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BARNET SAFER COMMUNITIES PARTNERSHIP

LONDON BOROUGH OF BARNET

SAFER COMMUNITIES PARTNERSHIP

Keeping Barnet Safe

DOMESTIC HOMICIDE REVIEW

into the death of
Esther and Rachel

August 2017

OVERVIEW REPORT

Report Author

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Preface

The Domestic Homicide Review Panel and the members of the London Borough of Barnet Safer Communities Partnership would like to offer their sincere condolences to the family and friends of the two women whose deaths have brought about this Review. The family have lost a much loved mother and grandmother, a sister and aunt.

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The key purpose for undertaking a Domestic Homicide Review (DHR) is to enable lessons to be learnt where there may be links with domestic abuse. In order for these lessons to be learnt as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each death, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future. The victims death met the criteria for conducting a Domestic Homicide Review according to Statutory Guidance[1] under Section 9 (3)(1) of the Domestic Violence, Crime, and Victims Act 2004. The Act states that there should be a "review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by-

(a) a person to whom he was related or with whom he was or had been in an intimate personal relationship, or
(b) a member of the same household as himself, held with a view to identifying the lessons to be learnt from the death".

The Home Office defines domestic violence as:

> *Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse: psychological, physical, sexual, financial, and emotional.*
>
> *Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour. Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim*

The term domestic abuse will be used throughout this Review as it reflects the range of behaviours encapsulated within the above definition and avoids the inclination to view domestic abuse in terms of physical assault only.

[1] Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (Revised August 2013) Section 2(5)(1)

DOMESTIC HOMICIDE REVIEW

1. Introduction

1.1 This report of a Domestic Homicide Review (DHR) examines agency responses and support given to Esther and Rachel and their family, who were residents of the London Borough of Barnet prior to the point of their deaths in August 2017.

1.2 In addition to agency involvement the Review will also examine the past to identify any relevant background or trail of abuse before the homicide, whether support was accessed within the community and whether there were any barriers to accessing support. By taking an holistic approach the Review seeks to identify appropriate solutions to make the future safer.

1.3 The circumstances that led to the Review being undertaken concern the homicide of the two victims by a close family member who was a resident in the same household. Due to the family connection the deaths came within the definition of domestic violence thus meeting the criteria for a Review as outline in the previous page.

1.4 The Review will consider agencies contact/involvement with Esther, Rachel, and Seth[2] from 2016 when Seth was first referenced in an agency record as posing a risk to his sister Rachel, and August 2017 the date of the victims' deaths. Relevant information from 2002 when the perpetrator was first in contact with Mental Health Services is included for context.

1.5 The key purpose for undertaking DHRs is to enable lessons to be learned from homicides where a person or persons are killed as a result of domestic violence and abuse. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

Timescales

1.6 Following the decision to undertake a DHR the chair of the Barnet Safer Community Partnership Board wrote to agencies at the end of August 2017 informing them that a DHR was to be undertaken. The Home Office was notified of this decision on 29 August 2017. This was within the timescales required by statutory guidance. Agencies confirming contact with the parties to this Review were asked to immediately secure their records. The chair for the Review was appointed in October 2017. A DHR Core Group meeting was held on 6 November 2017 at which the Review panel membership was agreed, and arrangements were made to coordinate with the Mental Health Board Level Inquiry to avoid the victims' family from being overburden by the two processes.

1.7 The Review was concluded on 27 August 2019. Reviews, including the overview report, should be completed, where possible, within six months of the commencement of the Review. This timescale could not be met due to the timing of the criminal trial which did not take place until the summer of 2018. On learning of this timescale the chair informed the Home Office of the unavoidable delay in the Review process on 1 May 2018. There were further delays while various attempts were made to contact family members, and due to the time taken to obtain a copy of a psychiatric report which was felt to be important

[2] All the names used in this Review are pseudonyms to protect the identity of those involved.

information for the Review. Additional delays occurred due to the large number of Individual Management Reviews and reports required, to enable the Mental Health Board Level Inquiry outcome to be considered, and the time taken by agencies to complete their action plans.

Confidentiality

1.8 The findings of each Review are confidential. Information is available only to participating officers/professionals and their line managers until the Review has been approved by the Home Office Quality Assurance Panel for publication. In the case of this Review the Home Office Quality Assurance Panel agreed that a DHR Learning Document only will be published. The full report and summary will only be available to local participating agencies and policy makers to inform training and service improvements.

1.9 To protect the identity of the victims, perpetrator, and their family members the following pseudonyms have been used throughout this report.

1.10 Esther: aged 63 years at the time of her death.
Rachel: aged 34 years at the time of her death.
Seth, the perpetrator: aged 27 years at the time of the offence.

Other pseudonyms used in this Review:

Simon: Seth's elder brother who lives independently.
Ben: Seth's brother who also lived in the family home.

1.11 All the parties involved in this Review are of white British ethnicity. They were of the Jewish faith.

Terms of reference of the Review

1.12 **Terms of Reference for the Review: Statutory Guidance Section 2(7) states the purpose of the Review 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 these lessons to service responses including changes to policies and procedures as appropriate; and
- Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.
- Contribute to a better understanding of the nature of domestic violence and abuse; and
- Highlight good practice.

Specific Terms of Reference for the Review

1. To describe agency contact following the perpetrator's first contact with Mental Health Services in 2002, and examine in detail agency contact with the victims and the perpetrator between 2015 when the perpetrator was first referred to in a record as posing a risk to his sister, and August 2017 the date of the victims' deaths. To provide context all agencies with relevant information prior to this timeframe are asked to provide a

chronology of their involvement highlighting key events and addressing the terms of reference for this Review.

2. What plans were made, and actions taken to ensure that the perpetrator could be released from prison and/or Court to ensure that his continuing care and welfare was catered for, and the safety of others was assessed and planned for? (Question asked by the family).

3. The relevant criminal justice and health agencies to examine why no pre-sentence report and psychiatric report was provided in July 2017 to fully inform the Court of the perpetrator's health and offending history, including violent offences and domestic abuse, and in the absence of these reports what process did the Court then follow to consider risk given his previous offences?

4. Was there anything which could have been done differently to help the family at times of crisis to manage the perpetrator's behaviour? (Question raised by the family)

5. Were either of the victims or family members:

   (a) informed about carer's assessments and the support which might be available?
   (b) offered a carer's assessment?
   (c) signposted to appropriate voluntary or statutory services for support relating to their roles as carers, as victims of crime or domestic abuses?
   (d) offered the services of an advocate?

6. All agencies are to examine communication and information sharing between or within agencies to establish whether:

   (a) it was adequate, timely, and in line with policies and procedures?
   (b) there were any gaps in information sharing or breakdown in systems which impeded the effective treatment or management of the perpetrator's behaviour and health?
   (c) effective information sharing was undertaken to inform an all-embracing safety plan to protect the victims?
   (d) the MARAC terms of reference are fit for purpose and facilitate the comprehensive and timely sharing of information and execution of actions arising from information?
   (e) information was effectively shared between agencies inside and outside of the prison where the perpetrator was held?

7. What services were offered to the perpetrator in prison, did he receive comprehensive health care?

8. All agencies are to describe and analyse:

   (a) What risk assessment tools or processes were undertaken with the perpetrator by services with whom he had contact to establish his risk to others?
   (b) Whether risk assessment was thorough, and in line with procedures; if not why not?
   (c) Whether the risk assessment tools and procedures designed to support decisions and assessments are judged to be effective by the practitioners using them? Are there any adjustments which may enhance practice?
   (d) What background history and information from other agencies informed risk assessment?
   (e) Whether family members were involved in providing information which informed assessments and was there liaison with them concerning the outcome of assessments and any risks identified?
   (f) Was risk reviewed regularly and when the perpetrator's circumstances or mental wellbeing changed; were risks escalated, if so, how was this done and what

decisions were made and recorded?

9. Were there any resource issues, including staff absence or shortages, which affected agencies' ability to provide services in line with procedures and best practice? Include caseloads, management support of staff, supervision, and any impact of changes due to restructures or to service contracts.

10. How did agencies seek to engage with the victims, and how successful was this? Are there any changes to systems or practice which could help increase the engagement of high risk victims with support services designed to promote their safety?

11. Had the staff in contact with the perpetrator and family members undertaken domestic abuse training which included, adult family abuse, risk assessment, safety planning, and how and when to refer to MARAC?

12. Are there any cultural issues which may have impacted upon the family's engagement or interactions with care provided and were these given due consideration?

13. Over the period of time covered by this Review two criteria applied for assessing an adults' vulnerability. Up to March 2015 a 'vulnerable adult' was defined by the Department of Health 'No Secrets' guidance as:

    "An adult (a person aged 18 years or over) who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or serious exploitation." No Secrets, Department of Health 2000

    Under the Care Act 2014 which was enacted in April 2015 the term 'an adult at risk' was adopted. An 'adult at risk' is considered in need of safeguarding services if she/he:

    a. *has needs for care and support (whether or not the authority is meeting any of those needs),*
    b. *is experiencing, or is at risk of, abuse or neglect, and*
    c. *as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.*

    Were the victims or the perpetrator assessed as a 'vulnerable adult' pre 31 March 2015 or an 'adult at risk' post 1 April 2015? If not were the circumstances such that consideration should have been given to such an assessment?

Methodology

1.13 The Barnet Safer Communities Partnership chair was informed by the Police of the fatal incident soon after it took place and in consultation with members of the Partnership's multi-agency core group the decision was taken that the circumstances met the criteria for a Domestic Homicide Review to be undertaken. As stated at paragraph 1.6 agencies were contacted to establish their involvement and to secure their records; a total of sixteen agencies confirmed contact with the parties to this Review.

1.14 Following the appointment of the chair in October 2017 agencies confirming their involvement were asked to provide a chronology. These were subsequently combined by the Review author to form a draft narrative chronology which was further amended from

information contained in Individual Management Reviews supplied for the DHR. This amended chronology appears in section 3 of this report.

1.15 At the first DHR Panel on 6 December 2017 the Review draft terms of reference were discussed. These were then shared with family members who added two additional questions they wished to have addressed. The amended terms of reference were circulated to Panel members and finalised via email. The chair liaised with the independent chair of the Mental Health Trust Board Level Inquiry concerning the DHR terms of reference to enable them to be considered during the Inquiry process.

1.16 Twelve Individual Management Reviews (IMRs) were requested and, based on the level of their involvement, four agencies provided reports. The independent chair undertook briefing and de-briefing meetings with some of the IMR authors. It was necessary to request additional information from a number of IMR authors to further address the terms of reference or to provide clarification. Due to the lengthy timescale of criminal proceedings IMRs were undertaken by agencies prior to the completion of the criminal trial in order for them to capture any important lessons where action needed to be taken promptly. However, IMRs were not presented to the multi agency DHR Panel until the trial was completed. The author consulted the senior investigating officer regarding any disclosure issues during this process.

1.17 Three additional specialist Jewish services were identified during the Review process and these were contacted directly by the chair. All had attempted to engage the perpetrator at times of hospital admission, but he had not engaged with their support services.

1.18 The chair wrote to the psychiatrist who undertook an assessment of the perpetrator for the criminal proceedings and was granted permission to access his report for this Review. The chair is grateful to Dr Philip Joseph, Consultant Forensic Psychiatrist, for his consent and provision of his report.

Involvement of Family, Friends, Work Colleagues, Neighbours, and Wider Community

1.19 The chair made contact with the family in the first instance via the Police family liaison officer. An introductory letter was written by the chair which included the Home Office DHR leaflet, and a leaflet explaining the services of Advocacy After Fatal Domestic Abuse (AAFDA[3]), and this was delivered to the family.

1.20 To avoid overburdening the family with too many meetings at an early stage, the independent DHR chair liaised with the independent chair of the Mental Health Trust Board Level Inquiry, and with the assistance of the Police family liaison officer a joint meeting was arranged with family members. Accompanied by the family liaison officer the chairs met with the Esther's two sons, brothers of Rachel, to explain their respective Reviews and to listen to their views.

1.21 As mentioned in paragraph 1.15 the draft terms of reference for this Review were shared and discussed with Esther's two sons and two additional questions were included at their request. No other contributors were identified to take part in the Review.

1.22 Unfortunately, this was the only meeting to take place. Further update correspondence with the family offering a range of communication methods received no response. The chair had

[3] Advocacy After Domestic Abuse (AAFDA) https://aafda.org.uk/ - a charity specialising in expert and peer support to families who have experienced fatal domestic abuse including through major criminal justice processes such Domestic Homicide Reviews, Inquests, Mental Health Reviews and Independent Office of Police Complaints Inquiries.

contact with a support worker in the Victim Support Homicide Team whose services had been declined by the family. The support worker had been informed that they were a very private family and did not wish any support. A letter was sent to the family which informed them of the learning and recommendations within the report and offering them a further opportunity to see the final report. The family have been informed that a request was to be made to withhold publication of the report and to publish a brief summary, key issues, lessons learnt, and recommendations to ensure that the important learning from this Review are available to practitioners elsewhere. A further opportunity arose to see the family after the report was completed, and the chair sent them copies of the completed report ahead of a meeting. However, the arranged meeting was cancelled by a family member and it has not been possible to obtain their comments on the S. Nevertheless, the chair is content that the family have seen the report.

Contributors to the Review

1.23 The following agencies and the nature of their contributions are:

Name of Agency	Contribution to the Review
1. Community Rehabilitation Company	Chronology & Individual Management Review
2. Probation	Chronology & Individual Management Review
3. Police	Chronology & Individual Management Review
4. Barnet, Enfield & Haringey Mental Health NHS Trust including Prison Health In Reach Team	Chronology & Individual Management Review
5. Victim Support	Chronology & Individual Management Review
6. Royal Free London NHS Foundation Trust (Hospital)	Chronology & Individual Management Review
7. Hestia for Multi Agency Risk Assessment Conference	Chronology & Individual Management Review
8. Westminster Drug Project	Chronology & Individual Management Review
9. Camden & Islington NHS Foundation Trust (Mental Health Service hospital A & E Dept)	Chronology & Individual Management Review
10. Crown Prosecution Service	Chronology & Individual Management Review
11. London Ambulance Service	Chronology & Individual Management Review
12. Primary Care - GP Practice	Chronology & Report for 1 Victim & Perpetrator
13. Her Majesty's Court Service	Chronology & Report
14. London Barnet of Borough Council Adult Social Care	Chronology & Report
15. Central London Community Healthcare NHS Trust	Chronology & Report
16. Solace Women's Aid	Chronology and Report
17. Norwood - Jewish Charity supporting Families	Information - no engagement by relevant party
18. Jewish Care - Health & Social Care for the Jewish community	Information - no engagement by relevant party

19. Jewish Association for Mental Illness	Information - no engagement by relevant party

1.24 The authors of agency Independent Management Reviews (IMRs) were independent of the case, had no management responsibilities for the frontline staff who provided services to the parties involved, nor did they have personal contact with the parties to this Review.

1.25 IMRs were discussed at a DHR Panel convened for the purpose of quality assuring the IMRs and some required clarification or additional information which was provided. The GP report did not cover all the terms of reference, however, given the length of time taken to achieve this report the chair reluctantly decided that information provided from other sources, which was more detailed, provided an adequate picture of the victim and perpetrator who were registered with the GP. There remains a difficulty in the DHR process in achieving independent GP IMRs as many practices are not large enough to provide an IMR author sufficiently distant and independent of staff involved with the victim or perpetrator as a patient. Funding for independent authors for GP IMRs is not currently available.

The Review Panel Members

1.26 The following were members of the Review Panel undertaking this Review:

Name	Job Title	Agency Represented
Gaynor Mears	Independent Chair & Report Author	
Ruth Vines	Head of Safeguarding	Barnet Enfield & Haringey Mental Health NHS Trust
DS Kelly Hogben	Specialist Crime Review Group	Metropolitan Police
Luke Kwamya	Senior Public Health Commissioner	London Borough of Barnet
Siobhan McGovern/ Heather Wilson	Associate Director Safeguarding Adult Safeguarding Lead	Barnet Clinical Commissioning Group
Alena Buttivant	Patient Safety Manager, Mental Health	NHS England
Dawn Wakeling	Strategic Director, Adults, Communities & Health	London Borough of Barnet Council
Helen Swarbrick/ Deirdre Blaikie	Head of Safeguarding/ Adult Safeguarding Lead	Royal Free Hospital NHS Trust
Monica Tuohy	Senior Manager	Solace Women's Aid
Naomi Dickson	Chief Executive Officer	Jewish Women's Aid
Robert Edmonds	Chief Executive Officer	MIND in Barnet
Rachel Nicholas	Head of Service - Pan London DA	Victim Support
Anna Linkin	Serious Further Offence & Complaints Manager	London Community Rehabilitation Company
Clare Ansdell	Head of Service Barnet, Brent & Enfield	National Probation Service
Trish Stewart	Head of Safeguarding	Central London Community Healthcare

Radlamah Canakiah	Violence Against Women & Girls Strategy Manager	Barnet Homes

1.27 Members of the Panel were all independent of the frontline staff in this case and had no contact with the parties to this Review.

1.28 The Panel met on five occasions during the Review process in addition to regular updates via email.

Author of the Overview Report

1.29 The chair and report author for this Review is independent DHR chair and consultant Gaynor Mears OBE. The author holds a master's degree in Professional Child Care Practice (Child Protection) during which she made a particular study of domestic abuse and its impact, the efficacy of multi-agency working and the community coordinated response to domestic abuse. The author holds an Advanced Award in Social Work in addition to a Diploma in Social Work qualification, and it was her experiences of cases of domestic abuse as a Children and Families Team senior practitioner which led her to specialise in this subject.

1.30 Gaynor Mears has extensive experience of working in the domestic abuse field both in practice and strategically, including roles as county domestic abuse reduction coordinator; in crime reduction as a community safety manage working with Community Safety Partnerships and across a wide variety of partnerships and agencies, both in the statutory and voluntary sector. She was also regional lead for domestic and sexual violence at the Government Office for the Eastern Region and was a member of a Home Office national task group advising areas on the coordinated response to domestic violence. During her time at Government Office she worked on the regional roll-out of IDVA Services, MARAC, Sexual Assault Referral Centres, and Specialist Domestic Violence Courts, supporting Partnerships with their implementation. As an independent consultant Gaynor Mears has undertaken research and evaluations into domestic abuse services and best practice, and since DHRs were introduced in 2011 she has undertaken a large number of Reviews. She has also served as a trustee of a charity delivering Respect accredited community perpetrator programmes. Gaynor Mears meets the requirements for a DHR chair as set out in DHR Statutory Guidance 2016 Section 4(39) both in terms of training and the experience required for the role. She has previously undertaken a DHR for the London Borough of Barnet, but has not worked for, or had any connections with, any agency in the Borough apart from in the course of duties associated with the previous DHR.

Parallel Reviews

1.31 A coroner's inquest was opened and adjourned. Following the conclusion of the criminal trial the inquest was closed.

1.32 The Mental Health Trust undertook a Board Level Inquiry.

1.33 London CRC undertook a Serious Further Offence Review in line with Probation Instruction 15/2014 (Revised).

1.34 As per Hestia's Death & Dying Procedure an investigation template was completed to record the details of the deaths. Hestia coordinate the Barnet MARAC. Although entitled an investigation template, in practice due to the service delivered by Hestia in this case i.e. the MARAC, it simply records the information at the time of the deaths.

Equality and Diversity

1.35 The Equality Act 2010 places a duty on local authorities to eliminate unlawful discrimination, harassment and victimisation; to advance equality of opportunity between people who share a protected characteristic and people who do not share it; foster good relations between people who share a protected characteristic and people who do not share it. The protected characteristics covered by the Equality Duty under Section 4 of the Act are: age, disability, gender reassignment, marriage and civil partnership (but only in respect of eliminating unlawful discrimination), pregnancy and maternity, race which includes ethnic or national origins, colour or nationality, religion or belief which includes lack of belief, sex, and sexual orientation. The protected characteristics relevant to the review are discussed below.

1.36 Analysis of Domestic Homicide Reviews[4] reveal that women are overwhelmingly the victims of domestic homicide therefore sex is relevant to this Review. Both victims were women. The research also identified that mothers are predominantly the victims in adult family homicides; of the 40 cases examined 7 homicides were familial with 6 concerning the killing of a parent by a son, 5 of the victims were mothers, 1 was a father.

1.37 The Equality Act defines a disability as a physical or mental impairment that has a substantial, adverse, and long-term effect on a person's ability to carry out normal day-to-day activities. The condition must be deemed to last more than 12 months, and the focus is on the effect of the mental health problem, rather than the diagnosis[5]. With his mental health diagnosis of schizophrenia which required medication, but which he consistently refused to take, and years of involvement by the Mental Health Service, the perpetrator, may have fulfilled this category as having a disability. However, it is difficult to determine whether his day to day living abilities were impacted by his mental ill-health, his significant illicit drug use, or his character.

1.38 Age was relevant for Esther, and for a period of time before the homicide, although she was not formally assessed as disabled, her mobility was impaired following surgery. This made her particularly vulnerable in the context of family violence and abuse, and this is discussed during this Review.

1.39 No issues of inequality of opportunity in accessing services were found to be evident during this Review. However, of note is the fact that Seth, the perpetrator, was frequently volatile, abusive, and difficult to engage. In particular, he was racially abusive to mental health staff both in hospital and in the Community Mental Health Team, notably his care coordinator. This may have made him difficult to work with and may have subconsciously affected how staff tried to engage with him. Nevertheless, this did not affect his access to services at times of known crisis as is evidenced by his many admissions to hospital under the Mental Health Act, and the Mental Health Trust taking him back as a patient after relapse following his discharge for non-engagement.

1.40 The victims were Jewish, as is the perpetrator, however, the Review has not been able to establish whether they practised their faith. Nevertheless, the Review has had the benefit of expert advice on Jewish cultural matters from Jewish Women's Aid who have been panel members. In addition to mainstream statutory services, the family would have had available

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[4] Domestic Homicide Reviews: Key Findings from a Comprehensive Analysis of Domestic Homicide Reviews. Home Office 2016.

[4] Sharp-Jeffs N, Kelly L. (June 2016), *Domestic Homicide Review (DHR) Case Analysis Report for Standing Together.* Standing Together Against Domestic Violence & London Metropolitan University.

[5] https://www.mind.org.uk/information-support/legal-rights/disability-discrimination/disability

local services for the Jewish community, however, the Review found that they had not accessed these services.

Dissemination

1.41 In addition to the family the following will receive a copy of the Review:

All agencies taking part in the Review

- The members of the Barnet Safer Communities Partnership
- London Mayor's Office for Policing & Crime
- Secretary of State for the Department Health & Social Care
- Minister with Lead for Mental Health
- NHS England
- Barnet Adult Safeguarding Board
- Barnet Health & Wellbeing Board
- London Criminal Justice Board
- Ministry of Justice
- A copy will be sent to the family liaison officer to hold on file for information if or when the perpetrator is released, and the family need to be contacted at that time.
- Probation will be specifically requested to ensure that a copy of the report is available on file for any future appointed supervisor for the perpetrator.

2. Background Information (The Facts)

2.1 Esther and her adult daughter Rachel, who are the victims in this Review, had lived in the family home in the London Borough of Barnet for many years. Esther's two youngest adult sons Ben and Seth also lived at the property. Seth was asked to leave the family home in 2013 by his father, but he returned in 2015 and lived in an annex in the grounds of the house. He was not allowed into the main family home, although as events within this report will show he ignored this. It was in the family home that the homicides took place.

2.2 It would appear from the information available to the Review that Esther did not always stay in the family home. She would visit her brother in America for periods of time, and there is one reference to her having lived in a city in the north of England but returning for family events. Esther was living in the family home in the months prior to the murders as she was receiving medical treatment in a local hospital and seeing her GP practice.

2.3 Seth who was unemployed in recent years, was known to Mental Health Services since 2009. He had a diagnosis of paranoid schizophrenia and mental and behavioural disorder due to the use of cannabis. His medical notes show a history of cannabis use from 2004 when he was 14yrs old. During the 8 years of Mental Health Services involvement he had 8 inpatient admissions; he was detained under Section 2 and Section 3 of the Mental Health Act. Seth was treated with anti-psychotic medication by inpatient and community mental health teams with variable degrees of compliance. He was frequently resistant to engagement with community mental health practitioners. In addition to a long history of using cannabis, Seth also used other illicit substances including heroin and crack cocaine.

2.4 Seth's behaviour could be confrontational and challenging for his family. In the months before the fatal event he was arrested for assaulting Rachel, and in a separate incident months later he assaulted his mother. He spent time in custody for these assaults and had only been released from prison approximately 2 weeks before the homicides.

2.5 On the evening of the killings CCTV at the property showed Seth knocking on his mother's window. He was let in and Esther and Rachel followed him into the basement laundry room. Within minutes they were fatally attacked by Seth; he then left the property. Esther and Rachel were discovered by her other son Ben on his return home from work. He called 999 and the Police and London Ambulance Service attended within minutes. Ambulance staff found Esther and Rachel with multiple stab wounds. Resuscitation was commenced, but without success. There was blood throughout the house.

2.6 A post-mortem examination found Esther had suffered 13 stab wounds to the head, face, neck, body and right arm and a traumatic brain injury. Cause of death was recorded as stab wound to the neck and blunt trauma to the head. Rachel had been stabbed in the neck, severing her carotid artery which would have killed her in seconds. Cause of death was recorded as stab wound to the neck.

2.7 The day after the murders Seth was arrested and in interview admitted to stabbing his mother and sister. He was charged with their murders and remanded in custody. Following psychiatric assessment for the Court, the judge decided Seth was unfit to stand trial as he was suffering from paranoid schizophrenia, but a trial of issues was required to establish whether he did the act in question, rather than if he was guilty of any offence. After three days, the jury found Seth did commit the act of killing his mother and sister. The judge ordered that Seth was to be treated at Broadmoor secure hospital under an indefinite Hospital Order with Restriction under Section 37/41 of the Mental Health Act 1983[6]. The judge added that "if he becomes fit to stand trial, a trial will be held at that stage".

3. Chronology

Background Information:

3. 1 Records suggest that Esther was not always in the best of health. During the early months of 2002 she was diagnosed with type 2 diabetes which was controlled with insulin. Esther had annual reviews for her diabetes with the GP practice nurse. She was also taken extremely ill with sepsis which was successfully treated in hospital. In April 2004 Esther was discharged from the Department of Endocrinology & Diabetes as she had missed 3 arranged appointments. She frequently failed to attend hospital appointments made for her by her GP. It is not possible to determine why Esther this was, but in 2011 she told her GP that she had a poor memory, forgot appointments, and wrote times down wrongly. A mini mental state examination by the GP obtained a score within the normal range. It is understood from family information via the family liaison officer, that Esther had a brother who lived in America with whom she would spend time or she would be away in the UK on a regular basis, this too may account for missed appointments. At one point Esther had said she lived in a city in the north of England. She appeared to live separately from her husband, the father of her adult children.

3. 2 In May 2006 Esther was seen in the Accident and Emergency Department and diagnosed with Hyperglycaemia. She was treated in hospital for 5 days, and her notes at the time record 'social problems', but no detail of what these problems were is recorded. The following

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

month Esther was discharged once more from the Department of Endocrinology & Diabetes for non-attendance. In September 2007 Esther was screened for depression by a practice nurse; the result was positive. She was referred to her GP but did not attend. The following Spring Esther was discharged from the Cardiology Department for non-attendance. She had a further positive screening for depression by a practice nurse in March 2009 and this time saw her GP. It was recorded that she had been made redundant and was feeling down, however she declined medication.

3. 3 No record was found to show that Rachel was registered with a GP. Contacts by her with services were all in connection with incidents arising from Seth's behaviour and actions.

3. 4 Education records show that Seth had a statement of Special Educational Needs when at school which ceased in 2007 when he left education. It has not been possible to ascertain the reason for the statement as the records have long been archived. Later involvement with agencies indicates that he had low literacy skills for he needed help with reading and completing forms. However, although 'intellectual difficulties' are noted, he is recorded as achieving 4 GCSEs. He worked intermittently, probably in the family business, but in the period under review there is no indication that he was in work. From 2004 Seth was noted to have a history of cannabis misuse. This indicates that he was approximately 14 years old when he began using cannabis. He was also found in possession of cocaine on one occasion.

3. 5 Seth lived in a self-contained annex within the garden of the family home, but he would use some of the facilities of the house such as for laundry. As will be seen from the chronology below, his behaviour could sometimes be confrontational and disruptive, and it would most frequently be Simon, the eldest son in the family who lived independently, who would contact services to deal with various incidents or deterioration in Seth's mental health.

Chronology from December 2009 (date when Mental Health involvement commenced) *This is necessarily detailed to demonstrate escalation and the significant resource requirements of the emergency services, the Police and Ambulance Service)*

3. 6 On the 7 December 2009 19 year old Seth was referred by his GP to Mental Health Services due to what his GP recorded as 'paranoid ideation and delusional beliefs'. 3 days later on 10 December following a 999 call the Ambulance Service and Police attended the family home and Seth's elder brother Simon reported physical violence from Seth and that he had fought with his sister and other brother. Simon told ambulance staff that a Mental Health Team had visited but had not left any contact details. Seth was taken to the Royal Free Hospital Emergency Department where it was noted: 'Episodes of delusional/paranoid behaviour; escalating symptoms; seen by a Mental Health Team for the first time 2 days ago. Violent towards family, who called Police and London Ambulance Service. Used to use cannabis'. Seth was subsequently admitted to a psychiatric ward on Section 5 (2)[7] with a recommendation for a change to Section 3[8] following periods of fluctuation in his mental state and behaviour both on the ward and during home leave. Notes at the time stated, "Doctor explained that his problems are probably a complicated mix of psychotic illness, substance misuse, and his learning difficulties".

Contacts in 2010

[7] Section 5 (2) is a temporary hold of an informal or voluntary service user on a mental health ward in order for an assessment to be arranged under the Mental Health Act 1983. This ensures their immediate safety whilst the assessment is arranged.

[8] Section 3 of the Mental Health Act is commonly known as a "treatment order". It allows for the detention of the service user for treatment in the hospital for up to 6 months based on certain criteria and conditions being met.

3. 7 Further Police contact with Seth took place on 5 January 2010 when officers were called by Thames Ward at the Edgware Community Hospital following his failure to return to the hospital from unsupervised leave. It was reported that Seth suffered with a psychiatric disorder which required nightly medication. Officers attended the home address and were told by family members that he was unwell, but they intended to return him to hospital the following morning. Seth was returned to the Community Hospital. A missing person vulnerable adult MERLIN[9] report was recorded by the Police. The family appear to be unaware of the importance of his nightly medication.

3. 8 On 12 January 2010 whilst Seth was in hospital on Thames ward he was found in bed with another patient and was thought to have had unprotected sex. 8 days later on 20 January a ward round took place and in addition to his doctor and other members of the team his mother, sister, and two brothers were also present. A psychologist had assessed Seth on 16 and 17 January 2010 and at the ward round the psychologist expressed the view that Seth did not have learning disabilities but was functioning within the lower average IQ level. However, there is a free text entry stating that he did find that Seth had difficulties consistent with dyslexia. Involving the family in this ward round was good practice. Seth was discharged from the ward that day to the Home Treatment Team and Early Intervention Service.

3. 9 A month later on 3 February 2010 Seth reported to Police that he had been robbed whilst walking home. An acquaintance later returned his phone which had been discarded by the suspects. Seth did not attend a pre-arranged interview; he told the investigating officer that he did not wish to assist the Police and the case was closed. The officer noted that Seth was vulnerable due to mental health issues and learning difficulties. No Adult Come to Notice (ACN) MERLIN was created to record an incident involving a vulnerable adult[10]. On the 14 February 2010 Seth was assessed once more by Mental Health Services as needing an in-patient stay and he was discharged with the London Ambulance Service to the Springwell Centre, in Barnet under Section 2 of the Mental Health Act accompanied by a nurse escort and his brother.

