Domestic Homicide Review

- Overview Report –

Commissioned by

London Borough of Enfield

Victim: "H"

Died August 2016

Independent Chair

& Report Author: **Stephen Roberts QPM, MA (Cantab)**

Completed: **August 2022**

Contents

Review of the circumstances surrounding the death of "H"

"He was a very good Daddy. He always put his family first. He never took a holiday, he just worked and worked because he loved his kids and wanted to support his family"

"The family was everything to him. He worked so hard for them to build a better life for them all, especially his kids. He wanted them all to go to university."

"He was a wonderful family man." - Tributes from H's cousin

Preface

The Independent Chair and Review Panel would like to begin this report by expressing their sympathy to the family of H. It is a matter of great regret that this review was not commissioned until January 2020. The Independent Chair, on behalf of the Enfield Community Safety Partnership, offers sincere apologies for the delay.

This is a report of a Domestic Homicide Review (DHR) conducted under the terms of 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 person to whom [they were] related or with whom [they were] or had been in an intimate personal relationship, or
- A member of the same household [as themselves],

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

1. Introduction

1.1 This report examines the circumstances surrounding the homicide of H at the hand of his son, B. The report will explore the engagement of the various agencies with H and his family, and in particular with his son, B.

1.2 In addition to agency involvement, the review will also examine 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 a holistic approach the review seeks to identify appropriate solutions to make the future safer.

1.3 The focus period for this review starts in 2012 when B's behaviour resulted in his temporary exclusion from school and subsequent readmission, subject to him and his mother signing an Acceptable Behaviour Contract (ABC)[1].

1.4 The review will consider what has been learned of the family's history, domestic arrangements, and interactions with various local agencies and organisations prior to the tragedy. The key purpose of the review is to enable lessons to be learned from the tragedy to enable professionals to understand fully what happened and, most importantly, what needs to change in order to reduce the likelihood of future tragedies.

Timescales

1.5 It was evident from the outset that a principal area for concern in this case was the treatment of B by the Barnet, Enfield & Haringey Mental Health NHS Trust. Accordingly, the Trust commissioned a Severe Root Cause Investigation Report in August 2016, immediately after the incident. The report was completed on 18th October 2016 (i.e. within 80 days of the homicide). The report of the NHS investigation was provided to this DHR. The findings of the investigation are summarised below (see paras 3.22 & 3.33) and its conclusions and learning points have been incorporated into this Overview Report.

1.6 This review was formally commissioned on 6th January 2020. The delay in commissioning was attributed by the Enfield Partnership to internal staffing difficulties which coincided with the need to commission several other DHRs almost simultaneously with this case. The partnership, in common with others, has experienced increasing difficulties in securing the services of suitable Independent Chairs. Additionally, finding the resources required to support several DHRs at once has become problematic and introduced further delays both in commissioning and completion of reviews. In future the partnership will take a pragmatic view whereby

[1] An Acceptable Behaviour Contract is an early intervention made against individuals who are perceived to be engaging in anti-social behaviour. Though they may be used against adults, almost all ABCs concern young people.

each *potential* review should be subject to an extended scoping exercise to assess whether or not it is appropriate to commission a full formal review. The assessment will take account of, *inter alia*, the availability of evidence, whether the homicide has already been reviewed by, for example, a Mental Health Trust, (or could more appropriately have been) and whether the extended scoping review can sufficiently identify lessons for the future in a more cost-effective way.

1.7 It was evident from the outset that a principal area for concern in this case was the treatment of B by the Barnet, Enfield & Haringey Mental Health NHS Trust (BEHMHNHST). Accordingly, the Trust commissioned a Serious Incident Root Cause Investigation Report in August 2016, immediately after the incident. The report was completed on 18th October 2016, (i.e. within 80 days of the homicide). The report of the NHS investigation was provided to this DHR.

1.8 Efforts to interview B were delayed due to his mental illness. He and the consultant charged with his care consented to an interview which finally took place in March 2021.

1.9 B pleaded not guilty to murder by reason of diminished responsibility but guilty to manslaughter. In May 2017 he was sentenced to life imprisonment with a minimum term of six and a half years before he could be considered for parole. He was also ordered to be held and treated in a secure mental hospital.

