DOMESTIC HOMICIDE REVIEW

London Borough of Barnet Community Safety Partnership

Report into the death of Alyssa
March 2019

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Glossary

BEHMHT: Barnet Enfield & Haringey Mental Health NHS Trust
CCG: Clinical Commissioning Group
CRHTT: Crisis Resolution Home Treatment Team
CPS: Crown Prosecution Service
CSP: Community Safety Partnership
DHR: Domestic Homicide Review
IRIS: Identification and Referral to Increase Safety
LB: London Borough

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Preface

The Independent Chair and the Domestic Homicide Review Panel members offer their deepest sympathy to all who have been affected by the death of Alyssa[1], and thank them, together with the others who have contributed to the deliberations of the Review, for their participation, generosity of spirit and patience.

The Review Chair thanks the Panel for the professional manner in which they have conducted the Review and the report authors for their thoroughness, honesty and transparency in reviewing the conduct of their individual agencies.

1. Introduction

1.1 Domestic Homicide Reviews (DHRs) came into force on the 13th April 2011. They were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004). The Act states that a DHR 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 she was related or with whom she was or had been in an intimate personal relationship or

(b) A member of the same household as herself;

with a view to identifying the lessons to be learnt from the death.

Throughout the report the term 'domestic abuse' is used interchangeably with 'domestic violence', and the report uses the cross-Government definition as issued in March 2013. This can be found in full at Appendix B.

1.2 The purpose of a DHR 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 inform national and local policies and procedures as appropriate;
- prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated

[1] Not her real name

multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;

- contribute to a better understanding of the nature of domestic violence and abuse; and
- highlight good practice.

1.3. This Domestic Homicide Review (DHR) examines the circumstances leading up to the death of Alyssa who was murdered in March 2019.

The decision to undertake a DHR was made by Barnet Community Safety Partnership in March 2019 in consultation with local specialists. The Home Office was duly informed. An independent Chair was appointed in April 2019 and the Panel met for the first time in May where IMRs were commissioned, and agencies advised to implement any early learning without delay. Two further 'in-person' meetings were subsequently held and thereafter, switched to virtual meetings as a consequence of the pandemic.

1.4. The Barnet Safer Communities Partnership ('BSCP' or 'the Partnership') are responsible for overseeing the development and implementation of an overall strategy for reducing crime and anti-social behaviour; this includes Domestic Abuse (DA) and Violence Against Women & Girls (VAWG). The priorities and aims of DA and VAWG are set out in the BSCP's Domestic Abuse & VAWG Strategy for 2022-2025 which includes the partnership's commitment to working together to prevent and tackle all forms of VAWG.

1.5. LB Barnet has a number of specialist domestic abuse services. These include Jewish Women's Aid, an advocacy and advice service run by Solace Women's Aid and an Independent Domestic Violence Adviser service provided by Victim Support. In addition to this, Solace also provide the advocate-educator for IRIS[2] trained GP practices and a local community interest company – Rise Mutual – delivers perpetrator interventions.

2. Overview

Persons involved in this DHR

Name	Gender	Age at the time of the murder	Relationship with victim	Ethnicity
Alyssa	F	50	Victim	White European
John[3]	M	54	Partner and perpetrator	White European

Alyssa had three children who were all adults at the time of her death.

Address 1: Alyssa's home

[2] IRIS is Identification and Referral to Increase Safety, a primary care practice model; for responding to domestic abuse.
[3] Not his real name

Address 2: John's home, approximately 3 miles from address 1 and where the murder occurred.

2.1. Summary of the incident

2.1.1. In early March 2019, the police received a mid-morning call from a concerned neighbour, reporting that he could hear a woman screaming for help in a nearby flat and that he believed the woman to be the girlfriend of the occupant. Officers were sent to the address but before they arrived, the concerned neighbour called again saying that the woman had screamed she was being stabbed before everything went very quiet.

2.1.2. The police arrived minutes later and were taken to the flat by the concerned neighbour.

2.1.3. Officers tried unsuccessfully to force entry before John suddenly opened the door. He was naked and covered in blood. Officers immediately handcuffed him and detained him in the hallway outside of the flat. A few moments later, John remarked that *'It's the hospital's fault, they shouldn't have released me'.* It would later be established that he had been released from an acute mental health ward two days previously.

2.1.4. On entering the flat, officers found the lifeless body of Alyssa, lying on her back in a large pool of blood and with multiple stabs wounds all over her body. The attack had been so frenzied that internal organs were exposed. A bloodstained hammer and knife were found next to the body.

2.1.5. John was subsequently charged with murder which he denied. He admitted to manslaughter by reason of diminished responsibility. A psychiatrist report prepared for the trial concluded that although John did suffer from an emotionally unstable personality disorder, the killing was motivated by his unmodulated rage and is not simply reducible to the effects of a depressive disorder.

2.1.6. In August 2019, John was found guilty of murder and sentenced to a minimum tariff of 21 years.

3. Parallel reviews

3.1. There was an inquest and a criminal trial. As is common practice, the inquest was not reopened after the conviction of John.

3.2. Barnet Enfield and Haringey Mental Health Trust undertook a Board Level Inquiry. The completion of this took some time and was not finalised until the end of 2019.

4. Domestic Homicide Review Panel

The DHR Panel was comprised of the following:

Davina James-Hanman, Independent DHR Chair and report author

Aneta Mularczyk, Area Manager, Hestia Housing and Support

Beverley Williams, Detective Sergeant, Metropolitan Police

Heather Wilson, Adult Safeguarding Lead, Barnet Clinical Commissioning Group

Helen Swarbrick, Head of Safeguarding, Royal Free London NHS Foundation Trust

Julie Carpenter, Safeguarding Specialist, London Ambulance Service

Karen Morrell, Head of Mental Health, LB Barnet Adult Social Care

Kate Aston, Adult Safeguarding MCA and Prevent Lead, Central London Community Healthcare NHS Trust

Mathew Hutchins, Data Analyst, Community Safety, LB Barnet

Monica Tuohy, Senior Manager, Solace Women's Aid

Naomi Dickson, Jewish Women's Aid

Radlamah Canakiah, VAWG Strategy Manager, LB Barnet

Ruth Vines, Head of Safeguarding, later replaced by Celia Jeffreys, Barnet, Enfield & Haringey Mental Health NHS Trust

Stuart Coleman, Head of Housing Management, Barnet Homes

5. Independence

The author of this report, Davina James-Hanman, is independent of all agencies involved and had no prior contact with any family members. She is an experienced DHR Chair and is also nationally recognised as an expert in domestic violence having been active in this area of work for over three decades. Further details are provided in appendix C.

All Panel members and IMR authors were independent of any direct contact with the subjects of this DHR and nor were they the immediate line managers of anyone who had had direct contact.

6. Terms of Reference and Scope

6.1. The full terms of reference can be found at appendix A. The key lines of inquiry were as follows:

1. Each agency's involvement with Alyssa between January 2008 and her death resident at address 1

and

Each agency's involvement with John between January 2008 and the murder, resident at address 2,

with any involvement outside the timeframe summarised.