3. 10 It is not clear when Seth was discharged home, but Care Programme Approach (CPA) meetings took place at regular intervals to coordinate his care in the community. He was discharged from the Home Treatment Team to the Early Intervention Service who saw Seth on 5 March 2010. It was noted that his studies were going well and there were no difficulties with mood or behaviour; family was happy, and he was compliant with medication. On 1 April 2010 Seth's GP notes record a diagnosis of 'Schizo-affective schizophrenia'. However, notes on a visit by the Early Intervention Service on 14 May 2010 state that Seth was "Seen at home and said he didn't think the medication is making any difference to him and he did not take it most of his time in hospital. Feels that his problems were due to excessive use of magic mushrooms, but as he is no longer taking these, there is no problem." His medication olanzapine was reduced from 15 mg to 10 mg at night. A further visit in August found Seth to be "pleasant and friendly, and no symptoms were observed".

3. 11 On the 2 September 2010 Early Intervention Service returned a phone call to Seth's brother who reported that Seth had not been taking medication for approximately six weeks. His mental state had deteriorated significantly. Seth was not sleeping, was talking to himself, talking to the television, shouting in his room. It was difficult to engage him in conversation.

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[9] MERLINs were also brought in as a result of Lord Adebowale's report recommendations on 2 April 2013 the Adult Come to Notice MERLIN (ACN) record was brought in which is shared with Adult Social Care via the Multi-Agency Safeguarding Hub (MASH).

[10] The Metropolitan Police MERLIN process was introduced in April 2014 to bring to the notice of other agencies incidents involving someone judged to fulfil the criteria set out in the Police toolkit of a 'vulnerable adult'.

3.12 **Domestic abuse incident 1:** On 4 September 2010 at 20:02hrs the Police received a call from Seth's elder brother Simon stating that Seth was mentally ill and not taking his medication. At 20:04hrs the London Ambulance Service were notified of the incident and a Police supervisor declared the incident not to be a domestic incident and the Ambulance Service was advised that the Police would not be attending[11]. The ambulance arrived at 20:15hrs and staff were told that Seth had been in Thames Ward for 2 months and had come home 3 months ago. Simon reported that Seth had damaged the house, made threats towards his family, and the Denis Scott Unit at the Edgware Community Hospital had advised that the Police may need to be present to support Seth being taken to the Springwell Centre at Barnet Hospital. Simon said that the Crisis Team had not assisted, only given new medication which Seth was not taking. Seth refused to have clinical observations taken or to be taken to hospital. Ambulance staff deemed him not to have capacity to make this decision but did not have the authority to remove him without his consent as he was not a danger to himself.

3.13 At 20:56hrs the Ambulance Service sought Police assistance once more. They were advised that as Seth was on private property and the Police had no powers to remove him from the address. The ambulance staff felt that Police attendance may encourage Seth to attend hospital. The Springwell Centre was contacted and they advised that Seth be removed to Accident and Emergency under the Mental Capacity Act. A Capacity Tool was completed and assessed Seth as not having capacity to consent or refuse treatment, but staff were still unable to convince Seth to go. He was therefore left in the care of his family with the advice that they contact the Crisis Team, who were unavailable at that time, for an appointment, or the Police if he became violent. Seth then contacted the Police at 21:03hrs seeking their attendance due to his brother saying he wanted him to attend hospital. He was advised to contact the Ambulance Service or go to hospital.

3.14 The next contact with Seth by the Police was 5 days later on 9 September 2010 when a scheduled appointment took place at the home address to complete a Section 135 Mental Health Warrant[12]. Also, in attendance were Barnet Social Services, Seth's care co-ordinator and medical professionals. As the Ambulance Service were unable to attend the process was rescheduled for the following day, 10 September 2010. On this occasion an assessment took place and Seth was detained under Section 2[13] of the Mental Health Act and taken to hospital by ambulance. This was the second occasion when Seth's mental health had deteriorated when he ceased taking his medication. His behaviour had been noted by his family to be bizarre, he had been responding to hallucinations from the TV, and he had been verbally abusive and threatening towards his family.

3.15 Hospital notes of 17 September 2010 record that Seth remained paranoid and unpredictable, and he needed prompting to take prescribed medication. He was verbally abusive and threatened to physically attack a member of staff to the extent that he had to be restrained using approved Prevention/Management of violence and aggression techniques. He appeared calmer as the day progressed.

[11] The supervisor declared the call to be a mental health incident not domestic incident. The incident met the criteria of the domestic abuse police in place at the time. As such the venue should have been attended and a relevant CRIS report created.

[12] A Section 135 Mental Health Warrant is applied for at a Magistrates Court by an approved mental health professional. The warrant authorises the Police, the approved mental health professional, and a registered medical practitioner to gain entry to premises in order for an assessment to take place there, or to remove a person to a place of safety.

[13] Section 2 of the Mental Health Act allows compulsory admission for assessment, or for assessment followed by medical treatment, for a duration of up to 28 days.

3. 16 In Mental Health Team records of 4 October 2010, a note from a social worker shows that a Section 3 application under the Mental Health Act indicating a need for treatment was made. The record indicates some disinhibition, grandiosity, and elevation of mood consistent with the account of his behaviour at home on leave precipitating this Mental Health Act assessment.

3. 17 On 2 November 2010 Mental Health Team notes comment on Seth's disinhibited and inappropriate behaviour towards female staff and patients. Seth was involved in a fight on two separate occasions with the same male patient seemingly provoked by Seth's behaviour. The following day Seth underwent a routine head CT scan as part of a diagnostic procedure to rule out any organic courses for his behaviour. No Focal intra cerebral lesions or other abnormalities were found.

3. 18 At examination on 13 December 2010 Mental Health notes report that the impression of Seth was: 'improved mental state, and he was polite and calm'. The Section was rescinded, and he was discharged from the ward. The Home Treatment Team was to follow up daily.

Contacts in 2011

3. 19 On the 14 February 2011 following a CPA Meeting it was recorded that Seth was agreeable to continue treatment and follow up for 'a quiet life'. His carer's views were reported as Seth had improved functioning, reduction in mood swings, and appropriate behaviour. No problems or concerns reported. However, the notes do not record who the 'carer' was who made this report.

3. 20 Esther saw her GP on 17 June 2011 reporting that she had a poor memory, forgets appointments, writes times wrongly. A mini mental state examination resulted in a score of 28/30 (normal range). A further depression screening was undertaken by the practice nurse the following month when Esther denied feelings of depression.

3. 21 On 25 July 2011, a CPA review took place when it was reported by Seth's brothers that there were no concerns about his mental health.

Contacts in 2012

3. 22 **Domestic abuse incident 2:** After no involvement with the Police for 16 months, Seth called them on 15 January 2012 reporting that he had been hit by his sister following an argument about cleaning. He then made a further call to police asking when they would attend. Seth stated that his sister had made him touch her. Officers attended and established that he had mental health issues, had not been taking his medication and had been using cannabis. They ascertained that Seth and Rachel had argued after she had taken a vacuum cleaner from his room, which he intended to use. Rachel had then attempted to calm Seth down by restraining him, in the melee he had inadvertently touched her which he felt to be inappropriate. Seth and Rachel signed the officer's notebooks confirming that there had been no physical or sexual assault. A domestic crime report and intelligence checks were completed which was then reviewed by the Community Safety Unit. It was not highlighted or documented in the report what notifications were made regarding concerns that Seth was not taking his medication, his increasing paranoia, or if any safeguarding action was taken.

3. 23 On 24 January 2012 Seth called the Police and reported that his father was a paedophile as he had watched him whilst he was on the computer. He also reported that his father had broken his mobile phone. The call handler noted that Seth seemed to be intoxicated. A scheduled appointment was arranged for the Safer Neighbourhood Team (SNT) officers to conduct a welfare visit at his home address. Later that day Seth attended the local Police Station and reported being assaulted by different members of his family. He was taken to

his home address. Family members present denied any assault and stated that Seth had stopped taking his medication and was increasingly paranoid. Seth made a further allegation about an assault having taken place while officers were present, but they witnessed no such assault. No domestic crime report was recorded.

3. 24 Seth called the Police again 1 week later on 1 February 2012 at 10:08hrs reporting that his father had hit him and that his brother had held him down while his father armed himself with a hammer. A few minutes later Seth made a further call to Police; his brother then spoke to the operator and stated that he did not know why Seth had called. Officers attended and established that Seth was having difficulties with medication for his mental health condition. Seth agreed to attend his GP regarding the issues he had. There is no GP record at this time to indicate that Seth did attend his GP as he agreed. Neither Seth nor his family made any allegations of a crime and there was no evidence to support a crime having taken place. As with previous incidents no domestic crime report was made.

3. 25 Two weeks after the last call Seth phoned the Police at 10:48hrs on 14 February 2012 reporting that his father had hit him and set his dog on him. The Ambulance Service were requested to attend as the extent of any injury following a domestic incident was unknown. Ambulance staff found Seth sitting on a sofa; he was calm, alert, and orientated. The Police officers established that Seth had a mental health condition and had not been taking his medication. Seth alleged to ambulance staff that he had strained his ankle during a scuffle with his brother. He claimed his family were out to get him, and to throw him out on the street. His family were concerned that he had not been taking his medication for 3 months and believed he was becoming unsafe; he had been interfering with the home electrical supply.

3. 26 Seth was initially verbally aggressive but calmed down. Ambulance staff found no injury to his ankle. He said he felt 'spaced out'; he agreed to voluntarily attend the Royal Free Hospital by ambulance escorted by Police officers. He was assessed in Accident and Emergency by a clinician in the Mental Health Liaison Team[14] as needing an in-patient stay. Contact was made with Seth's father and brother to discuss their concerns, and his father was advised of his rights as 'Nearest Relative'. Contact was also made with the Early Intervention Service who confirmed that they had been contacted by the family recently stating their concerns and the plan was to arrange a mental health assessment. Seth had many delusional ideas including that his family were doing things to him, and he had been aggressive towards them. Seth was taken by ambulance to the Springwell Centre in Barnet under Section 2 of the Mental Health Act accompanied by a nurse escort and his brother. His father was informed.

3. 27 On the 19 June 2012 Esther underwent a routine screening with the practice nurse for depression, and once more denied feeling depressed.

3. 28 On 2 July 2012 there was a further CPA review of Seth at home. There are no notes commenting on his condition.

3. 29 On 3 August 2012 Seth consulted his GP with anxiety about his genitals. GP notes record that the GP discussed Seth with the Mental Health Team and they agreed to see him that day and monitor over the weekend. This call and actions from it do not appear in the Mental Health chronology.

3. 30 The following day, 4 August 2012, on receipt of a 999 call the London Ambulance Service were dispatched to Seth's home address. He had taken 4 x 400mg Quetiapine tablets (normally took 800mg per day) with cannabis. He was taken to the hospital Emergency

[14] The Mental Health Liaison Team in the Royal Free Hospital is provided by the Camden and Islington NHS Foundation Trust.

Department where it was recorded that he was not expressing suicidal ideations, but his brother who accompanied him reported that Seth had been low in mood recently. Seth was seen by a member of the Mental Health Liaison Team and admitted he had forgotten to take his medication and on the advice of a friend had taken twice as much with a can of larger. He had no intention to self harm and regretted the error. He was discharged home at 02:43hrs 5 August, to the care of his care coordinator who Seth said he was due to see the following day. A discharge letter was sent to his GP; however, this does not appear in the GP chronology. A CPA home visit took place on 13 August.

3. 31 **Domestic abuse incident 3:** At 14:16hrs on 26 October 2012 the London Ambulance Service received a 999 call to attend Seth's family home as the caller (understood to be Seth) said that he needed to be put away, that maybe he should commit suicide, and that his sister had gone for him with a knife and she was still feeling violent. It was also alleged that his father had tried to push him down the stairs 2 days previously. The Ambulance Service requested Police attendance at Seth's address. On arrival it was established that Seth had a mental health condition and had not been taking his medication. Seth made allegations that his family were attacking him, but his family said it was the other way around; he had thrown items at his brother and a glass at his sister. He agreed to voluntarily attend The Royal Free Hospital with ambulance staff. No domestic crime report was recorded following Police attendance.

3. 32 The hospital recorded that Seth was being confrontational with his family and having feelings of paranoia. He had pain in his head, was hearing voices, and he had not been taking his medication. Staff were aware of his previous history. Seth was reviewed by the Mental Health Liaison Team who noted his violence towards family that day. Seth was initially cooperative with the assessment, but then said he did not want to answer further questions as he was tired. When the clinician persisted, Seth threaten violence and was verbally aggressive. The assessment concluded:

- Seth currently had capacity and would accept informal admission but did not need sectioning at that time.
- He was considered paranoid and a risk to others based on previous risk history and current behaviour.

The clinician advised: Contact Barnet Crisis Team who would need to assess him in their unit. Arrange escorted transport to the unit; attempt to speak to Seth again in 20 minutes.

3. 33 There was a further attempt by a staff grade psychiatrist to assess Seth at 17:54hrs in the presence of a security officer. Seth had been punching and kicking the door of the observation room. This too was unsuccessful and ended with Seth being verbally aggressive and threatening violence. The deteriorating situation was discussed with a doctor and the recommendation to detain Seth under Section 2 of the Mental Health Act made. Nursing staff reported that Seth continued to try and kick the door down, was very agitated, and there were concerns he would harm himself. At 18:32hrs a bed was identified in the Haringey Assessment Unit. Seth's GP notes record his deteriorating mental health and admission to the Assessment Unit.

3. 34 **Domestic abuse incident 4:** At 14:56hrs on 10 November 2012 Seth called the Police again reporting that he had been slapped by his sister and she had taken his passport and bank card. A few minutes later his sister Rachel called Police to report that she had been slapped by her brother. Officers attended and spoke with them both. Rachel stated that her brother had been granted a day's leave from the mental health unit where he was a patient, however there is no record of his admission at this time. They had argued about Seth's belief that she had taken his passport, bank details and Facebook password. Rachel said that she then called police. No allegations of assault were made. It is noted that Seth was taken back to

his unit by his parents. However, there is no record of him being Sectioned or in hospital at this time. A domestic crime report and intelligence checks were completed and reviewed by the Community Safety Unit.

Contacts in 2013

3. 35 On 14 January 2013 at 16:30hrs Esther was seen in the Emergency Department of the Royal Free Hospital as she was unwell. She was discharged the same day.

3. 36 A CPA meeting took place on the 9 July 2013 when it is noted that Seth remained at home.

3. 37 On 20 August 2013 Seth visited his GP and it is recorded that he wanted a clear head; he was clearer when he came out of rehab (it is not recorded what rehab). He was living at home with his mother and was not taking medication. It was noted that Seth said he was 'talking to the FBI; Doctors have advised a hostel in Edgware'. Seth said he cannot read and needs his mother's support. No voices were noted; no one telling him what to do, and no thoughts of self harm. The GP recorded that it was difficult to engage in sensible conversation with him. The GP made a referral to the Mental Health Team.

3. 38 Three days later on the 23 August 2013 Seth attended the hospital Emergency Department with his mother with concerns about a head injury. Records include the information that his mother said that she lived in a city in the north of England, and when she came down 2 days previously for a family wedding Seth was complaining of a headache and vomiting. Seth said that he had been hit over the head with an ashtray by his father when he was a boy. He confirmed he had a diagnosis of schizophrenia, but he did not have any symptoms. Seth added that he did not know whether he was under the care of Mental Health Services. It was recorded that he smoked cannabis, but he denied using other drugs. Seth was very agitated at times. On examination no injury was found, and he was reassured. The doctor noted that 'Clearly this is a complicated social situation with a vulnerable young man who may need adult social care to be involved - may already be so in view of history'. The doctor sent a fax to Seth's GP highlighting this concern and asking, 'please consider onwards social services referral if you think appropriate'. This was also put into the discharge summary to his GP for them to act upon. No direct referral was made to Social Services or drug and alcohol liaison. There is no record of a GP referral to Adult Social Care for Seth.

3. 39 **Domestic abuse incident 5**: On 26 August 2013 at 13:00hrs Seth called the Police and initially reported that he had been threatened by a male in a park who had a knife. He then stated that this male had also threatened to kill his father, he had been assaulted by his brother who had pushed a door handle in his mouth and his family wanted to kill him. The Police and London Ambulance Service attended and when officers spoke with Seth he stated that he had showered in the family home whilst wearing his dressing gown and had removed the shower head. One of his brothers had confronted him, grabbed his arm, tried to place him on the floor, and then locked him in his bedroom. In the process of trying to lock him in his room the door handle was broken. His brother was then stated to have scratched Seth with the broken door handle. Seth was noted to have scratches to his neck and bruising to his arm. He had not been taking his medication for 3 months, and his family described his condition as worsening.

3. 40 His brother Ben who also lived in the family home was arrested, admitted assaulting Seth, and he was issued with an adult caution for common assault. A domestic incident report was completed, but the record did not document completion of intelligence checks. The Domestic Violence policy in place at the time stated that 5 year checks should be completed. The initial supervisor did not highlight or rectify this failure. The report and investigation was passed to the Community Safety Unit. There is no supervisory closing summary of the investigation and

the absence of 5 year checks was not highlighted or remedied. A vulnerable adult MERLIN was created and noted by the Public Protection Desk on 29 August 2013.

3. 41 Seth was conveyed to the Royal Free Hospital by ambulance where he was assessed by the Mental Health Liaison Team. He was thought disordered and known to suffer from schizophrenia; he could not remember when he last took his medication or saw his care coordinator. Seth reported that he had been assaulted by his brother and on examination bruising to the chest area was found. His behaviour became increasingly intimidating during the assessment and security had to be called. Information was obtained from Barnet Crisis Team that Seth had refused to continue Depot medication in March 2013, declined further input from the Early Intervention Services and was subsequently discharged back to his GP on 9 July 2013 as he was refusing all services. Seth's sister Rachel was also contacted, and she reported that he had become increasingly paranoid over the past few weeks, had declined a voluntary assessment at Barnet Community Mental Health Service on 23 August, and was awaiting an assessment on 27 August. Rachel reported that the family believed he was smoking cannabis and has becoming paranoid and suspicious towards them. She referenced Seth's attempt to have their father arrested, and his aggressive behaviour towards her. She was fearful of him. He had been verbally and physically aggressive towards the family in the past.

3. 42 Rachel asked that her telephone number be put on Seth's notes and that she be informed of the evening's outcome. Seth had particularly said he did not want his sister contacted and Rachel was aware of the limitations when a patient requests no information is shared. However, it was noted that in light of past and present risk factors towards family members, it was suggested the family who were potentially at risk needed to be informed of the outcome. This was good practice in recognising risk to others.

3. 43 Between 19.30hrs and 20:30hrs 6 telephone calls were made to the Barnet bed manager, but no bed was available and a call back was expected. A further call to the bed manager at 21:05hrs found no bed in the Trust or private sector was available. Camden emergency services were contacted. Seth was assessed for the first part of the Mental Health Assessment at 23:13hrs whilst waiting for a bed to be admitted, during this he said his sister had been annoying him, she was too tidy, and he felt persecuted by her. He could not remember why he had got into a fight with his brother. He presented as thought disordered and antagonistic, for example he asked the psychiatrist if they were going to take an IBM chip out of his head and put it in someone else's head.

3. 44 By 09:23hrs the next day, 27 August 2013, a bed had still not been found for Seth and the completion of the Mental Health Assessment was delayed. By 09:10hrs he had been in the A & E Department for 16 hours. There followed calls to a duty approved mental health professional[15], and as Seth was known to Barnet calls had to be made to their approved mental health professional duty team. Between 08:45 and 10:45 a total of 14 telephone calls were made to various sections of Mental Health Services in Camden and Barnet, 7

[15] Approved mental health professionals are authorised by the local authority (in this case Barnet) and they practice for them, even though they may be employed by a Trust or another local authority. They provide a broad range of tasks under the Mental Health Act. Their role to counter balance the medical model that can exist in mental health and bring a social or more holistic perspective. Their work involves nearest relatives and carers, making sure service users are properly interviewed in an appropriate manner, and ensuring they know what their rights are if they are detained under the Mental Health Act 1983. The approved mental health professional is also “the applicant” in the majority of Mental Health Act applications. They are part of a specialist team of professionals linked to Community Teams.

numbers went unanswered and messages were left. A phone call to a number found on a Barnet website "Get help in a mental health Emergency" was not answered after 10 minutes holding. Attempts were made to follow an escalation policy regarding the problem of finding a bed, but the manager was on leave. On calling a duty worker the Mental Health Liaison Team member was told that they had come through to the Complex Care Team and the duty worker was unable to give the number of the Barnet approved mental health professional duty team. At 10:00hrs a message was left for this team and a call was received from them at 10:45hrs when they agreed to attend the Royal Free Hospital for the Mental Health Assessment. This took place at 12:30hrs and Seth's father was informed. Seth was transferred to Haringey Assessment Unit and confirmed as arriving at 16:00hrs.

3. 45 On the 1 September 2013 Seth was transferred to the care of the West Community Support and Recovery (WCSRT) team from the Early Intervention Team.

3. 46 On 2 October 2013 at 20:14hrs Seth called the Police to report that his debit card, birth certificate, passport and house keys had been stolen and the door of his house was open. The operator noted Seth seemed confused. He then said that he was in rehab at Thames Ward. Officers attended and established that there had not been a theft and that Seth had mental health issues.

3. 47 6 days later on 8 October 2013 at 15:16 Seth called the Police again seeking to speak to the officer investigating the allegation of sexual assault he had made. No trace could be found of the report to which he referred. He then made a further call alleging that his family had hired a “hit man” to sexually assault him and had then asked him where his parents were in order that he could kill them. Officers attended Edgware Community Hospital and spoke to staff who advised that Seth was a patient under Section 3 of the Mental Health Act who suffered with paranoid schizophrenia, and despite taking medication was not stable. Staff stated that Seth had made a number of allegations. When officers spoke with him they noted that he was slurring his words and making allegations which were not credible none of which were in line with his previous calls.

3. 48 At 13:55hrs on 12 October 2013 Seth called police to report that his mother may have been assaulted by his father. The operator asked that his mother contact Police if she required assistance. Seth was noted to be a frequent caller and the call was linked with the calls on 2 and 8 October. No crime was recorded.

3. 49 2 days later on 14 October 2013 at 10:36hrs Seth called the Police once again seeking an update in respect of allegations he had made about his family hurting him. Officers attended the home address and spoke with his sister Rachel. She advised officers that Seth had been an inpatient at the Whittington Hospital for the previous two months.

3. 50 The following month on 1 November 2013 at 09:44hrs Seth called Police to report that he had been assaulted by a fellow patient at Edgware Community Hospital. Officers attended and Seth informed them that he had been assaulted during a group session by another patient. He then told officers that he was on a lot of medication and did not really know what was going on. Officers spoke with staff who checked hospital records, there were no documented incidents. The only documented incident was one involving the patient named by Seth and another patient. As a consequence of this incident the patients had been moved to other wards. The initial report and investigation was reviewed by the Community Safety Unit and subsequently closed due to absence of supporting evidence or likelihood of a successful prosecution.

3. 51 A Care Programme Approach (CPA) review meeting took place on 1 December 2013 which noted a history of paranoid schizophrenia, difficult to engage (Seth had been discharged from Early Intervention Service after 3 years), frequent admissions, poor compliance,

complex delusional beliefs, paranoid in content, grandiosity, history of aggression towards family members, history of drug abuse, limited insight. It was noted that there was high risk that 'he will not engage with service and stop having his medication'. It was recorded that his care co-ordinator was informed by Seth's brother that 'this a.m. he had a fight with his sister'. The Mental Health Trust chronology notes that Seth's level of cooperation varied during this period and he was unavailable when members of the team called for agreed appointments on a number of occasions, but there were no significant problems. Of note: This is the first indication within community mental health notes that Seth had a difficult relationship with his sister. No other details about the fight were recorded. There is no evidence that a fight with Rachel was reported to the Police around this time.

Contacts in 2014

3. 52 Mental Health Trust notes of 21 January 2014 record that 'It is reported that he is doing very well in community and he has been almost two months on S17 leave'. Who reported this is not stated. The chronology author notes that it is not clear when a Community Treatment Order[16] commenced. The Mental Health Board Level Inquiry records that a Community Treatment Order was in place between January and December 2014.

3. 53 Mental Health notes between 1 April and 31 July 2014 record regular reference to Seth's reluctance to take medication and some clear statements that he wishes to stop, but also times when he appears agreeable to take medication.

3. 54 There are no further records in the combined chronology until 18 December 2014 when Mental Health notes show that Seth had been fully compliant and was happy to follow the advice given to him. His family was not concerned about him and his father had talked to him about going back to work which he really wanted to do. The notes record that 'Seth socialises, but has been told he is rather quiet. He claims not to abuse drugs any longer, although there is some doubt about on-going use of cannabis. He was attending his appointments at the clinic and with his care coordinator and the decision was made to take him off the Community Treatment Order.

3. 55 **Domestic abuse incident 6:** On 26 December 2014 at 18:00hrs after a gap of 13 months with no Police contact with the family, Rachel called the Police to report that she had been assaulted by Seth and had locked herself in a bedroom to escape. Officers attended and spoke with Rachel. She informed officers that she had been cleaning when Seth had turned off the lights and assaulted her. He was arrested and on interview he admitted the assault. He was issued with an adult caution for common assault. The report was closed. The actions taken were compliant with policies. No MERLIN was created which toolkits at that time required. This incident came under the definition of domestic abuse, however no DASH[17] risk assessment was completed.

Contacts in 2015

3. 56 At 07:30hrs on 8 February 2015 Seth made a 999 call and said he was hearing voices, had head pain, was schizophrenic, and his medication was not working. A clinical advisor rang back at 08:46hrs to undertake further assessment; Seth was alert and orientated. He

[16] Community Treatment Orders were introduced in November 2008, by new sections 17A -G being inserted into the Mental Health Act 1983 by the Mental Health Act 2007. In the Code of Practice it is called Supervised Community Treatment. It is a legal order made by the Mental Health Review Tribunal or by a Magistrate. It sets out the terms under which a person must accept medication and therapy, counselling, management, rehabilitation and other services while living in the community.

[17] Domestic Abuse Stalking & Harassment risk assessment used to establish the level of risk faced by victims of domestic abuse to inform safety planning and further actions by agencies.

reported not sleeping for 4 days, was not suicidal and his medication had run out. Ambulance delays were discussed and Seth accepted to being taken to hospital by taxi. At 08:59hrs Seth was seen in the Hospital Emergency Department he repeated the information above. He was discharged at 09:36hrs and a letter sent to his GP.

3. 57 On 12 February 2015 Seth saw his care coordinator and said he had stopped using his medication since the Community Treatment Order ended but would consider a lower dose. He said he was not using cannabis, but then said he was a using a bit, but felt well. There are no notes as to what steps were taken regarding his medication.

3. 58 **Domestic abuse incident 7**: On 20 February 2015 at 16:01hrs the Police received a call from Seth and a disturbance could be heard. He then reported that he had been punched in the face and that his brother had thrown a book at him. Officers attended and spoke to his elder brother Simon who told officers that Seth had been diagnosed with paranoid schizophrenia but had recently stopped taking his medication. Simon explained they had argued over a book and Seth had made some hurtful and abusive remarks. Seth reacted by throwing the book at him and they both then pushed each other. The officers then spoke with Seth who confirmed his brother's account. He said he was no longer taking his medication. The investigation/report was allocated to the Community Safety Unit. On review the secondary supervisor highlighted the concerns regarding Seth's mental health and his failure to take his medication. The investigating officer liaised with his sister Rachel and her brother regarding Seth to establish an understanding of his behaviour. The supervisor then liaised with staff at the Dennis Scott Unit regarding the concerns for Seth. This was good practice by the officer. The officer established that the worker allocated to Seth was on sick leave and as a consequence he had not been assessed. The investigation was submitted for closing on 2 March 2015. The secondary supervisor then decided a MARAC[18] referral should be made. The initial reporting officers noted a DASH[19] risk assessment was not applicable, and a MERLIN was not created which was not compliant with procedures. A 5 year intelligence check was undertaken, but not all previous incidents were highlighted. The Community Safety Unit supervisor requested an Adult Come to Notice (ANC) MERLIN be completed and this was shared with Adult Social Care.

3. 59 Mental Health Team notes of the above incident on 20 February 2015 record the account of an incident at home which included verbal aggression and some pushing between Seth and one of his brothers, but there was no punching or serious violence. The Police were called, and a notification sent to the Psychiatric Team (probably the MERLIN forwarded by Adult Social Care). The chronology notes that this is the third occasion Seth's mental health deteriorated after he stopped taking his medication.

3. 60 2 days later at 12:48hrs on 22 February 2015 Seth called Police to report that his brother was at his family address and there were restrictions in place to prevent him from doing so. He suggested that he had argued with his brother. The operator advised Seth that there were no restrictions on his brother attending the address and as such officers would not attend.

3. 61 4 days after the above call on 26 February 2015 at 10:08hrs Seth phoned the Police again saying his brother was trying to force his way into his room, but he stated that he had not been assaulted. The operator noted previous calls to the Police and the fact that Seth had mental health issues. Officers attended and spoke to Seth. It was recorded that he was

[18] Multi-Agency Risk Assessment Conference (MARAC) a multi-agency meeting where information is shared, risk assessed, and safety planning takes place to protect and reduce risk faced by high risk victims of domestic abuse.
[19] Domestic Abuse Stalking & Harassment (DASH) an evidence based risk assessment tool use to determine risk to victims of domestic abuse.

suffering with mental health issues and that he was a 'little down'. No ANC MERLIN or domestic crime report were recorded.

3. 62 An undated comment in the Mental Health Trust chronology records that Seth remained relatively well and at home from February 2011 until February 2015. This presents an inaccurate picture and suggests that incidents and hospital admissions were not all recorded or reported.

3. 63 On 11 March 2015 Mental Health Team notes recorded a telephone call from Seth's sister Rachel reporting that he had pushed her up against the wall and then tried to strangle her. Rachel said she did not inform the team because she wanted to protect Seth; she did call the Police but did not press charges. This may refer to the assault by Seth on Rachel on 26 December 2014; there is no other assault of Rachel known to the Police between these dates. Rachel said she bit Seth and so he stopped and let go, but he was still screaming whilst she called the Police. (There is no record that Rachel reported Seth tried to strangle her in the December 2014 incident). Rachel said she was surprised that Seth had come off the Community Treatment Order because of what happened in December 2014 (when Rachel was assaulted by Seth and he was cautioned). She could not understand this as she thought her family would have mentioned it. Seth's father and brother had been agreeable for Seth to be taken off the Community Treatment.

3. 64 **Domestic abuse incident 8:** On 22 March 2015 at 18:20hrs an abandoned call was made to Police from a number previously used by Seth. Officers attended his home address and spoke to his brother Ben who was standing outside. He informed Police that he had found Seth rummaging through his drawers and when he tried to leave taking the only house key, they argued. He did not want Seth to leave as he believed he was going to buy drugs. A fight ensued during which Seth punched him to the head and he sustained scratches to his right arm. Seth's sister Rachel who had been present confirmed her brother's account. They both stated that Seth had been diagnosed with schizophrenia and had not been taking his medication. Rachel and her brother Ben stated that Seth had been hanging around with drug dealers. Seth was arrested. The following day, both Seth and Ben declined to provide a statement when contacted by an officer from the Community Safety Unit. Seth denied assaulting his brother. As there was no realistic prospect of conviction no further action was taken against Seth. The investigation was reviewed by a supervisor within the Community Safety Unit and the matter was closed. No MERLIN or DASH was completed.