1.10 The DHR Review Panel met on 19th August 2020, 26th January 2021, 20th April 2021, 26th April 2022. The Panel finally approved the review reports on 12th August 2022.The reports were accepted by the Enfield Community Safety Board on 13h March 2023.

Confidentiality

1.10 The findings of this DHR are confidential. Information is available only to participating officers/professionals and their line managers, until after the DHR has been approved by the Home Office Quality Assurance Panel and published.

1.11 As recommended by the statutory guidance, pseudonyms have been used and precise dates obscured to protect the identities of those involved.

1.12 In the absence of family indications as to suitable pseudonyms (see para. 2.7), the pseudonyms were chosen by the Independent Chair.

1.13 In order to maintain confidentiality on publication, the victim and perpetrator are referred to using the undermentioned pseudonyms:

	Pseudonym	**Age at time of incident**	**Ethnicity**
Victim	H	48	British Turk
Perpetrator	B	21	British Turk

2. Methodology

Terms of Reference

2.1 The review was guided by the following terms of reference:

- To establish what lessons may be learned from the case regarding ways in which local professionals and agencies worked individually and collectively to safeguard victims.
- To determine how those lessons may be acted upon.
- To examine and where possible make recommendations to improve risk management mechanisms within and between all relevant agencies.
- To identify what may be expected to change and within what timescales.
- To identify the relevance of resource constraints on structures and services relevant to mental health provision and the prevention of domestic abuse.
- To assess whether the relevant agencies have appropriate and sufficiently robust procedures and protocols in place and the extent to which they are understood and adhered to by their staff.

- To improve service responses including, where necessary, changes to policies, procedures and protocols.
- To enhance the overall effectiveness of efforts to reduce domestic violence and its impact on victims through improved inter and intra agency working.
- To maximise opportunities for fast time learning and overall partnership improvements as well as medium- and longer-term enhancements.
- To examine and make recommendations if appropriate to improve the accessibility of safeguarding services to isolated ethnic minorities.
- To examine and make recommendations if appropriate in relation to information sharing and improved risk management between mainstream local partnerships agencies and external non-governmental organisations.

2.2 The Review Panel agreed that the focus period for the review should start in 2012. In June 2012, B's mother was required to sign an Acceptable Behaviour Contract (ABC) to secure B's readmission to his school after a three-week exclusion due to his behaviour.

2.3 Each agency was asked to provide a chronological account of its contact with any member of the family.

2.4 Prior to the establishment of this review, B was convicted of the manslaughter of his father. The MPS granted access to the evidence gathered by its homicide investigation team. This enabled a more detailed picture to emerge of the family background than might otherwise have been possible.

Contributors to the Review

2.5 The following documentary evidence was provided by various agencies to the review:

- **MPS** (Specialist Crime Review Group) –IMR & Vulnerable Adult Policy
- **MPS** (Homicide Investigation) –The case summary prepared for the CPS, and a summary of key evidential statements etc.

- **Expert Psychiatric Reports[2]** prepared for Crown Court re. B
- **Barnet, Enfield & Haringey Mental Health NHS Trust –** IMR & Severe Root Cause Analysis Investigation Report
- **North Middx Uni Hospital Trust –** IMR & Chronology
- **CCG** (**Protagonists' General Practitioner Practice)** – IMR
- **Protagonists' GP Practice –** medical records
- **BPP University –** confirmation of B's attendance at the university and a statement of the university's arrangement for the well-being of students
- **LBE Multi Agency Safeguarding Hub (MASH) –** Numerical performance data showing referrals into the MASH and passed out to agencies, plus the referral sources.

2.6 Some four years after his conviction, the Independent Chair was able to have a brief interview with B. Due to B's residence in a secure mental hospital and restrictions due to the COVID pandemic, the interview was conducted via video link and facilitated by the Consultant Forensic Psychiatrist[3] responsible for his care. The Consultant and a nurse were present during the interview. The interview ended abruptly when B decided that he no longer wished to speak to the Independent Chair. Once B had left the room, the Consultant Psychiatrist agreed to discuss the interview with the Independent Chair and give her opinion about the care he had received before the homicide.