2. Whether an improvement in communication between services might have led to a different outcome for Alyssa.

3. Whether the work undertaken by services in this case was consistent with each organisation's:

(a) Professional standards

(b) Domestic violence policy, procedures and protocols

4. The response of the relevant agencies to any referrals relating to Alyssa or John, concerning domestic violence or other significant harm from January 2008. It will seek to understand what decisions were taken and what actions were carried out, or not, and establish the reasons. In particular, the following areas will be explored:

(a) Identification of the key opportunities for assessment, decision making and effective intervention in this case from the point of any first contact onwards.

(b) Whether any actions taken were in accordance with assessments and decisions made and whether those interventions were informed, professional, timely and effective.

(c) Whether appropriate services were offered/provided and/or relevant enquiries made in the light of any assessments made

(d) The quality of the risk assessments undertaken by each agency in respect of Alyssa and John

5. When, and in what way, were the victim's wishes and feelings ascertained and considered? Is it reasonable to assume that the wishes of the victim should have been known? Was the victim informed of options/choices to make informed decisions? Were they signposted to other agencies?

6. Was anything known about the perpetrator? For example, were they being managed under MAPPA? Were there any injunctions or protection orders that were, or previously had been, in place?

7. How accessible were the services for the victim and perpetrator?

8. The training provided to staff and whether this was taken up and refresher training provided as needed.

9. Whether thresholds for intervention were appropriately calibrated, and applied correctly, in this case.

10. Whether practices by all agencies were sensitive to the nine protected characteristics[4] of the respective family members and whether any special needs were explored, shared appropriately and recorded.

11. Whether issues were escalated to senior management or other organisations and professionals, if appropriate, and in a timely manner.

12. Whether the impact of organisational change over the period covered by the review had been communicated well enough between partners and whether that impacted in any way on partnership agencies' ability to respond effectively.

[4] These are: age; disability; gender reassignment; marriage or civil partnership; pregnancy and maternity; race; religion or belief; sex and sexual orientation

13. Whether friends and family of both Alyssa and John were aware of any issues and if so, what to do about any concerns they may have had.

7. Confidentiality and dissemination

7.1. The findings of this Overview Report are restricted. Information is available only to participating officers/professionals and their line managers, until after the Review has been approved for publication by the Home Office Quality Assurance Panel.

7.2. As recommended within the 'Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews' to protect the identities of those involved, pseudonyms have been used and precise dates obscured.

7.3 The Executive Summary of this report has also been anonymised.

7.4 This has not prevented agencies taking action on the findings of this Review in advance of publication.

7.5 Subsequent to permission being granted by the Home Office to publish, this report will be widely disseminated including, but not limited to:

- Barnet VAWG Delivery Group
- Barnet Safer Communities Partnership Board
- Barnet Community Leadership and Libraries Committee
- Barnet Enfield & Haringey Mental Health NHS Trust
- Barnet Clinical Commissioning Group, NHS
- Solace Women's Aid
- Met Police Public Protection Investigations, Northwest Basic Command Unit
- Specialist Crime Review Group, MPS
- Jewish Women's Aid
- Royal Free London NHS Trust
- Barnet Community Safety Team
- London Ambulance Service
- MOPAC
- Domestic Abuse Commissioner

7.6 A number of learning events have been planned to ensure that the lessons are disseminated as widely as possible; the first of these will be a confidential briefing to key local partners which will share the critical learning from this DHR. Once permission is granted by the Home Office to publish, this report will be more widely disseminated to the local professional networks including Barnet VAWG Delivery Group and VAWG Forum. Learning will be further incorporated into local domestic abuse training. All DHRs are published on a permanent hyperlink on LB Barnet's website
Domestic Homicide Review | Barnet Council

8. Methodology

8.1. Chronologies were provided by:

- Royal Free London NHS Foundation Trust
- Metropolitan Police

- Central London Community Healthcare NHS Trust
- London Ambulance Service

Contact for all of these agencies was minimal and / or not relevant and thus a full IMR was not requested. However, the Panel scrutinised each of the chronologies and asked further probing questions.

8.1.1. Barnet, Enfield and Haringey Mental Health Trust undertook a Board Level Inquiry, and this was accepted in lieu of an IMR.

8.1.2. John's GP declined to share information with the DHR Panel citing patient confidentiality. Detailed information was provided by the Chair as to the legal exceptions, but this did not change the GP's position. This is regrettable as it was potentially a missed opportunity to learn valuable lessons.

8.1.3. A further seven agencies advised they had not had any contact with either Alyssa or John.

8.2. The Review Panel has checked that the agencies taking part in this Review have domestic violence policies and is satisfied that they are fit for purpose. The exception is LB Barnet who currently does not have a domestic abuse policy and a recommendation has been made in regard to this.

8.2.2. The Panel and agencies providing reports have been committed, within the spirit of the Equalities Act 2010, to an ethos of fairness, equality, openness, and transparency, and have ensured that the Review has been conducted in line with the terms of reference.

8.3. This report is an anthology of information and facts gathered from:

- The chronologies detailed above
- The Board Level Inquiry undertaken for Barnet Enfield and Haringey Mental Health Trust
- The Police Senior Investigating Officer
- The criminal trial and associated press articles
- DHR Panel discussions
- Information from one of Alyssa's colleagues.

8.3.1. Barnet Community Safety Partnership is responsible for monitoring the implementation of the action plan (appendix E).

8.4. In preparation for the criminal trial, the Metropolitan Police took a number of statements from witnesses and family members. Summaries of these were provided for the Panel.

8.5. Involvement of family and friends

8.5.1. The family of the victim were informed about the commencement of the DHR through the Family Liaison Officer (FLO) and invited to participate. Home Office leaflets were provided along with information about specialist advocacy support (AAFDA). The terms of reference were enclosed, and an invitation extended to comment on these. No response was received.

8.5.2. A further contact was made after the criminal proceedings had concluded and the same information provided along with an invitation to meet with the Chair should they so choose. No response was received.

8.5.3. Once the report had been drafted, a further contact was made to ask if the family would like to see a copy of the report, provide any information for inclusion in the report and to appraise the Chair of any significant dates to be avoided for publication of the report. No response was received.

8.5.6. Post-conviction, the perpetrator was contacted and invited to participate. No response was received.

8.5.7. Alyssa worked part-time for a community welfare organisation. She had been there for approximately six months at the time of her death. A colleague met with the Chair to provide some background information.

8.6 Equality and diversity issues

All nine protected characteristics in the 2010 Equality Act were considered by the DHR Panel. Several protected characteristics were found to have relevance to this DHR. These were:

Sex: Sex is also relevant as there is extensive research to support that in the context of domestic violence, females are at a greater risk of being victimised, injured or killed[5]. Latest published figures show that almost half (48%) of adult female homicide victims were killed in a domestic homicide (99). This was an increase of 12 homicides compared with the previous year. In contrast, 8% of male victims were victims of domestic homicide (30) in the latest year.[6]

Disability: John was under the care of Mental Health services for over fifteen years which meets the threshold of him having a disability. This does not in any way excuse his culpability for his actions and his mental ill-health was not found to impact on his reasoning. Agency responses to his mental ill-health are discussed in more detail in the analysis section.