3. 65 **Domestic abuse incident 9:** At 18:29hurs on 3 April 2015 Seth called the Police reporting that he had been assaulted by his brother. Officers attended and Seth stated that he had become frustrated with his Wi-Fi and taken this out on a remote control, which he broke. His sister Rachel had phoned their brother Ben, who returned home, shouted at him, slapped him, and pushed him to the floor. Ben admitted to officers that he had pushed his brother. Rachel and her mother were in the house but did not see what had happened. Ben was arrested for the assault. On interview he stated that Seth had been aggressive towards his sister and had stolen money from him. When he found that Seth had broken the remote and did not seem to care, he had lost his temper and pushed him to the floor. Ben was charged with common assault to which he pleaded guilty.

3. 66 On 8 April 2015 Seth was reported missing to the Police. His family said he had his mobile phone, wallet, bank card, passport and £2,500 in cash. The family advised that this was not un-common behaviour and expected him to return when he ran out of money. The reporting officer noted that Seth had not been taking his medication since February 2015. On 11 April 2015 Seth returned to his family home but did not explain where he had been. At 11:47hrs Seth's mother Esther phoned the Police to report concerns for his welfare. She stated that he had mental health and drug dependency issues and she believed he was associating with drug users and dealers who were exploiting him due to him having access to money. Esther

explained that her daughter had told her that the people Seth was associating with had access to weapons. Esther said that Seth had returned from being missing that day and had now taken his possessions as he had found a property to rent. It was noted that Seth was under the care of the Dennis Scott Unit, Edgware Community Hospital. An ACN MERLIN was completed and shared with partner agencies.

3. 67 On 14 April 2015 GP notes for Esther record 'Gap in records with no routine appointments' but notes read "Back from USA, all luggage stolen" therefore it is assumed she was out of the country for a period of time.

3. 68 Seth's sister Rachel called the Police at 12:02hrs on 4 May 2015 to report that two males she believed were known to her brother had entered her house and stolen a Playstation. Officers attended and spoke with Seth and Rachel. Seth reported that two males he had previously lived with had come to his house and demanded money he owed, when he denied that he owed the money, the males entered the house and took £10 and a Playstation. They threatened to hurt him if he tried to stop them. Seth reported that the males had taken £3,000 from him when he stayed with them. Later that day Rachel called Police to report that the father of the two males who took the Playstation had returned it to her. The suspects were arrested. Investigating officers attempted to contact Seth, but were told by his parents that he had been Sectioned under the Mental Health Act for three months (this must have been a later visit as Seth was seen next day. See below). They informed the officer that they did not wish to take any further action as the property had been returned and they did not wish to put their son through a trial. A MERLIN was not shared on this occasion with Barnet Social Services.

3. 69 On 11 May 2015 at 14:37hrs Rachel called the Police to report that the two males responsible for stealing the Playstation on 10 May were outside and arguing with her brother Seth. Officers attended and stopped the two males. They established the males were not the same from the theft the previous day. The males stated that they had attended to get money from Seth which he owed them. They left when told that they were not owed any money.

3. 70 The Police were contacted by Seth's brother and father a week later on 18 May 2015 at 05:40hrs to report a burglary at their home; a very large amount of money had been taken. Attending officers were told that the burglary took place on the afternoon/evening of 17 May 2015 whilst they were at work. They believed Seth or his associates were responsible. Seth had not been seen since 17 May and it was not unusual for him to stay at a hotel when he had possession of a large quantity of money. The officers reported Seth as missing. Later the same day Rachel contacted Police and informed them of the hotel that Seth was staying in. Officers arrested Seth in respect of the burglary allegation and recovered the money taken. His father was contacted and advised of the arrest. He provided a statement detailing that he did not wish further action taken as the money had been recovered; his son had mental health problems and that they had arranged for the Mental Health Team to attend and assess him on 19 May. No further action was taken and the report was closed.

3. 71 **Domestic abuse incident 10:** On 19 May 2015 the Mental Health Team received a telephone call from Rachel reporting that Seth had attacked her. Rachel was advised to contact the Police which she did at 19:01hrs reporting that Seth was being aggressive towards her and that her father and brothers had to intervene to calm him down. She stated that her brother suffered with mental health issues. The Police and London Ambulance Service attended, and Seth stated that he was not getting on with his family and needed to leave in order to resolve his issues. He said he was hearing voices in his head and that he had a chip in his brain which had been put there at birth by IBM. Seth was taken to the Royal Free Hospital after he agreed to attend voluntarily for a mental health assessment.

3.72 Seth was seen by a clinical nurse specialist from Liaison Psychiatry. It was noted that he was open to Barnet Home Treatment Team and had been assessed on 15 May by a psychiatrist due to increased concerns about his acute signs of mental health relapse, and a recommendation had been made for informal admission, however, no bed was available. He was being managed by the Home Treatment Team at home whilst on the waiting list for a bed. During assessment Seth acknowledged that his sister felt threatened by him, hence she had called the Police, but he felt his sister was "acting like a mobster" who "kill your children, kill you and drink your blood". He said he felt he could not manage at home and would want to come into hospital without the need to be sectioned. Seth moved from one topic to another, and at one stage spoke of fighting the nurse. The nurse recorded that Seth was quite intimidating. It was noted that he was a heavy cannabis user. He agreed to informal admission. A bed was eventually found and at 01:50hrs Seth was transported to Chase Farm Hospital.

3.73 On 1 June 2015 Mental Health Trust notes record that Seth was transferred from a mixed health ward due to unspecified risk to female patients. From the notes it is not clear what this risk was. At interview Seth was expressing paranoid thoughts about his family. He blamed his sister for admitting him to a Mental Health ward at age 21 years. He appeared to have a fixed delusional belief about his sister.

3.74 At 17:17hrs on 3 July 2015 Seth contacted the Police to report that he had been assaulted by a fellow patient at Edgware Community Hospital. Officers attended and spoke with staff at the venue who stated that both Seth and the person who had assaulted him were patients being treated under Section 3 of the Mental Health Act. As a consequence of this incident and threats made by the assailant against the building, his care package was changed so that he was supervised by two nurses at all times. Staff advised the officers that neither were fit to be interviewed regarding the incident. The report was closed as not in the public interest to pursue as both Seth and his assailant were in appropriate setting receiving care for their mental health needs.

3.75 **In patient assessment early August 2015: Seth High risk to Rachel.** During this assessment it was recorded that Seth discussed his hatred and resentment towards his sister and showed no remorse about how he had beaten her up and grabbed her by the throat. It was noted that there was a high risk of re-occurrence of this behaviour towards her. He also appeared slightly threatening towards a care coordinator when discussing his situation, and that if he did not like what was said he could become violent physically or verbally. Seth also brought drugs onto the ward after going out on leave and when confronted he was confrontational and verbally and racially abusive towards staff.

3.76 On 14 August 2015 Barnet Borough Council Housing Department received a phone call from Seth and his support worker. They reported that he was due to be discharged from Edgware Community Hospital and he would need housing assistance because he can no longer return to his family home. Seth was advised to come in for an emergency housing need appointment. The list of documents he would require for the assessment was provided.

3.77 The Housing Department had an approach for an emergency housing appointment with Seth's support worker from Outreach Barnet on 20 August 2015. They were seen by the emergency duty officer. She checked the case with the medical team and they advised that the correct protocol had not been followed. The medical team contacted the hospital to advise that Seth will be returning to the ward until they have complied with the correct protocol. The following day, 21 August, Seth was discharged from Section 3 and was seen again at an emergency appointment at Emergency Housing (Barnet Homes) because he had been discharged from hospital. This time, the hospital sent the discharge documents to the medical team. Seth attended the appointment with his brother. It was confirmed that he was no longer able to live in the family home. He was re-housed that day. This is recorded

in Mental Health Trust notes. Seth's independent living was short-lived; the emergency accommodation was found to be sub-standard and he moved back to the family home.

3.78 At the end of September 2015 and during October 2015 Esther had appointments regarding a knee injury sustained in a fall on a bus. Her GP referred her to hospital outpatients for treatment, however, she either missed or cancelled appointments.

3.79 On 5 October 2015 Barnet Homes cancelled a homelessness application because Seth had secured accommodation through the service's private rent incentive scheme. His tenancy commenced from this date.

3.80 Seth commenced treatment with the Westminster Drug Project on 12 October 2015. He attended until 26 April 2016 when his case was closed due to successfully completing treatment. Of the 47 appointments which took place at regular intervals during those months Seth attended 18 of the 21 counselling sessions offered. He attended only the first 2 of 12 dealing with stress groups but did not attend thereafter. He attended all his key worker sessions. It was not possible to establish whether Seth was referred to the service and by whom due to the time which has elapsed.

3.81 At 00:24hrs on 24 October 2015 Seth called the Police to report that he had been threatened with a knife by two males known to him and they had stolen £10,000 given to him by his father. When officers attended Seth informed them that he had been with friends in his home when one of his friends had picked up his bag, which contained £10,000 and his other friend's bag which contained £5,000 and then run from the house. Seth stated that the money was for a holiday with his friends, but he was unable to provide any details regarding the holiday. Officers spoke with his sister Rachel who stated that her brother had not taken his medication for three weeks and thought it unlikely that her father would have given him £10,000. The officers attempted to contact the friend who had £5,000 taken but there was no response. The investigating officer spoke with Seth's father, who stated that he had not given his son £10,000, but he had taken it without his permission. His father did not want further action taken regarding the theft of his money by his son. Seth failed to respond to the investigating officer's attempts to contact him and the matter was subsequently closed.

3.82 During October 2015 Esther was initially seen by Central London Community Healthcare NHS Trust Adults Musculoskeletal Physiotherapy Team having been referred by her GP following a reported fall on a bus. Esther was seen for three sessions for assessment and treatment of a knee injury during October after which she missed appointment. She advised them this was due to being in the America following the death of her brother, her husband's ill-health, and her own health issues that resulted in her being admitted to hospital for 6 weeks. Esther had experienced an allergic reaction to medication which impacted on her diabetes.

Contacts in 2016

3.83 Seth was seen in the hospital Emergency Department on 8 January 2016 at 00:48hrs. He claimed to have collapsed in the shower and lost consciousness. He alleged he had been involved in a fight 2 days previously, but no wounds were seen. The doctor was aware from records that he had previously been Sectioned. Seth claimed to be off all medication and discharged from Mental Health. Seth absconded from the department at 04:34hrs; staff looked outside, rang him on his phone, but there was no answer. The absconsion protocol was correctly put in place. A letter was sent to his GP.

3.84 On 11 January 2016 Seth attended a counselling session at the Westminster Drug Project but did not attend the Dealing with Stress group held the same day.

3.85 Seth attended a key working session at the Westminster Drug Project on 14 January 2016. At 20:06hrs that evening he went to the hospital Emergency Department reporting that he had blacked out on a number of occasions; he denied having any injuries but felt like he needed medical help. After waiting 2 hours Seth announced he was leaving. He had not been seen by a doctor. A letter was sent to his GP.

3.86 On 18 January 2016 Seth attended a counselling session but did not attend the Dealing with Stress group on the same day. He attended a further counselling session on the 21 January.

3.87 From January 2016 Seth was receiving home visits from the Community Support Rehabilitation Team West. On 22 January 2016 a Mental Health Trust recorded entry following a home visit by a care coordinator described an unprovoked attack they had witnessed by Seth on one of his brothers. There were broken shards of glass, the bathroom window was smashed, remnants of a smashed wardrobe/shelving with discarded metal hinges scattered on the floor. A hammer was seen lying on the ground by his door as was a small plastic syringe. The plan was to refer for an urgent Mental Health Assessment.

3.88 **Domestic abuse incident 11:** At 09:45hrs that day (22 January 2016) the Police received a call from a worker at Barnet Mental Health Trust reporting that Seth had assaulted his brother who lived in the family home, but they stated that the Ambulance Service and Police were not required. The worker declined to provide a statement but advised that they were seeking a warrant from Court in order to assess Seth within the home; Seth's family had reported that he had deteriorated. When contacted by the Police his brother informed the investigating officer that he did not wish to provide a statement. He stated that Seth refused to accept he had a mental health condition and refused to engage with services. The investigation was then closed by the police with no further action taken.

3.89 On the 28 January 2016 an approved mental health professional attempted to affect a 135 warrant[20] for a Mental Health Act Assessment, however Seth would not allow the team to enter and entry could not be forced as the address on the 135 warrant was incorrect. There is an entry on the Health database RiO made on the 25 January 2016 to say Seth was staying at a temporary address in another London Borough. It is good practice to record a temporary address and it is not clear why this information was not known when the warrant was applied for.

3.90 Rachel phoned the Police at 02:58 on 30 January 2016. She had locked herself in a room as someone had broken in. She then stated it may be her brother who has mental health issues, but he was not allowed into the house. Her brother called police separately to report that he had received a call from his sister and that she feared someone had broken into the house. Officers attended and found that it was Seth who was in the property, but she informed them that she had not expected him that night. Seth informed officers that he lived at another address, but had returned because his boiler had broken, and he did not have heating or hot water. No further action was taken. No intelligence checks had been made prior to, or after, the officer's visit.

3.91 On 1 February 2016 a warrant with the correct address was obtained and the Mental Health Act assessment planned for 3 February with Police, ambulance and relevant professionals attending. However, the assessment was cancelled; no reason is given in the records. It is thought that the assessment was cancelled as not all the relevant professionals could attend. The assessment was rescheduled for the following day.

[20] A warrant under Section 135 of the Mental Health Act 1983 gives Police and Healthcare professionals the powers to remove a person from a private residence to be taken to a Place of Safety Assessment. or for an assessment to take place in the residence. The warrant is applied for by and approved mental health professional via the Courts and is issued for a specific address provided to the Court.

3. 92 On 4 February 2016 a member of the public called the Police at 14:13hrs to report a burglary in progress at an address. Officers attended and met Seth who informed them that he had locked himself out of his flat and had to break in to gain entry. Officers entered the flat and found that Seth had no food and the condition of the flat was reported as generally pretty poor. The officers contacted Seth's father, but were told the family did not wish to help as he was nothing but trouble and wished to have nothing to do with him. The Police recorded and shared a MERLIN with Barnet Adult Social Care.

3. 93 A further execution of the warrant was abandoned, and the assessment cancelled on 4 February 2016 as the Police attendance was delayed and Seth had left the property. The timing of this assessment visit is not recorded therefore it is not clear whether the Police visit to Seth above is before or after the assessment visit. The following day, 5 February, Seth's elder brother Simon phoned the Police at 14:36hrs regarding the incident the previous day. He was advised to contact their GP or local Mental Health Services, and an email was sent to the officers who attended the previous day. The execution of the 135 warrant and assessment was cancelled again on this day as Seth was at his father's address, therefore due to the different address the warrant could not be executed. It is possible that Seth's brother collected him and took him to the family home.

3. 94 On 12 February 2016 contact was made with Seth's family to arrange a date for the assessment, and he was eventually removed on 17 February to a place of safety. At the assessment he was found not to be detainable under the Mental Health Act and he was released to his home address. Seth explicitly stated that he did not want contact with Mental Health Services. He appeared to believe that his previous discharge as an inpatient meant that he was discharged from services completely. Despite this he agreed to an appointment on 14 March with a consultant to review his Care Programme. He did not keep this appointment and was discharged to the care of his GP. It is not clear from records why there was a delay and repeated cancellations for the Mental Health Assessment. A retrospective entry regarding the assessment on the 17th February in the 136 suite was made on the 26th February by a social worker. Why the entry was not made at the time of the assessment on the 17th February is not recorded.

3. 95 Seth attended a key worker session at Westminster Drug Project on 15 February 2016. The following day he cancelled a counselling appointment but attended counselling on 22 February.

3. 96 On 23 February 2016 Esther contacted Central London Community Health to report she would not be attending her physiotherapy appointment as she was in hospital but would rearrange the appointment when she was discharged. There is no record of her hospital admission at this time in the hospital chronology, therefore this may have been in another area.

3. 97 On 29 February 2016 Seth did not attend his counselling appointment at the Westminster Drug Project. He attended a key working session on 7 March and a counselling session on the 8 March.

3. 98 At 14:10hrs on 9 March 2016 Seth called the Police to report that he had taken cannabis and he needed an ambulance because he felt like he was dying and falling apart. A request was sent to the London Ambulance Service for assistance. Officers attended Seth's home address, but found he was not there. Officers made a further call to Seth and he informed them that he was in Sainsbury's in Camden, but he then refused to engage with officers. A few hours later officers re-contacted Seth and he informed them that he did not need the Police or an ambulance as he felt fine.

3. 99 An unnamed male called the Police on 12 March 2016 at 15:10hrs stating he had mental health issues and that he was having problems with his memory. The male would not provide his details but wanted help to get to hospital. The male then repeatedly hung up on the operator. London Ambulance Service were informed of the incident and an operator contacted the male, who stated that he wanted an ambulance because his head hurt. London Ambulance Service advised that they would not attend. Officers did not attend, and the incident was closed. The caller's identity was not confirmed, but the telephone number was noted as being the same as one used by Seth.

3. 100 At 17:31hrs on 13 March 2016 Seth was stopped and searched by Police and found to be in possession of cannabis. Seth's details were verified, and his father was contacted. He was issued with a fixed penalty. The reporting officer noted no vulnerabilities or mental health concerns, as such no MERLIN was created. A short time after being stopped Seth attended the hospital Emergency Department at 17:52hrs. There are no notes for this visit as he did not wish to be seen by a doctor. However, his discharge is given as 01:20hrs indicating that he was in the Department for 8hours 12minutes.

3. 101 On 14 March 2016 the Mental Health Trust notes record a CPA Meeting showing 'Discharged to GP for non-attendance'. On the same day Seth attended an appointment at Westminster Drug Project. This may be why Seth did not attend the CPA meeting. The Mental Health Trust and Seth's care coordinator were not aware that he was attending the Drug Project; this Review was told they would only have known if Seth told them.

3. 102 5 days later on 19 March 2016 at 15:55hrs London Ambulance Service contacted Police seeking assistance with a male suffering psychotic illness. Officers attended and met with Seth, his family, and the Ambulance Service. Seth was complaining of pain in his head. Seth replied to questions that he had not been asked. His family reported that he had not taken his medication for approximately two months. Seth packed a bag and walked out of his home whereupon he was detained by an officer under Section 136 of the Mental Health Act. He was then taken to Chase Farm Hospital by the Ambulance Service where he was admitted as an informal patient. A MERLIN was shared with Barnet Social Services on 21 March 2016.

3. 103 On the 22 March 2016 a CPA/Discharge meeting was held where the plan was made that Seth would be discharged to a Recovery House when a bed was available. The Westminster Drug Project record a key working session as being attended on this day by Seth indicating that he was having periods of Section 17 leave during his admission.

3. 104 **Domestic abuse incident 12:** On 25 March 2016 the Mental Health Trust record that Seth was discharged to Recovery House. At 16:35hrs that day the Police were called by Rachel who reported that Seth had turned up outside the family home and had damaged a car. She said she believed Seth had escaped from Chase Farm Mental Health Unit. This indicates that she was unaware that he was to be discharged from hospital. Rachel explained to officers that Seth had turned up outside their home and rang the doorbell, but she was reluctant to let him in as she feared he could be violent. Seth had reacted to this by putting soil through the letterbox and then threw a plant pot at her car windscreen causing it to smash. He was arrested and conveyed to custody.

3. 105 Officers established that Seth had been resident at Dennis Scott unit, Edgware Community Hospital but had moved to Elysian House on the 24 March. Staff at Elysian House informed officers that he had been aggressive whilst there. The investigating officers were unable to secure an appropriate adult from Elysian House, Barnet Crisis Team, or the appropriate adult scheme. As a consequence Seth was bailed to return to the police station on 15 April 2016. Officers conveyed Seth to Elysian House, but they refused to accept him. The escorting officer was sufficiently concerned for Seth’s welfare that they called Barnet Crisis Team and arranged for a psychiatric nurse to attend to assess him. This was good practice by the

officer. Following the assessment Seth agreed to attend hospital voluntarily and he was conveyed by police to Thames Ward at Edgware Community Hospital. Rachel declined to engage with police regarding the investigation of damage to her car, which was closed following an Evidential Review. A MERLIN was shared with Barnet Social Services on 30 March 2016.

3. 106 **In patient assessment: Seth high risk to family especially Rachel:** The following day, 26 March 2016 the Mental Health Trust notes record that Seth was informally admitted to Thames Ward. Risks recorded were that Seth was considered of greater risk to his family at that time especially to his sister. He could not guarantee that he would not confront his sister for calling Police about him and he declined to answer vital questions. He had also missed two days worth of medication and was at risk of further deterioration in his mental state. He was currently on bail and most likely to breach his conditions if he was not admitted on the ward.

3. 107 At 19:14hrs on 27 March 2016 staff at Thames Ward, Edgware Community Hospital called the Police to report that Seth had damaged a television on his ward. Officers attended and spoke with staff who advised that procedures required them to report the matter, but they did not wish any further Police action. They asked that officers speak with Seth regarding his conduct. He agreed to pay for the damage. The investigation was closed. No MERLIN was made following this incident.

3. 108 On 29 March 2016 Seth is recorded as attending Westminster Drug Project for a counselling session and a key worker session. This suggests he was given leave from the ward to attend and the following paragraph seems to confirm this.

3. 109 In the early hours of the following day at 00:54hrs, 30 March 2016 staff at Thames Ward, Edgware Community Hospital called the Police to report that Seth had brought cannabis onto the ward. Officers attended. Due to the small amount he had in his possession, and that he was in a place of safety, the decision was made not to arrest, but he was given a fixed penalty notice. A MERLIN was not made following this attendance.

3. 110 During this time Seth remained an informal patient. The records between 26 March and 3 April 2016 indicate that he remained agitated, volatile, verbally abusive, and paranoid; he claimed that there was something in his head that prevented him thinking. Staff were concerned regarding his deteriorating mental health and as a consequent an escalating risk to others. For example, he had made direct threats of violence toward staff and was intrusive towards other patients in order to entice a response from them. In addition, there were recorded periods where Seth had been sexually disinhibited. Current risks assessed at this time were: Risk of illicit drug use- HIGH. Risk of property damage- HIGH. Risk of non-compliance with medication- HIGH. Risk of disengagement - HIGH. Seth was therefore placed under Section 5(2) with a view to transfer to the Intensive Care Avon Ward. Section 5 (2) is temporary holding power which can be applied by the ward doctor or an Approved Clinician and would be due to increased concern about the deterioration in the service user's mental health. This can include a lack of capacity to remain informally or it could be that the individual has become a risk to themselves or others and are not felt safe to leave the ward. Seth was subsequently placed on a Section 3 and transferred to Avon Ward. He remained an inpatient until 29 April 2016 when the Section 3 was rescinded and he was discharged after a Care Programme Approach meeting. Follow up was arranged that the Community Support and Recovery Team would see him in the community. Seth accepted two injections of Depot medication following his discharge from hospital, but then refused to continue. From this point Seth did not engage with Mental Health Services.

3. 111 Seth attended a further counselling session at Westminster Drug Project on 4, 11, and 18 April 2016. Following the appointment on the 18 April the counselling case was closed. Seth

attended a key working session on 25 April and on 26 April following telephone contact his case was closed noting that treatment was successfully completed.

3.112 On 29 April 2016 Esther attended a Central London Community Health Service physiotherapy appointment during which she explained significant life events which had prevented her from attending previous appointments. This included the death of her brother in American and her attendance at the funeral, her husband's stroke, and her own significant ill-health due to diabetes. Clinicians decided to offer further appointments in light of Esther's circumstances which was good practice. However, she missed the next three appointments scheduled in June and July. Esther was seen in August when she reported starting to feel better.

3.113 On the 3 May 2016 Esther saw her GP regarding ongoing pain in her knee. During the appointment she disclosed that her husband had married in another country and did not tell her. Also her son was a drug abuser, and she had lots of issues concerning him; a lot for her to cope with. Esther was offered a referral for counselling which she declined. She preferred to see her GP again in 2 to 3 weeks. It is not shown in the GP chronology whether she told her GP about her son's mental illness. Esther and Seth were registered at the same GP practice, but did not see the same GP consistently.

3.114 Seth had a 7 day follow-up post discharge with a Mental Health Service consultant on 5 May 2016. There appears to be no record of any discussion about possible risk to his family now that Seth is living back at home (in an annex).

3.115 On 10 May 2016 Seth saw GP2 when it was recorded that he was discharged 2 weeks ago, head feels a little full, is a little lethargic, no medication for 3 days. Smokes 3 joints a day. No alcohol consumption. Seth had a further appointment with GP2 on 25 May to discuss his medication. His use of marijuana was also discussed. He was advised to stop.

3.116 Seth returned to see GP2 on 14 June 2016 when it was recorded that he had stopped Depixal[21] as discussed with a community psychiatric nurse and psychiatrist. It is not clear from the GP records whether this information is from Seth (who had refused further Depot injections) or whether the information was known to the GP from Mental Health Services; there are no update letters to the GP from Community Mental Health Services in the GP chronology.

3.117 After a number of phone calls to arrange to see him, Seth's care coordinator 1 eventually arrange a clinic visit on 15 June 2016. Seth was accompanied by his brother (which one is not known), which may have ensured he arrived. No Depot injection was given, nor his previous missed doses discussed. The rationale given by care coordinator 1 for this was that they felt they had not established a therapeutic relationship with Seth, and he was unlikely to accept. Care coordinator 1 was aware of Seth's pattern of presentation and his ambivalence towards medication. It was discussed with his brother who advised that Seth was likely to be hostile. A medication review took place on 4 July due to Seth's non-compliance and an oral medication regime was commenced. Following this Seth's family reported the he was taking his medication. Seth picked up his medication from the Mental Health Service or his care coordinator took it to him on home visits.

3.118 On the 14 July 2016 Seth attended Edgware Community Main Outpatients Department There is evidence that he attended but refused to stay in the Department. A discharge summary was sent to his GP with this information. Stated 'Did not want to be seen by doctor', no record of who attended with him.

[21] Depixol injection contains the active ingredient flupentixol which is a type of medicine called an antipsychotic.

3. 119 Whilst on patrol on 21 July 2016 Police saw four males run on seeing them. A member of the public informed the officers that the males had gone to a building in the rear of Seth's family home. Officers attended the building and spoke with Seth through an open window. He allowed the officers access to his property. Seth was under the effects of drugs and he smelt of cannabis. Officers identified the males with him as those who ran from them and believed they used Seth's address to hide from the Police.

3. 120 Mental Health Trust notes of 25 July 2016 record that Seth presented as mentally stable and less hostile. Seth was not taking medication at this time and was reported to use cannabis occasionally. He remained under the care of the Home Treatment Team at this point. At the end of July there was a change of care coordinator when care coordinator 1 left their post. An attempt had been made to arrange a handover meeting with care coordinator 2 and Seth, however this did not take place as Seth did not engage.

3. 121 On 31 July 2016 Seth's brother Ben called Police to report that people were using the annexe in which Seth lived to deal and use drugs. He stated that Seth was being taken advantage of, but he was concerned that if Seth knew he had contacted Police, he would be volatile. On 5 August 2016 officers attended and spoke with Ben when he repeated the concerns he had regarding Seth. The matter was raised with the Safer Neighbourhood Team. No MERLIN was created on this occasion.

3. 122 Also, on 3 August 2016 Esther attended her GP surgery with her son (not stated which one in GP chronology) to see GP1. Notes record that her husband is still in hospital after a stroke and they were looking at long term care for him.

3. 123 Police officers attended Seth's home address on 19 August 2016 and executed a warrant under section 23 of the Misuse of Drugs Act 1971. Seth and two other males were within the property. A search was conducted but no suspicious items were found. No MERLIN was created.

3. 124 On 19 August 2016, after continued attempts to engage with Seth, care coordinator 2 met him for the first time at the family home. In the notes for the visit care coordinator 2 recorded "He stated I could see he was well". Seth stated that he did not need Mental Health Service and he would contact care coordinator 2 if he needed. The care coordinator then went on planned leave. There followed 5 booked home visits where Seth was not in.

3. 125 At 10:00hrs on 21 August 2016 Esther called the Police to report concerns for her son Seth and that his TV and Tablet had been stolen. She informed police that her son had the learning age of a twelve year old and he was being taken advantage of by males who were taking his money and using his flat to deal drugs. A scheduled appointment was arranged for 25 August. A MERLIN was shared with Barnet Social Services on 26 August, and a record created for the Neighbourhood Policing Team.

3. 126 Police officers attended Seth's address on 23 August 2016 and spoke with him. Two males were in the property with Seth and there was a smell of cannabis. Officers created a record of those within the address for information only. No further action was taken, and no vulnerabilities or mental health issues detailed.

3. 127 Officers attended the family home on 25 August 2016 and spoke with Esther and Seth. Esther re-iterated the concerns she detailed on the 21 August. She said that her son had befriended a male whilst a patient at Edgware Community Hospital and it was this male who was taking advantage of him. She said that males would come and go from her son's flat between 10pm and 4am. Seth was reluctant to let officers see his flat but he did disclose that he had sold his TV and Tablet at Cash Converters, but did not wish to tell his mother. The officers created a MERLIN and record for the Neighbourhood Policing Team.

3. 128 On 26 August 2016 care coordinator 2 and a colleague made a home visit to Seth. He maintained that he was well and was taking his medication. Later that day at 16:40hrs Seth called the Police to report a burglary. Officers attended and spoke to his mother Esther, Seth, and his brother. They reported that a safe had been taken from the brother's room, which contained a very large sum of cash. Esther and her son believed that Seth or persons who had visited him were involved because only the safe had been taken and its position was only known to a few people. Forensic enquiries were negative. On 9 September the investigating officer visited Seth to establish whether he knew anything further about the incident. He gave a rambling response, detailing a number of explanations, some of which were not plausible. The investigating officer then gave crime prevention advice to the family and the report was then closed. A MERLIN was shared with Barnet Adult Social Care.

3. 129 Esther attended her GP surgery and saw GP1 on 2 September 2016. She was stressed due to the burglary which took place the previous week. There is no note of what support was offered.

3. 130 On the 13 September 2016 the Police arrested a male who was in possession of a bank card in Seth's name. Seth initially told investigating officers that it had been stolen, but then said that he had given the card and the PIN to the male in lieu of a drug debt. Seth's family informed the officers that a group of males were taking advantage of him and stealing his possessions. They also provided details of his medical history and stated that he frequently did not take his medication. A MERLIN was shared with Barnet Social Services on 27 September.

3. 131 Police observed a number of males in an area of Barnet on 25 September 2016 who were believed to be connected to the supply of drugs, and who were behaving in an anti-social manner. Seth was among them. Officers believed that Seth was being taken advantage of and he was taken to his family home. Family members had the same concerns as the officers and thought the group were also stealing from Seth. A MERLIN was completed and shared with Barnet Social Services.

3. 132 On 6 October 2016 care coordinator 2 and a colleague visited Seth at home for the first time since July, following a number of attempts. Seth said he was well and taking his medication. This was confirmed by his elder brother who was present.

3. 133 Seth saw a GP accompanied by one of his brothers on 1 November 2016 (not recorded which brother). The doctor was asked to sign an exclusion health insurance form to enable Seth to travel to Israel to do voluntary work in a kibbutz. Seth said he had not taken his medication. The doctor noted that his condition was stable. (There is no information to suggest that Seth did go to Israel).

