult Social Care, London Probation and HandF Housing would have been shared. This would have led to the full picture of EF and the risks to his family being unravelled. Dynamic Risk Assessments could have been completed and comprehensive risk management plans put in place. As EF was not managed by any offender managers in the Metropolitan Police, therefore, there was not a handover to West Midlands Police and EF was not managed (or even known to be) there.

46. Gaps in Information sharing relating to Probation's lack of MAPPA referral: The probation officer based in Lewisham has confirmed that he did not refer to the Lewisham MAPPA during April-June 2011 as he did not have sufficient information.

47. Failure to convene a multi-agency strategy meeting from February-September 2011, but particularly in September: EF was referred to HandF Adult Social Care by police on 02.09.11. Although this information was shared by means of a Merlin, the information was not assessed, acted upon or followed up. Furthermore, police did not request any information in return from Adult Social Care. Consideration could have been given at this

point to convening a strategy meeting with relevant agencies. Had a strategy meeting taken place, information could have been shared and collated. A plan of action could then have been prepared to locate EF, identify the possible risks, review the attributed level of risk and manage the risks posed. The lack of a consistent 'lead' agency in this case impacted the way information was shared and thus on interventions and support offered to EF.

Missed opportunities to offer support to EF and his family regarding EF's mental health and substance misuse needs

48. Safeguarding concerns for EF's sister and her children: On 05.09.11 EF presented to HandF Housing Options as homeless but he was not accommodated due to the fire incident at the hotel. He also had a mental health assessment on this day as well, but was not sectioned or hospitalised. EF disclosed to both the housing officer and the mental health professional that he was staying with his sister at the time. Despite the fact that his sister had children, neither the housing officer nor the mental health professional identified the need to make a safeguarding referral on the basis of potential risks to the children. Additionally, neither organisation undertook a full risk assessment in relation to domestic violence between EF and his sister, despite EF's history and the fact that EF expressed hostility towards his sister during the mental health assessment and indicated that 'while he loved her he may become violent towards her.' This should have flagged as a potential risk to professionals. No consideration appears to have been given to exposing his sister and her family to alcohol and khat use. Additionally, no consideration appears to have been given to whether EF's history of fire setting in his family home and in two multiple occupancy settings with vulnerable people would put his sister's family at risk. This exposed the family to unacceptable levels of risk.

49. Addressing violence within the wider family and professional responses: Family Services records indicate that there is a history of violence within this family: EF's mother reported domestic violence in her marital relationship, EF was charged with ABH, allegations were made of older siblings being incited to act violently by EF's mother, several of the siblings have a known (police) history of violence, violence by siblings towards EF's sister, etc. The evidence suggests that this is not a family who welcomed outside intervention from Family Services and experienced violence as a part of their family life. Family services have identified their limited capacity, as individuals and as a family unit, to recognise risk.

50. There could have been a referral made by social services to the main local specialist service provider, ADVANCE (or other specialist services, albeit these were very limited at the time) as a result of EF's mother's request for assistance for domestic violence in 1997 and again

in 2011 as a result of the domestic violence incident between EF and his mother. In 1997, this could have resulted in a risk management and safety plan and joint work with children's services to support the mother and any children involved and affected by domestic violence. In 2011, ADVANCE could have offered support to EF's mother, which would have included support from the point of reporting the incident and through the court process. However ADVANCE have no record of referrals being made.

51. Substance misuse support: From the reports available, it appears that the only discussion with EF regarding seeking support for his substance misuse with local substance misuse services, was on 05.09.11 with Hammersmith and Fulham assessment centre. There were at least seven other missed opportunities for discussion by professionals regarding EF's substance misuse and the local services available to him; however his engagement would have been voluntary. If substance misuse services had been notified of the case, joint working could have taken place and a drug and alcohol worker could have attended at an appointment with other services to complete assessment.

Missed opportunities to demonstrate full understanding of the dynamics of domestic violence.

Issues with formal risk assessment processes and lack of referral to MARAC

52. By Probation: The Probation Officer assessed EF as posing a medium risk of serious harm towards his mother based on the information available to him at the time (police list of previous convictions, Crown Prosecution papers and information received through safeguarding checks with social care). Details of un-convicted behaviour and police intelligence were not made available to Probation.

53. Probation's lack of MARAC referral: The probation officer advised that based on the *partial* information made available to him by the police and social care in relation to EF's mother and family there were no grounds in his opinion to refer her to the MARAC in Hammersmith and Fulham. Therefore, the officer assessed EF as posing a medium risk of serious harm towards his mother based on the information contained in the Crown Prosecution Papers for the offences committed in the family home on 20.02.11.

54. By Police: It is not known whether SPECCS+[3] or DASH 2009 was used to complete the Risk Assessment in responding to the first incident of domestic violence between EF and his mother on 19.02.11. The investigation officer confirmed the Primary Risk Assessment as

[3] SPECCS+ is a heightened factors risk assessment (Separation/child contact, Pregnancy/new birth, Escalation, Cultural awareness, Stalking, Sexual Assault) and DASH 2009 (Domestic Abuse, Stalking and harassment and Honour Based Violence) is another national risk assessment tool.

'standard'. It is unclear as to whether a Secondary Risk Assessment was completed in full or whether the initial Risk Assessment was merely endorsed. Given that the Risk Assessment was 'standard', there was no obligation for a Secondary Risk Assessment to be completed. This reduced the opportunity to consider whether or not to refer the case to MARAC on the basis of a professional judgement that the risk was high.