Religion: Both Alyssa and John were Jewish. Although considered by the Panel and assisted with the expert advice of Jewish Women's Aid, there is no indication that this played any part in the circumstances under review.

9. Key events

9.1. 2008 was chosen as the start date for the DHR as this is when John first became known to mental health services. Alyssa was first known to services in the UK in 2013.

9.2. Background information about Alyssa

9.2.1. Alyssa lived in Israel for many years with her husband and raised three children. She experienced domestic abuse in her marriage which culminated in her husband being imprisoned for threatening her with a gun. Alyssa and her children moved to the UK in 2011.

9.2.2. Very little was known about Alyssa through agency contact. Between 2012- 2018 she had a variety of medical appointments but none of these had any relevance to the homicide.

[5] Smith, K. et al. (2011) Homicides, Firearm Offences and Intimate Violence 2009/10. Home Office Statistical Bulletin 01/11. London: Home Office

[6] https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/homicideinenglandandwales/yearendingmarch2019

However, her medical issues were a contributory factor to her gaining weight and subsequently joining Slimming World which she attended regularly with John.

9.2.3. Alyssa spoke openly about her past experiences of abuse; in the months before she died, she told work colleagues that she was happy with John, happy to be losing weight and enjoying her job. *'I finally feel as if my life is getting back on track'* she said.

9.2.4. Alyssa had several part-time jobs and at the point of her death she had been working as a Welfare Officer for a Jewish charity for six months.

9.3. Background information about John

9.3.1. Some agency records state that John was born in Watford; others that he was born in Australia. Either way, he grew up in Southend. He has one older brother. He left school at 16 without any qualifications, and worked in his father's business for 20 years, and also worked as a shop assistant and a dementia carer. Both his parents are now deceased. John's most recent employment was with a cash loans firm which he left in January 2019 as it was making him feel depressed. At the time of the incident he was living alone in his own flat. He told health staff that he neither drank alcohol nor took illicit drugs.

9.3.2. In 1995, he was married for approximately six months before divorcing. His brother reported in his witness statement for the criminal trial that this was due to trust issues.

9.4. John's psychiatric history

9.4.1. John's contact with mental health services dated back to 2003, when he was admitted to a mental health unit in Basildon Essex. Several recent life events – his mother being ill, his divorce, conflict with his family and a move to London from Southend - were noted as stressors. He was diagnosed as having 'moderate depression'.

9.4.2. In June 2008, he was seen at the Denis Scott Unit (Edgware Community Hospital) having presented with suicide ideation and depressive symptoms which he attributed to various work, family and relationship stressors. He was prescribed anti-depressants and referred to the Home Treatment Team[7].

9.4.3. The following month, he was again seen at the Denis Scott Unit complaining of anxiety and fearfulness. He was assessed as being in crisis and records state that he was difficult to engage, irritable and abusive to staff. He was again discharged to the Home Treatment Team. They did make contact, but John told them he did not want to take anti-depressants. This resulted in him re-presenting to A&E three days later complaining of anxiety, depression and suicidal ideation.

9.4.4. A week later he was admitted to Chase Farm Hospital, and transferred to Edgware Hospital, under s 2 of the Mental Health Act 1983 following an assessment at Colindale Police Station. He reported to staff three major stressors: recent unemployment, loneliness and the recent break up of a relationship. He was treated with antidepressants and an antipsychotic drug used for sedation. At the end of July 2008, John was discharged to the Home Treatment Team and was last seen by them on 19 September 2008.

9.4.5. There was then a lengthy period during which John was not in receipt of mental health services. However, in December 2015, John was found walking along the motorway and when he was approached, said that he was having suicidal thoughts having left his job two

[7] See appendix D for descriptions of mental health services.

weeks previous due to hostility with colleagues. This had left him feeling very isolated. He said he had no friends or social support and also (untruthfully) said he had no family.

9.4.6. He was admitted to a Recovery House[8] due to suicidal ideation but was discharged a few hours later to the care of the Home Treatment Team. The clinical impression was of a moderate depressive episode with clear dependent traits. His antidepressant was changed from citalopram to mirtazapine.

9.4.7. John called for an ambulance at the end of January 2016 stating that he was once again feeling suicidal. He was taken to hospital but later discharged back into the care of the Home Treatment Team with his case marked urgent[9].

9.4.8. A few days later, John attempted to jump off a bridge in Southend having travelled there to visit his brother. He was prevented from doing so by police officers. He was placed under section 136 of the Mental Health Act 1983. Two days later, John was again stopped by police officers after being observed driving erratically. He was acutely distressed and suicidal. He also disclosed that he was diabetic and hadn't eaten for two days John was admitted to the Denis Scott Unit at Edgware Hospital under s. 2 of the Mental Health Act 1983. This was rescinded on 22 February, and he remained as an informal patient. He described difficulties coping with his feelings for a female work colleague not being reciprocated.

9.4.9. On 8 March, John did not return to the hospital after an authorised leave. The police were notified but it later transpired that John was in St. Mary's Hospital, Paddington. He had injuries after jumping from the third storey of a car park in Brent Cross. John suffered multiple fractures to his pelvis and required surgical repair and rehabilitation. He was subsequently re-admitted to Denis Scott Unit as an informal patient on 31 March 2016 and his medication changed.

9.4.10. Notes made by his psychologist in May state that John asked about how to get over rejection. He said he had been researching on the internet and had found that romantic rejection was the biggest cause for depression. The psychologist agreed that this could be the case for some people, but reactive depression usually had an expiry date. A discussion ensued about how it is normal to feel bad in the face of rejection, but some reactions are more extreme than others. John was quite curious about what factors could go into why he was left feeling particularly devastated by rejection. They explored how John had coped with past rejections, his historical levels of self-esteem and his view of feeling 'better again' after the loss of this attachment. John repeatedly said phrases such as '*she destroyed me... look at what she's done... it's unbelievable... I can't believe I developed feelings for her'.* The psychologist pointed out that John had choices to not allow someone to be responsible for the entirety of his feelings and that whilst he could not change what had happened, he did have the choice to either allow his work colleague to be the reason he could not move forward, or he could choose to look at how he can rebuild his life following this crisis.

9.4.11. On 1 July 2016, John was discharged to the care of the Home Treatment Team with a plan to continue psychology sessions in the community. In early August 2016, the plan was to discharge him to the complex care team, but this did not take place as John reported intending to move to Southend. He was consequently discharged from services although in practice, John did not move out of London.

[8] See appendix D for a description of mental health services
[9] See appendix D for a description of mental health services

9.4.12. Throughout 2017, John attended a number of medical appointments relating to the care and management of his diabetes.