3. 134 Esther missed a further physiotherapy appointment on 14 November 2016, and on 30 November a discharged letter was sent to her and her GP.

3. 135 At 09:00hrs on 29 November 2016 Seth called the Police to report that a male had threatened him and demanded money. He stated that the male had threatened to harm his parents if he did not give him the money. A few minutes later a member of the public called on behalf of Seth stating that a male had attempted to rob him. Officers attended and located Seth. He then gave officers conflicting accounts, but ultimately stated that a male had entered his house without his permission and demanded monies from him. He reported that the male then made him go to the Bank to withdraw money whilst he waited outside. Seth said that when he was in the bank he could see the male at a café, so ran to another bank and called Police. The attending officers completed enquiries at both venues and the

information they obtained contradicted Seth's account. No vulnerabilities or mental health issues were noted.

3. 136 A supervising officer contacted Seth's mother Esther and his elder brother who reiterated their previous concerns, namely that Seth was being taken advantage of due to his mental health, drug, and learning issues. They stated that the same people were also stealing from him. Seth declined to engage with the supervising officer and did not wish to attend a community support group that was suggested. The secondary supervisor undertook the following:

- Created a MERLIN which was shared with Barnet Social Services on 30 November.
- Set up a special scheme on the family address in order that any officer who attended would be aware of previous issues.
- Engaged with the relevant Safer Neighbourhood team and the gangs unit within Barnet.
- The investigation was closed due to Seth's lack of engagement.

3. 137 On 13 December 2016 a Care Programme Approach meeting was held. In attendance were Seth, care coordinator 2, a consultant psychiatrist, and Simon, Seth's elder brother. The overall impression noted was that Seth had improved and had plans to travel to Israel to work on a kibbutz in the next year. Simon reported that Seth was compliant with his medication at this time, but Simon rated his health as 50:50. Previously Seth's family had initiated guardianship proceedings, but these had ceased in light of his improved mental health. Their father remained in a nursing home at the time of this meeting, but he died a short time later.

3. 138 Following a re-referral by her GP, Esther was seen once more for physiotherapy on 13 December 2016. As she was on the waiting list for knee surgery the plan was agreed with Esther that she would be discharged and seen post surgery.

3. 139 Seth was seen by care coordinator 2 with his brother on 16 December 2016. Which brother is not recorded. His brother raised concerns that other drug users were being intimidating towards Seth, and there had been some damage to the family home, but Seth had the view that he could just replace items. (This entry was created retrospectively on 15 September 2017)

Contacts in 2017

3. 140 On 1 January 2017 at 03:58hrs Seth's sister Rachel called the Police to report that a group of youths had gone through the side gate of her home. She explained that her brother who had mental health issues was living in a property within the garden, but she was not sure if he was at home. Officers attended and spoke with Seth. He stated that the males had come to a party he was having. The officers did not find any drugs or illegal activity. The officers informed Rachel of the outcome. Officers did not note any vulnerabilities or mental health concerns.

3. 141 Esther was seen at an Orthopaedic Clinic on 9 January 2017 for a full assessment. She admitted she was depressed when her husband died the previous year. She said she felt okay now but was suffering with pain in her knees which severely limited her movement and sleep. Esther said she lived with her children and would not require support on discharge home, they would look after her. She was place on a list for surgery.

3. 142 Also, on 9 January 2017 at 14:56hrs Seth called the Police to report that a male was coming to his house the following day to take money from him. He explained that the male came to his home and let himself in, and he had been robbed in an alleyway and his phone was taken the previous day. The operator noted Seth sounded confused. Officers attended but there was no response and the house was in darkness. An appointment was arranged and on 12

January officers attended Seth's address. He refused to let officers in and refused to provide any details about the 9 January allegation. A MERLIN was shared with Barnet Adult Social Care on 13 January and forwarded to Mental Health Assessment Services and acknowledgement received the same day, confirming that the information had been sent to Barnet Community West Support & Recovery Team as the patient was under their care. A crime report should have been recorded detailing the robbery allegation.

3. 143 **Domestic abuse incident 13:** At 14:20hrs on 17 January 2017 Seth attended Colindale Police station and reported that his two brothers had assaulted him with a hammer and punched him to the head. Seth referred to contacting the Queen. London Ambulance Service attended and spoke with Seth. He left soon after. The reporting officer created a domestic incident report and intelligence checks were completed, but limited results documented. A domestic incident crime report was completed. The initial reporting officer completed a DASH risk assessment which was assessed as high. No 5 year intelligence checks were recorded as completed. A MERLIN was shared with Barnet Social Services on 18 January which was forward to the Mental Health Assessment Team and an email acknowledgement of the MERLIN was received the same day. This informed Adult Social Care that it had been forwarded to a different team as the patient was not under their team.

3. 144 On the 18 January 2017 the report was reviewed by a Community Safety Unit supervisor who noted the answers recorded in the DASH were incoherent, and a full reassessment was required. They contacted Esther who stated that no such incident had taken place. She gave background regarding Seth covering his mental health and drug issues. Due to the inconsistencies officers were resent to the family home and to check on his Seth's welfare.

3. 145 On 19 January 2017 officers attended Seth's address and spoke with his elder brother Simon. He showed the officers CCTV footage from within their home, which showed Seth trying to use a hammer to smash the patio door. Simon stated that he decided with his brother and mother that they should get the hammer, but Seth refused to hand it over and fought with his brothers. Neither the brothers nor his mother wished to provide statements. When officers spoke with Seth he stated that he did not wish to report his brothers he just wanted to speak with someone about what had happened. The officers then challenged Seth regarding his behaviour that they had seen on the CCTV. He responded by saying that it was his house as well and he just needed to use the washing machine. The secondary supervisor reviewed the report on 25 January 2017 and documented that there was no evidence of an assault and closed the report. A MARAC referral was not documented as being considered and no MARAC referral was made; a reassessment of risk was standard.

3. 146 Seth's brother Ben contacted the Police at 03:00hrs on 24 January 2017 to report a burglary in the annexe in which Seth lived during which a bicycle had been taken. Officers attended and viewed CCTV footage, but it was judged to be of insufficient quality to identify who had stolen the bicycle. The incident was closed due to insufficient evidence.

3. 147 On 28 January 2017 at 21:30hrs Police officers checked the rear of Esther's property with her permission. Officers noted that there were a number of people in the rear annexe who did not match Seth's description. Officers informed Esther who gave permission to enter the annexe. The males stated they were there with Seth's permission. Seth returned to the property soon after and spoke with officers. Whilst in the annexe the officers saw a bag of cannabis, Seth admitted to officers that it was his; he was then arrested and during the subsequent search officers found two small bags of cocaine. On interview Seth admitted purchasing and possessing the cannabis and cocaine. He received a caution for possession of the drugs. A MERLIN was shared with Barnet Social Services and picked up by them on 30 January; it was forwarded to the Mental Health Team that day. An email acknowledgement was received on 1 February informing Adult Social Care that it had been sent to Community Support and Recovery Team West.

3. 148 Seth's mental health care coordinator 2 recorded that there had been a fight between Seth and one of his brothers in January, but no details were given.

3. 149 Seth's brother Ben called the Police at 17:07hrs on 29 January 2017 following Seth's release from custody. He was concerned that the males who had been taking advantage of his brother would return because of his release. He requested that officer's attend to check on his welfare because he was not able to due to being stuck in traffic. Ben expressed his concerns about people coming to the home to see his brother and wanted to know what he could do. Officers offered advice. Seth was not present at the time of the officer's visit.

3. 150 At 18:25hrs on 3 February 2017 the Police received a call from Seth's brother Ben reporting that Seth had threatened his fellow tenants in the annexe. Officers attended and spoke with Ben and the tenants who explained that Seth demanded they pay rent when he realised that they had not been paying. When they refused, Seth left and returned with a male who threatened them with a knife and demanded that they give Seth the money. They stated that they offered to pay the following week. In response the male threatened to come back with a gun if they did not. The report was allocated to CID for investigation. The secondary supervisor noted previous concerns relating to Seth. The tenants declined to provide a statement regarding the incident due to having resolved their differences with Seth. It was noted that the family were in the process of issuing an Eviction Notice to Seth. On 26 February the investigation was reviewed and closed due to insufficient evidence.

3. 151 **Domestic abuse incident 14:** On 4 February 2017 at 19:46hrs Seth flagged down Police officers in the street and alleged that his brother Ben had threatened him with a knife and punched him to the head. The officers then returned with Seth to his home and he repeated his account in front of his fellow tenants in the annexe. The tenants then interjected and stated that this was not the case. The tenants said that Seth and Ben argued and Seth had gone to assault his brother who had responded by restraining Seth; Ben then left with a knife that was in the annexe for safe keeping. The tenants also gave information regarding the incident the previous day. Ben provided the same account as the tenants. A DASH risk assessment resulted in standard risk. A MARAC referral was considered, but not deemed necessary, and intelligence checks were made. The report was reviewed by the Community Safety Unit and closed on 7 February. A MERLIN was shared with Barnet Social Services on 6 February who emailed it to the Mental Health Assessment Service the same day. An email confirmation was received by Adult Social Care on 8 February stating that it had been sent to Community Support and Recovery West Team.

3. 152 On 8 February 2017 Esther's GP notes record that she asked for a letter to help with a benefit application. She was due a pre-assessment and surgery on her knee on 23 February following a number of previous cancellations. Esther was advised to apply for a disability blue badge.

3. 153 On the 13 and 15 February 2017 Esther had contact with Occupational Therapy to plan for any aids she may require on discharge from hospital following surgery on her knee. The operation was planned for 23 February but was cancelled due to lack of theatre time.

3. 154 **Domestic abuse incident 15:** At 13.41hrs on Friday 24 February 2017 Rachel called the Police to report that she had been assaulted by Seth and she was injured. Officers attended and Rachel described how she had gone to the annexe where her brother lived to persuade the group present to leave, she stated that she had told Seth that she no longer wished his friends to visit. As she left she took the key to the annexe. She explained that Seth followed her demanding the key, when she refused he pushed her to the floor and punched her to the head. When Rachel threatened to call Police Seth snatched her phone and ran off. A few hours later Rachel called the Police to report that her brother had returned. Officers attended

and arrested him. On interview Seth gave a confused account denying and then partially admitting to assaulting his sister and taking her phone; he was charged with common assault and remanded in police custody. Officers completed a domestic abuse report and a DASH risk assessment, but the risk was incorrectly graded as low (it is suggested that this may be because Seth had been removed into custody). The DASH risk assessment totalled 10, under the threshold for MARAC, however, a MARAC referral was made on the basis of professional judgement. This was good practice by the officer concerned. The MARAC referral was received by the Hestia Barnet MARAC secure email on Sunday, 26 February. No MERLIN was created.

3. 155 Victim Support received an automatic referral from the Police for Rachel as a victim of crime on 27 February 2017. Victim contact officer 1 contacted Rachel the same day, however she said she did not require support at that time. She consented to being sent a text with Victim Support contact details. The case was closed.

3. 156 On Monday 27 February 2017 Seth appeared in Hendon Magistrates Court. The Crown Prosecution Service had authorised two charges: common assault by beating and theft. Crown Prosecution information about the offences describe how Seth had taken exception to Rachel telling his friends to leave the annex, he had grabbed her coat, pushed her to the ground and then punched her twice to the head causing a small cut above her right eye. Rachel had threatened to call the Police; Seth then grabbed her phone and took it along with her Oyster card and £30 in cash. Seth refused assessment by Court Liaison and Diversion Service[22]. He pleaded not guilty to both charges maintaining that he had been assaulted by his sister. He was remanded in custody.

3. 157 Mental Health records do not include reference to this Court appearance and there is no evidence of liaison with the Barnet, Enfield & Haringey (BEH) Trust's Community Mental Health Team on record. Information held by the Mental Health Trust regarding Seth being in prison was held by the Trust's prison In-reach Team who provided healthcare for prisoners. Care coordinator 2 in the Trust Community Mental Health Team did not have access to prison health records; the Trust's prison healthcare team use SystmOne, whereas the Community Mental Health Team use the RiO database. Seth was seen by the Trust prison In-reach healthcare service on 28 February when he reported feeling stable in his mental state and euthymic[23] in mood. He denied suffering from any psychotic symptoms. The plan was to discuss his case at the In-reach Team meeting. Notes of this assessment contain an indication that a Safeguarding alert may have been raised regarding a report by Seth that he had a pregnant girlfriend. However, the Mental Health Service Individual Management Review (IMR) found no indication of where or how the issue of Safeguarding was to be dealt with given what is described as a *"serious domestic assault".*

3. 158 Also on 28 February 2017 the Mental Health Trust records show that a social worker referred Seth to MARAC, on the grounds that a multi-agency approach was required to help him come off drugs and concerns that he was becoming involved in gangs. From Mental Health Service records it is unclear what became of this referral, what action was taken, or any follow up to

[22] The Hendon Liaison and Diversion Service is operated by Central and North West London NHS Foundation Trust (CNWL) in partnership with Barnet, Enfield and Haringey Mental Health NHS Trust (BEH is the Mental Health Service provider with whom Seth was a patient) and Together For Mental Wellbeing. The model aims to provide a more accessible referral pathway within the Criminal Justice System and provides a gateway to primary and secondary mental health services and early point of identification within the CJS for detainees, and those on bail considered to be in need of further assessment and intervention who are young people, and/or people who are vulnerable including due to mental illness, intellectual disability, substance misuse and social issues. The team works on a rota basis in order to cover Hendon Magistrates Court and also Wembley, South Harrow and Colindale Police Custody Suites.

[23] Euthymia is a normal non-depressed, reasonably positive mood.

check the referral's progress. The referral is thought to have been to what is understood locally to be a Community MARAC.[24] No referral was uploaded onto the RiO database. There is no record of a referral being received by the Community MARAC.

3. 159 Seth's GP received a request for his medical records on 28 February 2017 from HM Prison Service. The records were faxed.

3. 160 On 1 March 2017 the Police referral to MARAC for Rachel (completed 26 February) resulted in initial action by the MARAC coordinator who referred Rachel to Solace Women's Aid for advocacy support. The referral was allocated to Victim Support Service for Independent Domestic Violence Advocacy (IDVA) support straight away, therefore there was no contact with Rachel by Solace. (Barnet Domestic Advocacy Service provides a Single Point of Entry for all Victims). The MARAC coordinator was off work on 27 and 28 February hence a slight delay in referral to Solace.

3. 161 Seth appeared in the Magistrates Court once more on the morning of 3 March 2017. He refused assessment by the Court Liaison and Diversion Service. Seth was granted bail with the conditions that he should not enter the district in the Borough in which the family home was located, and he must not have direct or indirect contact with his sister Rachel. His trial was listed for 21 June 2017. That afternoon his mother Esther took him to Barnet Homes. It is recorded that his mother made him approach for housing assistance because she stated she could no longer cope with him. She alleged that he wrecks the house, steals, hit his sister and uses drugs in the house. An emergency appointment was offered. Notes state that Seth requested his documents back and left the building before he could be seen. It is also noted that he said he would get an hotel. No assessment was able to take place. There was no further contact with Housing.

3. 162 At 10:18hrs on 6 March 2017 Victim Support Pan London Domestic Abuse Service received the referral from Solace Women's Aid electronically including a completed MARAC form dated 26 February. The case was allocated and at 10:32hrs Rachel was called by an IDVA who explained the service and matters of confidentiality. Rachel declined the offer of support. She was informed of the MARAC referral, and asked whether any other support was required from other agencies. Rachel said she is fine at the moment. He brother (Seth) was due at Court on 21 April; Rachel was willing to attend Court, and she was offered support at Court by the IDVA. Rachel was asked if she would like a worker to call back next week to receive an update on MARAC, to which she replied yes.

3. 163 On 7 March 2017 it is recorded that the Police received a prison release notification that Seth was to be released to his family address on 6 March. However, he was actually released with bail conditions not to attend the family home where Esther and Rachel lived. Seth was bailed to an address out of the Borough.

3. 164 At 22:21hrs on 8 March 2017 the Police were contacted by a tenant of the annexe at Seth's family address to report a burglary. The tenant stated he returned from holiday to find Seth in his room. The following day (9 March) officers attended and spoke with the informant and Seth. He informed the officers that he believed the tenant had been evicted due to non-payment of rent and as such he could freely go into all of the rooms. The reporting officers did not note whether any items were stolen. The secondary investigator made attempts to contact the informant, but they did not respond. The investigation was closed on 21 April. The initial officers noted no vulnerabilities or mental health concerns. Seth was in breach of his bail conditions by being in the vicinity, but this appears not to have been recognised.

[24] The area is uses a MARAC type system for a multi-agency forum for none domestic abuse cases which is called a Community MARAC. This should not be confused with MARAC which is nationally understood to assess risk and safety plan for high risk victims of domestic abuse.

3. 165 As a result of the MARAC notification Central London Community Health put a flag on their system regarding Rachel's referral to MARAC. She was not however, known to the service, although her mother Esther was.

3. 166 On 14 March 2017 Mental Health Trust notes record that a care coordinator called Seth's brother (which one is not recorded) and was told that Seth had been behaving well towards the family although he was observed laughing hysterically for no reason. The record notes that the week before the arrest Seth pushed his sister after she chased his friends out of the house. He was bailed to the garage/flat conversion pending Court presentation. This was incorrect; his bail conditions stated he was not allowed at the family home or in the area and the assault was more than a push.

3. 167 A MARAC took place on 15 March 2017 at which Rachel's case was discussed. Information shared included:

- Victim Support: IDVA has supported victim in February and will contact her again to offer support. The perpetrator is her brother, but she is now safe living with her mother in the current address since the perpetrator is residing at his bail address.

- Police: Perpetrator is a drug addict and gets involved with criminal activities. He is currently on bail with conditions not to contact the victim directly or indirectly and to stay at his bail address away from the family home. His family is trying to get help for his drug problems.

- Mental Health: Perpetrator is known to the service (no diagnosis disclosed) and drug use is the problem. (no information about the MARAC was entered onto Seth's RiO notes.) There were no records of actions for the Mental Health Service.

Actions from the MARAC were:

- Action for Victim Support: the IDVA would contact client again to offer support. Following MARAC, Victim called five times and voicemail message left by worker, unable to contact.

Victim Support updated the MARAC coordinator by email on 28 March to inform them that the IDVA action could not be completed as Rachel could not be contacted directly. The case was closed.

IDVA records show that the IDVA tried to call Rachel on 20 March to update her on MARAC. The call went to a non-personalised voicemail therefore no message was left for safety reasons. Further unsuccessful phone calls were made on 21, 23, 24 and 28 March.

- Action for Police: If perpetrator is convicted include as part of order that he attends a drug programme.

Police updated the MARAC coordinator on 3 April that Seth was due for a Court appearance on the 21 April. The outcome of this was not sent or requested by MARAC.

No drug treatment order appears to have been requested at Court. However, a Police officer involved in the case remembers a discussion with the family who were concerned about Seth going to prison. They wanted him to get help for his drug use and his mental health. Representations were made regarding this to the Court, but no order was made.

3. 168 Esther entered hospital for surgery on her knee on 21 March 2017 and was discharged home on 29 March 2017 having had a total knee replacement. Central London Community Health

Adults Community Nursing in Barnet were notified that she would require district nursing on discharge for wound care management, and a referral was opened on SystmOne for Esther on the 29 March. Esther contacted the service's switchboard on 1 April to say that she had had a total knee replacement and needed her wound redressing and was awaiting a visit. District Nurse Team details were passed to Esther, and a home visit arranged. District nursing visits commenced on 4 April with an assessment. One of Esther's sons opened the door to the nurse. Visits continued up to 14 April when Esther appears to have gone to her GP practice nurse for ongoing care. Care by the district nurse was closed at that point.

3. 169 At 22:05hrs on 2 April 2017 a member of the public called the Police to report that a male on a nearby main road was being aggressive, spitting at people and making the Nazi salute. Officers attended, and identified Seth as being the male responsible and arrested him. On interview Seth denied making Nazi salutes and spitting on people, he suggested he was practising basketball shots. He admitted to throwing food and other items around his cell. A Police MERLIN was created and shared with Barnet Social Services on 4 April which was forwarded to the Mental Health West Locality Team that day. Receipt of the MERLIN was acknowledged via email on 5 April saying it have been passed to a named worker in the LINKS Working Team.

3. 170 On 3 April Seth was charged with criminal damage (whilst in custody), racially aggravated public order and racially aggravated common assault. He refused assessment by the Liaison and Diversion Service. On the 4 April at Harrow Crown Court the charges for the criminal damage offence against Seth was withdrawn. Bail was refused and Seth was remanded in custody. A MERLIN was shared with Barnet Social Services which was picked up on 4 April and forwarded to the Mental Health Trust West Locality Team. This was confirmed as received the same day and was passed to a member of the LINKS Working Team. The other charges relating to racially aggravated public order and racially aggravated common assault were discontinued on the 26 April as the neither of the eye witnesses wanted to attend Court. They were of the view that Seth needed to be diverted to other agencies due to perceived mental health difficulties.

3. 171 On the 5 April 2017 Seth was assessed in prison by member of the prison In-reach Team. It was record that he “Objectively appeared to be thought disordered and suffering from pressure of speech. Appeared to be suffering from paranoid ideations about his neighbours and other prisoners”.

3. 172 On 11 April 2017 Seth told a prison resettlement officer in the Out-Reach Team that he would need accommodation on release and a referral to a housing provider was to be made when his release date was known. He declined to engage with the assessment of any other needs. A further assessment was started on the system on 10 May 2017 but not completed.

3. 173 On the 12 April 2017 a prison resettlement officer in the Out-Reach Team contacted care coordinator 2 and was told that Seth had not been engaging in the community and they were in the process of discharging him. Care coordinator 2 reported that every time they tried to engage Seth he had been racially abusive. Details of Seth's charges were requested and his Court date of 2 May at Harrow Crown Court was given.

3. 174 On 21 April 2017 Seth was due in Court but did not appear as he was in custody on other matters. His bail was enlarged in his absence.

3. 175 The Police received a prison release notification on Thursday 27 April 2017 that Seth was to be released to his family address that day. At 00:35hrs on this day Seth's brother Ben called the Police to report that Seth had returned to the family address despite there being bail conditions preventing him from doing so and the males he associated with had also returned.

Officers attended and spoke with Ben, but Seth and the males he was with had left prior to their arrival.

3. 176 Esther visited her GP on 28 April 2017 following her knee surgery. Her notes record that Seth is home. There is no detail about any concerns or comments Esther may have expressed about this.

3. 177 **Domestic abuse incident 16:** At 15:53hrs on Sunday 30 April 2017 Rachel called the Police to report that a male was trying to break into the annexe at the rear of the family address. Officers attended and detained a male, who they established to be Seth. The family confirmed that they were happy for him to remain and provided him with a spare key for the annexe. Approximately 30 minutes after the Police left Esther called the Police to report that she had been threatened with a knife by Seth and that he was in the annexe smoking drugs. Officers attended and Esther explained that she had argued with Seth after she asked his friends to leave. He responded by punching her to the face. Her other son ejected Seth only for him to return later. After officers left they argued again and Seth threatened to cut and slash her face, so she made a further call to the Police. The officers arrested Seth for assault. Esther informed the secondary investigator that she did not wish to provide a statement as she did not want her son to go to prison and mix with undesirables.

3. 178 Seth had a mental health assessment by approved mental health professional 1 and a doctor at the Police station whilst in custody on 30 April 2017 due to his erratic behaviour. He was found not fit to be interviewed, but not detainable under the Mental Health Act. The assessor could not view his RiO records as their laptop could not access the database in the Police station. The Crown Prosecution Service were consulted, and they authorised Seth be charged with common assault; the Police were asked to obtain material relating to Seth's mental health, including a clinician's report.

3. 179 The approved mental health professional's report included the information that "in the past [Seth] has tried to strangle his sister" and that he had damaged her car during an altercation. The report records that Seth's mother was spoken to on the phone and she stated that she did not wish to pursue criminal charges, however she had been shocked that he had threatened her in the way he had. No safeguarding concerns were identified. The care coordinator was informed. The assessment report was not shared with Seth's GP as he was under the care of Mental Health Services.

3. 180 Seth was remanded in Police custody to appear at Court. A MERLIN was created according to procedures, received by Adult Social Care on 2 May and forwarded by them to the West Locality Mental Health Team the same day. The investigating officer completed a DASH risk assessment for Court proceedings highlighting that Esther and Rachel were unwilling to support a prosecution, and the vulnerability of both Esther and Seth. No MERLIN was created for Esther; at this time she was using crutches and had difficulty mobilising due to experiencing pain following her knee surgery.

3. 181 On 1 May 2017 Seth was assessed once more at the Police station by another approved mental health professional 2 who stated that he did not need to be sectioned as he "had prior MHA assessments and at no time has it been established that he has a mental disorder". The assessor did not have a RiO enabled laptop therefore could not check the records, thus the assessment was not informed by Seth's prior history, hospital admissions under section, and his diagnosis of schizophrenia. The decision was that the criminal justice system was an appropriate response rather than the mental health route. Mental Health Trust progress notes on 1 May 2017 record the incident when the Police were called to the family home after Seth slapped his mother and made threats to slash her face with a knife. However, the notes simply record that he was "rude, abusive and became aggressive leading

to him pushing his elderly mom". There is no reference to him slapping her or the threats towards his mother with a knife, nor recognition of her vulnerability following knee surgery.

3. 182 On 2nd May 2017 approved mental health professional 1 wrote an email concerning Seth's presentation (not on the RiO system) to the responsible clinician, the Community MARAC lead, and the inspector responsible for mental health across Barnet because he sat on the Community MARAC. The email suggested that Seth's case might need to be discussed in that setting because if he did not go through the criminal justice system he might be discharged. Approved mental health professional 1 wrote to the care coordinator and said if the Court decides to discharge him there was a need to protect the family and Seth himself. There is a note entered by care coordinator 2 indicating awareness that Seth was back in prison and that he had not been detained under the Mental Health Act following assessment. There is no note recording the email regarding the referral to Community MARAC and concerns about Seth and his family.

3. 183 Court proceedings took place that day, 2 May 2017, when Seth appeared in Hendon Magistrates Court from custody. He had committed offences whilst on bail; 2 counts of common assault against his mother. This was his second set of offences committed whilst on bail for the first offences against Rachel in February 2017. The Court was unable to deal with any breach of bail because he had not been presented before the Court within the required time limit (i.e. 24hr from arrest). It is of note that the 30 April 2017 when he was arrested was a Sunday and the following day was a bank holiday which could have affected the ability of officers to bring him to Court in the required time. Seth entered not guilty pleas to both assaults, and he was remanded in custody until 9 May for mental health assessment. Seth declined assessment by the Liaison and Diversion Service who liaised with the prison In-reach Team.

3. 184 Also, on 2 May 2017 Victim Support received a referral from the Police for Esther concerning the Assault Occasioning Actual Bodily Harm on her by Seth. Esther was phoned at 14:42hrs by victim contact officer 2. She stated that she was fine at the moment and that she was more concerned about her son. She was going to call the Police to find out what was going on with him. The case was closed.

3. 185 On the 4 and 9 May 2017 Esther had follow-up Orthopaedic appointments following her knee surgery. She was noted as being unhappy, mobilising very slowly, using two elbow crutches, and in considerable pain which she found worse than pre-surgery. The plan was to review progress in 6 months time.

3. 186 On the morning of 9 May 2017 Court proceedings took place and Seth was remanded in custody once more. He refused to be seen for the mental health assessment required by Court. Her Majesty's Court Service report shows that '*The Court was informed in the Mental Health Assessment report dated the 9th May 2017, that "if the Court is minded to bail Seth, he will be followed up by his care coordinator in the community. If the Court is minded to remand him, I will ensure the In Reach team monitor his mental health needs." Probation informed the Court that the post sentence supervision would assist the defendant on release from a custodial sentence'.* The mental health assessment was provided by a forensic mental health practitioner from the Together Court Liaison and Diversion Service.

3. 187 On the 5 June 2017 there was a further Court hearing held via video link when Seth was again remanded in custody for trial.

3. 188 Seth appeared in Court on 21 June 2017 at North West London Magistrates Court and found guilty of assaulting his sister Rachel. A theft charge was dismissed. He remained in custody, and the case was adjourned for another trial until the 23 June.

3.189 Also, on 21 June 2017 Esther saw a GP. She had been visiting a friend for two weeks in a town outside London when she became unwell. Esther also reported pain in her wrist and continuing pain in her knees; she was to see the orthopaedic surgeon in November. The wrist pain was diagnosed as Carpel Tunnel Syndrome. Analgesia was prescribed.

3.190 When Seth appeared in Court on 23 June 2017 he was also found guilty of 2 assaults on his mother Esther. Seth was to be remanded in custody for a pre-sentence report, and after concerns were raised by the defence solicitor the Court also requested that a psychiatric report be commissioned. Sentencing was deferred until 10 July. The Probation Service who are in Court on most occasions, as in this case, undertook to ensure that it was requested. There is no formal process for requesting psychiatric reports. Court probation officer 1 noted that the perpetrator was not "well enough" (i.e. mentally) to be interviewed that day. His defence solicitor stated that Seth was seen to have punched the glass screen when interviewed by his lawyer in the cells. Court probation officer 1 contacted senior probation officer 1 informing them that the defendant was too unwell to be interviewed on the day and that a pre-sentence report was required. There was no Court probation officer available to undertake a report that day had Seth been fit to undertake an interview. Court probation officer 1 sought confirmation from senior probation officer 1 that the best course of action would be to await the psychiatric report and for Seth to be interviewed on the day he returned to Court. The report request was logged with the Probation Court admin and allocated to Court probation officer 1 who sent an email to Barnet Enfield and Haringey Mental Health Services requesting a psychiatric report on behalf of the Court.

3.191 26 June 2017 RiO Progress notes contain a copy of an email from a probation officer sent to Seth's care coordinator and the consultant in the South Locality Team requesting a full psychiatric report after concerns regarding Seth's mental health were raised by his solicitor. He had appeared in the dock in a calm manner but when he spoke he was not making sense and sounded delusional. The note reported that Seth had been found guilty after trial for 3 Assault (Domestic). The request was that the report be allocated to the appropriate professional ready for a sentencing hearing at Hendon Magistrates Court on 21/07/2017.

3.192 The note also indicated that Probation would be preparing a report but would wait for a copy of the psychiatric report before interviewing him.

3.193 On 27 June 2017 Victim Support received a referral from the Witness Service concerning Rachel. Victim contact officer 3 tried to contact her by phone on 3 July, but she did not answer. A further call was made on 14 July by the senior service delivery manager who spoke to Rachel, but she declined support. A text was sent giving her Victim Support contact details again. It was noted that the case was likely to be linked to the first case of assault on 27 February 2017. The case was closed.

3.194 On the 5 July 2017 a community consultant psychiatrist on returning from annual leave received the request from Probation for an assessment. The consultant requested advice from the Trust's Community Forensic Services regarding the psychiatric assessment for Seth via court processes. The advice was to access this via the prison psychiatrist. The consultant emailed the probation officer the same day that they were not in a position to review a patient in prison and suggested that there were two prison psychiatrists who could be approached for a report. There is no evidence from the Mental Health Service notes that the prison psychiatrists were asked to do a report.