Involvement of Family, Friends, Work Colleagues, Neighbours & Community

2.7 The Independent Chair sought to engage family members in the review without success. In light of the delayed commissioning, an initial approach was made by the Police Family Liaison Officer (FLO). The FLO was already aware that the family were upset that B was convicted of manslaughter rather than murder and were very fearful that B might contact them. When approached again, once the review had been commissioned, the family were unwilling to engage. The FLO provided the family with

[2] Dr PLA Joseph BSc. MD. FRCPscych & Dr A N Suddle MBCHB MRC(Psych)

[3] Dr A Kotze, Consultant Forensic Psychiatrist

details of specialist support organisations and the relevant Home Office leaflets. Whilst appreciating the distress of the family, the Independent Chair made a final attempt to engage; sending a personal letter to H's widow, explaining the process of a DHR and offering to meet, either in person, virtually or by telephone. The letter received no response and the Independent Chair felt it inappropriate to make further contact and risk adding to the widow's trauma.

2.8 The MPS Homicide Investigation Team prepared summaries of relevant statements for the review from the homicide investigation. Included among the summaries was information from B's mother, brothers and two of B's former teachers.

2.9 In 2014, B enrolled for a Law degree at BPP University. He completed the first and second years of the course but then gave up his studies after "missing classes due to mental health issues". BPP University had no additional information relating to him. The university did, however, provide a statement of its approach to and arrangements for the wellbeing of its students.

2.10 In an effort to secure some form of representation from the local Turkish community, the Independent Chair sought advice from LB Enfield. No suitable representatives were identified. The Review Panel agreed that the Leader of the Council should be approached to assist. The Leader of the council did not participate in the process of the review but was able to offer feedback on the draft Overview Report from an administrative as well as a cultural perspective. The partnership accepts that future reviews should, wherever possible, involve the participation of suitable community/cultural representation as well as the involvement of relevant charitable/third sector organisations.

Review Panel Members

2.11 A Review Panel was formed for the purpose of this review, consisting of the following members:

Stephen Roberts, QPM, MA (Cantab) – Independent Chair

Julie Tailor – Domestic Violence Co-ordinator, London Borough of Enfield (LBE)

Ginika Achokwu – Safeguarding Children's Lead, Barnet, Enfield & Haringey Mental Health NHS Trust (BEH MHT)

Andrea Clemons – Head of Community Safety & DHR Commissioner LBE

Sharon Burgess – Safeguarding Adults Lead, LBE

Justin Armstrong – Specialist Crime Review Group (SCRG), MPS

Carole Bruce-Gordon (subsequently Eva Rix) – Ass. Dir. Safeguarding, NHS North Central London NHS Clinical Commissioning Group

Memory Tigere – Safeguarding Adults Advisor, North Middx University Hospital NHS Trust

Dierdre Blaikie – Adult Safeguarding Lead, Royal Free NHS Hospital Trust

Sian Carter-Jones – Head of Safeguarding, BEH MHT

All members of the Review Panel were independent of day-to-day service delivery.

Chair & Report Author

2.13 Stephen Roberts, QPM, MA, was appointed by the LB Enfield Community Safety Partnership as Independent Chair of the Review Panel and Report Author. He is a former Deputy Assistant Commissioner of Police. He is a former Director of Professional Standards and Director of Training & Development for the Metropolitan Police. At no time in the Chair's police service did he have any operational responsibility for policing within borough of Enfield. He retired in 2009 and now works as a private consultant. He has extensive experience of partnership working at borough and pan-London level. He is entirely independent of the Safer Enfield Partnership and all other agencies mentioned in this report. He has no ongoing relationship with LBE. He has completed training for the role of Independent Chair and has successfully chaired and authored eight domestic homicide reviews for various London Community Safety Partnerships.

Parallel Reviews

2.14 An inquest was formally opened into the death of H. These proceedings were formally opened, adjourned and suspended pending the criminal trial of B. Once B's trial was concluded, HM Coroner determined there were no grounds to resume proceedings, since the circumstances surrounding the death of H had been judicially considered during the criminal trial of B[4].

[4] Schedule 1, Coroners & Justice Act 2009

2.15 As previously mentioned, shortly after the tragedy, BEHMHNHST commissioned a Serious Incident Root Cause Investigation Report, because B had engaged with the Trust in 2016. The report was provided to this review in addition to an IMR from the Trust.