55. Relating to the incident on 19.02.11, the book 124D[4] and the initial entry on CRIS (the Metropolitan Police crime reporting information system) were reviewed by a uniformed Police Sergeant (PS) and the Primary Risk Assessment of 'standard' confirmed. The investigation was allocated to a secondary investigator in the CSU. The case was not referred to the Multi Agency Risk Assessment Conferencing (MARAC), due to the threshold of 'high' risk not having been met.

56. For the incident on 20.02.11, a book 124D was completed along with a Heightened Factors Risk Assessment SPECCS+ / DASH 2009, which was recorded as 'medium', which indicated an escalation of risk compared to the assessment completed on 19.02.11. There is no record of a Secondary Risk Assessment being conducted, in line with MPS policy. Given EF's sudden escalation of violent behaviour (in a 24 hour period), remarks threatening to kill family members, a previous conviction for ABH (on a pregnant female), status as a named suspect for a historic allegation of a serious incident involving a female and his determination to return home, a Secondary Risk Assessment along with risk management and emergency planning should have been completed and documented. A review of these facts coupled with the professional judgement of a specialist from the CSU would have ensured full consideration was given to whether or not to raise the level of risk to 'high' and refer the case to MARAC for a multi-agency approach to safety and risk management. It also remains an issue that the threats to kill were left off and not charged as a separate criminal offence.

57. In view of all the circumstances a grade of 'high' was more appropriate on this occasion. A review, followed by supervision would have allowed officers to deliberate as to whether or not it was necessary to raise the risk from 'medium' to 'high' on the basis of escalation, visible risks and / or professional judgement. A 'high' grading would have resulted in consideration of a referral to MARAC. Had such a referral been made to MARAC,

[4] Book 124D is key to ensuring that initial investigating officers are dealing with incidents effectively in relation to the investigation, risk identification and assessment, as well as early evidence gathering to support subsequent prosecutions. Effective early intervention at the point of initial investigation will prevent escalation and repeat victimisation. The booklet will be completed at all incidents falling within the definition of domestic violence, whether identified as a crime or non-crime incident. Incidents that fall outside of the ACPO definition but have obvious implications in relation to risk and repeat victimisation, and are likely to come under the remit of the Community Safety Unit (CSU), should also be recorded in book 124D to ensure that appropriate risk management takes place and sufficient detail is obtained to allow the CSU to intervene effectively.

information held by other agencies including Social Services, Probation, Health, Housing and the Independent Domestic Violence Advocate, could have been shared and a clearer understanding of the risks posed appreciated.

Lack of adherence to policies/procedures and Issues with the Police's investigation of domestic violence incidents in February 2011

58. A statement was taken from EF's mother regarding the first and second incidents, however EF's brother did not substantiate the allegation and declined to provide a written account. The subsequent CRIS report recorded that photographs were not taken despite the fact that EF's brother had "*reddening to his right eye*" and *"treatment declined as injuries only minor*". EF's mother's remarks in relation to, "*hiding kitchen knives" / being in fear of "what he might do*" and her expectation that EF would return to the family home to collect his belongings, were not explored, risk assessed or risk managed during the custody Pre Release Risk Assessment (PRRA). Police could have made arrangements to attend the family home to prevent a breach of the peace when EF collected his belongings.

59. On 20.02.11, at 11:55 AM (an hour after EF's release from Hammersmith and Fulham Police Station in relation to the incident on 19.02.11), police received an emergency call from EF's brother from his mother's address. He reported that EF had smashed the door down with a hammer, was inside the house smashing it up and was threatening to kill them all. No record was made of the initial remarks of EF's brother, who reported that EF was "*threatening to kill*" them all. The threat was not explored, risk assessed, risk managed, investigated or brought to the attention of an Inspector, in accordance with the MPS Threats to Life Policy. The reason for not recording the remarks or following procedures is not known.

60. Procedural Issues with Court Process: As the case was correctly initially heard in the Specialist Domestic Violence Court (SDVC) within the WLMC, at this point, EF's mother could have had the opportunity to have been referred to another specialist service for support through the criminal justice process. There was a court Independent Domestic violence Advisor (IDVA) in place, however EF's mother was not an ADVANCE client as they have no record of EF's mother. Additionally it is unclear why the sentencing was moved to another court and not heard within the SDVC (preventing the court coordinator at STADV from recording case outcome).

61. Procedural issues regarding 2003 Serious Incident regarding a female: This allegation was correctly recorded in line with the Home Office Counting Rules. Policies and procedures in

place at the time of the incident were followed in relation to initial actions (immediate response) and evidence gathering. However, correct procedure was not apparently pursued in connection to the Primary Response phase for allegations of this kind. Police action was frustrated by the victim's reluctance to proceed with the investigation, through fear of reprisal action by the suspect. EF was identified as a potential suspect from telephone records however his identity was never confirmed through identification procedures. He was not given an opportunity to prove or disprove his involvement in an interview. Furthermore, the investigation failed to link him to the mobile phone, to the victim or to the scene. Despite this and in contravention of Home Office Counting Rule D4, EF was shown as responsible for the serious incident against a female and the matter shown as Detected / Cleared Up. EF has therefore been identified as a suspect without him having had the opportunity to clear his name.