3.195 The Probation Court administrator chased up the psychiatric report on 7 July 2017 in a telephone call to the prison Mental Health In-reach Team. The Probation contact log on the NDelius database records the following entry: *"Spoke with C who said Seth presents as awkward. He is not psychotic and not "ill enough" to be on the hospital wing in custody. However, he lacks insight into his behaviour, is very immature, and does not recognise that*

his criminal behaviour has consequences. He has spoken with the brother who concurs with this view. He has no formal diagnosis - he has refused an assessment from the learning disability nurse. He has previously been diagnosed with Paranoid Schizophrenia and with mental and behavioural disorders due to cannabis and psychoactive substance abuse and Nicotine dependence (F12, F17 and F20 on ICD). This fits with his current presentation and immaturity. He is not currently taking medication, as he had stopped when in the community and this cannot be enforced at present. He has had a depot previously which was of benefit and he was more stable. C said he believes Seth would benefit from a hospital order to stabilise him and ensure he takes medication."

3. 196 On the 10 July 2017 there was a further Court hearing when Seth appeared by prison video link for update reports. There is no evidence to suggest that the information from the prison In-reach Team was seen by the Court probation officers or given to the Court. However, the record was not clearly identified as key information with regards to Seth's mental health and appears to have been overlooked by the probation officers as its significance was not clearly identified. No pre-sentence report was available as this required the psychiatric report. Seth was remanded in custody until 31 July. At this time there was no Mental Health Diversion team at the Court therefore no immediate access to information regarding Seth's mental health was accessible at the Court. Court probation officer 1 again sought confirmation regarding the pre-sentence report being completed on the day Seth next appeared in Court so that it could be informed by the psychiatric assessment. The Court probation officer was unable to say if a Mental Health Diversion Team in another Court had been contacted or whether information provided by the Defence about Seth's mental health had been followed up.

3. 197 On 31 July 2017 Seth appeared at Court via prison video link at North West London Magistrates Court. The psychiatric report was still unavailable; there is no log on the Probation database that it was chased up once more. Court probation officer 2 explained that a non-report had not been prepared and apologised to the Court for the lack of information on which they could base their sentencing. The Court deemed the offences so serious that there was no alternative to a custodial sentence. Seth was sentenced to 18 weeks imprisonment for the common assault and battery on his mother, and 10 weeks imprisonment for the earlier assault on Rachel which was to run concurrently. The custodial element was deemed to have been served on remand therefore he was released from Court on Standard Licence conditions[25]. No additional orders were requested, and no restraining order was imposed by the Court. Based on the assessment completed by Court probation officer 3 Seth was allocated to London Community Rehabilitation Company (CRC). This was based on the scoring as posing a medium risk of serious harm using the Risk of Serious Recidivism score (RSR) and information contained in the Risk of Serious Harm Screening (RoSH) and Case Allocation Screening (CAS). Seth was instructed to report to London Community Rehabilitation Company the following day and he signed a copy of his licence which stated this instruction.

3. 198 Mental Health Trust records note that Seth was released from prison on 31 August 2017, an incorrect date, however, from the steps taken the Mental Health Team understood that this was a misprint.

[25] Standard Licence conditions are the conditions that all offenders subject to licence conditions are subject to on release from custody. They can be supplemented by additional licence conditions to address specific risks and needs. The standard conditions are: to be of good behaviour; not to commit any offence; keep in touch with your supervising officer in accordance with instructions given; to permanently reside at an address approved by your supervising officer; not to travel outside of the UK.

3. 199 On the 1 August 2017 the perpetrator's case was administratively transferred to London CRC through the electronic process. He failed to attend the appointment given the previous day at Court. This was recorded as an unacceptable failure to comply.

3. 200 A senior probation officer SPO1 formally allocated Seth's supervision to offender manager 1 on 2 August 2017. Seth was registered as 'Medium Risk of Serious Harm' and as a domestic abuse perpetrator. A home visit was carried out and it is recorded that offender manager 2 saw him and recorded, "*I met with his sister who took me to the annex where the perpetrator was asleep. He looked a bit rough and after greeting him he told me that he was not aware of the fact that he has to report at Hendon Probation Office*". Offender manager 2 explained to Seth that he was on licence, and that normally he had to report at the office on the day of release. He was shown a copy of the licence the offender manager had taken with him and Seth recognised that he had signed it. The offender manager told Seth that he did not have to do this, but because he lived on his way to work; he wanted to give him a second chance. Offender manager 2 instructed Seth to report that day at the office before 12:00pm. As Seth did not have a phone the offender manager took his sister Rachel's number. Offender manager 2 undertook the home visit rather than offender manager 1 because offender manager 1 had picked up the licence when it came through from the prison and acted on it as a duty matter to follow up.

3. 201 Seth reported to the Community Rehabilitation Company office as instructed accompanied by his sister Rachel. The requirements of his licence were explained and he signed the relevant standard documents. It is recorded by the inducting officer that he displayed poor literacy skills. Seth said he was a millionaire who owned a business. Standard induction procedures were carried out and the offender manager recorded appropriate concerns and issues. He smelled of alcohol whilst at the visit; he was given a further appointment for 6 days later on 8 August 2017 to see offender manager 2.

3. 202 Also, on 2 August care coordinator 2 contacted Seth's brother to arrange a home visit and attempted to visit Seth at home on 3 August 2017, but neither Seth nor his brother were at home. A message was left on Seth's brother's phone to advise of a further visit on the 9th August 2017.

3. 203 On 8 August 2017 a response to a Police Borough Intelligence Unit check was received and recorded by offender manager 2. Following a manual search because IT systems were down, Police had found no domestic abuse related callouts in the previous 12 months. This failed to identify the assault on Rachel and Esther and was clearly incorrect.

3. 204 Also, on 8 August 2017 Seth reported to offender manager 2 as arranged. He was accompanied to the office by his brother (which brother is not recorded), but he was not present for the session with offender manager 2. Seth arrived an hour late which meant the session was briefer than it would have been. The licence and expectations were explained to him and an assessment for the OASYs Initial Sentence Plan was started. Offending was discussed briefly. Offender manager 2 wrote, " *He said that he felt bad about the offence, but the way he described a previous offence against sister indicated in my assessment some attitudes that violence is acceptable. Concerning the battery caution in 2014 it appeared to have occurred against his sister because he said that she "was lippy to me so I had to slap her to shut her up"* before adding that "*she had slapped him first*". It was recorded that Seth related the offence to his dad dying of a stroke in July 2016. He said his dad was 90 when he died which the offender manager felt appeared unlikely based on the perpetrator's age of 27.

3. 205 During the session the family structure was noted and that he lived at the family home with 2 siblings and his mother. He said the home was being sold and he would be moving to his own accommodation shortly. Offender manager 2 asked him to bring in details of this.

Offender manager 2 recorded in conclusion that he, "*did not engage well in the appointment asking to leave as soon as he had sat down. He refused to listen when I attempted to explore his failure to complete a safeguarding form and appeared to struggle to understand certain questions. On some occasions it was hard to follow his conversation and he appeared to struggle with dates".* Offender manager 2 thought there may be some form of learning disability which needed to be explored further, and if a family member attended the next appointment they intended to ask them to come into the appointment. His next appointment was given to him in writing.

3. 206 On 9 August 2017 a Mental Health Trust care coordinator attempted a home visit as they had planned, but no one was home. Records indicate the care coordinator was aware that Seth was discharged from prison with no medication. It is not clear if this fact was known on the 2 August.

3. 207 A short time later at 20:50hrs Seth's brother Ben contacted the Police having returned home and found the severely injured and lifeless bodies of his mother and sister. London Ambulance Service and Police attended. Ambulance Service practitioners pronounced both deceased at the scene. Witness and CCTV enquiries identified Seth as being a suspect for the murder of his mother and sister. He was arrested the following day after a call to the Police from a member of the public. During his interview he admitted to stabbing his mother and sister and was later charged with their murders and remanded in custody.

4. Overview

4.1. Before 2017 apart from one involvement with the Courts in April 2015 when Seth's brother pleaded guilty to assaulting him, the primary agencies involved with the victim's and perpetrator's family were the various branches of Mental Health Services both in the community and as an inpatient, the Police, Ambulance Service, Hospital Accident and Emergency Department, and GP practice. Members of the family had contact with these services, although it is not always clear which member of the family.

4.2. In the 8 years of the Mental Health Trust's involvement Seth had 8 inpatient admissions, he was detained under Section 2 of the Mental Health Act on 5 occasions, and Section 3 on 4 occasions. Over that time there appears to have been varying degrees of understanding about Seth's original diagnosis of paranoid schizophrenia. The information held by the Mental Health Trust demonstrates that they were well aware of his propensity to disengage from support and for non-compliance with his medication. From January until 18 December 2014 Seth was subject to a Community Treatment Order which does appear to have been successful in achieving compliance with his medication and becoming more stable. Of important note is the fact that 2014 was one of the few years where the Police were not called regularly by the family; the only call to them was at the end of December 2014 when Seth was cautioned for an assault on his sister Rachel.

4.3. The Police had significant involvement and were aware of Seth's mental ill-health, drug use, and vulnerability to exploitation by others. Family members regularly informed attending officers of this. The Police and Ambulance Service were also called upon to assist when Seth was at his most volatile and in need of hospital treatment. Following the introduction of the Vulnerable Adult Policy by the Police in 2014 which brought in the use of Adult Come to Notice (ACN) MERLIN notifications for sharing information with partner agencies, a total of 26 MERLINS were issued since 2010. There were also 10 occasions when MERLINS should have been shared, but they were not completed. Among the incidents where MERLINS were not completed were those involving assaults on Rachel.

4.4. The Police send MERLINS to Adult Social Care who act as the portal for their distribution. This meant they had some limited knowledge of Seth and his family. However, as he was

known to be involved with Mental Health Services the MERLINS were forwarded to that service and this concluded Adult Social Care's role. The following table shows the MERLINS within the period 2016 to 2017 which is under detailed review:

Date MERLIN Created	Received by Adult Social Care	Action Taken
1) 4 February 2016	MERLIN Ref: 16PAC029882 received on the 5 Feb 2016 (MERLIN re: Seth breaking into flat; locked himself out of he was living - poor living conditions discovered and no food)	"e-mailed to (Mental Health) Barnet Assessment Services" by MG
2) 19 March 2016	MERLIN Ref: 16PAC069411 received 22 March 2016 (MERLIN re: incident of Seth smashing windscreen of Rachel's car, also put soil through letter box)	e-mailed to Barnet Assessment Services by MM
3) 26 August 2016	MERLIN Ref: 16PAC211618 26 August 2016 (MERLIN re: theft of safe in home; Seth and others suspected. Seth gave 'rambling' response on interview. Family declined further action)	e-mailed to Barnet Assessment Services by PS at 14:33.
4) 13 Sept 2016	MERLIN Ref: 16PAC228016 14 Sept 2016 (MERLIN re: male had Seth's bank card. Seth vulnerable to exploitation).	e-mailed to Barnet Assessment Services by PS at 15:28
5) 25 Sept 2016	MERLIN Ref: 16PAC238628 28 Sept 2016 (MERLIN re: Officers believed Seth being taken advantage of and mixing with known drug suppliers. Family members similarly concerned and thought group were stealing from Seth.)	Emailed to Barnet Assessment Services by CD at 11:07am.
6) 29 Nov 2016	MERLIN Ref: 16PAC297525 1 Dec 2016 (MERLIN re: Seth alleges threats unless he pays money; concerns he is being taken advantage of due to his mental health, drug, and learning issues).	Emailed to Barnet Assessment Services by CD at 09:26 am
7) 9 January 2017	MERLIN Ref: 17PAC009435 13 Jan 2017 (MERLIN re: Seth alleged he had been robbed. Noted as confused)	Emailed to Barnet Assessment Services by RM at 9:45am. Email confirmation received 13 Jan 17 at 11:57 stating 'I am writing to acknowledge your referral and inform that it has been sent to Barnet Community West S&R Team because the patient is under their team. Thank you Barnet, Enfield and Haringey Mental Health NHS Trust Barnet Assessment Service'
8) 17 January 2017	MERLIN Ref: 17PAC013936 18 Jan 2017 (MERLIN re: Seth alleging assault by his brothers)	Emailed to Barnet Assessment Services by RM. Email confirmation received 18 Jan 17 stating ' ...to inform that it has been sent to a different team because the patient is not under our team but under a different team (BEHMT)

9) 28 January 2017	MERLIN Ref: 17PAC024095 30 Jan 2017 (MERLIN re: Seth being cautioned for possession of cannabis and cocaine)	Email sent to Barnet Assessment Service and saved in Wisdom by SE 30 Jan 17. Email confirmation received 1 Feb 17. Email confirmation received 1st Feb 17'. '...acknowledge your referral and inform that it has been sent to CSRT west.
10) 4th February 2017	MERLIN Ref: 17PAC030666 6 Feb 2017 (MERLIN re: Seth alleged threatened with knife by brother, but found to be Seth assaulting his brother)	E-mailed to Barnet Assessment Service and saved in Wisdom 6 Feb 17' by SE. Received by MH Assessment Service 7 February, mentioned on 7 February, but not loaded. E-mail confirmation received by ASC 8 Feb 17' '. Informed that MERLIN sent to CSRT West team'.
11) 2nd April 2017	MERLIN Ref: 17PAC084186 4 April 2017 (MERLIN re: Seth being aggressive, spitting at people and making the Nazi salute. Arrested for criminal damage, racially aggravated public order, and racially aggravated common assault. Charges later withdrawn)	sent to MH West 4th April 17' Emailed to BEHTR West Locality Team by CD at 16:38 E-mail confirmation received 5 April 17. stating '. Thank you for passing this referral on to the LINK Working Team. I am writing to acknowledge your referral and inform that it has been sent to MF, LINK Worker. (they) will inform the referrer that this has now been passed to the LINKS Working Team
12) 30 April 2017	MERLIN Ref: 17PAC108520 2 May 2017 (This MERLIN reports incident where Seth punched his mother in the face and threatened to cut and slash her face).	Emailed to BEH West Locality Team by CD at 16:26 E-mail confirmation received 3 May 17 by AO stating 'Thank you for passing this referral on to the LINK Working Team. I am writing to acknowledge your referral and inform that it has been sent to MF'.

4.5. The GP practice attended by Esther and Seth were aware of his mental ill-health and diagnosis. From the information provided to the Review the Mental Health Trust informed Seth's GP when he attended appointments and when he failed to attend. There is no record that the practice knew that Seth had attended the Westminster Drug Project between 1 October 2015 and 26 April 2016, nor does this attendance appear to be known in Mental Health Trust notes. There are entries in the GP chronology which indicate that Esther and Seth saw a range of GPs in the practice, and there are a few occasions when it is possible to identify that they saw the same GP at separate times, thus there may have been awareness of the interplay between the two patients i.e. Esther informed a GP that Seth was at home in April 2017 and this GP had seen Seth the previous year for review. In May 2016 Esther had talked about her son who abuses drugs and that there were lots of issues with him. Counselling was suggested by the GP, but Esther refused. Whether this information was picked up by the other GPs she saw is not visible in her notes.

4.6. Esther had 23 attendances at the Royal Free Hospital Trust, 7 of which were significant contacts including visits to the Emergency Department, others were in relation to her diabetes, for surgery, and orthopaedics. A GP referral to the hospital included a comment

about 'social problems', but there are no records elaborating on this, and there are no notes that Esther mentioned Seth during her attendances, Similarly, Community Health who provided physiotherapy and nursing to Esther after her knee surgery, although aware of her bereavement following her brother's death and her husband's illness, had no indication of any difficulties with Seth. Community Health was aware of the MARAC referral for Rachel, but she was unknown to them.

4.7. In 2017 additional agencies became aware of the victims and the perpetrator following the MARAC referral, and the instigation of criminal proceedings following Seth's assault of Rachel and then his mother. As is visible from the chronology in the previous section, this was a crucial period where liaison between agencies and the quality of information shared, both via MARAC and during the criminal justice process, between Mental Health Trust services in the community and prison, Police, Probation, the Courts and the family was not as it should have been. In some instances information was not shared at all. These issues will be discussed in the Analysis section of this report.

Other Relevant Information:

4.8. It is clear from Dr Joseph's interview with Seth for his psychiatric assessment for the murder trial that he was very thought disordered, paranoid, and had grandiose ideas. When asked he admitted to smoking skunk (a strong form of cannabis) after he was released from prison. He had no memory of his appointments with his offender manager at the Community Rehabilitation Company and said he had never seen a probation officer.

4.9. Seth insisted to Dr Joseph that he had only been out of prison for two days prior to the killings. He said *"I was at home and had a bath. I was trying to clean myself because I had a rash. I had blisters. They were going to kill me the night I came out of prison. I locked myself in my room. I was scared of being killed. People were coming up to me and trying to kill me. Somebody came into my house and then left, and it was not me. It was seen on CCTV"*. This illustrates the mental distress Seth was suffering, and yet he had been released from prison with no medication as he was not prescribed any whilst in custody.

4.10. Seth was aware of the charges he faced, and when asked what had happened he maintained that he killed his mother and sister because they were trying to kill him and his brothers were also involved by paying someone to kill him. Seth refused to hear the contents of a statement made by his brother which Dr Joseph offered to read to him; he told Dr Joseph to speak to his solicitor and left the interview room talking loudly as he went.

4.11. Seth was variously described as having learning difficulties, as having dyslexia, or being below average intelligence. Dr Joseph found him to be of significantly below average intelligence and to have difficulty in marshalling his thoughts in a logical sequence. Nursing staff confirmed that despite changes in medication Seth continued to have auditory hallucination. On the basis of Dr Joseph's findings that Seth's ongoing psychotic symptoms significantly impaired his ability to maintain his concentration and think coherently, he concluded that he was unfit to plead at his trial. As a consequence, Dr Joseph recommended Seth be made subject to a Hospital Order under section 37 of the amended Mental Health Act. He also recommended that, taking into account the risk of serious harm he presented to the public if set at large, particularly to his family, that he be made subject to a Restriction Order under section 41 of the same Act without limit of time. Dr Joseph judged the killings to be directly attributable to Seth's mental illness and believed he did not present a significant risk to others when not mentally ill.

4.12. There is information to suggest that Rachel, although just 5 years older than Seth, had somewhat of a maternal role concerning her younger brother. During mental health assessments he frequently made threats of harm towards Rachel and sometimes his family,

but these do not appear to have been taken seriously as they were made during periods of psychotic episodes.

4.13. No GP registration could be found for Rachel, therefore information concerning her is limited to the contacts she had with the Police and the very brief contact with an IDVA whose services she declined. Despite Seth's attitude towards her and her obvious fear of him at times, she appears to have been very reluctant to see him criminalised as her mother was also. They wished to see him provided with support for his mental illness and drug addiction.

5. Analysis

This section will address the terms of reference.

Term of Reference 1: *To describe agency contact following the perpetrator's first contact with Mental Health Services in 2002, and examine in detail agency contact with the victims and the perpetrator between 2015 when the perpetrator was first referred to in a record as posing a risk to his sister, and August 2017 the date of the victims' deaths. To provide context all agencies with relevant information prior to this timeframe are asked to provide a chronology of their involvement highlighting key events and addressing the terms of reference for this Review.*

5.1 This term of reference has been addressed in the chronology section of this report. The context provided by information from 2009 when Seth was first referred to Mental Health Services up to 2015 from which events are examined in detail, is itself full of relevant information. Assaults on Rachel were identified in November 2012 and December 2014 in addition to other evidence of assaults between Seth and his brothers, therefore the earlier years contain significant events which illustrate the stresses faced within the family and the many calls on services for support.

Term of Reference 2: *What plans were made and actions taken to ensure that the perpetrator could be released from prison and/or Court to ensure that his continuing care and welfare was catered for, and the safety of others was assessed and planned for? (Question asked by the family).*

Term of Reference 3: *The relevant criminal justice and health agencies to examine why no pre-sentence report and psychiatric report was provided in July 2017 to fully inform the Court of the perpetrator's health and offending history, including violent offences and domestic abuse, and in the absence of these reports what process did the Court then follow to consider risk given his previous offences?*

These terms of reference will be addressed together as the processes which address them are linked.

5.2 It is clear from the chronology that there were a number of systems inadequacies and failures which impinged on how Seth was released from prison without being in a stabilised mental condition, and without the safety of others, particularly his family, being considered. From his arrest for assaulting his sister on 27 February 2017 up to and including his release from prison, there were a series of gaps in liaison between agencies, lack of clear pathways or following those which existed, and miscommunications, all of which contributed to a lack of full understanding of Seth's mental diagnosis and the risk he could posed.

5.3 The trail of events started with the lack of a Police MERLIN being completed when Rachel was assaulted in February 2017. This meant that information about this serious incident did not reach the Mental Health Service to inform his care coordinator. Thus, the increase in risk posed by Seth was not able to be adjusted. When first in prison custody Seth was

seen by the Mental Health Trust prison healthcare In-reach Team for assessment on 28 February 2017 when he reported feeling stable in his mental state and he denied having any psychotic symptoms. At this early stage it could be expected that the In-reach Team would contact the Community Mental Health Team to retrieve his history and contact his care coordinator. This did not happen. His GP had faxed his records to the prison therefore they must have known that he was under the Community Mental Health Service. It was not until 12 April that a resettlement officer employed in the prison Out Reach Team contacted Seth's care coordinator for details of his history and was told that he was to be discharged due to lack of engagement. No summary of his previous care and hospital admissions appear to have been shared. This could have given an inaccurate impression about the seriousness of his diagnosis and that concerns were such that he could be discharged.

5.4 The problems with accessing information on Seth's mental health history is a significant issue. The fact that the approved mental health professional operating in the Police station could not access the RiO database is a major impediment to effective and accurate assessments. One such assessment found that Seth *"had prior MHA assessments and at no time has it been established that he has a mental disorder"*. This was clearly incorrect and did not recognise that Seth had a history involving 5 admissions under Section 2, and 4 under Section 3, in addition to previously being on a Community Treatment Order. The Police referred for assessment when in custody due to his presentation and history and the fact that he was found unfit to be interviewed indicated a degree of mental health problems, although he was judged not appropriate for sectioning at that time.

5.5 The difficulties in information gathering to inform the Court's decision making, and ultimately Seth's release, continued throughout the Court process. The Court request for a psychiatric report was based on Seth's defence solicitor's information and illustrates that his mental ill-health needed clarification or confirmation for the Court. Thus, some history must have been given in Court for the Court probation officer to hear. The Probation Service IMR explains that when the Court commissions a psychiatric report the Probation Service in Court will undertaken to ensure that it is requested. Somewhat surprisingly there is no formal process for requesting psychiatric reports; it depends on established practice and custom. If the Probation Service is aware that an offender is currently known to a psychiatric consultant they will be approached to provide the report, providing the Court agrees to their fee. If there is no known consultant then a psychiatrist known to cover the specific area such as Barnet will be approached and a request for a report sent. This is what took place in this case. However, given the length of time Seth had been known to Barnet Mental Health Service one would expect that a call to the service could have identified one of the psychiatrists that knew him.

5.6 Court Probation Service officer 1 sought confirmation from senior probation officer 1 that the best course of action would be to wait for the psychiatric report and to interview Seth on the day he returned to Court, and this was agreed. This was a reasonable decision as the Court would then have all relevant information on which to base sentencing. Court Probation Service officer 1 requested the report from the Mental Health Trust (BEH) via email on 23 June 2017 and the request was logged with the Probation Court Administration. However, this request was not responded to until the 5 July when a community consultant psychiatrist returned from annual leave and said they were not in a position to review Seth, and suggested prison psychiatrists were approached for the report. This reduced the time to obtain the report before the next Court hearing on the 10 July. It also delayed the pre-sentence report. The Probation IMR has made a recommendation regarding the commissioning of mental health assessments and psychiatric reports.

5.7 Court Probation officer 1 was unable to say when interviewed whether the Mental Health Division in Hendon had been contacted, or whether the information provided in Court by the

Defence about Seth's mental health had been followed up. There is no Mental Health Division team in Willesden Magistrates Court which was primarily a 'trials court' at that time.

5.8 The Probation IMR offers the opinion that Courts requesting reports often do not understand the difference between a mental health assessment and a psychiatric report. They are of the view that in this case a mental health assessment would have been sufficient and could have been achieved much faster. Court probation staff are also often not aware of the difference or assertive in informing sentencers of the difference. This being the case there is clearly a training need identified here.

Recommendation:
Information and/or training should be provided to those responsible for sentencing, and to Probation Court personnel, to explain the differences between a mental health assessment and a psychiatric report to enable the most appropriate and timely access to information to inform sentencing.

5.9 It is unclear when or whether a formal request was sent to prison psychiatrists for a report. This may highlight the impact of having no agreed referral pathway for such reports as stated in the Probation IMR. The information gained from the In-reach prison healthcare team when a Probation Court administrator chased up the report on 7 July 2017, (the contents of which are recorded on the Probation database) was helpful, but again seemed to minimise Seth's mental health condition. The person spoken to described Seth as immature and lacking in insight into his criminal behaviour, a view with which his brother concurred, but Seth was said not to be ill enough to be on the hospital wing, It was stated that Seth had "*no formal diagnosis... He has previously been diagnosed with Paranoid Schizophrenia and with mental and behavioural disorders due to cannabis and psychoactive substance abuse".* This seems misleading as it states his previous diagnosis which one would assume was a 'formal' diagnosis. Unfortunately, this information was not read on the system by the Court probation officer as it was not saved as key information and its significance was not clearly identified. The Probation IMR identified that no further chasing up of the psychiatric report had taken place; the Court administrator acknowledged that it had "dropped off" their radar.

5.10 By the time of the final hearing for sentencing the Court had no psychiatric report, had not been given the information from the Mental Health In-reach Team, and had no pre-sentence report on which to base its sentence. Court Probation Service officer 2 gave apologies to the Court. The information recorded from the In-reach Team included the view that Seth would benefit from a Hospital Order "*in order to stabilise him and ensure he takes his medication".* Had this option been recommended and taken by the Court Seth would not have returned immediately to the family home following his release. There was no consideration by the Court of the risk he could continue to pose to his mother and sister following the assaults on them for which he had been found guilty, and no consideration of a Restraining Order to keep him away from them which would have been available to the Court. The Probation IMR points out that normal practice would be for a non-report to be provided when a report with an appropriate sentence proposal cannot be made. This was not done on this occasion, but what value a non-report would have in this case other than to follow procedure, is doubtful.

5.11 The Probation IMR found that their Court staff were not active in highlighting to offender managers in the community the potential risks of harm that could be posed by offenders released from the Court or from prison if they have appeared by video link. As part of the allocation process for post release supervision of offenders Court Probation Service officer 3 completed a Probation risk of serious harm assessment. Surprisingly, the answer to risk of serious harm to family members was answered 'No'. All questions about risk of harm were answered 'No'. The assessment was not completed to expected standards, and available

information concerning mental health, substance misuse, family relationships and the offences committed had not been considered. The Probation IMR was of the view that had these combined factors been used for a thorough assessment the conclusion drawn would have been that Seth posed a high risk of harm to his mother and sister and he would have been allocated to the National Probation Service. As a consequence he was allocated to the Community Rehabilitation Company (CRC) who manage low to medium risk offenders, and they had no information supplied to them about Seth which would have enabled them to see immediately that he was a risk and to whom that risk was likely to be directed. The Probation IMR has made a recommendation regarding Court staff and risk assessments.

5.12 Seth was released straight from the prison due to time served on remand. There was no pre-planned release package put in place. The resettlement officers who prepare Basic Custody Screening assessments have a limited remit; they interview prisoners and complete a brief assessment of their needs in custody on reception and for post release when a Resettlement Plan is normally prepared, for example regarding treatment and accommodation needs. The assessment depends on the cooperation of the prisoner and Seth did not initially cooperate. When he did attend for interview he said he had accommodation issues. This was still in his remand period and a full plan was yet to be completed. The CRC IMR suggests this may have been because there was a further Court hearing and it was anticipated that there would be another period in custody. Seth was an un-sentenced prisoner on remand rather than a sentenced prisoner who had a known sentence and time for release. There is limited expectation for resettlement officers to liaise with external agencies such as Probation when dealing with remand prisoners, however, the resettlement officer had contacted the Community Mental Health Team in April 2017, but was given information that Seth was to be discharged which belied the seriousness of his mental health condition and the risk he posed. There was no evidence of contact with the In-reach Team before he was released straight from being on remand.

5.13 There are significant risks connected with releasing those who have mental ill-health from remand in prison straight from Court or prison (if final hearing was via video link as in this case) without the prison having time to prepare for their release. The author is aware of a previous Domestic Homicide Review[26] where the perpetrator was released straight from Court after a period on remand, without accommodation arranged, without essential anti-psychotic medication supplied, nor follow up in the community. His mental health deteriorated, and he savagely killed a woman who was trying to support him. Whilst appreciating that a person cannot lawfully be held once the Court gives a sentence which sets them free, steps must be put in place to ensure that in domestic abuse cases actions are taken to protect the victim/s from the perpetrator. No risk to Rachel and Esther was considered; had it been then a restraining order and re-referral to MARAC to safety plan should have been the minimum actions taken to protect them while a thorough risk assessment of Seth took place. Courts need to be aware that prison and community services need time to put in place a sufficiently robust plan in respect of vulnerable prisoners to ensure that they are not released without the necessary arrangements in place for such things as accommodation and medication.

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

[26] https://setdab.org/wp-content/uploads/2019/01/Tendring-DHR-2015-2.pdf

Term of Reference 4: *Was there anything which could have been done differently to help the family at times of crisis to manage the perpetrator's behaviour? (Question raised by the family)*

5.14 This term of reference will examine what if anything could have been done differently by the services which could have been in a position to help the family at times of crisis whilst Seth was outside of custody in the community or in hospital, and whilst on remand.

5.15 As will be evident from the chronology there were many episodes of crisis from the time of Seth's diagnosis in 2010 when Mental Health Services became involved. One way his most difficult behaviour was managed was through hospital admission under the Mental Health Act, and this must have given the family welcome respite from the difficulties they faced in managing his behaviour.

5.16 The Mental Health IMR found examples where concerted efforts were made to engage with Seth's family and evidence that this was successful at times. There were also missed opportunities to support members of the family in managing his behaviour. The IMR suggests that there were inconsistencies in approach by the family and the IMR found family members expressed the view that Seth's problems were behavioural or drug related and his mental illness was minimised. Not all information now known was shared with the Mental Health Team. The review of the records in the IMR found differences in views could not all be accommodated by Seth's treatment team, but there are notes which evidence that attempts were made to address this. Minimisation of a perpetrator's behaviour is often seen in cases of domestic abuse, and victims or families frequently do not wish to see a family member criminalised. This makes it all the more important that families are helped to understand the antecedents and symptoms of their family member's condition and the risks which may arise when their mental health relapses. Such explanations may need to be repeated over time. What would also have helped the family would have been a clear plan as part of Seth's Care Programme Approach explaining what to do and when, and who to contact at different times of the day or night when Seth relapsed so that action could be taken in coordination with the Mental Health Service. Seth's care plan was found lacking in this respect. This is contrary to NICE guidelines[27] which recommend giving carers written and verbal information in an accessible format including on how to get help in a crisis.

5.17 In common with intimate partner violence where good practice is not to withdraw from support when a perpetrator is removed from the home, but to step up the support to a victim to increase their understanding of domestic abuse, build resilience, and increase safety, so too should support be stepped up with families faced with Seth's family's stresses. Each time he was sectioned, or when he was in custody, it is likely that the family metaphorically heaved a great sigh of relief in the knowledge that they would have a period of calm until he was released. This would have been an ideal time to bring the whole family together to discuss family safety and a longer term management strategy.