9.4.13. Around this time, John became friendly with one of his neighbours as they went to the same gym together. They started to socialise in each other's flats. The neighbour thought that John was lonely as he had never seen any friends or family come and visit him. John told him that he did not trust women and felt that all women were liars. At the same time, however, he also said that he wanted to find love and have a relationship. The neighbour set him up on internet dating sites and gave John a makeover. Despite showing the neighbour matches he had made, he persistently made negative comments about the women and seemed distrustful of internet dating in general.

9.5. The relationship between John and Alyssa

9.5.1. John and Alyssa met in February 2018 at her father's shiva[10]. John attended the event with a female guest. At this time, John was not known to Alyssa's family although she seemed to recognise him. They chatted together and from then on, kept in touch via Facebook and Messenger. Both John and Alyssa were overweight and in John's case, this had contributed towards him developing type 2 diabetes. Consequently, they both joined Slimming World which they attended each Wednesday in addition to some other Slimming World events. For a time, they were just friends but around September 2018, they began an intimate relationship.

9.5.2. In statements given to the police for the criminal trial, Alyssa's family stated that they tried to include John at family events but noted that he always seemed withdrawn and not very talkative. Alyssa's eldest daughter didn't like John at all, always feeling that something about him was 'off'. It is possible that this is why Alyssa tended to stay at John's address at the weekends: certainly, Alyssa alluded to John's anti-social demeanour as a source of frustration to her as she was very outgoing and fun-loving. In early 2019, they attended a wedding together and Alyssa threw herself into dancing and laughing with other people whilst John maintained a brooding and glowering presence at the side lines. At one point he walked over and pinched her arm hard as a 'punishment' for talking to another man for too long. In the weeks before the homicide, Alyssa told one of her colleagues that John seemed convinced – on the basis on no evidence at all – that she was going to leave him. She wrote him a long reassuring letter, but it only temporarily quelled his fears.

9.6. The month before the homicide

9.6.1. On 6 February, John was referred to his local mental health team by his GP due to depressive symptoms and suicidal ideation. Two days later, he presented at Northwick Park Hospital Accident & Emergency Department with the same symptoms. He reported that the way he was feeling was negatively impacting on his relationship. He was referred to the Barnet Home Treatment Team who saw him the following day. He appeared depressed and anxious. He was prescribed Lorazepam as required and the plan was for the Home Treatment Team to visit him twice a day. Later that day, John presented to A&E with Alyssa. He was struggling to cope and felt suicidal. Inpatient admission was recommended. He was admitted informally to Ruby ward at Elysium Potters Bar, a local bed being unavailable. He described relationship difficulties and issues since leaving his job. John asked to be seen alone, not wanting to talk about suicide in front of Alyssa. He spoke about feeling completely inadequate and a burden on Alyssa, stating that he was not good enough for her.

[10] Shiva is a week-long mourning period in Judaism during which time various rituals and customs are observed. This includes visits from other people to pay their respects.

9.6.2. On 16 February 2019, he was transferred to Suffolk Recovery House in Enfield and was seen by the Enfield Home Treatment team. He was accompanied by Alyssa. He remained low in mood and suicidal.

9.6.3. Around this time, work colleagues noticed that Alyssa was generally very distressed and on occasion, crying. She was very worried about John and upset that her daughter did not like him. Her family noted that she stopped talking to John on the phone in front of any family members. She would either go to her room to call him or if he called her, she would go out and sit in her car to talk to him. Around this time, Alyssa was contacted by John's older brother who told her his brother had trouble dealing with relationships and suggesting she should end their romance. Alyssa said that she wanted to 'be there for him'.

9.6.4. A few days later, John was found by staff crying on the phone to the Samaritans and saying he wanted to end it all. He was transferred to the Priory Bristol under s 2 of the Mental Health Act 1983 as there was no local bed available. Alyssa did not visit him there as she felt it was too far to travel. It is probable that John interpreted this differently. Two days later, he was transferred to Dorset Ward[11] at Chase Farm Hospital in Enfield as a bed had become available.

9.6.5. On admission, he reported feeling anxious but denied suicidal ideation. During reviews with medical staff, he expressed anger at his father and linked this to his chronic feelings of low self-esteem. He said that he became depressed after quitting his job. He told staff he was trying to re-establish his relationship with Alyssa stating that he had a pattern of becoming suicidal in the context of relationship issues and loss.

9.6.6. John's records show that he reported having been with Alyssa for the past five months and that his mental health problems were causing difficulties in his relationship. He explained that he generally could not handle relationships stating '*I can't cope with relationships. I become suicidal'*. He stated that this latest episode of anxiety had been triggered by worries that 'something is going to go wrong' in his relationship with Alyssa. At various points he said that the relationship had ended but would then talk about his partner as if the relationship was on-going. Over a period of ten days, there are at least eight references to John voicing his worries about his relationship with Alyssa.

9.6.7. By the end of the month, John told the Consultant that his anxiety had receded and that he no longer felt suicidal. He said he did not need to be in hospital and was in agreement with the plan to be transferred to the care of Barnet Home Treatment Team. Alyssa was with him during this assessment and agreed that he no longer needed to be in a hospital environment. He was discharged the following day.

9.6.8. On the day before the homicide, Alyssa appeared very distracted and in a very bad mood. Offers of support were made but she was adamant that she did not want to talk about it. Given her history, it is possible that Alyssa was concerned about the potential stigma of having 'picked' another abuser. It is also possible that she was not framing John's behaviour as abusive but as symptomatic of his mental ill-health.

9.6.9. When Alyssa arrived home from work, she was asking family members to hurry up and get ready as, in common with most Fridays, the family were to have a meal together. On this occasion, they were going out for a meal and Alyssa was to travel on to John's flat. Alyssa seemed anxious and stressed, repeatedly saying to family members *'I need to be at John's by 9 pm*' and urging them to get ready.

[11] See appendix D for a description of mental health services

9.6.10. At about 20:20, the family departed for a local restaurant, arriving 20 minutes later. Alyssa parked outside to drop them off before departing to John's flat. This was the last time the family physically saw Alyssa.

9.6.11. John would later make an impulsive confession to a psychiatrist that he had been planning to kill Alyssa for a few days. His plan was to kill her and then to take his own life after she invited him to accompany her to a friend's 60th birthday party. He was terrified she would meet someone else there and end up leaving him.

9.6.12. The following morning, Alyssa was murdered by John in a frenzied attack, stabbing her 86 times. Further details are provided in section 2.1. The judge would comment at the criminal trial that John had acted on a 'toxic mixture of rage, self-pity and resentment'.

10. Analysis

The information received by the Panel has been carefully considered through the viewpoint of Alyssa, to ascertain if agency contacts were appropriate and whether they acted in accordance with their set procedures and guidelines. Where it has not been the case, lessons have been identified and recommendations made. Additionally, the Panel has deliberated at length on what could – and should – be different to prevent such tragedies occurring again.

The Review Panel is satisfied that all agencies have engaged fully and openly with the Review and that lessons learned and recommendations to address them are appropriate.