62. This issue raises concern in its own right around the following of Home Office procedures, proportionality of actions and the protection of EF's human rights. There is also the issue of the victim's knowledge of subsequent events and whether she should be informed of both the concerns about process and this review. Concerns also exist because of the lack of action taken by police following the identification of potential risk. Once a decision was reached to show EF as responsible for the serious incident against a female, officers had a duty to complete a Community Concern Assessment and consider convening a 'Gold' Strategy Meeting. The purpose being to assess the impact of the incident on Public Safety and to ensure the effectiveness of the police response. These actions were not completed and the risks posed were not adequately identified, recorded, assessed, reviewed, managed or supervised. Since this incident, policies and procedures have been overhauled and professionalised (Standard Operating Procedures, Item 4, Notices 25/10, 16 June 2010) along with the introduction of specialist investigative units, referred to as Operation Sapphire. Community Impact Assessments, investigative reviews, supervision, risk assessment and risk management are now embedded processes. It is unlikely that the same outcome would result if a similar matter were reported today.

63. Upon further exploration of the above allegation by Commander Christine Jones, there is no record whatsoever of a CRB check or a check under the new Disclosure and Disbarring Service (DBS) being made in respect of EF. Thus EF's employment prospects were not in any way affected by the recording of his name as a suspect for this incident. Further, Commander Jones confirmed that even if there had been such a check, the historic allegation made against him would NOT have been disclosed as it does not amount to an

investigative finding. However, had EF been arrested for the allegation, this could have potentially triggered a referral to MAPPA at some point in his interaction with Police.

64. As a result of this DHR, the Metropolitan Police are now examining 'cleared up' crime allegations of this nature to ascertain how suspect details have been recorded. The practice discovered in this case is unacceptable and does not accord with the principles of cleared up crime - particularly as EF was never actively assessed as a suspect in this case. To this end, Deputy Assistant Commissioner Martin Hewitt is overseeing a broad review to establish whether other instances of such recording have taken place - and if so to deal appropriately with any that are identified.

General procedural issues and failure to effectively manage risk to the public

65. Procedural issues with charging decisions and risk management regarding incidents of fire starting: The result of the investigation of the incident at the bail hostel on 30.05.11 was that EF was charged with 'Criminal Damage to a dwelling (under £5000). No mention was made in relation to the occupants being present inside the address and having to be rescued by police and the LFB at the time of the incident, the level of violence used or the fear suffered by the victims. The remark by EF at the scene where he stated he would "*burn the house down with everyone inside*" was sufficient evidence of intention to consider a charge of Attempted Arson, bearing in mind the continued risk he posed.

66. For the incident on 30.08.11 in the hotel in W12, EF was arrested by police for breach of the peace. No CRIS report was recorded, no Primary or Secondary Investigation was conducted, no research was completed, no referral made to the CID, no Risk Assessment carried out, no risk management plans prepared, no supervision or review conducted. The incident took place in a hotel occupied by other residents. Police actions in this case were inadequate and not in line with policy. Consideration should have been given to recording the incident as a case of attempted arson with intent to endanger life or criminal damage by fire or attempted arson.

67. The justification provided for EF's arrest differed from the information recorded on the call to police. The reasons for this are unknown and are a cause for concern. This was the second time EF had come to police notice for setting a fire in a multi-occupancy address. Despite the fact that only his property was damaged, this matter should have been recorded as a crime. Had intelligence checks been completed, the previous criminal damage by fire would have been identified along with EF's full previous criminal and mental health history. (Due to

the incident on 31.05.11, additional warning markers of Mental Health and Self Harm had been added to PNC).

68. Procedural issues with Police and SLaM regarding EF's mental health assessment in May 2011: EF was assessed by a health care professional (HCP) on six separate occasions whilst in custody following the fire starting incident on 31.05.11. Ultimately he was not sectioned and due to the length of time he had been held in custody, EF was charged and remanded in custody. During this assessment process, professionals were not in agreement as all but the final AMHP who dealt with EF were under the impression that he would be sectioned.

69. The police requested a second mental health act assessment but this was refused. Many professionals recommended hospitalisation for EF but the AMHP decided against it (based on the belief that EF's presentation was more social then mental health/risk indicated). However, it remains unclear how much the issues of bed availability and financial responsibility were factored in to the AMHP"s decision.

70. The custody team worked quickly to prevent a challenge of unlawful detention. There was no time to refer the case to an Evidence Review Officer (ERO) or the CPS. The Duty Officer (overseeing prolonged detention) relied upon the classification provided by the CID of 'simple' criminal damage. A more appropriate charge would have been attempted arson with intent to endanger life or attempted arson.

71. It has been agreed by the panel that the AMHP who decided against hospitalisation at this time, despite EF agreeing to be admitted as an inpatient voluntarily did not act appropriately on this occasion. At the time this report, SLaM remain involved in a disciplinary process for the professional involved.

72. Procedural issues regarding lack of missing persons' report (including in relationship to missed opportunities for multi-agency working and risk assessment): EF should have been reported as missing on 02.09.11 when the Public Protection Desk were informed by the Claybrook Assessment Centre that EF's location was not known and he had missed a Mental Health Assessment. His circumstances fit the Association of Chief Police Officers (ACPO) definition of a missing person and he presented a 'high' risk of harm to himself and others. He should have been circulated immediately as wanted/missing on the PNC and a Merlin entry created. The information reported to police was sufficient to justify recording EF as a missing person. Research would have identified EF's full criminal / forensic history and

the escalation in risk posed by him. His status as 'missing' could then have been circulated nationally on PNC. No intelligence report (a CrimInt) was completed or Metropolitan Police Service Briefing and Tasking System (MetBaTs) briefing distributed. As a result officers were not tasked to locate EF who was effectively a vulnerable missing person.