5.18 What is most notable is the fact that it is Seth's brothers or sometimes his father who are the contact points for the Mental Health Service, and most often his eldest brother who did not live in the family home. Rachel and her mother do not appear in the notes of Care Programme Approach meetings and rarely as contact points, and yet they were living in close proximity to Seth experiencing his behaviour and ultimately at greatest risk. The Mental Health IMR points out that the care team should make assertive attempts to identify the nearest relative as a main point of communication, or an alternative family member as nominated by the nearest relative to avoid miscommunication amongst the family. This relies on the main point of contact disseminating information appropriately and accurately

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[27] 'Psychosis and schizophrenia in adults: prevention and management', NICE 2014 Paragraph 1.1.5.3 https://www.nice.org.uk/guidance/cg178/chapter/1-Recommendations#care-across-all-phases. Accessed 4/3/17

both within the family and with mental health practitioners. Greater contact with, and support for, Rachel and Esther was warranted and a whole family approach taken. Their perspective on Seth and his behaviour would have presented a more rounded picture of what was taking place and provided an additional route for recognising crisis. NICE guidance[28] recommends regularly reviewing how information is shared, particularly where there are communication and collaboration difficulties between a service user and a carer, which was an issue in this case notably when Seth was confrontational with family members. Holding meetings with all the family at times of crisis might have resulted in the prospect of achieving a consistent approach between the whole family and mental health practitioners, and a clear plan for supporting them.

5.19 In the five domestic abuse incidents involving Esther and Rachel two resulted in a conviction. They both declined to support Police prosecution as they believed that Seth needed medical support rather than prison. Officers consistently offered Esther and Rachel referrals to support services, and injunctions were offered and discussed. Family members often do not appreciate that prosecution can result in access to services which can benefit the offender, for example via a Drug Treatment Order or Mental Health Treatment Order. Seth had complied with his medication whilst on a Community Treatment Order and may have done the same with court mandated orders. Explaining this option to the family may have helped them to take the step they routinely avoided. Giving families information on these options for offenders, perhaps in leaflet form so that they could be considered over time may be worthwhile, especially in cases where the Police are called very frequently, and incidents are escalating in seriousness and frequency. However, it is appreciated that resources are limit and this may not be practicable.

5.20 Back in 2009 when the family experienced their first crisis with Seth he was taken to the Royal Free Hospital by ambulance. This was his first assessment in the Emergency Department. The family had called the Police because they told hospital staff that they could no longer cope, it was noted that he had been violent towards the family. The hospital IMR records that this term of reference was discussed with staff, and the teams believe that with their increased knowledge of domestic abuse and the introduction of a hospital based specialist IDSVA, where such concerns arise today they would make a referral to the IDSVA, Social Services, and Safeguarding. The introduction of the IDSVA is to be commended, and if such specialist support can be offered at the time of crisis it stands an increased chance of being accepted.

5.21 The MARAC minutes and referral described in the IMR suggest that the meeting lacked sufficient victim focus. The referral and notes are all about Seth and his drug problem, being taking advantage of, being at risk of being drawn into gangs, and his next Court appearance. The matter was viewed as supporting the perpetrator would result in support for the victim. Although Rachel did not actively engage with the IDVA Service, it would have been helpful for the family if a safety plan had been constructed to cover when Seth was released from custody. This would have enabled the family and agencies to know what to do at that time and what to expect of services. No such plan was made as it should have been.

Recommendation:
Where a perpetrator is in custody the MARAC must ensure that safety plans are drawn up ready to be put in place when the offender is released to protect the victim/s. Where applicable this should include requesting a Restraining Order from the court and any other relevant requirement such as Drug Treatment Order, Mental Health Treatment Order, or suitable Order available under legislation at the time.

[28] ibid NICE 2014 paragraph 1.1.5.5.

5.22 Although perhaps not a crisis as such at the time, Seth's release from custody back to his home without medication and fast supervision of his mental health was bound to have repercussions for the family based on previous experience. As mentioned previously, had the Court put in place a Restraining Order this would have provided a mechanism to manage Seth's behaviour once released from custody. However, when bail conditions were put in place preventing Seth from living at home after he assaulted Rachel he had ignored this restriction, and his family had relented and let him live once more in the annex. This begs the question were the family fully informed about the bail conditions and the consequences if Seth breached them? Esther had said she did not want to make a statement as she did not want Seth to go to prison. Rachel wanted Seth to get help. If they had understood that by breaching his bail condition Seth would go to prison, this may have supported the family to be firmer in their resolve to support Seth living elsewhere.

5.23 The Probation IMR identified that a more pro-active approach by Court Probation staff to assess what was known about Seth's mental health instead of relying on a psychiatric report, could have led to increased information being available to CRC at the start of their involvement to assist in early risk identification. This would also have provided information for a referral to MARAC and appropriate licence conditions being put in place to help manage risk and supervise Seth's behaviour. CRC were aware of Seth's assault offence and mental health issues, and the offender manager had met Rachel and one of her brothers on the two occasions Seth went to the office. There are no records of the family making representations to Probation staff, however this was Seth's first contact with Probation, therefore would the family have known that it was possible for them to have any input? The killings took place before the offender manager could gain more information for assessment. Whilst it was acknowledged in the London CRC Serious Further Offence Review that there was a short timescale between initial contacts with Seth and the homicide (a matter of days), the offender manager has been required to demonstrate to their line manager that relevant enquiries and referrals in new cases are made sufficiently promptly.

Term of Reference 5: *Were either of the victims or family members:*

(a) informed about carer's assessments and the support which might be available?
(b) offered a carer's assessment?
(c) signposted to appropriate voluntary or statutory services for support relating to their roles as carers, as victims of crime or domestic abuses?
(d) offered the services of an advocate?

5.24 The primary agency involved whose role included offering a carer's assessment is the Mental Health Service. NICE guidance[29] states:

"Offer carers of people with psychosis or schizophrenia an assessment (provided by mental health services) of their own needs and discuss with them their strengths and views. Develop a care plan to address any identified needs, give a copy to the carer and their GP and ensure it is reviewed annually."

The Mental Health IMR found that a carer's assessment was offered to Seth's brother on 5 July 2017, but it was declined. Considering how long Mental Health Services had been involved with Seth and his family this was a very late offer of carer support. The Care Act 2014 which was enacted in April 2015 brought in the requirement for a carer's assessment at that time. Which brother the assessment was offered to is not known, nor is it on record which potential services were offered or whether the support available was explained. If the

[29] "Psychosis and schizophrenia in adults: prevention and management", NICE 2014 paragraph 1.1.5.1. https://www.nice.org.uk/guidance/cg178/chapter/1-Recommendations#care-across-all-phases. Accessed 4/3/17

assessment was offered to Seth's elder brother, he did not live in the family home having day to day contact with Seth, therefore the question arises who in fact should have been considered as the carer? And should more than one person have been considered in such a family situation? It appears that no serious consideration was given as to how to support the family with the demanding situation they faced as Seth's behaviour and mental ill-health became more challenging. No one assessed the family's social needs at any point or their need for respite from Seth and his behaviour.

5.25 It may sometimes be the case that family members do not recognise themselves or the tasks they undertake as being that of a carer role; they are simply doing what a caring family member would do. Therefore, how a carer assessment may help a family and the range of support available needs careful handling and explanation. Having a family member with a severe mental illness can be stressful, and violence from that family member can impact on carer's health and wellbeing[30]. There is evidence that Esther may have been finding Seth's behaviour stressful; she mentioned his return home to her GP, and there is reference to 'social problems' in her hospital notes. The number of calls to the Police indicated escalating difficulty in managing Seth's behaviour. It is also necessary to consider that violence may be under reported by the family due to stigma around mental illness, and the burden this places will inevitably impact on the outcome for the patient as well as the whole family[31], as in this very tragic case. Of course a majority of those suffering from psychosis or schizophrenia will not go on to commit acts of violence against family members; those experiencing mental ill-health are often more likely to be a victim of violence[32], but for those who do not engage in the management of their illness the impact on their family members cannot be underestimated and they deserve sensitive support.

5.26 No evidence was found of signposting the family to other forms of information or support such as specialist voluntary services for mental health, domestic abuse, faith based support groups for mental health and substance misuse, or community based support groups. For example, in the geographical area in which the family lived there are a range of services i.e. Jewish Women's Aid; Norwood a Jewish Charity supporting families; Jewish Care - Health & Social Care for the Jewish community; Jewish Association for Mental Illness. Given the private nature of the family, and Rachel and Esther having declined IDVA support and Victim Support, it is possible that they would not have accessed such services. Nevertheless, information should still be given so that families and service users have a range of options to access at a time right for them to support their individual social and psychological needs.

5.27 Rachel was contacted by a Victim Support contact officer 1 on 27 February 2017 following a data transfer referral from the Police after the assault by Seth. She declined support but agreed to be texted Victim Support's contact details. Following the MARAC referral by the Police Rachel was offered the services of an advocate via the Victim Support IDVA Service. The MARAC and IDVA support referral went to Solace Women's Aid in the first instance and was then passed to Victim Support. Solace Women's Aid were asked whether Rachel was offered a referral to Jewish Women's Aid. They reported that as per their Duty Work Guidance the worker on duty that day confirmed that they had followed this procedure. However, this and the outcome was not recorded in the Allocation Log. This has been addressed as early learning, and where a service user refuses a referral to another specialist service this will be recorded.

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[30] Onwumere J, Zhou Z, Kuipers E, *'Caregiving Relationships in Psychosis: Reviewing the Impact of Patient Violence on Caregivers'*. Frontiers in Psychology, September 2018, Volume 9, Article 1530. www.frontiersin.org . Accessed 4/3/17

[31] ibid

[32] Mind Factsheet Violence and Mental Health. https://www.mind.org.uk/media/998781/Violence-and-mental-health-Mind-factsheet-2014.pdf

5.28 As mentioned above Rachel declined IDVA support, other than to be updated following the MARAC. However, despite phone calls by the IDVA over a 4 day period Rachel could not be contacted. No message was left for safety reason as the phone number had an non-personalised voicemail message. Rachel also declined the support offered by the Victim Support Witness Service.

5.29 Like Rachel, Esther was contacted by Victim Support contact officer 2 after the assault by Seth on 2 May 2017 following an automatic referral by the Police. She too declined support; records show she was more concerned about her son and was going to call the Police to see what was happening to him. The case was closed. There could have been an opportunity to engage Esther had the contact officer offered to liaise with the Police regarding Seth and feedback to her. Such a practical demonstration of help might have helped Esther understand the support the service could offer and been a route to engaging her further.

5.30 During the Police visit to the family home on 30 April 2017 following Seth's assault on his mother, officers explained to her about injunctions and the domestic abuse service referrals they could make. She declined any referral. Esther told the officers she was only concerned that Seth would end up in prison with people who would take advantage of him. Rachel also stated that she did not support prosecution and that Seth needed medical support.

Term of Reference 6: *All agencies are to examine communication and information sharing between or within agencies to establish whether:*

(f) it was adequate, timely, and in line with policies and procedures?
(g) there were any gaps in information sharing or breakdown in systems which impeded the effective treatment or management of the perpetrator's behaviour and health?
(h) effective information sharing was undertaken to inform an all-embracing safety plan to protect the victims?
(i) the MARAC terms of reference are fit for purpose and facilitate the comprehensive and timely sharing of information and execution of actions arising from information?
(j) information was effectively shared between agencies inside and outside of the prison where the perpetrator was held?

5.31 There were flaws in information sharing among a number of agencies involved with Rachel, Esther, Seth, and their family members.

5.32 In general, the Police were reasonably consistent in following their procedures for completing MERLIN notifications concerning Seth which were then shared with Mental Health Services via Barnet Adult Social Care (see table page 48-49). These would have indicated Seth's deteriorating behaviour in the period under detailed review between 2016 and 2017. Although these MERLINs contained information regarding assaults on his brothers, and damage to Rachel's car evidencing his volatility, and the assault on his mother Esther, as mentioned at paragraph 5.3 for the incident involving Seth's assault on Rachel in February 2017, no MERLIN was created resulting in a gap in information to the Mental Health Team. This mistake may have been made because the officer completed a DASH risk assessment and a referral was made to MARAC. All other MERLINS were forwarded. The Police IMR has made a recommendation concerning MERLINs.

5.33 It is not clear from the Mental Health IMR what internal action was taken as a result of MERLIN notifications, indeed the IMR identified fewer MERLINs on record than had been forwarded by Adult Social Services, and there is very little reference in Seth's notes to the information contained within MERLINs which is of concern given the relevance to risk assessments. The information regarding Seth damaging Rachel's car is referenced in an

assessment when Seth was an in-patient in March 2016, but it is not clear from records what the source of the information was; it may have come from a family member.

5.34 The Mental Health IMR explains the process for dealing with the receipt of MERLIN notifications. They are received from Barnet Adult Social Services through a Barnet Assessment inbox which is monitored by the administrator, uploaded onto the patient record, and the care coordinator and Team manager are emailed to inform them the notification is there. The IMR only identified MERLINs for 24.1.17, 2 dated 05.4.17, and 2 dated 05.5.17. As will be noted in the table of MERLINS at paragraph 4.4 pages 48-49, there were 12 MERLINs forwarded between 2016 and 2017. There were also 11 MERLINs covering the earlier period from when MERLINs were introduced in 2014. The table of MERLINs indicates that the last 2 notifications were sent to the West Locality Team rather than the Barnet Assessment inbox as Adult Social Services had received an email instructing them that the MERLIN had been forwarded to that team previously.

5.35 There needs to be a review of the procedure to record MERLINs on a patient's RiO notes to ensure they are in a place where the notification can clearly be seen and incorporated into risk assessments and reviews. The high number of MERLINs received between 2016 and 2017 should have flagged that Seth's behaviour was escalating in its volatility and aggression. In such circumstances the calling of a strategy meeting by the Community Mental Health Team to share information between family members, Police, and other relevant agencies would have been beneficial to coordinate a response and manage the risk he posed. Whilst recognising the limits of patient confidentiality the escalation in his negative and disruptive behaviours warranted the sharing of information under the legislation provided to ensure the safety of the person and others at risk from that person for example the Crime and Disorder Act 1998 and Human Rights Act 1998.

> **Recommendation:**
> The Mental Health Trust should review its process for disseminating MERLIN notifications from the Police to ensure that they are easily visible on patient case notes, the case holder is informed directly, and that risk is reviewed following their receipt. Where 5 MERLINs are received in a 12 month period a multi-agency and family strategy meeting should be held to coordinate a risk management/care plan. If 3 consecutive MERLINs report acts of violence against a person this should trigger such a strategy meeting.

5.36 The rightful decision by the Police to generate a MARAC referral following the assault on Rachel should have mitigated the lack of MERLIN from the Police on that occasion as a Mental Health Trust representative attended the MARAC. However, the fact that the Mental Health Service representative did not inform Seth's care coordinator of the MARAC and its outcome, or record this on Seth's RiO notes for information, meant that the assault and this escalation in risk was not shared with the person charged with coordinating his mental health care. The IMR found that, although there is a MARAC operating protocol setting out what is expected of MARAC representatives and the sharing of information, the Mental Health Trust itself had no formal protocol for recording MARAC and safety plans on RiO notes. The Trust IMR has made a recommendation to correct this omission.

5.37 Whilst having the Mental Health Trust send a representative to the MARAC is most welcome and good practice, on the occasion of hearing Rachel's case the information provided to the MARAC regarding Seth lacked sufficient detail to inform risk. The MARAC notes simply record that Seth's 'problem was drugs'. No mental health diagnosis was given and no background regarding his previous aggression when he relapsed and failed to take his medication. This indicates that the representative had either not familiarised themselves with Seth's case as is expected to enable them to come to MARAC sufficiently informed. Or they had not had

MARAC training to understand how relevant confidential information *can* be shared in MARAC. The MARAC is specifically constituted to enable representatives to share *all* relevant information to inform safety planning and risk assessment. Legislation enables such sharing e.g. the Crime & Disorder Act 1998 Section 115 to prevent crime or serious harm, as does the relevant Caldicott Guardian guidance[33]. Understanding Seth's mental health history and behaviour was crucial to assessing the risk he posed to Rachel, particularly as he had made threats towards her during assessments and had assaulted her before. The Mental Health IMR makes a recommendation concerning their internal MARAC process.

5.38 The Mental Health IMR identified confusion regarding the Community MARAC and the domestic abuse MARAC and which Seth had been referred to. This indicates that adopting the name of a well established risk management process for domestic abuse victims such as MARAC has had a confusing effect, or the purpose of the MARAC within domestic abuse training was not fully understood or embedded in the practice of the individual practitioners involved. The Mental Health Trust IMR has made a recommendation for a clear distinction to be made between the two types of MARAC.

5.39 As will be clear from the analysis for terms of reference 2 and 3, information sharing and liaison between and within services, both in the criminal justice process and in the community experienced shortcomings. Key among these was information sharing between and within the Court Diversion and Liaison Team, Prison In-reach Team, Community Mental Health Team, and Probation. Significant detail concerning this has already been given in the previous section.

5.40 The Barnet, Haringey and Enfield Mental Health Trust works in partnership with two other services to provide the Court Liaison and Diversion Service and is responsible for the provision of the Prison In-reach and Community Mental Health Services. However, there was found to be no clear and reliable process in place for information sharing between them. A lack of clear pathway and concerns over patient confidentiality compromised each sections' information sharing and their ability to provide well informed assessment and care to Seth. Nevertheless, contacting a professional in another branch of the same Trust should not have been so difficult. The Mental Health Trust IMR has made a recommendation concerning this issue.

5.41 The unreliable access to RiO experienced by an approved mental health professional within police stations, and one having no RiO enabled device, led to a lack of patient history to inform their assessments, and one assessment was completely inaccurate. If RiO is inaccessible and practitioners are undertaking assessments during the working hours of the Community Health Team it would be helpful if they had a dedicated phone line they could call to obtain a patient's history if they are known to the service. This could avoid assessments completed on little or no information. If out of hours the Barnet Crisis Resolution and Home Treatment Team operates a 24 hour 7 days a week phone line and a non-public duty line for access by approved mental health professionals could provide them with a patient history when access to RiO is not possible. A recommendation was initially made concerning this, but the Panel was assured that action has already been taken as a result of this early learning.

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[33] The Dept of Health document '*Striking the Balance*' 2012, Practical Guidance on the application of Caldicott Guardian principles to Domestic Violence and MARACs (Multi Agency Risk Assessment Conferences). This guidance states: *'This provides a ground rule for Caldicott Guardians - all information shared about both victims and perpetrators must be in the context of the normal requirements of information sharing without consent, in this case on the basis of prevention and detection of crime or serious harm'.*

5.42 Gaps in recording on Seth's mental health case notes was identified by the Board Level Inquiry which impacted on the internal information sharing during the transfer process from one care coordinator to another. The Mental Health IMR also found that gaps in information contributed to the view that Seth was not mentally unwell, particularly when he was under the care of the Community Team. This was compounded by incomplete and insufficient information on incidents at home and about Police contacts. For example there are discrepancies in the description of offences which diminishes their seriousness such as when Rachel's assault was recorded following a phone call with her brother which only mentions that she was pushed (no mention that she was punched) and the rest of the record concerns the theft and rudeness offences. This particular conversation with Rachel's brother may of course have been the incident being played down by him, but by then Seth's care coordinator was aware that he was held in custody and had contact with the prison In-reach team. The care coordinator could and should have checked further on the exact offences with which Seth was charged. There is also evidence from notes that Seth's assault of his mother and threats with a knife were inadequately and inaccurately recorded in a way which significantly reduced their seriousness (paragraph 3.180).

5.43 Seth's GP practice IMR chronology records letters received from the Mental Health Team informing them of missed appointments by him. His GP was aware that he was in prison in March 2017 as the practice faxed his medical records following their request. However, there is no record in the chronology of letters informing the GP that Seth had been assessed in Police custody by an approved mental health professional, the reason for custody, and the outcome of the assessment. As Seth was under the care of the Community Mental Health Service at this time the information went to that service, it was not shared with a GP for this reason. The Panel deliberated over whether a patient's GP should also be copied in regarding the outcome of the assessment and what would be the learning and outcome if this took place? The GP practice was also Esther's practice. Such knowledge may have enabled a greater understanding of the dynamics and risk in the family at the time, especially as Esther was about to have knee surgery and be seeing her GP and practice nurse during her recovery. Also a patient may be under the care of Mental Health Services for their mental health care, but they would still see their GP for their physical health needs, therefore it is arguable that a GP needs the full picture regarding health assessments carried out in other settings in case it has an impact on their physical health. There is a section on the existing Approved Mental Health Professional form that requires them to inform the GP. However, staff say that in practice they often rely on other health professionals to do this particularly if the patient is already in a mental health setting. There is agreement that staff should be more proactive in informing GPs particularly if the decision is not to admit the patient and the reasons for not to detaining them should be given.

Recommendation: A discussion should take place between the Mental Health Trust and GP practices to establish the efficacy of sharing assessments undertaken with patients by mental health professionals in a Police setting with their GP, even though they are under the care of the Mental Health Trust.

5.44 The Mental Health Trust IMR explained the remit of the Liaison and Diversion Service which offers a gateway to primary and secondary mental health services. It is an early point of identification within the criminal justice system of detainees and those on bail considered to need further assessment and intervention. The service was not able to assess Seth at the court on 27 February 2017 as he refused. There was no expectation that they inform the Community Mental Health Team as he was remanded in custody. Communication with the prison In-reach Team was more appropriate. There is evidence of telephone contact with the In-reach Team which is recorded on the prison SystmOne database.

5.45 The Crown Prosecution Service (CPS) IMR explained that the service is able to share information with other agencies on request. They may share information with the Courts, Probation Service, and Mental Health Services to aid their understanding of the case. The CPS have nothing on their files to indicate that any agency requested any material from them.

5.46 Victim Support shared what little information they had with the relevant agencies, including MARAC. However, internally information that Rachel and Esther were family members and related to the same abuser appears not to have been linked. Had the links been made that Esther was a second family member to suffer domestic abuse by Seth, then arguably Esther should have been allocated to an IDVA and another referral to MARAC could have been justified based on the level of assault, her vulnerability, and professional judgement. She may not have been a repeat victim, but Seth was a repeat offender.

5.47 The Community Rehabilitation Company followed procedures and contacted the Police for information held about Seth's history. However, this was hampered by a very limited search of Police databases by the officer as the system was down. It would have been better for the officer to re-check the databases when they were once more accessible and to provide an accurate picture of Seth's many contacts with the Police to CRC.

5.48 Of note regarding information sharing with family members is the fact that when Rachel called the Police on 25 March 2016 regarding Seth appearing at the family home and damaging her car, she was under the impressing that he had escaped from hospital and she feared he could be violent. In fact, Seth had been discharged as an inpatient and had moved to recovery accommodation. Rachel had clearly not been informed of this even though she lived in the family home where Seth also lived. Family members affected by the discharge of a patient need to be informed of such changes.

5.49 In summary, the mistakes made in information sharing occurred for a variety of reasons both practitioner based and systemic. Poor recording on case notes, lack of knowledge regarding Seth's history by care coordinators exacerbated by an absence of, or inadequate handovers between staff, and high caseloads (see paragraph 5.96) may have contributed to mistakes. Lack of clear agency processes and understanding by some in the Mental Health Trust regarding what information could and should be shared also led to mistakes. IT system shortcomings were also a reason why information sharing failed. The RiO notes could not be accessed in the police station, and the Police databases were inaccessible at a crucial time when CRC contacted the police for Seth's previous history. In addition, Probation and court process timeframes proved challenging to meet in the face of difficulties in gaining a psychiatric assessment, thus his psychiatric history was not shared with the court. However, existing information held by the CPS and the Police could have been used had the court probation officer accessed it.

5.50 ***Term of Reference 7:*** *What services were offered to the perpetrator in prison, did he receive comprehensive health care?*

5.51 The day following his transfer to prison on remand Seth was seen by a mental health nurse in the In-reach Team for assessment. The screening information recorded that Seth was feeling stable and euthymic in mood, and he denied experiencing any psychotic symptoms. The nurse found Seth guarded about his past mental health history and upbringing, but he did not present as thought disordered or as having hallucinations. Seth denied using alcohol and illicit drugs but in fact he had used cannabis two weeks previously. He did confirm that he was under the care of the Community Mental Health Team, and stated he was not currently on medication; his last Depot was 3 years ago.

5.52 The Prison In-reach team notes for 28 February 2017 contain an indication that a Safeguarding alert may have been raised regarding Seth having spoken of having a pregnant girlfriend. However, there is no indication of where or how the safeguarding matter was to be dealt, whether checks were made, or discussion with management held given Seth's offence of what is described in records as a *"serious domestic assault".* It may be that the information was recognised as untrue due to Seth's state of mind, but such matters need meticulous recording to demonstrate the checks and decisions which have been taken and why.

5.53 When Seth was returned to prison following a further offence he was seen by the In-reach Team mental health nurse the following day on 5 April 2017. This time he was noted as behaving bizarrely and experiencing paranoid ideation. A risk assessment and mental capacity assessment was undertaken, and Seth was judged to have capacity to understand the assessment process. The plan was to discuss Seth in the In-reach Team meeting. He was not in the hospital wing. The Mental Health IMR explains that the threshold for admission to the hospital wing at Wormwood Scrubs is high as there are so few beds compared to the number of inmates with health problems.

5.54 The In-reach Team notes recorded that contact was made with care coordinator 2 on 12 April 2017 who related that Seth had not been engaging with him and they were in the process of discharging him. This may have given the In-reach Team the impression that Seth was not deemed mentally ill enough to warrant their support, nor did it recognise the risk he posed to others in his family. The care coordinator reported that every time attempts were made to engage Seth he became racially abusive. There is no indication in any reports that Seth was challenged about his abusive behaviour towards care coordinator 2. It must be noted that the In-reach Team uses the SystmOne database whereas the Community Mental Health Team use RiO, therefore although in the same Trust, the In-reach Team cannot access an inmate's notes to check on history or prescribed medication.

5.55 From the chronology in this Review it appears that Seth was rarely challenged about his disruptive and abusive behaviour, or when he was, such as the time his brother challenged him about breaking the remote control, it ended in violence. It would have been helpful for a joint Mental Health Service and family strategy to have been formulated to address his actions in a united and consistent manner, and to explore the impact of his mental ill-health on his actions in context with his drug use and the perception it is thought his family held at times, that Seth's problems were behavioural.

5.56 Seth's case was discussed at a Community Mental Health Team clinical meeting on 18 May 2017 when care coordinator 2 reported that he remained in prison, but he was not deemed to be showing symptoms of mental illness as previously assessed. Although Seth had been assessed as suffering from paranoid ideation, the In-Reach Team did not feel this warranted medication. Seth remained on the general wing of the prison where he was monitored, and risk assessments were updated. This is not what Seth's family wanted. Care coordinator 2 spoke to one of Seth's brothers (which is not recorded) who asked that the care coordinator help to have Seth moved to the hospital wing. Care coordinator 2 had reassured Seth's brother that an assessment would have been made by the In-reach Team and he would have been placed appropriately. The care coordinator contacted the prison and was able to confirm that Seth had been allocated a psychiatric nurse. It was recorded that the care coordinator planned to contact the psychiatric nurse, however, there is no evidence that this took place. This is a significant omission in liaison between practitioners which meant the full extent of Seth's mental health history was not shared.

5.57 The Mental Health IMR points out that the fact that Seth was maintained on the general wing of the prison during his time in custody, albeit monitored by a psychiatric nurse, indicates

that the prison service considered him well. However, this does beg the question had there been sufficient space in the hospital wing would Seth have been monitored in that facility and encouraged to recommence his medication.

Term of Reference 8: All agencies are to describe and analyse:

(a) What risk assessment tools or processes were undertaken with the perpetrator by services with whom he had contact to establish his risk to others?
(b) Whether risk assessment was thorough, and in line with procedures; if not why not?
(c) Whether the risk assessment tools and procedures designed to support decisions and assessments are judged to be effective by the practitioners using them? Are there any adjustments which may enhance practice?
(d) What background history and information from other agencies informed risk assessment?
(e) Whether family members were involved in providing information which informed assessments and was there liaison with them concerning the outcome of assessments and any risks identified?
(f) Was risk reviewed regularly and when the perpetrator's circumstances or mental wellbeing changed; were risks escalated, if so, how was this done and what decisions were made and recorded?

This term of reference will be addressed by agency to enable the different agency's processes to be explored individually.

The Police:

5.58 Had this case had been viewed solely as a domestic abuse case then an overview would have revealed one of the key risk factors; that of escalation and frequency in incidents. The number of Police attendances and the frequency with which assaults on family members, especially Rachel, were occurring should have rung alarm bells much louder. However, the Police were called on a variety of occasions due to Seth's mental health and the people he was mixing with in relation to his drug use, and not unsurprisingly this may have clouded the picture.

5.59 The Police did not risk assess the perpetrator as such, but the DASH risk assessment does ask questions about the perpetrator which requires information from the victim in addition to their own 5 year timescale records as required by police procedures. This affected the quality of risk assessments concerning the perpetrator. The referral to MARAC in February 2017 on professional judgement was the correct response and good practice. It recognised the risk Seth posed to Rachel at that time. There should have been a second referral to MARAC when Seth assaulted his mother as this was an escalation involving a threat with a knife as well as an assault of a woman with limited mobility, for although he was held in custody he would inevitably be released at some stage and a safety plan should have been prepared for that eventuality. It was a mistake to view his removal at that time as a removal of risk.

5.60 On other occasions Seth was assessed in terms of his own vulnerability to risk due to his mental ill-health which resulted in the completion of a MERLIN. These notifications were shared in a timely manner. The MARAC referral was also undertaken in good time. A DASH was also completed for the court, although this information did not appear to inform the court's sentencing decision as no restraining order or conditions were placed on Seth on his release.

Mental Health Trust:

5.61 Seth was under the Care Programme Approach which provides a framework for multi-disciplinary collaboration and the IMR points out that it is within this context that risk assessment should take place. The Trust Clinical Risk Assessment and Management Policy (2015) states that the risk management plan should include a summary of all risks identified, formulations of the situations in which risk may occur, and actions to be taken by the practitioner and service user in response to a crisis. It is noticeable that this does not include the carer or family members of the service user and how they might respond to a crisis. The policy is clear however, that risk to family members and carers must be considered, especially as victims of violence are more likely to be family members, or those attempting to deliver care. It is recognised that antecedent factors may include when the service user stops taking medication and has been aggressive during an acute phase of their illness.

5.62 The RiO record keeping system used by the Mental Health Trust Community Team contains a risk summary which allows the practitioner to score risk based on the following criteria:

- Low = No significant current indicators of risk
- Medium = Current indicators of risk are present, but the outcome is unlikely to occur unless additional risk factors intervene
- High = Current risk factors are present, suggesting that the risk outcome could occur at any time.

The risk summary for Seth ranges across all criteria from low to high between 2010 and 2017. However, the MARAC referral following the assault on Rachel in February 2017 did not result in any reassessment of risk which was a significant gap in assessing the risk Seth posed.

5.63 The Trust Clinical Risk Assessment and Management Policy (2015) states:

In conducting a thorough risk assessment, this underlines the importance of:

- Obtaining all available background information prior to assessment.
- Good communication between all agencies concerned with the client.
- High standards of clinical recording.

The three main sources of information are:

- Clinical interview/ multidisciplinary assessment/ structured questionnaires.
- Carers, involved professionals - (Police, Probation, Housing, Social Services, School, Safeguarding teams etc.); Other Service Users, Community network – Community/religious leaders, concerned neighbours etc.
- Documentary evidence – case notes/electronic records etc

5.64 The analysis provided by the Mental Health Trust describes insufficient recognition of the risks to the family and consideration of domestic violence and abuse. Opportunities to refer to MARAC going back several years were missed, and knowledge of MARAC was limited. Worryingly, a safeguarding alert was made in 2015 due to concerns about Seth's behaviour and that altercations could lead to someone in the family getting seriously hurt, but there is no record of any outcome from this action.