10. 1. Each agency's involvement with Alyssa and John between January 2008 and her death.

This is detailed in the narrative chronology above.

10. 2. Whether an improvement in communication between services might have led to a different outcome for Alyssa.

There was limited inter-agency work in this case. That which did occur – between London Ambulance Service, the Police and mental health services was all done within expected standards.

However, there were some instances where communication between different mental health services could have been improved. For example, when John was released from the Priory Hospital in Bristol and sent back to Chase Farm Hospital in Enfield, the notes of his stay were not uploaded on to the electronic system before a decision was made to discharge John. Whilst the notes from the Priory may not have meant a different decision was reached, it would have highlighted some discrepancies in the information John gave to staff. For example, at the Priory he spoke to staff about his relationship being over and blamed this for his suicidal thoughts, but this was not the impression given to staff on Dorset Ward at Chase Farm Hospital not least because Alyssa visited him there and was referred to by John as 'my partner'.

There was also an administrative error in arranging for follow up care to be provided by the Home Treatment Team subsequent to John's discharge. This meant that he was not seen before the homicide when he would normally have been seen at least once. In this instance, systems for processing referrals have already been changed so no recommendations are made here.

10.3. Whether the work undertaken by services in this case was consistent with each organisation's:

(a) Professional standards

(b) Domestic violence policy, procedures and protocols

No agency invoked their domestic abuse policy and procedures as no domestic abuse was disclosed. Professional standards were met by all agencies having contact with the subjects of this Review except where noted below.

10.4. The response of the relevant agencies to any referrals relating to Alyssa or John, concerning domestic violence or other significant harm from January 2008. It will seek to understand what decisions were taken and what actions were carried out, or not, and establish the reasons. In particular, the following areas will be explored:

(a) Identification of the key opportunities for assessment, decision making and effective intervention in this case from the point of any first contact onwards.
(b) Whether any actions taken were in accordance with assessments and decisions made and whether those interventions were informed, professional, timely and effective.
(c) Whether appropriate services were offered/provided and/or relevant enquiries made in the light of any assessments made

(d) The quality of the risk assessments undertaken by each agency in respect of Alyssa and John

There were no domestic abuse referrals.

Undoubtedly, the fragmented nature of John's in-patient treatment reduced opportunities for staff to get to know him and to gain a better understanding of his pre-occupation with his relationship ending. Nevertheless, over a period of ten days, John's notes show eight references to John voicing his anxiety about his relationship. It does not appear that this was seen as a potential risk factor.

Risk assessments in relation to John's suicide ideation were appropriate and detailed.

10.5. When, and in what way, were the victim's wishes and feelings ascertained and considered? Is it reasonable to assume that the wishes of the victim should have been known? Was the victim informed of options/choices to make informed decisions? Were they signposted to other agencies?

It should be noted that only mental health services were aware that they were in a relationship.

Although Alyssa did not express any concerns to staff, she was afforded limited opportunities to do so. At no point was there a clear assessment undertaken of her needs, and those of her family**.** John was judged to be a low risk to others, but it is unclear on what this was based given that Alyssa was never asked if she felt at risk of harm from him. Certainly at the very end, Alyssa was exhibiting signs of being controlled by John.

10.6. Was anything known about the perpetrator? For example, were they being managed under MAPPA? Were there any injunctions or protection orders that were, or previously had been, in place?

Prior to this homicide, John had no criminal history and hence was not the subject of any perpetrator management nor had any civil orders been taken out against him. John spoke openly to mental health services about his insecurities and catastrophic feelings of loss when relationships ended but until this homicide, this had only resulted in suicide ideation.

This is, of course, a well-known risk factor for domestic homicide but John's controlling behaviour (and single (known) incident of physical assault – a pinch) was not known to any agency. Had mental health services ever explored John's relationship in more depth or indeed spoken to Alyssa on her own, this may have come to light and led to a different risk assessment. Given that John sought help over his catastrophic feelings of loss when relationships ended, it is possible that had he been offered a referral to a domestic violence perpetrator programme, he may have accepted.

10.7. How accessible were the services for the victim and perpetrator?

Both Alyssa and John readily engaged with services and there was no evidence or suggestion of any barriers. It seems that although Alyssa had identified some of John's behaviours as problematic, she was not yet naming them as domestic abuse. As such, she did not seek help from any domestic abuse services although we do know that she was familiar with, and had used in the past, the services offered by Jewish Women's Aid.

10.8. The training provided to staff and whether this was taken up and refresher training provided as needed.

The Panel is satisfied that the availability, uptake and quality of domestic abuse training is sufficient in each participating agency in respect of understanding the issues and responding effectively to victims. However, there is a need for an increased focus on responding to perpetrators by non-criminal justice system agencies, particularly in settings where they are most likely to be identified, namely health and social services.

10.9. Whether thresholds for intervention were appropriately calibrated, and applied correctly, in this case.

No agency was aware of any domestic abuse and thus there were no thresholds to calibrate.

10.10. Whether practices by all agencies were sensitive to the nine protected characteristics[12] of the respective family members and whether any special needs on were explored, shared appropriately and recorded.

No protected characteristics or special needs were found to be relevant in the delivery of services. As has been previously mentioned, John's mental health needs were of sufficient duration to 'count' as a disability, but this did not affect how he was treated.

10.11. Whether issues were escalated to senior management or other organisations and professionals, if appropriate, and in a timely manner.

There were no instances where the circumstances warranted escalation to senior management.

10.12. Whether the impact of organisational change over the period covered by the review had been communicated well enough between partners and whether that impacted in any way on partnership agencies' ability to respond effectively.

[12] These are: age; disability; gender reassignment; marriage or civil partnership; pregnancy and maternity; race; religion or belief; sex and sexual orientation.

Pressure in the mental health system led to practice that was suboptimal. This is not a criticism of the staff who did the best they could for John with limited and dwindling resources. Having been admitted on 9th February, on 16th February John was moved from Elysium Health Care Potters Bar to Suffolk Recovery House, on 19th February he was re-admitted to Priory Hospital Bristol, and was then transferred again to Chase Farm Hospital on 22nd February, thus being treated in four different settings within a three week period. While the discharge to and re-admission from the Recovery House was a consequence of a change in clinical presentation, treatment in three different inpatient services over a short period was a consequence of system pressures. The Panel noted the negative aspects of people who are anxious and depressed being moved between services, which is likely to limit the possibility of establishing therapeutic relationships with staff, and also with family and carers. While the medication prescribed was appropriate, disjointed care also limits the opportunities for reviewing the effects of medication over time and adjusting it to maximum effect.

The Panel further noted that mental health services have been dubbed the 'Cinderella service' of the NHS for many years and staff cannot be expected to deliver a safe and effective service whilst chronically underfunded and understaffed.