73. Research would have identified the escalation in violence, the increased risks associated to arson, his vulnerability and his mental health issues. Police had access on their databases to his next of kin. Basic enquiries with his mother would have revealed EF's move to Birmingham to live with his father, GH. This information could have been shared with West Midlands Police, the Claybrook Assessment Centre, Social Services and other interested agencies. Consideration could then have been given to convening a Level 3 MAPPA meeting, a Gold Group Meeting or an Adult Care Strategy Meeting. The matter could also have been reviewed as a Critical Incident.

74. Procedural issue with information recording within HandF Housing: Some emails on the housing file are not recorded properly and this was problematic when following an accurate trail or knowing the exact date and time, sender and recipient of emails.

75. Procedural issues within Prison InReach: Not all the activity by EF's main nurse and the Mental Health In-reach Team concerning EF were adequately documented in his electronic patient record (SystmOne). Although the Mental Health In-reach Team had contact with Hammersmith and Fulham Assessment Service, there is no evidence that arrangements were made to conduct a joint pre-release meeting. The Mental Health In-reach Specialty Doctor prescribed medication to EF but there is no evidence that he was seen or assessed by a doctor in psychiatry. The Mental Health In-reach Team appeared unclear about the involvement of two community services in EF's care and did not receive confirmation about who was responsible for his care in the community. Contributory factors for these issues include: that there was no consistent involvement from a single care provider in the community, no CPA care planning whilst he was in custody and EF was released from prison without notice.

Procedural Issues within SLaM and WLMHT

76. This was subject of significant investigation and review in the earlier SIR, which led to other actioned recommendations, practice and policy change, which are documented in Appendix 5.

77. The SIR review panel considered the events surrounding EF's care and treatment and identified three Care Delivery Problems (CDP's) and one Service Delivery Problem (SDP). CDPs are problems relating to direct provision of care, while SDPs are problems identified during the analysis of an incident, which are associated with the way a service is delivered and the decisions, procedures and systems that are part of the whole process of service delivery. The CDPs and the SDP identified within that review are outlined below so that all issues identified with this case are captured in this DHR.

78. Care Delivery Problem (CDP) 1: EF was found guilty of Manslaughter of his father on the grounds of diminished responsibility whilst in receipt of services from WLMHT.

79. Similar to the findings of the DHR panel, the SIR panel's view was that EF's mental illness posed serious risk to the public and that a number of opportunities to provide him with effective mental health services were missed. The SIR panel were particularly concerned that the recommendations from the Consultant Forensic Psychiatrist (SLaM) following a comprehensive assessment were not followed up effectively. As stated above, the SIR panel believed this was partly due to the ongoing discussions about LA's entitlement to services within Hammersmith and Fulham.

80. Additionally, the SIR panel were extremely concerned that the two examples of fire setting (in May and August 2011) were not dealt with seriously enough in the interest of public safety. At his assessment on the 5th September 2011 EF indicated that he had burnt the family house down in Somalia when he was 8 years old. To further emphasise this significant risk to others the SIR panel learnt that following their father's death EF's sister reported to WLMHT services that she had been frightened that he may set a fire in her family home, putting herself, unborn child and children at risk.

81. The SIR panel did not understand why the accumulation and seriousness of risks indicated by his fire setting did not appear to be recognised or influence treatment decisions in the assessments on either the 31st May or 5th September 2011. At this stage it was clearly identifiable that there was a significant risk to the public. The outcome of the assessment on the 5th September 2011 may have been influenced by the fact that EF self-presented requesting support with housing and his presentation being affected by his substance use. In SIR panel's view the professionals undertaking the assessments on the 31st May and 5t september 2011, were not clear about the extent to which EF was mentally ill and the extent to which he was possibly manipulating the system. This was evident with the Doctors being unclear as to why he was not admitted on the 31st May 2011, despite a joint medical

recommendation being completed. This was also evident on the 5th September 2011 where although the view was his problems were mainly caused by his substance misuse, medication was prescribed as recommended by the Consultant Forensic Psychiatrist (SLaM). In the SIR panel's view a period of assessment in hospital may have assisted in clarifying this issue.

82. CDP 2: EF was not admitted to hospital on the 31.05.11. The SIR panel were not persuaded by the AMHP's reasons for not admitting EF in view of his presentation, medical recommendations and level of risk. There was a lack of thorough recording by the SLaM AMHP of his assessment and the lack of availability of a social circumstance report, which is standard practice. While the panel was clear that the decision as to whether a section should go ahead is the responsibility of the AMPH, they were concerned that this decision was a missed opportunity for him to be assessed and treated. In the panel's view this decision may have been influenced by bed availability and the decision of WLMHT not to offer a hospital bed. The decision not to admit on this occasion and subsequently on the 5th September 2011 may have been influenced by perceptions as to whether EF was mentally ill.

83. In the Mental Health Act assessments on the 31.05.11 and 05.09.11, and in the Judges' summing up on the 29.06.12 there were questions as to whether EF was using mental illness as an excuse for his criminal behaviour, to gain accommodation and for not taking responsibility for his actions. The SIR panel's view is that while there was evidence that his alcohol and khat consumption may have masked symptoms the assessment and recommendations of the Consultant Forensic Psychiatrist were carefully thought through and offered an alternative and possibly a more accurate formulation of diagnosis and risk. This was a missed opportunity to admit EF for an assessment, which may have provided more accurate information. The SIR panel heard while he was in prison (presumably without access to alcohol and khat) EF continued to put cotton wool in his ears to mask the voices, indicating that he had a mental illness.