5.65 During 2016 there were at least 3 references on RiO indicating specific risks to Seth's sister Rachel, but no MARAC or safeguarding referrals were made. The IMR suggests that the

family may have minimised the violence in their communications with the Trust, but this is not unusual; the family were frequently clear that they did not wish to criminalise Seth through a prosecution. However, on 19 May 2015 Rachel phoned the Community Mental Health team to report that Seth had attacked her, and if her father had not intervened the situation could have been more serious. Rachel was advised to call the Police. A day later Seth was admitted to hospital after Police had to be called following further aggression to the family. This response suggests that a risk plan of actions to take in a crisis (as per policy) by the practitioner and service user was either inadequate or being ignored. The Police were being used in a crisis. Practitioners and management's failure to recognise risk and follow their own procedures led to mistakes in adequately managing the risk Seth presented.

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

5.66 The risk assessment tools and procedures designed to support decisions and assessments as described above were judged to be fit for purpose. The problem in this case was that they were not used or completed adequately, with an additional problem of inadequate monitoring by management.

5.67 As already highlighted, there was a missed opportunity to renew a risk assessment when Seth breached his bail conditions. Had the information from the MARAC been added to his RiO notes and his care coordinator had been aware this would have indicated heightened risk. The failure to add MARAC information onto Seth's notes and flag it to his care coordinator was a mistake which again impacted on the quality of risk assessment.

5.68 The electronic record system has a 'Risk Summary' page which is intended to be a rolling record of events relevant to the risk assessment. The summary was not always completed; therefore, the risk assessment was inadequate. This affected decision making. There was a need to rely on progress notes and significant events, which would have been time consuming to go through. Risk assessments are not static instruments; they need to be up to date and easily visible. Risk assessments are only as useful as the information within them and need to be updated in line with changes in events and situations. A lack of record keeping was a noted issue in this case which contributed to mistakes in risk assessment.

5.69 Background history was poorly assessed and utilized. The IMR and Board Level Inquiry identified a tendency to minimise the difficulties relating to Seth's psychotic illness over time. This is evident from the fact that his early diagnosis of schizophrenia by a psychiatrist appears to be lost, and we see a comment in assessments in 2017 that 'at no time has it been established that he has a mental disorder' which was untrue. Any information informing assessments from other agencies comes from within branches of other sections of Mental Health allied services, and clear pathways to accessing this between them, even within the Trust, is unclear. There were no established and agreed processes. A recommendation concerning this has been made by the Trust in its IMR.

5.70 The IMR described that In March 2016 during Seth's hospital admission as an inpatient a formulation meeting took place. A formulation meeting is a meeting where the professionals involved consider the historical context of the mental health presentation, what may be sustaining it and how to move forward in the management of the problem. In addition, the doctor who admitted Seth recorded that his sister took on a maternal role when Seth was growing up. The notes went on to suggest this had coloured Seth's relationship with his sister

and that she was often the person to whom his aggression was aimed. Seth had described how he hated his sister with a passion and stated he could use a knife to stab her but had stopped thinking about it. The risk to others was clearly identified, however there is no evidence that the concerns were acted on or information was shared with other relevant agencies.

5.71 Progress notes described a number of the worrying incidents which took place in 2015. During this year Seth came off the Community Treatment Order, refused ongoing treatment, and his mental health relapsed resulting in threats and disruptive behaviour for his family. There was no mention found in notes of a plan to manage the risks at this time.

5.72 In March 2016 Seth made threats towards Rachel whilst an in-patient saying he hated his sister and had thoughts of stabbing her. The following month a mental health report noted that Seth had tried to strangle his sister, and he had tried to damage her car. The assessment form indicated that there were no safeguarding concerns when clearly there were. Seth's threats towards his sister appear to have been viewed through the lens of his psychosis instead of being taken seriously. Coupled with his actual assaults on his sister reported in MERLINs his comments warranted more attention and inclusion in the 'risk to others' section of Seth's risk assessments.

5.73 It is unclear where the information from MERLINS went to and whether the incidents described within them informed assessments. There appeared to be no direct liaison with the Police by the care coordinator.

5.74 In addition to the minimisation of the impact of Seth's mental health diagnosis, from the information provided there was a lack of consideration of the part Seth's drug use played in increasing risk. He had been using cannabis and its more potent form of skunk since the age of 14years. Longitudinal research such as the Dunedin 2002 research[34], which followed a large cohort from birth and which supports the findings of an earlier large cohort historical study[35], finds that whilst there may yet to be an emphatic proven causal link, there is an association between cannabis use and an increased risk of experiencing schizophrenia symptoms. Research suggests that younger cannabis users may be most at risk as their cannabis use becomes longstanding, as Seth's did. In the Dunedin research of those using cannabis by age 15years a tenth developed schizophreniform disorder by the age of 26 compared with 3% of the remaining cohort. The risks identified were specific to cannabis use. Seth said he used skunk in the days after he came out of prison before killing his mother and sister.

5.75 The research cited above also found that young male cannabis users were nearly 4 times more likely to be violent than non-users. The risk for alcohol users was around 3 times. Violence appeared to be linked to the psychosis or the withdrawal from the drug. The Dunedin study found parents and siblings may be injured and homicides were not uncommon[36]. For context analysis of UK Domestic Homicide Reviews (DHRs)[37] found that of the 40 Reviews analysed, 7 were familial homicides: All the familial homicides were

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

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

[36] Cannabis Effects & How It Works - How it works in the brain. https://www.cannabisskunksense.co.uk/the-facts/how-it-works-in-the-brain. Accessed 20.01.19

[37] Home Office (December 2016) Domestic Homicide Reviews: Key Findings from Analysis of Domestic Homicide Reviews.

committed by a male perpetrator, mental illness was an issue in all 7 cases, and substance use by the perpetrator was present in all but one case. The victims in these cases were mothers and one a father. Other analysis of DHRs[38] makes similar findings with a quarter of the Reviews being familial homicides; 5 cases involved sons killing mothers (matricide), 2 cases involved sons killing fathers (patricide) and 1 case involved a brother killing his brother (fratricide).

5.76 Research by Short et al (2013) found an increased risk of violence in those living with schizophrenia, compared to the general population, finding a significantly higher risk of violence offences and involvement in family violence[39]. The 2009 meta-analysis by Fazel (2009)[40] also found a robust body of evidence that an association between psychoses and violence exists, and where substance misuse also existed violence was estimated to be around four times higher compared with individuals without co-morbidity. However, the increased risk of violence was the same as those abusing substances alone. In other words, schizophrenia and other psychoses did not appear to add any additional risk to that conferred by the substance abuse alone.

5.77 The Fazel research highlighted the importance of risk assessment and management for patients with substance abuse co-morbidity. However, a factsheet produced by the mental health charity Mind in 2014[41] reports that despite the attempts of several experts, no violence risk assessment tool had yet been developed which took into account mental health to adequately identify those who will be violent, partly because such incidents are not very common. It is suggested that whilst tools can predict who is at risk of carrying out violent crimes, they cannot accurately tell who among these will actually go on to kill or harm someone so that extra support and management can be put in. Admittedly the picture is complex, but the research discussed here, along with the context of a patient's life, family background, relationships, and stressor points need to be factored into risk assessments to give practitioners the information they need to inform decisions. There were many incidents involving Seth's violence towards family members of which the Mental Health Team were aware, and his use of cannabis was also well known. The chronology in this Review indicates an escalation in his violence, and an increased frequency in his use of violence and aggression. There is no evidence that these were brought together to inform risk as they should have been in Seth's case.

5.78 The above findings from research are pertinent to this case. However, it is not suggested that all those experiencing schizophrenia or psychotic symptoms and who are managing their symptoms effectively will go on to be violent. A majority of people living with this condition will not be violent; those experiencing mental ill-health are in fact often more likely to be a victim of violence[42]. However, research findings although nuanced and challenging need to be taken into consideration when designing risk assessments which need to be holistic in content, and illicit drugs and alcohol need to be clearly visible for consideration in risk assessments. The Board Level Inquiry found that the structure of the database used to record risk assessments and other information required did not facilitate ease of visibility of

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[38] Sharp-Jeffs N, Kelly L (June 2016) Domestic Homicide Review (DHR) Case Analysis. Report for Standing Together.

[39] Short T. et al (2013) 'Comparing violence in schizophrenia patients with and without co-morbid substance-use disorders to community controls' Acta Psychiatrica Scandinavica, Feb 4 DOI 10.1111/acps.12066 [Epub ahead of print]

[40] Fazel S. et al (2009) 'Schizophrenia and violence: systematic review and meta-analysis' PLOS Medicine, Vol 6: Issue 8. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2718581/ Accessed 21.01.19

[41] Mind Factsheet Violence and Mental Health. https://www.mind.org.uk/media/998781/Violence-and-mental-health-Mind-factsheet-2014.pdf

[42] Mind Factsheet Violence and Mental Health. https://www.mind.org.uk/media/998781/Violence-and-mental-health-Mind-factsheet-2014.pdf

important case details. The Board Inquiry made a recommendation for the Trust concerning this finding.

5.79 The Mental Health IMR describes the Trust's expectations concerning the ongoing updating of risk assessments which evolve over time, and records are to clearly show rationales for decisions made within the framework of the Care Programme Approach process. However, there was information missing in this case which may have impacted on decisions made.

5.80 Seth's family was recorded as providing information and their views are recorded notably when he was an inpatient. However, there was little evidence of their involvement in risk assessments during 2016-17 the period of detailed examination leading up to the homicides. Of note is the fact that the liaison which took place was predominantly between Seth's elder brother and his father when he was alive. His sister and mother who lived in the family home were absent from consultations or CPA reviews. There were references in records to difficulties in contacting family members, however, Seth's brothers and Rachel worked, and services need to recognise that not everyone can be contacted between 9am and 5pm.

5.81 Rachel, Esther, and the rest of Seth's family appeared to be unaware of the risks attached to his mental illness when not managed effectively due to his non-compliance with medication, unwillingness to engage with mental health practitioners, and the additional impact of his drug use. This begs the question was this ever fully explained to them as a whole family, and were they given a relapse plan? The Carer's Trust has developed guidance with carers and clinicians[43] which recognises the importance of the carer, service user, professional relationship, and the wish of many carers to be seen as active partners in the service users care. The 'Triangle of Care' framework provides a practice guide which points out that:

> *"An effective Triangle of Care will only be complete if there is a willingness by the professional and carer to engage. Most carers recognise that this three-way partnership between service user, carer, and clinicians, with all the voices being heard and influencing care treatment decisions, will produce the best chance of recovery. This places an onus on professionals and services to actively encourage this partnership"* (p6).

Thus, the framework promotes carers and those cared for being involved in the development and improvement of services. The Board Level Inquiry chair and the DHR chair heard directly from the family at their meeting that they felt let down by community services. They often felt they were left to handle difficult situations with Seth or falling between the two stools of Mental Health Services and the Police. On phoning the Mental Health Team they would be told to call the Police if Seth was violent.

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

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

MARAC:

5.82 Assessment of risk at the MARAC was flawed as not all relevant information about Seth was presented by the Mental Health representative. The fact that drugs were said to be the problem which could result in a significant degree of volatility in a person's behaviour, and it was known that Seth was bringing other drug users to the premises and into the house on occasions did not appear to have been taken into account. No risk assessment was evident regarding how these issues might increase risk appeared to have been considered. The MARAC also failed to look at other members of the household to whom Seth may also have posed a risk. His mother was not mentioned. The MARAC should have considered both women, especially as before her surgery in late March 2017 Esther was in pain from her knee which was affecting her mobility, as it did post surgery. The MARAC should always consider others who may be at risk in the household of a victim, be that children or an older adult with health problems.

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

Probation Service:

5.83 A Risk of Serious Recidivism Tool and a Case Allocation Screening Tool were completed the day after Seth was sentenced to decide whether he was allocated to the National Probation Service or Community Rehabilitation Company (CRC). However, the IMR found that the assessment was not of a sufficient standard and, even without the provision of the psychiatric report for the court, key information that was available from sources such as CPS papers, and entries on the NDelius database was not used, nor was the fact that the psychiatric report had been commissioned taken into account for the risk assessment.

5.84 A pre-sentence report was not completed in line with procedures, and an OASys offender assessment tool and SARA (Spousal Abuse Risk Assessment) not completed as they would have been had the report been completed. As mentioned above, the psychiatric report was not available at the time of sentencing to inform a risk assessment, thus the quality of risk assessment was inadequate.

5.85 The Probation IMR deals comprehensively and openly with the question concerning whether risk assessment tools and procedures support decisions and assessments as requested by this term of reference. This is quoted in full to avoid misinterpretation of the facts by summarising.

5.86 A Standard pre-sentence report is allocated 3 weeks for completion, a Short Format Delivery report is allocated 5 working days for completion, and an On the Day Report is delivered on the day of sentencing. As this report had identified domestic abuse as the underlying reason for the offences of common assault it is usual practice to either sentence on the day if there is sufficient information so that the Court can confidently move to sentence safely. However, many domestic abuse cases are dealt with by a Short Format Report to allow for time to complete safeguarding checks and other concerns, for example: Mental Health. In this case a psychiatric report was requested so sentencing was adjourned for three weeks, to allow for the production of that report. This was unusual as normally a six week adjournment would be requested where a psychiatric report has been commissioned. Given that the case involved domestic abuse, and a psychiatric report requested, the

assessment and sentence proposal would be completed by a court probation officer, who as part of the process would normally complete the SARA, RSR, CAS/ROSHA, and pre-sentence report, which could possibly be a standard PSR but more frequently a Short Format Report.

5.87 In this case it is not clear what was requested, but common practice in Magistrates Courts at the time of writing this Review is to provide a Short Format Report. This would have had an associated OASys assessment but again this would be a shortened version, a risk screening, as full assessment of the offender had moved to post sentence, and by the allocated offender manager who would be the supervising officer. The Court Probation teams responsibility is to provide sufficient information to provide for safe sentencing.

5.88 Many practitioners have expressed concern that there is not better integration between the risk assessments and therefore the thread is fragmented and lost. The RSR is still too often seen as a tool for allocation purposes rather than providing information to inform risk assessment. In addition, as in this case, where an offender has been lightly convicted, it is of little use.

5.89 The introduction of the RSR tool was perhaps introduced too hastily as part of the Transforming Rehabilitation Process in 2014 to enable an allocation system for either the NPS or CRC. Poor understanding of its role as a tool for risk assessment has led to it being undervalued and misunderstood by many staff.

5.90 From the perspective of Probation practice in the Court, the move towards on the day sentencing and "speedy justice" can hamper a sufficient assessment. The completion of a Case Allocation Screening tool, Risk Assessment Tools and Pre-Sentence Reports and in a domestic abuse case the SARA, plus potentially a RISK review and triggering the relevant risk globes in NDelius, all on a tight timescale, can lead to the cutting of corners. There is evidence in this case of the Risk of Serious Recidivism/Case Allocation Screening being rushed and also undertaken by an officer who had no previous knowledge of the case and who did not have sufficient time to read all the evidence that was available such as CPS papers and NDelius entries. However, in the IMR author's assessment the issue in this case was that Court probation officer 1 appeared to have put an over reliance on the production of the psychiatric report rather than using the evidence that was already to hand, which was sufficient to move to safe sentencing, and to signposting to the allocated Probation service the key concerns with regards to Seth's offending behaviours.

5.91 In terms of background information from other agencies, the Probation Service had the Crown Prosecution Services papers, but no other information. It was noted that Seth had two cautions, but no previous convictions therefore no other records were available. The psychiatric report did not arrive in time to inform sentencing.

5.92 No contact was made with the family for information as it is not usual practice for Probation to do so. The purpose of the pre-sentence report is to provide information to the Court so that they can proceed safely to sentencing.

5.93 The risk review mechanism, a procedure that allows for a specific change of circumstance in the first months of a sentence to be reviewed and a decision made as to whether the case should be escalated from the CRC to the NPS, was not activated at Court. This procedure is used where the NPS may identify a case to be suitable for the CRC but consider the assessment to be so borderline that it requests a later review by the CRC. The NPS at Court set a specific date for the review, for example if the psychiatric report was eventually produced and contained information that indicated the risk of serious harm was sufficient to meet the criteria for escalation of the case to be supervised by the NPS. This review was

not triggered in this case. There is also a risk escalation process whereby cases presenting with new indicators in managing the risk of serious harm for that offender can be escalated by the CRC for consideration of the NPS managing the offender due to the presenting risk of serious harm. The definition of Risk of Serious Harm is 'a risk which is life threatening and/or traumatic and from which recovery, whether physical or psychological, can be expected to be difficult or impossible'.

5.94 The IMR has made recommendations concerning the practice and supervision of Court staff and training in the use of risk assessment tools. The IMR also makes a recommendation regarding the process for the commissioning of psychiatric/psychological reports for the court. As this requires a national level response and to reinforce its importance, the recommendation is included as a Review recommendation.

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

5.95 Term *of Reference 9: Were there any resource issues, including staff absence or shortages, which affected agencies' ability to provide services in line with procedures and best practice? Include caseloads, management support of staff, supervision, and any impact of changes due to restructures or to service contracts.*

5.96 In August 2013 staff in the hospital based Mental Health Liaison Team had considerable difficulty in finding an in-patient bed on a mental health unit for Seth (paragraphs 3.43 - 3.44). They also experienced considerable difficulty and delays in locating the right team to call, and telephone calls went unanswered when a line should have been staffed. When attempts were made to escalate the matter in line with procedures the relevant manager was on leave and there appeared to be no deputy identifiable to call. This resulted not only in Seth being held for many hours in an inappropriate A & E setting, but A & E resources could not be freed up as they should have been in a timely manner.

5.97 On 15 May 2015 Seth had been assessed by a psychiatrist due to increased concerns about his acute signs of mental health relapse, and a recommendation had been made for informal admission. However, no bed was available. He was being managed by the Home Treatment Team at home whilst on the waiting list for a bed. Days later he assaulted Rachel during which he tried to strangle her. The fact that Seth could not be accommodated at the time he needed to be in hospital clearly contributed to him being at home in close proximity to Rachel, hence risk increased, and the assault took place.

5.98 The Board Level Inquiry identified that Seth's care coordinator 2 had not read Seth's case notes or his risk summary in the 10 months of holding the case, even when Seth was arrested for assaulting his mother. It was found to be understandable that they had not read his notes soon after taking up the care coordinator role due to the size of caseload (25 cases) and having understood from his previous care coordinator 1 that Seth was relatively stable, especially when compared to others on their caseload. Nevertheless, this was unacceptable given Seth's history of violence towards his family. The question of practitioner's caseload size is an important issue, especially when managing risk and service users with high needs. Management oversight and supportive supervision is essential to ensure that caseloads are realistic and commensurate with the risk being managed. Roles which involve coordination and multi-agency working in a semi-autonomous way such as IDVAs, care coordinators, social workers etc require particular skills which not every practitioner may have. Nevertheless, the fact that shortcomings in recording and liaison with partner agencies in

the Mental Health Service are a factor in this case, suggests practitioners may have succumbed to time constraints, become overwhelmed, and the regularity of management supervision and support has been insufficient and not vigilant enough to pick these problems up.

5.99 The Mental Health Trust Supervision Policy states that clinical staff should receive monthly supervision and more specialised supervision e.g. safeguarding as required. A supervision record is maintained by the supervisee and the supervisor. Staff should also have a supervision contract that is reviewed each year. A Mental Health Board Level Inquiry recommendation was made to reinforcing the need to ensure all cases are reviewed not just those that the clinician brings to supervision.

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

5.100 The availability of Court probation officers was noted as a resource issue. For example, at the trial on 23 June 2017 there was no probation officer available to undertake a pre-sentence report had Seth been fit to be interviewed. The Probation Service IMR also explained that in 2017 Willesden Magistrates Court was predominantly a trials court and a rota'd skeleton staff provided Probation Services to that Court. This included a court probation officer, a court probation service officer, and an administrator to cover all the work coming out of the Willesden Courts at that time. These staff would have been on a weekly rota and therefore subject to regular change, which would have impacted on the consistency of knowledge of cases.

5.101 The IT system did not support the effective working of mental health professionals within the Police station.

5.102 Although Seth was experiencing paranoid ideation as part of his mental illness symptoms, he was not considered ill enough to reach the threshold for admission to the hospital wing at Wormwood Scrubs as the threshold for admission is so high due to there being so few beds compared to the number of inmates with health problems.

5.103 Victim Support experienced delays in contacting Rachel following her referral for witness support on 27 June 2017. The first attempts to contact her took place on 3 July 2017. Victim Support was heavily involved in providing a response to terrorist attacks on 3 June, and 19 June, and providing on the ground response to the Grenfell Tower fire on 14 June 2017. These events had a significant impact on the services resources due to increased phone calls and requests for support.

Term of Reference 10: *How did agencies seek to engage with the victims, and how successful was this? Are there any changes to systems or practice which could help increase the engagement of high risk victims with support services designed to promote their safety?*

5.104 The Police who attended incidents involving Rachel and Esther took the necessary procedural steps required, but they were unable to persuade them to proceed with a statement to prosecute Seth. Perhaps if some of the positives outcomes of the court process could have been explained to them in terms of the access to support via Drug Treatment Orders or Mental Health Treatment Orders, they may have felt able to support Police actions. Both Rachel and Esther wanted Seth to have support via Health. If Seth had been sentenced to community based supervision under such orders as mentioned, he may have sustained

engagement and his compliance with medication may have moderated his behaviour and increased their safety.

5.105 Victim Support's procedure for domestic violence cases prescribes 3 phone calls on different days at varying times of day, but despite these attempts Rachel did not actively engage with the Victim Support staff member following her assault by Seth, nor with the IDVA following the referral to MARAC. Although they managed to speak to her once to offer their support, in the first instance she declined, and when the IDVA called to update her on the MARAC she did not answer her phone. Similarly, Esther declined support when she was called by the victim contact officer; her main concern at that call was for Seth and she said she was going to call the Police to find out what was happening. There was a missed opportunity here, for if the victim contact officer had offered to liaise with the Police for her there might have been an opening to build a rapport and engage Esther. It is probable that neither woman appreciated the risk they faced from Seth and further support may have opened up a dialogue where this could have been explored. It is important to recognise however, that repeated phone calls risk being seen as harassment, which is why the first contact is so important as a means of engaging a victim.

5.106 The Mental Health Team's main liaison point with the family was with Esther's eldest son Simon. There were no records of direct communication with Esther herself. Rachel is recorded as contacting the Mental Health Team on a few occasions when she had concerns about Seth's mental health, otherwise there is little evidence of attempts to engage with them directly. The IMR notes that there were inconsistencies in approach by the family in coping with Seth's mental health and substance misuse, but whether this is every member of the family or just those with whom the Team had contact is not clear. There appeared to be little recognition of the escalating violence Seth was committing, and even the MARAC for Rachel did not result in her being seen as at increasing risk, nor did the assault and threat with a knife against Esther in April 2017 result in the two women in the family being reappraised as at risk from Seth.

5.107 There is no evidence from the GP IMR that Esther was offered any support or information on sources of support concerning Seth, or if she discussed any concerns about her youngest son with her GP.

Term of Reference 11: *Had the staff in contact with the perpetrator and family members undertaken domestic abuse training which included, adult family abuse, risk assessment, safety planning, and how and when to refer to MARAC?*

5.108 Reports confirmed that the staff within the criminal justice agencies involved in this Review had all received domestic abuse training. The Metropolitan Police Service delivered mandatory training on domestic abuse awareness during 2015-16 to all staff, up to and including chief inspector level. This included all operational, custody, and community safety officers and staff. At the end of 2017 the training of frontline officers was completed covering 10 sites per day for 3 months. There is ongoing training of all new recruits covering early and late shifts. Training packages are reviewed every 2 years giving the opportunity for revisions to be made. The mandatory training is supported by guidance and toolkits. Training includes the DASH risk assessment and MARAC referrals.

5.109 The domestic abuse prosecutions were dealt with by CPS specialist reviewing lawyers. All prosecutors received domestic abuse training. Prosecutors' work does not involve them in undertaking risk assessments or referrals to MARAC. They rely on information provided by the Police. Magistrates and legal advisors have also received domestic abuse training. Court probation officer 1 had received domestic abuse training which included adult family abuse, risk assessment, and how and when to refer to MARAC. The officer was also trained in the completion of SARA (Spousal Abuse Risk Assessment tool), however, due to the nature of

their work, court officers do not make referrals to MARAC; this would be within the remit of the offender manager allocated to supervise an offender.

5.110 The CRC offender manager 1 was a qualified probation officer who had received the appropriate risk assessment and risk management training and knew how to refer to MARAC. Their line manager senior probation officer 1 had flagged up that a MARAC referral should be considered, but there was insufficient time to pursue this before the fatal incident.

5.111 Of the Health Services relevant to the Review, the Royal Free Hospital confirmed domestic abuse is part of safeguarding training at induction; staff are aware that the Trust views domestic abuse as a safeguarding concern; they are informed of the pathway when such abuse is suspected, and the possibility of referring to one of the Trust's three IDSVAs (independent domestic and sexual violence advisors). The IDSVAs also provide training to the Emergency Department and regularly attend morning patient handovers to add their knowledge and act as a reminder to hospital staff when domestic abuse is relevant. All clinical staff receive more in-depth awareness regarding possible presentations and how to explore concerns via the use of case studies. Emergency Department, Maternity, and Paediatric Department staff also access level 3 safeguarding training which includes domestic abuse which goes into more depth, plus there is a level 3 update seminar programme which includes awareness of MARAC and when to refer. During 2016 seminars specifically addressing risk assessment and MARAC were held. It is good to see this regular training taking place and the valuable contribution that IDVSA are able to make to increasing clinician's knowledge. In light of this Review it would be beneficial to add further elements to staff training to ensure that adult family violence is adequately covered, and the risk factors identified in this and similar DHRs involving familicide is included.

5.112 The Barnet, Haringey and Enfield Mental Health NHS Trust include 1½hrs of domestic abuse awareness in their corporate induction facilitated by Barnet and Haringey IDVAs, and domestic abuse is included in all levels of safeguarding training in line with competencies prescribed by the Draft Intercollegiate Guidance on Competencies for Health Staff.[44] One of the approved mental health professionals involved in this case has received MARAC training and is the Barnet MARAC representative for the Trust. In the 12 months covering January 2017 to January 2018 the Trust led on the LINKS domestic abuse pilot project which

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[44] Draft Intercollegiate Guidance on Competencies for Health Staff is relevant for All staff working in health care settings, including: GPs, paediatricians, child and adolescent psychiatrist, children's nurse, child and adolescent mental health nurse, forensic nurses, Midwife, school nurse and health visitor, paediatric intensivists, forensic physicians. The requirements are:

Core competences:

- Recognising potential indicators of child maltreatment – physical abuse including fabricated and induced illness, emotional abuse, sexual abuse, and neglect including child trafficking and Female Genital Mutilation (FGM)
- Understanding the potential impact of a parent/carers physical and mental health on the wellbeing and development of a child or young person, including the impact of domestic violence the risks associated with the internet and online social networking, an understanding of the importance of children's rights in the safeguarding/child protection context , and the basic knowledge of relevant legislation (Children Acts 1989, 2004 and of Sexual Offences Act 2003)
- Taking appropriate action if they have concerns, including appropriately reporting concerns safely and seeking advice

Knowledge:

- Know about relevance of parental, family and carer factors such as domestic abuse, mental and physical ill-health, substance, and alcohol misuse

Skills:

- Able to assess as appropriate to the role the impact of parental, carer and family issues on children, and young people, including mental health, learning difficulties, substance misuse, and domestic abuse

https://www.rcpch.ac.uk/sites/default/files/Safeguarding_Children_-_Roles_and_Competences_for_Healthcare_Staff._Third_Edition_March_2014.pdf

involved having an IDVA based within Community Mental Health. The aim of this IDVA's role was to improve mental health workers' response to service users and their families who may be at risk of domestic abuse. Research shows that mental health staff are less likely to refer to domestic abuse services, therefore the project includes specific detailed training by the IDVA in risk assessment, safety planning and how to refer to those services and to MARAC. At the end of the pilot project the evaluation showed a 660% increase in referrals to specialist domestic abuse services by members of the Mental Health Team and the project was shortlisted in the 'Innovations in mental health' category in the HSJ Awards 2017[45]. (see Appendix A for outline of the LINKS project).

5.113 Care coordinator 2 was in post at the time of the LINKS project and therefore is understood to have completed this training. However, from the chronology and evidence presented previously, it would appear that Seth's care coordinator did not absorb this training, did not identify the risk Seth posed to Rachel and then Esther, and did not think of consulting the IDVA about their needs. It is regrettable that such a valuable resource and skilled professional as the mental health IDVA was not made available to Rachel and Esther. This raises the question; what checks take place to assess how the knowledge imparted in training has been assimilated, and is learning being acted upon when the circumstances in a practitioner's case demands. Such evaluation and monitoring should be part of management supervision and a practitioner's personal development plan.

Recommendation: Mental Health Trust management supervision sessions with practitioners should routinely include evaluation of domestic abuse training undertaken, check the practitioner's levels of understanding against training outcomes, and assess evidence within case discussions to ensure that the learning is being acted upon. appropriately

5.114 The mental health IDVA was only funded for one year, and the project was partly affected by a restructure and move of the Team, however the findings from such a short pilot are extremely promising and identified some important distinctions about working as an IDVA in a mental health setting. The Mental Health Trust is currently involved in 11 other DHRs, and the Review chair's own experience of such DHRs suggests mental health IDVAs embedded in Mental Health Teams would be an extremely valuable asset in the efforts to reduce domestic abuse homicides involving mental ill-health and boosting the knowledge and skills of frontline practitioners.

Recommendation: In order to facilitate an improved response to the risks associated with domestic abuse and mental ill-health for victims and perpetrators, it is recommended that the Department of Health & Social Care provide funding to enable IDVA's to be placed in NHS mental health provider settings.

5.115 The Draft Collegiate Guidance is now replaced by The Adult Safeguarding: Roles and Competencies for Health Care Staff, First edition: August 2018. Core competencies remain. The guidance advises that: '*Training, education and learning opportunities should include multi-disciplinary/multi-agency and scenario-based discussion drawing on case studies and lessons from research and audit. This should be appropriate to the specialty and roles of participants, encompassing for example, the importance of early help, domestic abuse, adults with cognitive impairment and individuals requiring support with communication*'. (p33) It is good to see the value of multi-agency training acknowledged; this not only increases learning, but enables practitioners from different disciplines to learn

[45] https://awards.hsj.co.uk

about other's roles and make links with professionals with whom they may need to have contact in the event of supporting a victim of domestic abuse.

5.116 The Camden and Islington NHS Foundation Trust who saw Seth during 2012 and 2013 confirm that domestic abuse training is incorporated into the Trust's safeguarding adults and safeguarding children core skills training. Members of the Mental Health Liaison Team who assessed Seth at that time would have been required to attend this training on a 3 yearly basis. Such training is delivered at level 3 Intercollegiate Guidance and includes how and when to refer to MARAC.

5.117 Central London Community Healthcare NHS Trust district nurses and therapists who had contact with Esther are required to undertake mandatory safeguarding training which includes adult abuse and domestic abuse. The Trust's domestic abuse policy ratified in 2017 includes referral to, and attendance at, MARAC.

5.118 The London Ambulance Service NHS Trust staff have annual refresher training which included domestic abuse in 2015 and 2016. It is also included in new recruits' level 2 training. The Trust does not refer directly to MARAC.