3. Case History (The Facts)

3.1 H was a British man of Turkish extraction living in the London Borough of Enfield. He is described by relatives as a "dedicated family man" who worked hard to support his family. The immediate family consisted of H, B's mother and his two brothers. H owned a café in Kilburn: a family run business serving breakfasts, lunches and dinners. H was 48 at the time of his death.

3.2 At the time of the homicide, B was 21 years old and lived in the family home in Enfield. B described his father as a strict disciplinarian but stated that he felt loved by him. B was educated in Enfield. As a teenager, B had several interactions with the MPS. He was the subject of police stop/search activity on a total of eight occasions between 2008 and 2013, including being arrested for Handling Stolen Goods, which culminated in police taking no further action.

3.3 In 2012, B was temporarily excluded from his school after a fight with another boy. Three weeks later B and his mother were interviewed by the Director of the school sixth form and the police officer attached to the school. As a result, B and his mother signed an Acceptable Behaviour Contract as a condition of him returning to the school. The school police officer completed an entry in the MPS MERLIN[5] database but the information was not shared with LBE Social Care. The issue was regarded as being contained and managed within the school and as such did not fulfil the agreed criteria for sharing within the partnership.

3.4 As part of the police homicide investigation, B's sixth form teacher was interviewed and described B as being an "aggressive" individual. Notwithstanding his behaviour, in the summer of 2014, B left school having achieved four A Levels.

[5] Merlin is a database run by the Metropolitan Police that stores information on individuals who have become known to the police as being vulnerable, at risk of involvement in crime as a victim or perpetrator. The database also contains information on vulnerable/at risk adults who have come to notice. This can range from being a victim of bullying to being present whilst a property is searched. It also holds data for missing persons.

3.5 The following September, B enrolled in a Law course at BPP University in London. B subsequently claimed during police interviews that he enrolled in the course under pressure from his parents. Apparently, he struggled with the requirements of the course. B's mother noticed a deterioration in his mental state in late 2015. He apparently became aggressive at home, punching his mother and damaging furniture. In January 2016 B punched one his brothers, fracturing his eye socket. Neither assault was reported to Police. In a psychiatric interview after the homicide, B claimed that during this period he was "hearing voices and feeling spirits". B stopped attending university in January 2016.

3.6 By February 2016 B had left the family home. Initially he stayed with an uncle then moved into rented accommodation before returning to the family home by April.

3.7 In mid-April 2016, B's mother had become so worried by his mental state that she went, on her own, to seek advice from her GP. She was distressed when she spoke to the GP, saying that B had been very aggressive toward her, threatening to kill her and then himself. She was advised to call police immediately if she felt in danger and was also given the telephone number of the BEH Mental Health Trust Crisis Resolution Home Treatment Team (CRHTT)[6]. The GP told her that the state of B's mental health would need to be assessed and asked her to try to get B to come to the surgery.

3.8 Two days later, B's mother returned to the GP saying that B had declined to come for assessment. She also stated that although B had been threatening and aggressive, he had not actually physically hurt her. The GP reiterated the advice to call police using the 999 system if she felt threatened and again gave her the telephone number for the CRHTT.

3.9 At the end of April, B attended the Accident & Emergency Department of the North Middlesex Hospital, claiming that he had taken an overdose of his mother's prescription medication. He said that he had taken the overdose because he was feeling "fed up". B was referred to the BEH Mental Health Liaison Team based at North Middlesex Hospital for assessment. The assessor noted that B was affected by various

[6] The Enfield Crisis Resolution Home Treatment Team (part of the BEH Mental Health Trust) is a multi-skilled team of mental health professionals providing intensive care and support in patients' homes as an alternative to acute inpatient admission. The home treatment team will carry out an assessment and wherever appropriate will provide intensive support for a limited period within the service user's home.