84. CDP 3: EF's care plan following his MHA assessment on 05.09.11 was not appropriate for his treatment needs or level of risk.

85. Following the assessment on 05.09.11, the Team Manager for the HandF Assessment Team expressed surprise that EF had not been admitted and at the team meeting the following day an additional appointment was recommended. Whilst fully recognising the independence of the AMPH role it is unclear why the levels of concerns of professionals indicated in his medical records and informed to the SIR panel did not appear to have influenced the

decision as to whether to admit to hospital. The SIR panel strongly believe that this was a further missed opportunity to undertake a full assessment as recommended by the Consultant Forensic Psychiatrist.

86. Following EF's Mental Health Act assessment, EF informed professionals that he would be staying with his sister locally. Her address was not recorded until 08.09.11, which left an unacceptable risk of losing EF from services again. Following the assessment the SIR panel learnt that an additional appointment for EF to be reviewed had been made and attempts to contact his sister by telephone had also been made. These factors suggested to the SIR panel that there were concerns about EF's risks within the HandF Assessment team. It was of significant concern to the panel that although the team had an address (from 08.09.11) they made no attempt to visit EF at his sister's home, even after he did not attend his appointment on 16.09.11. It is the SIR panel's view that a home visit would have provided opportunities to assess the suitability of this residency for him and to assess the risk to his sister's family. This risk was further emphasised when the panel learnt that following his father's death his sister reported to WLMHT services that she had been frightened that he may set a fire in her family home, putting herself, her unborn child and her children at risk.

87. Although the HandF Assessment team had been concerned about EF for a number of months this does not appear to have influenced the outcome of the assessment on 05.09.11. The panel noted that professionals undertaking the assessment may not have given sufficient consideration to the information that was available to them. In the SIR panel's view this preparation could easily have taken place as the assessment was carried out at the team base were EF's medical records including the Consultant Forensic Psychiatrist's report was easily accessible.

88. In the SIR panel's view the HandF Assessment team did not have a clear plan of EF's treatment in the community and did not understand why the following issues were not considered in more depth:

- If the team had discussed their plans with EF's sister they may have learnt of her concerns of the risk he posed to her and her children. This may have alerted them to the precarious situation of EF residing with his sister and her children given his history of expressed violent thoughts, mental illness and substance misuse. This information may have influenced the decision making process.
- Had the team discussed their plans with his sister and the family in general they could have shared the risks of non-compliance with medication.
- If the follow-up plan had been described in more detail and following discussion with his family the team may have considered his suitability for additional community

based services.

- In the panel's view the treatment plan was not consistent with the recent escalation of noted concerns and EF was allowed to go to an unknown address with limited follow up plans.

89. When EF stated that he would be living with his sister and her family there was no record of a discussion as to whether the sister's house was a suitable place for him to stay or that issues pertaining to the family's safety received any consideration. EF had been convicted of assault on his mother and had a restraining order in place. During the assessment process EF expressed hostility towards his sister and indicated that while he loved her he may become violent towards her. This should have flagged up potential risk to the professionals. No consideration appears to have been given to exposing his sister and her family to alcohol and khat use. In the panels view all professionals should understand the dangers of exposing children to people whose substance use is causing such difficulties to their lives.

90. Additionally no consideration appears to have been given to whether his history of fire setting in his family home and in two multiple occupancy settings with vulnerable people would put his sister's family at risk. In the panel's view this exposed the family to wholly unacceptable levels of risk.

91. SDP 1: There was a lack of effective systems to proactively manage EF in the HandF assessment service from 27.05.11 to the date of the incident (25.09.11).

92. Decision making issues (prioritising and systematically following up high risk patients): Following the request for the HandF services to provide services to EF there were 10 days of deliberation as to whether he had residency and access to the mental health services in HandF. Following an acceptance on 23.05.11 an appointment was offered on 27.05.11, which EF did not attend. On 31.05.11 WLMHT, including the HandF Assessment team again disputed his eligibility. In the SIR panel's view it was a missed opportunity to offer him a bed enabling him to have a fuller assessment.

93. While EF was in prison, the SIR panel felt that there should have been more attempts made by both the HandF team and In-Reach team at Wormwood Scrubs to assess EF, undertake a joint CPA and develop significant opportunity which is compounded by the fact that the teams were aware that EF was to be released to services in HandF on 29.07.11. While EF was in prison the HandF Assessment team facilitated a referral for a WLMHT Forensic assessment, the result of this referral was a refusal to provide services again as a result of a dispute about his residency and who would pay for this referral/assessment. The outcome of

this referral went to an unmanned email account and was not picked up for one month by the team. This suggested to the panel a serious lack of systems for following up important forensic referrals. The panel heard that the staff member knew that there were problems of emails going to this account and were surprised and disappointed that this significant risk EF's safety had not been dealt with.

94. The team were aware that EF would be coming out of prison on 29.07.11; they did not however, make any attempts to contact him until 08.08.11. On 08.08.11 they offered him an assessment for 18.08.11, the panel considered that the delays of almost three weeks between him leaving prison and being offered an appointment a significant risk to the public. EF did not attend his appointment on 18.08.11 and on 23.08.11 was offered an appointment for the 31st August, and again the panel found this delay was unacceptable. This is of particular concern as the hotel manager had indicated his anxiety about EF's mental health and behaviour. In the SIR panel's view the assessment service as a minimum should have visited the patient at the hotel.