A recent report by the Parliamentary and Health Service Ombudsman revealed the dire state of mental health services. There are 5,000 fewer mental health services now than in 2010, mental health spending fell between 2010 and 2015 and the number of mental health nurses fell 13% between 2009 and 2017, and England's 53 mental health trusts are short of about 10% of staff. The Ombudsman has also found that NHS mental healthcare staff can lack the capacity, skills and training they need to do their job effectively, and do not always have the support they need to learn from mistakes.[13]

10.13. Whether friends and family of both Alyssa and John were aware of any issues and if so, what to do about any concerns they may have had.

As documented in the narrative above, Alyssa did not spend much time with John around her family, so they had few opportunities to observe the dynamics between them. About three weeks before the homicide, Alyssa did tell her daughter about John's mental health issues. Alyssa was open about her previous experiences of domestic abuse with her work colleagues and did occasionally share examples of how John treated her, but these only took on significance after the homicide. At the time, the incidents Alyssa disclosed were seen as John being a bit anti-social, moderately jealous and latterly, as having mental health issues. John's older brother did warn Alyssa that John was not very good at relationships but even this warning was in the context of John becoming suicidal rather than abusive.

11. Good practice

No examples of good practice were noted.

12. Key findings and lessons learned

12.1. Care and treatment from a number of different services

As noted above, the lack of continuity of care due to repeated moves during John's in-patient treatment was potentially a contributory factor in limiting therapeutic relationships with staff,

[13] Maintaining momentum: driving improvements in mental health care Parliamentary and Health Service Ombudsman March 2018

identifying people in John's life who may be at risk from him and in monitoring his medication to find the optimal dosages.

12.2. Assessment of risk

The assessment of suicide risk was detailed and appropriately recorded. The assessment of risk to others was limited, which is likely to be a consequence of the lack of relevant previous history suggesting this was not an area of focus for assessment. However, a separate interview with Alyssa was not undertaken and there was no informant history to support risk assessment.

12.3. Confusion of mental health symptoms and toxic masculinity

This report has detailed several instances where John was overly possessive, controlling and in at least one instance, physically abusive. The fact that he was also low in mood and experiencing suicide ideation does not excuse this behaviour and nor should it be assumed that stabilising his mood would change his attitudes towards women with whom he was romantically involved. Whilst acknowledging that mental health professionals knew only a limited amount about John's controlling behaviours, that which they did know should have prompted more exploration with him and a private conversation with Alyssa.

12.4. Delay in uploading notes from the Priory hospital, Bristol

The decision to discharge John from Chase Farm Hospital was appropriately made on the basis of the available evidence. However, the decision was not made with all of the available evidence due to the delay from Bristol. On balance, and considering John's improved mental state, it is probable that the decision to discharge would have been made anyway so this is not a missed opportunity on this occasion but worthy of note for future similar circumstances.

12.5. Failure to interview Alyssa separately in order to ascertain her needs

John was assessed by the Dorset Ward multi-disciplinary team on 27th February, and he asked to be discharged. Alyssa said she wanted him home and did not express any concerns. Risks were considered and documented and the risk to others was not noted as a concern. However, there was a failure to interview Alyssa on her own. It is impossible to know whether she would have expressed any concerns in a private meeting which she did not express in John's presence, but it should be regarded as the norm that opportunities for a private conversation should be offered to all partners, particularly those in which the relationship has been noted as a factor in the presenting illness.

12.6 Lessons Learned

- Decisions to discharge patients should not be made unless all reasonable efforts have been made to ensure information is available to inform the decision, particularly if patients have been moved/transferred on more than one occasion.
- Risk assessments must go beyond risk to the patient and fully consider the risk to others, including holding private conversations with close family members and partners prior to discharge.
- Whilst Barnet Enfield and Haringey Mental Health NHS Trust has made great strides towards addressing the mental health impacts on patients of experiencing domestic abuse, gaps remain in staff understanding of patients who perpetrate domestic abuse. Some of this is about recognising risk, some of it is about understanding the complex interplay between mental ill-health and abusive behaviour and some of it is

about an increased understanding of other services and resources which could result in improved interventions.

- It remains unclear if Alyssa understood John's behaviour as abusive or if she attributed it to his poor mental health. It is possible – even probable - that the extreme physical violence she experienced from her ex-husband provided her with a framework for seeing John's behaviour as 'mild', 'not serious' and 'not frightening'. It is also possible that her understanding had started to shift in the immediate weeks before the homicide as her demeanour significantly changed. The day before, she seemed particularly anxious to be at John's flat at the previously agreed time as if there was no space for her to simply let him know that she was running late without this evoking some kind of consequence that she was anxious to avoid. This is obviously speculation, and we may never know. The fact remains, however, that domestic abuse is still far too often seen as principally a crime of violence with other manifestations of abuse framed as less serious or as part of the 'ups and downs' of all relationships.

13. Recommendations

Recommendation 1: The benefits of repatriating patients to their Locality Ward where possible is fully acknowledged. However repeated transfers can have a negative impact on a patient's continuity of care. This case has highlighted the need for Bed Management Teams to make every effort to minimize these transfers as much as possible.

Recommendation 2: There was a delay of 13 days before the Bristol note were uploaded onto RiO. It was the responsibility of the Bed Management Team to upload this information. It should be reinforced to the Bed Management Team that information received from other providers must be uploaded immediately.

Recommendation 3: Decisions to discharge patients should not be made unless all reasonable efforts have been made to obtain information relevant to the decision particularly if patients have been moved/transferred on more than one occasion.

Recommendation 4: The need for clinical staff to speak separately to relatives and carers whenever possible in order to assess their needs more fully, must be reinforced.

Recommendation 5: Risk of harm to others should be carefully considered if there is a pre-occupation with a relationship ending, particularly if the patient has suicidal ideation. This should be reinforced in domestic abuse training offered to all staff.

Recommendation 6: BEHMHT to explore with Respect the potential for basing a domestic abuse worker who understands mental health issues and perpetrator interventions within the Trust. The profile is for an expert for identification, risk assessment and advising on certain cases. Loosely based on what has become known as the Hackney Model, the worker would not have a caseload but would focus on increasing the knowledge and skills on working with domestic abuse perpetrators among Trust staff.

Update: As well as an IDVA, BEHMHT now employs a Domestic Abuse and Sexual Safety Coordinator whose role is to lead on the prevention and management of domestic and sexual abuse across the Trust

Recommendation 7: Review existing training and awareness raising materials in LB Barnet to ensure that all forms of abuse are given an equal profile, that coercive control is properly understood, and that the absence of physical violence is not interpreted as the abuse being less serious or non-existent.

Recommendation 8: IRIS has already been rolled out to some GP practices in LB Barnet. It is recommended that those surgeries be advanced to the next stage, namely IRIS +. This is an extension of the original in that it incorporates training about, and a referral pathway for:

- male victims/survivors and perpetrators
- female perpetrators (as well as victims/survivors)
- children exposed to domestic violence and abuse

Recommendation 9: At the next iteration of the VAWG strategy, include training and awareness raising work in workplaces so that employers and colleagues know how to safely respond.