issues at home. B reported that there were constant arguments and that he suffered from panic because of what he described as “culture clashes”. He said he had felt forced to go to university whereas he would have preferred to go into business with his brother. He confirmed that the overdose was a “cry for help” rather than an attempt to actually kill himself. A mental state examination was carried out, including questioning about any perceptual abnormalities. He denied hearing voices or substance abuse, although the assessor noted that B had told an A&E nurse that he did take drugs. The conclusion of the assessment was “no overt mental health issue elicited.” B declined consent for his parents, family member or friend to be spoken to for collateral information and the assessment was concluded. B then self-discharged and simply walked out of the room. The plan was for B to be discharged from the Mental Health Liaison Service back to the care of his GP with a written request that he be reviewed within the next few days. The GP was advised by letter to consider anti-depressant medication or referral to the CRHTT for psychological intervention. GP records indicate the request was noted within a week, including the assessment by the Mental Health Liaison Service that the risk of self-harm and harm to others was low. *There is no record of any follow up on the recommendations of the MHLS by the GP or the CRHTT despite the fact that B attended the GP surgery on other health issues a week after the letter was received and several times thereafter.*

3.10 At some point in April/May 2016 it is alleged that B assaulted his then partner, fracturing her cheekbone. This allegation was only made when the victim was interviewed after the homicide. The victim did not want the matter investigated or prosecuted and declined contact with this review process.

3.11 At the end of June, B self-presented at his GP surgery saying he had been feeling very low for the previous two months and had experienced panic attacks, breathlessness, a tight chest and palpitations. He said he was not taking illicit drugs and had not had suicidal thoughts or had auditory or visual hallucinations. He said he wanted to start treatment for depression. The GP prescribed anti-depressant medication but B did not actually collect this from the pharmacy. The GP also sent a referral letter to the BEH Mental Health Trust stating that B was suffering from a “mental breakdown.”

3.12 Later that same day B telephoned the Police stating that he was depressed and needed the Police. He claimed his family depressed him and, initially, that his father (H) has “gone close to him sexually.” B claimed that he had self-harmed in the past and wished to meet police officers at a road junction some distance from his family address. He claimed his family was pressurising him to do well at university. B later retracted the sexual allegation and was taken by police officers to North Middlesex Accident &

Emergency Department, where he was seen by medical staff and assessed by member of the North Middlesex Hospital Mental Health Liaison Service (NMMHLS).

3.13 B told the Liaison Service nurse that he had been suffering from mental health problems of a “manic depressive nature.” He described sometimes behaving “like an animal wanting to tear things apart, feeling horrible and in the next minute coming to himself.” B gave consent for his mother to be contacted. She reported him becoming “very upset with a very limited threshold” and that he got “angry with himself quite easily.” She said that he “did not get on with any of the family.” A Mental State Examination was carried out, finding “no current psychotic phenomenon reported.” The nurse noted that there was no current suicidal or self-harm ideation but that B was of a high risk/possibility of an impulsive suicide attempt. B requested admission to hospital.

3.14 At about 2.00 a.m. (i.e. the day following B’s call to Police) a request was sent to the BEH Mental Health Trust for B to be informally admitted. There were no beds available in the BEH Trust but a bed was identified at a suitable facility in Sussex.

3.15 Later that morning B was reassessed by a member of the NMHLS because he had refused to be taken to the hospital in Sussex. She assessed him as “having good insight” and having the capacity to make decisions about his health needs. He declined contact with the CRHTT but said that he would make contact if he was in any mental health crisis or felt under pressure at home. *B was discharged from the Mental Health Liaison Service. There is no record of a letter to the GP being uploaded onto the RIO system but the GP records indicate that a discharge summary was received by the GP.*

3.16 Nine days later B attended North Middlesex Hospital A&E Department saying that he had smoked drugs and was hallucinating. He left the hospital before any treatment. *A Clinical Discharge summary was sent to the GP, who wrote to B asking him to book a routine appointment. No appointment was made and there was no follow up by either the GP or hospital despite the concerns regarding B’s mental health.*

3.17 In early August 2016 B’s mother went to the GP surgery asking for advice, telling them that she believed the situation was serious. She had found notes in B’s bedroom suggesting he intended to kill his father, although she apparently did not disclose this to the GP. *She was advised to call the CRHTT. The CRHTT advised her to call police. She did not do so, fearing escalation of the problems.*

3.18 The following day, B went to his father’s café. He was observed to be acting strangely by various witnesses. At about 18.30, B stabbed his father repeatedly and then called police saying that he'd murdered his father. He was arrested and subsequently charged with murder.