95. Between May 2011 and September 2011 it is evident that the HandF Assessment team manager had raised questions on a number of occasions as to what was happening to EF. These requests resulted in limited flurries of administrative activity. In the SIR panel's view this time could have been used to follow up EF in more proactive ways.

96. During the review the panel became aware of the extremely high levels of referrals the assessment team receive. While the panel understand the challenges of prioritising work, EF had a forensic referral and criminal history. The panel were concerned at the lack of effective systems in the team to prioritise and follow up high risk patients of this nature. The panel were referred to the HandF Assessment team operational policy, which states that the team only become clinically responsible for the patient when they have been seen. Whilst understanding this, the panel believed that team members should have used their expert clinical judgement to ensure that this high risk patient was proactively followed up. It is of concern that the operational policy seems to have been rigidly applied in this case. Information provided to the panel by the senior clinician of the assessment service was that EF was 'theirs'.

97. During the period that EF was being referred to WLMHT, Consultant Psychiatrist input to the service was part time. The panel heard that as a direct result of this and other cases the medical support into the assessment service has been strengthened to provide clear Consultant Psychiatrist led clinical leadership to the team.

Conclusions

98. What is shown within the IMRs and through discussions within the DHR panel is that communication and information sharing amongst the agencies involved with EF could have been much improved. The DHR panel generally agreed that had one or more of the agencies involved raised concerns about this case and in particular, utilised opportunities to refer EF to a multi-agency forum such as MAPPA or MARAC, inter-agency discussions, better outcomes, interventions and support for EF and his family might have occurred (especially in the context of EF's escalating mental health and substance misuse issues). There is no doubt that referral to a MARAC or MAPPA would have been appropriate.

99. There are also a number of occasions when information was not shared or collected at all and/or done only partially, which led to delays in service delivery, issues with risk assessment and missed opportunities to offer support to EF and his family. There are also issues with the way information was communicated, including a potential over-reliance on electronic communication rather than professionals speaking to one another directly or via a group strategic meeting.

100. Furthermore, the DHR process highlighted a range of missed opportunities within agencies to demonstrate a robust response to domestic violence, including issues with risk assessment procedures and adherence to standard policies and procedures. Finally, general practice issues were identified alongside failures to effectively manage risk to the public.

Equality and diversity

101. The nine protected characteristics as defined by the Equality Act of 2010 have all been considered within this review. They are: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation. The panel highlighted that race/ethnicity and mental health (disability) potentially played a role in the circumstances of this case.

102. Race/Ethnicity: All family members in the case are Somali by background. There seems to be some indication in professionals' notes (Family Services, WLMHT and SLaM) that according to EF, domestic violence was tolerated in the family context. The nature of this belief was not explored to establish if this represented a symptom of his illness or a personal belief. We advise caution in this instance as it remains unclear why this was not explored or challenged by a variety of professionals and we query the potential that this may be due to

an acceptance (and therefore condoning) of a cultural or religious stigma about the normalisation of violence in certain communities.

103. Disability/Mental Health: Many of the professionals involved in this case were aware of EF's mental health history. It appears that the extent of EF's mental health issues in relation to the risk he posed in the community and to his family were underestimated or not properly understood by the professionals he dealt with. During the two MHAs EF had in the six months leading up to killing his father, two mental health professionals (in the LBHF Assessment Team in September and the AHMP at SLaM in May) indicated that despite historic and forensic evidence, they believed EF was 'playing the mental health card' to gain access to accommodation. This could indicate that EF's mental health issues, potentially exacerbated by substance misuse, were not taken seriously or given adequate risk assessments, which impacted on the care and support EF received This also impacted upon the potential for safeguarding his family which appear to have been insufficiently considered.

104. It is evident that EF's mental health was deteriorating over the six months prior to his father's death and that a number of agencies were aware of this and attempted to offer EF support.

105. Despite these interventions, which occurred alongside a degree of communication amongst the organisations involved, a complete understanding of risk was not facilitated within a multi-agency context, especially regarding EF's historic and current mental health and substance misuse issues and their impact on risk to himself, his family and the general public.

Preventability

106. If one or more of the following actions had been carried out appropriately, GH's death may have been prevented:

- The May or September mental health assessments could have resulted in EF being hospitalised in order for his condition to be monitored and treated effectively;
- If EF had received appropriate housing based on his level of support need and risk posed to the public and his family;
- If the risk to the public, but especially to EF's family, had been robustly assessed, understood and responded to effectively; and
- Information regarding risk was shared in multi-agency settings such as MARAC, MAPPA and Adult Social Care and collectively addressed

107. When the issue of preventability is considered more clearly the concerns expressed in the preceding paragraph indicate that this death could have been prevented if EF had received the help he needed, especially if information-sharing structures had been effectively instituted. Overall, the processes and procedures which could have made a difference to EF's situation and reduced the risk to, and increased the safety of EF's family and especially GH, were available to professionals during these events. It was the failure to utilise them effectively and jointly that contributed to GH's death. Had EF been appropriately supported, it is unlikely he would have had to move out of London, where his family were no longer able to manage the risk he posed and care for him themselves, in order to live with his father in Birmingham. EF would not have been living with his father whom he killed within two weeks of moving, largely as a result of his untreated mental health issues.

108. This case highlights the collective failure of agencies to ascertain and respond to EF's needs and the risk he posed, which left him effectively homeless and in a vulnerable and unsupported position. It is to be hoped that the recommendations contained in this report will make such an event in the future much less likely.