Recommendation 10: All local VAWG strategies should include support for specialist agencies on the basis that the cultural understanding they offer and their linking with local communities means that they are able to meet the need of service users more swiftly and effectively than mainstream services.

Recommendation 11: Develop a domestic abuse policy for LB Barnet.

Appendix A: Terms of Reference

DOMESTIC HOMICIDE REVIEW (DHR)
INTO THE DEATH OF ALYSSA

TERMS OF REFERENCE

Overarching aim

The over-arching intention of this review is to learn lessons from the homicide in order to change future practice that leads to increased safety for potential and actual victims. It will be conducted in an open and consultative fashion bearing in mind the need to retain confidentiality and not to apportion blame. Agencies will seek to discover what they could do differently in the future and how they can work more effectively with other partners.

Principles of the Review

1. Objective, independent & evidence-based
2. Guided by humanity, compassion and empathy with the victim's voice at the heart of the process.
3. Asking questions, to prevent future harm, learn lessons and not blame individuals or organisations
4. Respecting equality and diversity
5. Openness and transparency whilst safeguarding confidential information where possible

Key lines of enquiry

The Review Panel (and by extension, IMR authors) will consider the following:

1. Each agency's involvement with Alyssa between January 2008 and her death, resident at address 1

and

Each agency's involvement with John between January 2008 and the murder, resident at address 2.

Any involvement outside the timeframe should be summarised.

2. Whether an improvement in communication between services might have led to a different outcome for Alyssa.

3. Whether the work undertaken by services in this case was consistent with each organisation's:

(a) Professional standards

(b) Domestic violence policy, procedures and protocols

4. The response of the relevant agencies to any referrals relating to Alyssa or John, concerning domestic violence or other significant harm from January 2008. It will seek to understand what decisions were taken and what actions were carried out, or not, and establish the reasons. In particular, the following areas will be explored:

(b) Identification of the key opportunities for assessment, decision making and effective intervention in this case from the point of any first contact onwards.

(b) Whether any actions taken were in accordance with assessments and decisions made and whether those interventions were informed, professional, timely and effective.

(c) Whether appropriate services were offered/provided and/or relevant enquiries made in the light of any assessments made

(d) The quality of the risk assessments undertaken by each agency in respect of Alyssa and John

5. When, and in what way, were the victim's wishes and feelings ascertained and considered? Is it reasonable to assume that the wishes of the victim should have been known? Was the victim informed of options/choices to make informed decisions? Were they signposted to other agencies?

6. Was anything known about the perpetrator? For example, were they being managed under MAPPA? Were there any injunctions or protection orders that were, or previously had been, in place?

7. How accessible were the services for the victim and perpetrator?

8. The training provided to staff and whether this was taken up and refresher training provided as needed.

9. Whether thresholds for intervention were appropriately calibrated, and applied correctly, in this case.

10. Whether practices by all agencies were sensitive to the nine protected characteristics[14] of the respective family members and whether any special needs were explored, shared appropriately and recorded.

11. Whether issues were escalated to senior management or other organisations and professionals, if appropriate, and in a timely manner.

12. Whether the impact of organisational change over the period covered by the review had been communicated well enough between partners and whether that impacted in any way on partnership agencies' ability to respond effectively.

13. Whether friends and family of both Alyssa and John were aware of any issues and if so, what to do about any concerns they may have had.

Panel Membership

The Panel will consist of the following agencies:

Barnet Clinical Commissioning Group

Barnet Homes

[14] These are: age; disability; gender reassignment; marriage or civil partnership; pregnancy and maternity; race; religion or belief; sex and sexual orientation

BEHMHT

Central London Community Healthcare NHS Trust

Hestia Housing and Support

Jewish Women's Aid

LBB Adult Social Care

LBB Community Safety

London Ambulance Service

Metropolitan Police

Royal Free London NHS Foundation Trust

Solace Women's Aid

Family involvement and Confidentiality

The review will seek to involve the family of both the victim and the perpetrator in the review process, taking account of who the family wish to have involved as lead members and to identify other people they think relevant to the review process.

We will seek to agree a communication strategy that keeps the families informed, if they so wish, throughout the process. We will be sensitive to their wishes, their need for support and any existing arrangements that are in place to do this.

We will identify the timescale and process and ensure that the family are able to respond to this review endeavouring to avoid duplication of effort and without undue pressure.

Contact with the family and other members of their social networks will be led by the Chair.

Consent will be sought to share information relating to John (although at the time of writing there may be an issue with respect to capacity).

Disclosure & Confidentiality

- Confidentiality should be maintained by organisations whilst undertaking their IMR. However, the achievement of confidentiality and transparency must be balanced against the legal requirements surrounding disclosure.
- The independent chair, on receipt of an IMR, may wish to review an organisation's case records and internal reports personally, or meet with review participants.
- A criminal investigation is running in parallel to this DHR, therefore all material received by the Panel must be disclosed to the SIO and the police disclosure officer
- The criminal investigation is likely to result in a court hearing. Home Office guidance instructs the Overview Report will be held until the conclusion of this case. Records will continue to be reviewed and any lessons learned will be taken forward immediately.
- Individuals will be granted anonymity within the Overview Report and Executive Summary and will be referred to by pseudonyms.
- Where consent to share information is not forthcoming, agencies should consider whether the information can be disclosed in the public interest.

Timescales

At the time of writing, the next court hearing is set for the end of May 2019 with a trial provisionally scheduled for early August. Statutory guidance requires DHRs to be completed within six months with provision for the process to be suspended so as to allow criminal proceedings to conclude. As such, the Panel will aim to conclude its deliberations by the end of 2019 with a possibility of concluding earlier subject to the outcomes of the criminal justice process.

Media strategy

All media enquiries should be directed to the Chair until the report is submitted to the Home Office for quality assurance. Thereafter media enquiries should be directed to Barnet Community Safety Partnership. Individual Panel Members should not speak to the media about this case, and this includes self-generated publicity such as press releases or tweets. Panel members should remember that they are representing their agency and that this media ban also applies to other staff from their agency.

Appendix B: Cross-Government definition of domestic violence[15]

The cross-government definition of domestic violence and abuse is:

any incident or pattern of incidents of controlling, coercive, 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. The abuse can encompass, but is not limited to:

- psychological
- physical
- sexual
- financial
- emotional

Controlling behaviour

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

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.

[15] This is the definition which applied at the time of the events described in this report. It is acknowledged that a new statutory definition has since superseded this one.

Appendix C: Further information about the chair and report author

Davina James-Hanman is an independent Violence Against Women Consultant. She was formerly the Director of AVA (Against Violence & Abuse) for 17 years (1997-2014), which she took up following five years at L.B. Islington as the first local authority Domestic Violence Co-ordinator in the UK (1992-97). From 2000-08, she had responsibility for developing and implementing the first London Domestic Violence Strategy for the Mayor of London. A key outcome of this was a reduction in domestic violence homicides of 57%.