3.19 B was remanded by the court and initially sent in custody to HMP Pentonville. A Consultant Forensic Psychiatrist attended the prison to examine B but concluded that he required urgent assessment in hospital, suspecting that he had developed a psychotic illness and presented a high risk of suicide. He was transferred to a medium secure unit at Chase Farm Hospital where he was assessed for his fitness to plead to any criminal offence and for psychiatric defences to the charge of murder.

3.20 The assessment of the Consultant Forensic Psychiatrist responsible for his treatment at Chase Farm Hospital was that B first became psychotic while at university and that his symptoms gradually worsened resulting in a diminishing grasp on reality, extreme paranoia, bizarre delusions and overwhelming multi-sensory hallucinations. The Consultant concluded that B suffered from a severe and enduring mental disorder, namely paranoid schizophrenia and that symptoms of his disorder were evident prior to the homicide.

3.21 B pleaded not guilty to murder by reason of diminished responsibility but guilty to manslaughter. In May 2017 he was sentenced to life imprisonment with a minimum term of six and a half years before he could be considered for parole. He was also ordered to be held and treated in a secure mental hospital.

Emerging Themes

3.22 The Serious Incident Root Cause Analysis Investigation by BEH Mental Health Trust identified issues concerning the psychiatric assessment of B:

I. The need for assessors to have explored more deeply into the background and history of B's behaviour, in relation to his attendance on 30th April 2016
II. The absence of a referral to the CRHTT in light of the initial decision on 1st July 2016 that he should be admitted to the available bed in The Dene Hospital, West Sussex. *This initial plan was frustrated by B walking out of the hospital but thereafter alternative arrangements for his care were not put in place. The GP was only informed some twelve days later.*
III. The absence of adequate documentation about the assessment interview with B.

Overall, the concern is that documentation shows a change in the management plan for B from an initial recommendation for informal admission to discharge with no referral for follow-up from mental health services (CRHTT) or immediate communication with B's GP. This represents an apparent lack of consistency in attending to risk assessment and the most appropriate mitigation of previously identified risks. It should be noted however that the perceived risks were of self-harm/suicide rather than harm to anyone else.

Since this tragedy the BEH Mental Health Trust has instituted training to emphasise that the link between suicide and homicide should be regarded as a high-risk factor in the risk assessments. In the training there is an emphasis around potential risk to support networks (i.e. partners/family members) at times when a person becomes unwell and the need to understand and address any risk to those close to the service user. The North London Mental Health Partnership have also implemented training around risk and suicide prevention with multiple learning events running across 2023 due to embed the suicide prevention strategy that was launched November 2022.

3.23 In relation to the need to explore B's background more deeply, there is no record to suggest that contact with the Enfield Adult Safeguarding Multi-Agency Safeguarding Hub (MASH) was considered or made – thus ignoring a potential useful source of background information from partners outside the health sphere. (see Recommendation 7)

3.24 The MPS IMR notes that when B called Police on 30th June 2016, stating he was depressed and had self-harmed in the past, he was taken to North Middlesex Hospital in a police vehicle because no ambulance was available. This encounter with an obviously vulnerable adult should have been the subject of a MERLIN record by the attending officer. *The officer failed to make such a record. Thus, even had medical professionals made enquiry via the MASH, they would have discovered nothing about the police encounter. (See Recommendation 6)*

3.25 BPP University is a privately owned organisation. Teaching arrangements entail less continuity of contact between students and teaching staff than in traditionally organised universities. In response to a request for information about its student welfare policies, BPP provided the following response:

> *Student wellbeing is extremely important at BPP University ("**BPP**"), and BPP is proud of its accessible and inclusive learning facilities. If students are experiencing low mood, depression, anxiety or have an existing mental health condition, they are encouraged to contact the Learning Support Team. In 2015, if a student was identified as having a mental health condition that prevented attendance, the student would have been actively encouraged to contact the Learning Support Team. The process is that a faculty member (such as their student manager) would have*

a conversation with the student asking them to self-refer to the Learning Support Team for information, guidance, advice and/or support.

On referral to the Learning Support Team, the student would be offered a series of reasonable adjustments for both classes and exams and, where appropriate, a referral would be made to the Disabled Students' Allowances. Any support provided would be recorded in a Learning Support Agreement. The Learning Support Team would, where appropriate, also ask the student to complete a disability disclosure form and notify the student of the counselling services available.