5.119 Westminster Drug Project (WDP) confirmed that as of October 2015 all WDP staff in Barnet were required to complete domestic abuse and safeguarding training. However, training records for the practitioner involved in Seth's treatment show they had not completed this training at the time of his attendance at WDP.

5.120 During the timescale covered by this Review the All London Procedures for Adult Safeguarding were in use and available to all GPs in the Borough. All GPs within Barnet were also receiving annual adult safeguarding training provided by the Safeguarding Team and updates are provided by the Clinical Commissioning Group (CCG). Information for GPs is also available on the Barnet CCG website. However, GPs need greater understanding of adult family violence, particularly of the additional risks where mental ill-health and substance misuse is present. The need for further training has been acknowledged and the Iris programme has been commissioned

5.121 The Victim Support victim care officer who had contact with family members following incidents had undertaken the service's core training which includes domestic abuse awareness. One of the officers had also undertaken the advanced serious crime and domestic abuse training which covers risk assessment and safety planning. The IDVA who tried to engage Rachel had undertaken Safelives IDVA training.

Term of Reference 12: *Are there any cultural issues which may have impacted upon the family's engagement or interactions with care provided and were these given due consideration?*

5.122 It is striking that, according to Mental Health Services notes, the primary point of contact with the family appears to be Seth's elder brother Simon who did not live in the family home (it is not always possible to distinguish from records which brother was contacted). This contact even resulted in a carer's assessment being offered on one occasion. When he was alive Seth's father was also consulted at key points. Evidence of regular liaison with Rachel who lived in the family home all the time is notable by its absence, as is liaison with Seth's mother who was not always at the family home, but she was there at key intervals during the period under detailed review. Whether it is a family culture for the males to take the lead in such matters is not known. A male perspective on mental health and any consideration of Seth's violence as domestic abuse may have impacted on reporting by the family and interactions with agencies providing Seth's care, but we do not have evidence to support this hypothesis.

5.123 Without the family's contribution to the Review it is difficult to discern whether there were any family culture issues which might have influenced or affected how they related to services. As already mentioned, families often wish to avoid criminalising their family member which can impact on their willingness to support Police prosecution, and this is evident in this case. Equally, the additional perceived stigma of having a family member with a mental illness and drug abuse problems may be an additional barrier.

5.124 There is a sense from what we know from the information within this Review, that the family had a culture of trying to do their best to manage Seth within their own resources, and that they were used to being self-sufficient until a crisis caused by Seth's behaviour caused them to contact the Police on many occasions. Their admirable resilience to cope over so many years does appear to have lessened commensurate with Seth's demanding and self-destructive behaviour in recent years, especially after suffering the loss of their father and Esther her husband.

5.125 Jewish Women's Aid are listed in the MARAC protocol as a member; however, they were not recognised as needing to be present at the meeting held on 15 March 2017 when Rachel's case was heard as one would have expected. Their input may have helped cultural considerations to be brought to bear when considering safety planning or regarding a means of further contact attempts with Rachel. The MARAC IMR suggests that they would be invited via Solace Women's Aid rather than directly by the MARAC coordinator. This may not be the best approach to ensure their attendance for relevant cases. A mechanism for discerning when a specialist service such as Jewish Women's Aid needs to attend may be best left to the MARAC coordinator.

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

5.126 The Mental Health IMR helpfully looked at the impact of culture on staff perceptions of the family interactions. For example, care coordinator 2 referred to the fights between the brothers as “men fights” and indicated that this was normal behaviour; it was viewed in the context of “rough and tumble”. Framing family violence in this way is concerning and requires constructive challenge in supervision sessions.

5.127 Seth consistently demonstrated a dislike towards Mental Health Service workers in general as he found them intrusive and felt he did not need their support. Whether this was born out of a cultural dislike for authority per se or due to a lack of appreciation of the benefits that support and taking his medication could bring due to his learning difficulties, we do not know. The IMR found his abusive outbursts did not appear to have been targeted at specific individuals, but services as a whole. However, there is evidence on record that he was racially abusive in his comments to individual staff in hospital and in the community. Seth's approach towards staff was given consideration and appropriate precautions taken when necessary. This may have altered the way services could be delivered to him but did not present a barrier to him receiving care. The main barrier was Seth himself as he continually rejected involvement with services trying to help him. He only accepted Mental Health Services when too ill to object i.e. when he met the Mental Health Act criteria for hospital admission, or adhered to medication when under a Community Treatment Order

to do so, Any attempts to meet any social needs he may have had over the years were impacted upon by his rejection of services, for example the final attempt to offer support before the homicides by the Liaison & Diversion in the Courts which he refused to deal with.

Term of Reference 13: *Over the period of time covered by this Review two criteria applied for assessing an adults' vulnerability. Up to March 2015 a 'vulnerable adult' was defined by the Department of Health 'No Secrets' guidance applied. Under the Care Act 2014 which was enacted in April 2015 the term 'an adult at risk' was adopted. Were the victims or the perpetrator assessed as a 'vulnerable adult' pre - 31 March 2015 or an 'adult at risk' post 1 April 2015? If not were the circumstances such that consideration should have been given to such an assessment.*

5.128 The person to be regularly identified as a vulnerable adult was Seth. The Police were aware of his mental ill-health and drug abuse and a MERLIN was completed in the vast majority of their contacts with him.

5.129 Rachel would not have met the criteria for a 'vulnerable adult' or 'adult at risk'. The fact that she was able to take appropriate actions to call the Police, and to liaise with the Mental Health Team when necessary, meant she did not meet the definition for the two criteria.

5.130 When Police attended the family home in April 2017 following Seth's assault on his mother Esther, the Police IMR reports that officers initially highlighted her vulnerability, but no MERLIN was completed. At this time Esther had recently had knee surgery and was finding movement difficult. When she saw health professions at the beginning of May 2017 it was noted that she was mobilising very slowly, using two elbow crutches, and was in considerable pain, which she found worse than pre-surgery (paragraph 3.183). Therefore, it is justified to assess that she would have met the definition of an 'adult at risk' below and a MERLIN should have been created:

> a) *has needs for care and support (whether or not the authority is meeting any of those needs)* - Esther was in receipt of nursing care following her surgery.
> *b) is experiencing, or is at risk of, abuse or neglect,* - She had been domestically abused by Seth and threatened with a knife.
> *and*
> *c) as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.* - Esther was experiencing pain, her mobility was affected, and an she was mobilising with the support of crutches making it difficult or impossible to protect herself.

5.131 No other agency identified Esther as an 'adult at risk' during this time. The approved mental health professional who spoke to Esther on the phone did not identify any safeguarding concerns. Their role was to assess Seth in Police custody, they would not undertake home visits. Therefore, they would have been unaware of Esther's vulnerability due to her recent surgery and mobility problems at that time.

6. Conclusions

6.1 Looking back on the chronology in this Review it is clear that Seth's behaviour due to his mental ill-health and drug use was extremely resource intensive for the agencies with whom he came into contact, and it could have been more so had Community Mental Health been more proactive following the change in care coordinator in July 2016. That being the case we should ask what was it like for his mother Esther, sister Rachel, and the rest of the family living day to day, year on year, with such significant emotional, physical, and time demands on them.

6.2 There is a sense that some agencies thought the family down-played Seth's mental illness and his behaviour at times, but living with the ups and downs of his actions since his diagnosis in 2009 probably meant that in the context of his more volatile periods where he was sectioned, by comparison his behaviour at other times was viewed as relatively tolerable and stable. There is also the question how much knowledge and understanding did all the family members have about Seth's diagnosis and were any consequential risks shared with them?

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

6.4 Timely sharing of information played a major part in agencies' lack of sufficient information to process Seth through the criminal justice process in 2017 effectively and safely. The Review revealed a lack of clear processes for communication between services. Seth was released from prison due to time served without the court being given the report they had requested and without sentencing advice. The opportunity to restart Seth on his medication in prison appears not to have been taken, and he was released so quickly that there was not enough time to complete a release plan and organise alternative accommodation. The court did not use its powers to put in place a restraining order to protect Rachel and Esther from Seth even though he had been found guilty of their assault. No other supervision or community orders were put in place to try and regulate his behaviour and assist with his compliance with treatment and medication.

7. Lessons to be Learnt

Information Sharing:

7.1 A failure to share relevant information is a constant finding in DHRs and Serious Case Reviews and this Review is no exception. On occasions this was due to individual oversight or failure to follow procedures, such as in the Court process where the Court Probation Service did not gather the information which was available to inform the magistrates. On other occasions information was not shared or provided due to a failure in systems such as in the lack of clarity as to who provided a psychiatric report for the court, or diverse data systems which impeded information sharing between Community Mental Health and Prison In-reach Team, and an incomplete intelligence report provided by the Police to CRC to inform Seth's assessment. There were also times when safeguarding concerns should have been recognised as high enough to override patient confidentiality and warrant sharing information about the threats made by Seth against his sister Rachel during Mental Health Assessments. There is danger in always believing that threats of violence made in assessments by a mentally unwell patient will never be enacted, even when threats are made more than once. The number of Police callouts involving assaults on family members for which Merlin notifications were send to Mental Health, should have indicated that the perpetrator was capable of, and did use, violence against family members. But the sharing of this information resulted in no action.

7.2 Information was not fully shared by the Mental Health representative at the MARAC. They only reported the problem was Seth's drug use, no mental health history nor his diagnosis of schizophrenia was given, and no MARAC actions were offered for Mental Health's contribution to Rachel's safety plan, nor does it appear that this was challenged. The MARAC representative did not inform Seth's care coordinator of the MARAC following the

meeting, and linked to the learning below, nor was this recorded on the RiO notes for the MARAC to be visible when the care coordinator accessed the notes. Those referred to MARAC are necessarily viewed as high risk victims. There is no room for complacency as the threshold for MARAC is high; anyone referred must be recognised as high risk, and by association their perpetrator poses a high risk. At the very least this should have result in the care coordinator discussing the case with their manager and/or the holding of a strategy meeting and revising Seth's risk assessment.

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

7.4 Early in the Review process it became clear that there was confusion between a local meeting called the Community MARAC and the MARAC understood nationally as the multi-agency vehicle convened to safety plan for high risk victims of domestic abuse. The lack of understanding about the former of these two meetings led to confusion and a referral which could have shared vital information was not sent. Thus, the increasing risk pose both to and from Seth due to his drug use and contact with drug dealers was not shared. The Mental Health Trust IMR made a recommendation asking for a clear distinction to be made between the two. This is strongly endorsed by the author of this DHR. Unfortunately, early action on this learning did not take place before the completion of the Review due to the strategic level negotiations needed to make the change of name.

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

Record Keeping

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

7.7 The accuracy of record keeping is also vital. For example, the recording of the assault on Esther was inaccurate in mental health notes and it was overlaid with the racially aggravated incident in the street which was confusing. Disappointingly record keeping and the need for management scrutiny to ensure policies are being adhered to have been a recommendation for the Mental Health Trust in a previous Barnet DHR[46] in 2015. It is essential that this issue is addressed at the highest level in the Trust.

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[46] https://www.barnet.gov.uk/sites/default/files/final_september_2015_barnet_dhr_overview_report_final_read_only_0.pdf

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

Risk Assessment:

7.9 Risk assessment outside of incidents involving the Police was lacking in any understanding of risk associated with domestic abuse, and the additional risk factors that research shows come with substance misuse and mental illness. The lack of understanding and consideration of adult family violence was notable; Seth's care coordinator once describe assaults between Seth and his brothers as 'men fights' in the context of 'rough and tumble'. This shows an absence of analysis of the whole picture, the number of Police callouts, the building tensions in the family, and Seth's growing propensity for violence which was increasing risk.

7.10 The fact that Seth had made threats of violence towards his sister Rachel during assessments appears not to have been carried forward to inform any ongoing assessment of risk to others. Rachel's assault in February 2017 should have rung alarm bells, and the assault on his mother should have rung yet more and resulted in another referral to MARAC. The frequency and level of Seth's violence was increasing. The care coordinator would have been ideally placed to make this referral as it should have been clear to them that Seth was the perpetrator of abuse to both victims.

7.11 A review of the literature by Onwumere et al[47] observed "that carers, particularly those who are female and living with the patient (e.g., typically mothers), are more likely to be the identified target of violent acts compared to other family members and the general population" (p3). The Onwumere et al research acknowledged that although most adults living with psychotic disorders are not violent, they recommend that domestic violence in psychosis cases should be an issue of public health and concern, and information on this patient sub group who are violent toward their caregivers might help the development of preventative and targeted interventions which would have the potential to improve outcomes for all.

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

"His mother didn't want him to be reported to the police and I was sympathetic towards that. I decided we'd do it her way, and that was a mistake, it was a mistake that she paid for". (Ferriter & Huband, 2003, p555)[48]

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

[48] Ferriter M, and Huband N (2003) Experiences of parents with a son or daughter suffering from schizophrenia. J. Psychiatry. Mental. Health Nurse. 10, 552–560. doi: 10.1046/j.1365-2850.2003. 00624.x cited in Onwumere J, Zhou Z and Kuipers E (2018) Informal Caregiving Relationships in Psychosis: Reviewing the Impact of Patient Violence on Caregivers. Front. Psychol. 9:1530. doi: 10.3389/fpsyg.2018.01530

7.13 The Mental Health Trust had introduced the LINKS pilot project IDVA into the Mental Health Team in January 2017. This innovative approach was to educate staff about domestic abuse including risk assessment. Despite the availability of the IDVA to give advice to practitioners it appears that Seth's care coordinator did not absorb the training and did not seek support with risk assessment when first Rachel was assaulted and then Esther was assaulted and threatened with a knife. It is vital that practitioners recognise risk, when they need to seek expert advice, keep the risk assessment under review as circumstances change, especially when new incidents occur which indicate escalation or an increase in frequency. Management needs to assure itself that learning from domestic abuse training results in implementation of that learning in case management.

Family Support & the Think Family Approach

7.14 Some professionals appeared to think that the family members with whom they had contact were minimising Seth's mental health condition and/or not always informing his care coordinators of the whole picture. However, the male family member with whom they had most contact did not live in the family home where Seth resided, and he worked long hours in the family business. Consequently, they may not have had the most detailed up to date information. There is also a question regarding how much the family understood about Seth's diagnosis, the risks during relapse, and the additional support which might be available including through specialist voluntary services. For example, Rachel was not referred to Jewish Women's Aid which may have improved the chances of her engagement with support.

7.15 The person who was offered and turned down a carer assessment was Seth's elder brother who did not live at the family home which seems counter intuitive. Nothing further was offered. Other family members, particularly the women, are absent from offers of support, raising the question of conscious or unconscious gender bias on the part of the care coordinators. Family members who are carers or informal carers may not consider themselves as such, but research shows that the adverse health effects on informal carers (predominantly women) in managing their relative's psychosis can not only affect the carers health, but also impact on outcomes for the patient resulting in higher admissions to hospital[49]. Whilst it is impossible to say whether such a private family would have accepted support, it should nevertheless be offered as a positive option outside of statutory agency services, especially as there are specialist agencies locally offering services to the Jewish community[50].

7.16 The impact of Seth's mental illness on the whole family appears not to have been considered. Practitioners working in the field of mental health need the help and support of family members to provide information when devising care plans and ongoing monitoring of a service user's progress. It is essential that this is a two-way process undertaken in partnership as described by the Carer's Trust research and guidance Triangle of Care[51].

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https://www.researchgate.net/publication/327397274_Informal_Caregiving_Relationships_in_Psychosis_Reviewing_the_Impact_of_Patient_Violence_on_Caregivers

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

[50] Examples of Services: Norwood - Jewish Charity supporting families; Jewish Care - Health & Social Care for the Jewish community; Jewish Association for Mental Illness; Jewish Women's Aid.

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

Family members need to be supported with education about their relative's diagnosis, managing symptoms and relapse, identification of risk, and who to contact about any difficulties or concerns. Whilst the ethos of patient confidentiality is understood, where a patient is living within the family home, it seems only reasonable that the family should have all the knowledge they need to support their relative, but also be realistic and able to recognise risk to themselves. If the patient does not consent to information sharing it can still be achieved if the information shared does not contain personalised data, for example explaining the diagnosis, providing information already in the public sphere, and the use of a carer's plan.

7.17 As previously mentioned, families frequently prefer not to prosecute their family member as they do not wish to criminalise them. Esther was clear that she did not want Seth to go to prison. However, sometimes this can prove a helpful step to take. Seth had complied with the Community Treatment Order and had he been put before a court earlier a recommendation could have been made to the Court for a Drug Treatment Order and a further Community Treatment Order with which he may have complied once more. It is useful if family members have this explained and are supported to see this as a helpful option.

Working with Challenging Service Users

7.18 There is no doubt that Seth presented a challenge to the services with which he came into contact, particularly the Community Mental Health Service. When his illness was at its worst, he lacked capacity and could therefore legally be admitted to hospital regardless of his views. There were occasions when he recognised he needed hospital treatment and he accepted voluntary admission. However, once at home in the community he stopped taking his medication and there was little success in keeping him engaged apart from the Community Treatment Order in 2014; this proved to be the most stable and 'quietest' year for his family and the emergency services. There appears to have been little effective practice to keep him engaged; no use of the assertive approach[52] seems to have been considered which can prove effective.

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

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

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

Barriers to Safe Planned Release of Offenders

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

7.22 Whilst fully appreciating that an offender cannot be held beyond their sentence tariff, a way needs to be found to avoid them being released straight from Court or prison without a pre-release plan in place. A Court hearing date is usually pre-arranged; therefore, pre-planning for release could aim to be in place for that date. However, the problems arise if like Seth there are a number of hearings and finally the Court decides to release immediately due to time served on remand. This presents prison staff with a challenging problem particularly in relation to accommodation. The Review author is aware of a similar DHR where the offender was release straight from Court without services and anti-psychotic medication in place, and the Panel were concerned about the ramifications of this process of release immediately following Court for vulnerable offenders with additional needs, and victims who may be at risk following their release.

Early Learning:

7.23 In August 2018, the Mental Health Trust took steps to ensure information arising out of safeguarding alerts, MARAC, and MAPPA discussions are recorded in the patient record, that these are used to inform subsequent risk assessments, and the formation of risk management plans. Safeguarding, MAPPA, and MARAC referrals are to be regularly explored in personal and team supervision. The Trust has developed a MARAC protocol formalising MARAC arrangements which was signed off by the Integrated Safeguarding Committee on 23 January 2019. The protocol was shared with the MARAC Steering Group in October 2018. No response was received; therefore, the new protocol was assumed to be satisfactory.

7.24 The difficulty experienced by approved mental health professionals (AMHP) in accessing the RiO database from within Police stations has been addressed. They now rely on the senior nurse assessor based at Edgware, or the bed manager at Chase Farm Hospital to ask for information about the client. This is the same system applied when the client is from out of area. This arrangement was introduced in December 2018. Full time AMPHs now have mobile working devices which means they can access RiO out of hours/off site. This has been in place since June 2018. The DHR Panel heard that locum AMPHs do not have access to a laptop/mobile working and this has been raised with the Local Authority who employ them. The Mental Health Trust is happy to support access to RiO for the 4 locum AMHPs, but this would need to be added to their devices. Barnet Adult Social Care have a project and work plan looking at IT solutions which will enable staff to access RIO through their devices. Staff who do not have direct access are able to contact managers and colleagues who have access. The locum AMHP while on day time duty is based in the AMHP office where there is access to RIO.

7.25 Interagency Mental Health Law Monitoring Group minutes of 11 September 2018 record that the three approved mental health professionals' (AMHPs) managers all confirmed that their AMHPs are now recording on RiO the views of the assessing doctors when an application for detention is not made following a Mental Health Assessment.

7.26 During 2018 the Mental Health Trust reviewed the Court Diversion and Liaison Service and the Prison In-reach Team schemes operated by the Trust to ensure that protocols and

service agreements were developed which are clear, and provide readily available pathways for the appropriate sharing of information between services. It has liaised with the Court and Prison mental health schemes with which it has regular contact to ensure that pathways of care and contact details are clear to all staff involved. The In-reach and Liaison and Diversion Team have presented to the Barnet Community Teams to improve awareness of the services. This was completed in August 2018. Referral processes were also reviewed: the Liaison and Diversion Team (L & D) do not need to complete referral forms they simply send the L&D assessment to the In-Reach Teams who automatically pick patients up for In-Reach Team allocation. Operational policies for prisons and L&D have been reviewed to include a clear section on cross referring and information sharing arrangements. A Zoning protocol has been reviewed with clear reference to timescales for medical review. Court reports are not part of the Trust contracts in L&D or prisons and all Courts use a different system, however, the Trust are setting up a centralised system for allocating report requests that come into their service.

7.27 Following the early learning from the National Probation Service internal inquiry, the review of training of Probation Court staff recommended in their IMR was commenced and training sessions were completed in June 2018.

8. Recommendations

8.1 The following recommendations have arisen from analysis of information provided to the Review, Panel discussions, the lessons learnt, and agency IMRs.

National Level:

Ministry of Justice:

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

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

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

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

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

Department of Health & Social Care:

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

Home Office:

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

Local:

Multi-Agency

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

Barnet, Enfield & Haringey Mental Health NHS Trust:

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

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

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

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

Recommendation 11:
BEH should develop a MARAC protocol to ensure there is a clear understanding of process, attendance, and recording requirements on the patient record. Management, and the MARAC representative and their deputy should see advice for Mental Health MARAC representatives at:
http://www.safelives.org.uk/practice_blog/role-mental-health-representative-marac
(IMR Recommendation). *This recommendation was acted upon by the Mental Health Trust Safeguarding Committee in January 2019*

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

Recommendation 13:
BEH should engage with the Court and Prison mental health schemes with which it has regular contact to ensure that pathways of care and contact details are clear to all staff involved. (IMR Recommendation). *Action complete August 2018*

Recommendation 14:
BEH should review the use and operation of the Risk and CPA facilities on RiO and develop systems that provide easy and direct access to information necessary for risk assessment and management. (IMR Recommendation). *Board Level Inquiry action plan confirms this action was closed in June 2018. Simplified Risk assessments are in place on RiO.*

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

Barnet Adult Social Care

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

Barnet MARAC - Hestia & MARAC Chair

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

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

(b) Agencies must submit updates on actions to the MARAC Co-ordinator by the given deadline, and the chair and MARAC coordinator should review minutes and actions before the start of subsequent MARAC meetings to ensure actions are reported completed and

the plan remains fit for purpose to minimise the risk to the victim/s. The Domestic Abuse MARAC coordinator to assist in bringing these items to the attention of the chair.

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

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

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

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

Community Safety Team

Recommendation 21:
There needs to be a clear distinction between Community MARAC and Domestic Abuse MARAC. (IMR Recommendation)

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

Metropolitan Police

Recommendation 23:
SX BOCU Level: - (IMR Recommendation)
It is recommended that SX BOCU SLT dip sample domestic abuse reports to: -
- Ensure five year intelligence checks are being completed as per toolkit.

- Ensure compliance with current MARAC referral threshold and that rationale is being recorded within report.

Recommendation 24:
SX BOCU Level: - (IMR Recommendation)
It is recommended that SX BOCU SLT reinforce the requirement for all staff: -
- to understand the Vulnerability and protection of adults at risk policy
- to understand the Vulnerable Adult Framework
- to complete ACN MERLIN reports where they have identified vulnerability whether they are a victim, witness, suspect or member of the public they have encountered using VAF.

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

National Probation Service

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

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

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

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

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

Royal Free London NHS Foundation Trust

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

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

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

Victim Support:

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

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

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

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

Westminster Drug Project:

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

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

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

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

APPENDIX A

The Barnet Enfield & Haringey Mental Health Trust

LINKS Project

Barnet Enfield & Haringay Mental Health Trust recognised in common with research findings their staff had a very low level of referrals to MARAC and specialist domestic abuse services, and a lack of confidence in recognising and risk assessing domestic abuse was partly the reason for this. The aim of the LINKS Pilot Project was to enhance the safety and health of Barnet Enfield & Haringey Mental Health Trust patients by adapting the IRIS model which has successfully supported the improvement of access to specialist domestic abuse services for GP patients identified as affected by domestic violence and abuse. With the support of 1 year funding from NHS England the LINKS Project employed an Independent Domestic Violence Advocate (IDVA) within mental health services with the aim of:

- Increasing the identification of BEH-MHT patients that are experiencing domestic abuse
- Increasing referrals for BEH-MHT patients for support to specialist domestic abuse services
- Increasing awareness, knowledge, and confidence of BEH-MHT staff in responding to domestic abuse.

The LINKS project model was based around the deployment of an IDVA as an 'advocate-educator' within the clinical environment. It ran between January 2017 to January 2018. The role encompassed:

- Training/ awareness raising for clinical and administrative staff
- Ongoing consultancy/ specialist IDVA support to staff
- Direct referral of patients for expert advocacy
- Electronic prompt in medical record.

Although the project was affected by an organisational restructure and office move which impact on the number of staff trained from the original plan, the evaluation identified an increase in staff knowledge and confidence in dealing with domestic abuse, including identifying domestic abuse amongst their service users, and a 63% increase in staff knowledge about referral pathways. The evaluation identified the need for more work around the understanding of the impact of domestic abuse among the older population as they represent a significant section of the Barnet population and featured in the most recent domestic homicide reviews in the borough.

The evaluation of the Project over the time span of the pilot, found there was a 660% increase in referrals to Solace Women's Aid from the Trust. The Trust increased the number of referrals from 5 referrals in 2016/17 to 38 referrals in the same time period a year later. This is a substantial amount and a testament to the work of staff within the Trust and Solace Women's Aid.

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APPENDIX B

Home Office

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Peter Clifton
Barnet Safer Communities Partnership Board
2 Bristol Avenue
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London
NW9 4EW

29 June 2020

Dear Mr Clifton,

Thank you for submitting the Domestic Homicide Review (DHR) report (E&R) to the Home Office. Due to the COVID-19 situation the Quality Assurance (QA) Panel was unable to meet as scheduled on 27 May therefore the report was assessed by a virtual panel process. For the virtual panel, Panel members provided their comments by email, the Home Office secretariat summarised the feedback and the Panel agreed the feedback.

The QA panel found this to be a thorough, well written, detailed report which was easy to read and clear to follow. There are good lessons learnt and strong recommendations. They noted that the report demonstrates good analysis and excellent use of research. The Panel commended the inclusion of specialist representation on the panel and also the efforts made to engage the family even after the DHR was completed. The Panel felt this was good practice and demonstrates that the Chair sees the family as a key stakeholder. The Panel suggested that it would have been good practice to include a representative from a substance use service on the panel and recommended that this is considered for future reviews where substance use is a factor.

The QA Panel felt that there are some aspects of the report which may benefit from further revision but the Home Office is content that, on completion of these changes, the DHR may be published. As requested, the Panel are happy for a learning document to be published.

Areas of final development include:

- The Panel suggested that the Equality & Diversity would be strengthend by inclusion of a brief summary of the other protected characteristics relevant to the review.

- Whilst the thoroughness is commendable, the executive summary is lenghty. The Panel suggests this might be edited to reduce the length somewhat, without loss of substance
- There is a need to check tenses as it is inappropriate to use present tense for deceased victims e.g. para 3.1.
- There is an incorrect use of name e.g. para 3.35. please rename the hospital Royal Free Hospital which is located in Hampstead Heath.
- The chronology is extremely detailed covering events over many years involving Seth's mental ill health and many incidents of violence towards his family, and allegations against his family. The report could do more to explain why there was little assessment of his social needs, nor those of his family. Or indeed *why* mistakes e.g info sharing, quality of risk assessment occured.
- A thorough proof read is required due to the number of typographical errors within the report.

Once completed, the Home Office would be grateful if you could provide us with a digital copy of the revised final version of the report with all finalised attachments and appendices and the weblink to the site where the report will be published.

Please send the digital copy and weblink to DHREnquiries@homeoffice.gov.uk. This is for our own records for future analysis to go towards highlighting best practice and to inform public policy.

The Home Office believes it helpful to sight Police and Crime Commissioners (PCCs) on DHRs in their local area, and this letter will therefore be copied to your local PCC for information.

On behalf of the QA Panel, I would like to thank you, the report chair and author, and other colleagues, for the considerable work that you have put into this review.

Yours sincerely

Linda Robinson
Chair of the Home Office DHR Quality Assurance Panel

PLEASE SEE THE FOLLOWING PAGE FOR THE REVIEW RESPONSE AND HOW THE FEEDBACK FROM THE QUALITY ASSURANCE PANEL HAS BEEN ADDRESSED

Comments on content of QA Panel feedback.

- *The Panel suggested that the Equality & Diversity would be strengthened by inclusion of a brief summary of the other protected characteristics relevant to the review.*

➢ An additional paragraph has been added at 1.38.

- *Whilst the thoroughness is commendable, the executive summary is lenghty. The Panel suggests this might be edited to reduce the length somewhat, without loss of substance*

➢ The chronology section has been further reduced, and some precising of other sections completed.

• *There is a need to check tenses as it is inappropriate to use present tense for deceased victims e.g. para 3.1.*

➢ Checks have been made of the tense used in the Review and a number of changes have been made.

• *There is an incorrect use of name e.g. para 3.35. please rename the hospital Royal Free Hospital which is located in Hampstead Heath.*

➢ Name corrected.

• The chronology is extremely detailed covering events over many years involving Seth's mental ill health and many incidents of violence towards his family, and allegations against his family. The report could do more to explain why there was little assessment of his social needs, nor those of his family. Or indeed why mistakes e.g. info sharing, quality of risk assessment occurred.

➢ Re: Social Needs:
The report does include when attempts were made to the perpetrator with housing for example paragraphs 3.77 and 5.12, Additional sentences have been added to paragraph 5.127 to enhance the information within the report which has regularly described how the perpetrator rejected services' attempts to support him in any way including his social needs, thus these could not be assessed as he would not engage.

Extra sentences have been added to Term of Reference 5 commencing at page 59 to be explicit that that the family's social needs could not be assessed as they declined support offered, either via Victim Support, or IDVA. There was no evidence found that the Mental Health Trust assessed their needs as a carer's assessment was declined, and no evidence was found that they had a relapse plan to assist them with their lives in times of crisis, and this is already covered in this section of the Review. The private nature of the family meant that they tended to decline outside support except in emergencies and this is covered within the Review.

➢ Re: Information Sharing:
Explanations concerning gaps found in information sharing, both on a practitioner level and systems level are well covered in Term of Reference 6 commencing at page 61 in addition to other Terms of Reference on which this problem impacted. However, extra sentences have been added in some paragraphs explicitly using the word 'mistake' to address this comment. An additional paragraph at 5.49 has been added which summarises this analysis to be noticeably clear where and why mistakes occurred.

➢ Re: Risk Assessment:
In addressing Term of Reference 8 which analyses risk assessment commencing on page 66 of the Overview Report, the author has reassessed whether there are shortcomings in explaining why

mistakes happened in risk assessment. The analysis of this Term of Reference is detailed, and the author has found it difficult to identify gaps in the explanations given as to why inadequate risk assessments occurred. For example, paragraph 5.40 “A lack of clear pathway and concerns over patient confidentiality compromised each sections' information sharing and their ability to provide well informed assessment and care to Seth”, and paragraph 5.80 states “Assessment of risk at the MARAC was flawed as not all relevant information about Seth was presented by the Mental Health representative. The author has not used the word ‘mistake’ explicitly but believes that the reasons that risk assessments were inadequate is fully explained and this is reflected in the learning and recommendations.

- A thorough proof read is required due to the number of typographical errors within.

➢ Proof read undertaken and corrections made.