She has worked in the field of violence against women for over three decades in a variety of capacities including advocate, campaigner, conference organiser, crisis counsellor, policy officer, project manager, refuge worker, researcher, trainer and writer. She has published innumerable articles and three book chapters and formerly acted as the Department of Health policy lead on domestic violence (2002-03). She was also a Lay Inspector for HM Crown Prosecution Service Inspectorate (2005-10). Davina has authored a wide variety of original resources for survivors and is particularly known for pioneering work on the intersections of domestic violence and alcohol/drugs, domestic violence and mental health, child to parent violence, developing the response from faith communities and primary prevention work.

She acted as the Specialist Adviser to the Home Affairs Select Committee Inquiry into domestic violence, forced marriage and 'honour' based violence (2007-08) and Chairs the Accreditation Panel for Respect, the national body for domestic violence perpetrator programmes. From 2008-09 she was seconded to the Home Office to assist with the development of the first national Violence Against Women and Girls Strategy. Davina was also a member of the National Institute of Health & Care Excellence group which developed the domestic violence recommendations and subsequent Quality Standards. She remains an Expert Adviser to NICE.

Davina is a Special Adviser to Women in Prison and a Trustee of the Centre for Women's Justice.

Appendix D: Description of Mental Health Services

Crisis Resolution Home Treatment Teams (CRHTTs)

CRHTTs are the gatekeepers to all inpatient hospital admissions and borough recovery houses. CRHTTs primarily provide crisis assessment, followed by home treatment where appropriate, where the crisis episode is of such severity that admission to hospital is being considered. Barnet, Enfield and Haringey CRHTT service operates 24 hours a day; 7 day a week; every day of the year. Target timeframes for responding to crisis referrals, attending for face-to-face assessment is as follows:

- emergency – within 4 hours of referral
- urgent – within 24 hours of referral.

Dorset Ward, Chase Farm Hospital

Dorset Ward provides care to adults aged 16 – 65 years who have been diagnosed as having acute and/or enduring mental health problems and who cannot be cared for at home or in the community. The team is made up of doctors, community psychiatric nurses, social workers, psychologists and occupational therapists. Dorset Ward provides care and support to patients through their recovery period and help to get them well enough to be discharged and where necessary to receive care in their homes or in the community.

Recovery Houses

Recovery Houses provide short term support to people in crisis living in Barnet Enfield & Haringey. They provide a home environment with communal kitchen and lounges as well as quiet rooms and small gardens. Access to the Recovery Houses are given to people who have been referred through the Mental Health Home Treatment Team. They are open 24 hours a day, 7 days a week, 52 weeks of the year.

Appendix E

Appendix E : Recommendations and Action Plan

Recommendation	Scope	Action	Lead Agency	Target date	Completion date and outcome
Barnet CSP to receive six monthly updates on the implementation of this action plan until such time as full implementation has been achieved.	Local	Standing item on CSP agenda	Barnet CSP	On-going	Ongoing
The benefits of repatriating patients to their Locality Ward where possible is fully acknowledged. However repeated transfers can have a negative impact on a patient's continuity of care. This case has highlighted the need for Bed Management Teams to make every effort to minimize these transfers as much as possible.	Local	HoS to bed management team (now called access and flow) team meeting to raise the importance of minimizing out of area placements and multiple transfers. 7 min briefing to be disseminated to all staff The agreed practice is to repatriate patients locally at the earliest opportunity and minimise Out of Area Placements in line with Timely Access To Care; However there	BEHMHT	End December 2020 Ongoing/already in practice	Completed

		may be constraints as to where the local bed is (Division/Borough) but team is aware of minimising the number of transfers and also refrain from non-clinical transfers.			
There was a delay of 13 days before the Bristol note were uploaded onto RiO. It was the responsibility of the Bed Management Team to upload this information. It should be reinforced to the Bed Management Team that information received from other providers must be uploaded immediately	Local	HoS to bed management team (now called access and flow) team meeting to raise the importance of uploading other providers information in a timely way. 7 min briefing to be disseminated to all staff System in place for Discharge Intervention Team (DIT) to monitor all patients placed out of area. (See Bed Management	BEHMHT	End Dec 2020	Completed

		Policy 12.3). DIT obtain and upload inpatient notes and update progress on Rio. This has been reiterated with DIT Teams and Inpatient Leads and monitored via Bronze Access & Flow Meetings.			
Decisions to discharge patients should not be made unless all reasonable efforts have been made to obtain information relevant to the decision particularly if patients have been moved/transferred on more than one occasion	Local	Information to all trust staff to receive this information in a 7 min briefing. Meeting with inpatient service leads to take place to raise awareness regarding decisions to discharge.	BEHMHT	End Dec 2020	Completed
The need for clinical staff to speak separately to relatives and carers whenever possible in order to assess their needs more fully must be reinforced.	Local	Information to all trust staff to receive this information in a 7 min briefing. Meeting with inpatient service	BEHMHT	End Dec 2020	Completed

		leads to take lace to raise awareness regarding importance of speaking separately to carers and patients.			
Risk of harm to others should be carefully considered if there is a pre-occupation with a relationship ending, particularly if the patient has suicidal ideation. This should be reinforced in domestic abuse training offered to all staff.	Local	DVA training to be delivered to all safeguarding champions in Nov 2020 via Teams. Training to be delivered by MH IDVA and trust safeguarding adult lead. Training to address and reinforce assessing risk of harm to others. Dissemination of information in a 7 min briefing.	BEHMHT	End Nov 2020	Completed
BEHMHT to explore with Respect the potential for basing a domestic abuse worker who understands mental health issues and perpetrator interventions within the Trust. The	Local	Co-located MH IDVA in place in mental health trust. Head of Safeguarding to	BEHMHT	Jan 2021	Completed

profile is for an expert for identification, risk assessment and advising on certain cases. Loosely based on what has become known as the Hackney Model, the worker would not have a caseload but would focus on increasing the knowledge and skills on working with domestic abuse perpetrators among Trust staff.		explore potential of a RESPECT domestic abuse worker being co-located in the trust.			
Review existing training and awareness raising materials in LB Barnet to ensure that all forms of abuse are given an equal profile, that coercive control is properly understood, and that the absence of physical violence is not interpreted as the abuse being less serious or non-existent.	Local		Barnet CSP	December 2022.	Completed
IRIS has already been rolled out to some GP practices in LB Barnet. It is recommended that those surgeries be advanced to the next stage, namely IRIS +. This is an extension of the	Local		NCL ICB	April 2023	Ongoing IRIS in Barnet and new commissioning in April 2026.

original in that it incorporates training about, and a referral pathway for: male victims/survivors and perpetrators. female perpetrators (as well as victims/survivors) and children exposed to domestic violence and abuse					
At the next iteration of the VAWG strategy, include training and awareness raising work with local employers.	Local	Brough wide campaign with businesses and employers being planned for IWD 2023	LB Barnet / Barnet CSP	March 2023	Noted for Next DA& VAWG Strategy Development due 2025
Develop a domestic abuse policy for LB Barnet.	Local		LB Barnet	In progress and will be finalised by August 2024	August 2024