Recommendations

109. Some of the agencies involved in this DHR process had identified changes to their internal processes and approaches, especially via WLMHT's serious incident review process (for which there is a separate action plan in progress). For completeness these are shown below.

SIR Parallel Recommendations

110. A summary of recommended actions as identified through the SIR process is as follows:

1. **SLaM:** Decisions at MHA assessments must be clearly recorded and uploaded into patients medical records

2. **WLMHT:** The principles of the London Mental Health Trusts transfer of care protocol (1991) should be reinforced to staff. Clinical need should be prioritised over other factors such as residency.

3. **SLaM/WLMHT:** The Approved Mental Health Practitioner should, when appropriate, prepare available information and ensure that it is shared with Section 12 Doctors and this process should be clearly documented. This sharing of information must be regularly emphasised.

4. **WLMHT:** The HandF assessment team need to urgently undergo refresher training on the following: Risk assessment and prioritisation; Safeguarding children and adults; Responsibilities around assertive management. These refresher training must then be monitored by ongoing competency frameworks.

5. **WLMHT** must ensure that the systems in the HandF Assessment service for following up high risk patients are strengthened in the following ways:

    i. Develop, implement and monitor a pre assessment system to identify those patients who are high risk, as seen in this incident;

    ii. Develop, implement and monitor a management system which enables accurate tracking of high risk individuals (as seen in this incident) on a daily basis

6. **WLMHT:** Local services staff need to review the email activity in the following areas:

    i. All Trust staff must use the agreed Trust email accounts. Those staff that have dual email accounts must develop a system to ensure they are accessed to prevent any clinical risk.

    ii. The panel noted that the Trust email accounts currently 'drop' names off when they are sent or forwarded. Although this did not cause any specific problems in this case, the lack of visible audit trail potentially leaves the Trust exposed to risk. Therefore the panel would recommend that the Trust review this.

7. **WLMHT:** Consider how WLMHT and CNWL Prison In-Reach interface when patients/potential patients are in custody to ensure effective assessment and aftercare planning.

8. **CNWL:** The panel note that CNWL Prison In-Reach undertook a review of their services following the initial notification of this incident and as a result they have strengthened the recording of health records in recognition of gaps identified in this case. The panel recommend that this improvement is audited within a 6 month period.

111. See attached Action Plan for information on progress of these recommendations under Appendix 4.

CNWL Service Review:

112. A summary of recommended actions as identified through the CNWL Review process is as follows:

1. To discuss in team meetings the importance of documentation in the clinical record.

2. CNWL Care Records Standards Policy March 2012 is to be reviewed by Mental Health InReach Team members.

3. Conduct Audit of CPA compliance as per Prison KPIs.

4. **Follow through on arrangements for shared learning via:**

    i. Discussions at Care Quality Meetings

ii. Discussions at staff meetings
iii. Discussions during individual supervision

113. See attached Action Plan for information on progress of these recommendations under Appendix 5.

The Metropolitan Police Service

114. A summary of Police recommendations as identified through the DHR process is as follows:

Recommendation 1 – Service Level

115. It is recommended that the MPS update the CRIS System to remove the out of date SPECCS+ Risk Assessment System and replace with the new DASH 2009 Risk Assessment Model. *(Note: This is a repeat recommendation from other reviews which has been allocated to an ACPO lead for assessment of feasibility for implementation.)*

Recommendation 2 – Service Level

116. It is recommended that the MPS review and amend Domestic Violence Standard Operating Procedures to ensure that all cases of Domestic Violence receive a Secondary Risk Assessment by a Specialist from the Community Safety Unit. *(Note: This is a repeat recommendation from other reviews which has been allocated to an ACPO lead for assessment of feasibility for implementation.)*

Recommendation 3 – Service Level

117. It is recommended that the MPS reviews and amends the Domestic Violence Standard Operating Procedures to ensure the mandatory review of both primary and Secondary Risk Assessments by a Supervisor from the Community Safety Unit to ensure that the appropriate level of Risk has been attributed and Risk Management plans initiated where necessary.

Recommendation 4 – Service Level

118. It is recommended that the MPS update the CAD System to ensure that a 'Special Message Format' is created whenever there is Threat to Life to ensure the mandatory recording of the Inspector/ Detective inspector Informed, the recording of the relevant CRIS / CrimInt reference number (even where the risk identified is 'Minimal' to ensure MPS Policy and Procedures are followed) and grading of the risk (High / Medium / Standard).

Recommendation 5 – Service Level

119. It is recommended that the MPS review and amend Domestic Violence Standard Operating Procedures to make it compulsory when conducting research that it is not restricted to five

years and to check the following data bases: Integrated Information Platform (IIP) / CRIS, CrimInt, CAD, NSPIS, PNC, MERLIN and Police National Database (PND).

Recommendation 6 – Service Level

120. It is recommended that the MPS review and amend Domestic Violence Standard Operating Procedures in relation to the recording of Information and Intelligence to: Ensure that systems are developed to profile 'Domestic Abusers' by recording their Risk Assessments on their CrimInt Nominal Profile to enable easy retrieval and identification of escalation.

Recommendation 7 – Service Level

121. It is recommended that the MPS update the CRIS System to create mandatory fields similar to those used for 'Primary Investigation Details', An obligatory 'Risk Tab' and 'Drop Down' should be created to select relevant Topic / Offence. Selection of a risk topic should result in a creation of a compulsory screen which lists the Factors to be considered. I.e. when the 'DV Tab' is selected, the screen should prompt the DASH 2009 Risk Assessment Questions, Secondary Risk Assessment, the Risk Management Tool RARA (Remove / Avoid / Reduce Accept) and an Emergency Planning 'Toolkit'. This screen should not be closed until considered by the Initial Reporting Officer, Investigating Officer and Supervisor. I.e. When the 'Threat to Life Tab is selected, the screen should prompt, the Factors to be considered (Capability, Likelihood, Opportunity, Identification - Suspect / Witness / Scene), the outcome of the Risk Assessment, Risk Reduction - RARA and details of the Inspector / Detective inspector Informed. This Toolkit could be developed to address all cases requiring risk management.

Recommendation 8 – Service Level

122. It is recommended that the MPS review NSPIS Policies and Procedures in relation to Mental Health Assessments. A new Form should be created which requires the Mental Health Team to document their decisions and action plans in writing in relation to assessments and patient care.

Recommendation 9

123. The Medical Director (Forensic Healthcare Services and MPS Emerald Custody Directorate), to be provided with a copy of this report to allow consideration of practice within custody areas and potential further learning for the MPS and NHS.

DHR Panel Recommendations

124. The following recommendations are based on what should happen now, beyond what has taken place. It is to the credit of the agencies involved that they have taken action to remedy the problems discovered during this process. However if the likelihood of further incidents of this type are to be avoided additional activity is necessary.

125. The action plan is shown at Appendix 6 and incorporates all Recommendations.

Recommendation 10 – National Level

126. The Home Office should consider refining a process for the transfer of high risk offenders from one locality to another in order to ensure risk is assessed and managed properly.

Recommendation 11 – Service level

127. In order to undertake a thorough risk assessment on offenders at the Pre Sentence Report stage, Probation Service must seek relevant intelligence from the Police when requesting an up to date list of previous convictions, which includes behaviour that has caused or threatened serious harm. Probation officers need to improve their understanding of how requests for police intelligence on criminal history should be made so that the MPS can give the correct information needed to complete relevant and accurate Pre Sentence Reports.

Recommendation 12

128. Management within the Hammersmith and Fulham assessment team within WLMHT must accept the findings of this DHR and the consequent lack of exploration of the risks connected to domestic violence. Relevant and appropriate training must be delivered for WLMHT professionals to better understand domestic violence, including in a familial setting, and risk assessment, safety planning and prioritisation of such cases.

Recommendation 13

129. More robust information sharing mechanisms are established with Mental Health services, Probation and Police to ensure that effective risk management takes place. When Probation staff or other relevant agency has any concerns in relation to obtaining information on offenders or when case progression is faltering, a professionals meeting should be called. Procedures to enact a joined up, problem solving approach should be considered.

Recommendation 14

130. LBHF Housing Options and Single Persons Team to undertake an audit of its record keeping, including how emails are properly stored and file notes better created.

Recommendation 15

131. Communication pathways between Hammersmith and Fulham Housing Options and London Probation Trust should be reviewed and strengthened, including how risk assessments and offending details are shared.

Recommendation 16 – National Level

132. Home Office to conduct a needs assessment and service audit of suitable accommodation available for people who pose a high risk of harm to others, are not incarcerated or hospitalised and have been excluded from local authority housing (using EF as a case study) in order to develop care pathways and alternative accommodation possibilities.

Recommendation 17

133. Findings from this review should be referred to the LSCB to explore further work that needs to be done regarding mitigation of risks to children in cases of multi-generational familial violence along with how historical events impact on future risks in adulthood.

Recommendation 18

134. Ensure that routine checks/information sharing by WLMHT (especially the LBHF Assessment Service) and HandF Housing with Children's Services are undertaken if anyone with mental health issues and a history of violence proposes to stay where children are living and that a risk assessment is undertaken in such circumstances.

Recommendation 19

135. WLMHT to review protocols to include a discussion of substance misuse services available at appointments where a person presents with potential or actual substance misuse issues. When appropriate, WLMHT staff to communicate with substance misuse services to organise joint assessment or substance misuse assessment outside of drug and alcohol services. To facilitate this, Tri-borough Substance misuse services should arrange to attend Hammersmith and Fulham assessment centre and update staff on local substance misuse services and provision, along with contact details and pathways to arrange potential joint assessments.

Recommendation 20

136. Hammersmith and Fulham Police and ADVANCE should review their referral processes around support for people who are experiencing domestic violence in a familial setting, including where those cases appear in a court setting.

Recommendation 21

137. The Court Management Group (CMG) within the Hammersmith and Fulham domestic violence strategic partnership should receive data on survivor support that has been provided with cases which appear in the Specialist Domestic Violence Court and those that are heard elsewhere within the court system.

Recommendation 22

138. The CMG to review their processes within the SDVC system to ensure cases such as this go to the SDVC for sentencing.

Recommendation 23

139. HandF and Lewisham CCGs to be made aware of the issues within this DHR especially regarding complexity of commissioning services when patients are mobile and issue a policy statement about risk being addressed and care for individuals being paramount.

Recommendation 24

140. LBHF Family Services to increase capacity around their DV response by employing a DV specialist/ IDVA within the Troubled Families Team in LBHF to assist in addressing complex situations of multi-faceted, multi-generational, high risk violence within families.

Recommendation 25

141. The Hand Domestic violence Strategic Group to produce a briefing note, which highlights the key points around policies and practice arising from this review and circulate and/or presented to tri-borough LSCB/SAB/HWB/CSP chairs and members.