BPP ensures that students are provided with information and multiple opportunities to disclose mental health concerns, issues or a disability. These include, but are not limited to: the onboarding and application, welcome emails, the BPP website and prospectus, registration, student inductions, on-programme such as through faculty staff, flyers, posters, independent BPP funded counselling services, the Student Advice Team and on hand at graduation. <u>Some students, however, may not wish to disclose such mental health concerns, issues or disabilities, or they may have a mental health concern, issue or disability and self-manage their condition</u>. As such, whilst all students are (and would have been) made aware of the services available at BPP and are encouraged to self-refer, the students may still choose not to refer themselves to the Learning Support Team.

BPP continues to provide information and resources to students on wellbeing and mental health. In addition, BPP now also has a dedicated Safeguarding Team that manages all welfare issues which may impact students' studies such as: abuse, online safety, radicalisation and bereavement. BPP also has a dedicated Student Wellbeing and Mental Health Group that meets monthly and seeks to raise the profile of wellbeing and mental health in order to change attitudes and develop understanding in relation to the spectrum of conditions under the term 'mental health', and enhance existing provisions for wellbeing and mental health for staff and students.

The university cannot force students to accept help and even in cases where there are known to be mental health issues, the university would be in breach of its duty of confidentiality were it to share that knowledge without proper consent. B did not choose to disclose his mental health problems to BPP and as such the university is of only peripheral relevance to this review.

3.26 The IMR completed on behalf of the GP Practice responsible for B's care (and that of his mother) notes the slow and disjointed communications between GP practices and mental health professionals/agencies. This is regarded as especially important in respect of patients with complex problems and those with risk of self-harm. By implication, these issues are even more important where there are risks of harm to others. (See Recommendation 4)

3.27 On a number of occasions information which should have been sent immediately from secondary agencies to the GP Practice were either delayed or apparently not passed at all. Where information was passed to the GP there were occasions where there was a lack of follow-up on recommendations, even where B actually attended the GP Practice for unrelated health matters.

3.28 It is also evident from the IMR of the GP Practice that GPs do not access information which may be available from partner agencies where there is a suspicion of domestic abuse. The inter-agency sharing of background information about those involved (either as victims or perpetrators) in domestic abuse is the aim of the IRIS project[7].(see Recommendation 2)

3.29 It is evident that B found his Law studies very challenging. His decision to drop out of university aggravated family tensions that were already causing major problems, with increasingly serious assaults on family members and B's partner. The Psychiatric Consultant who gave evidence in B's defence concluded that the combination of issues resulted in B becoming increasingly psychotic and ultimately suffering from paranoid schizophrenia.

3.30 In interview with the Independent Chair, B was able to explain that he had experienced "mental health difficulties" and had been in conflict with his family. He acknowledged that he had threatened his mother and hit his brother, breaking his eye socket, hit his partner, breaking her cheek bone, and that on occasions, he had left home due to family conflict and slept in parks and "behind trees". He could not, however, explain why it was that he had walked out of the hospital rather than waiting to be taken to the available bed in Sussex – other than simply saying that his behaviour was due to his mental health. When asked what might have stopped him hurting his father, he simply decided that the interview had come to an end and asked to leave the room.

[7] **IRIS** is a specialist domestic violence and abuse (DVA) training, support and referral programme for General Practices that has been positively evaluated in a randomised control trial. It is a collaboration between primary care and specialist third sector organisations specialising in domestic violence and abuse. IRIS was identified as good practice by Home Office as part of the VAWG strategy.

3.31 In discussion with the Consultant Forensic Psychiatrist currently responsible for B's care, she expressed the view that resource constraints were and remain a significant factor in the care and treatment of people with mental illness. Specifically, the lack of acute mental health beds frequently means that the entire capacity is used for involuntary admissions leaving no capacity for voluntary admissions as in B's case. Intervention thresholds across the mental health system are thus raised in order to prioritise the most urgent cases.

3.32 A further issue raised by the Consultant is that it is not uncommon for families of people suffering from mental illness to find it hard to accept the behaviour of suffers as anything other than "wickedness". (see Recommendation 5)

Equality & Diversity

3.33 The Equalities Act 2010 defines nine protected characteristics, five (asterisked) of which applied to H:

Age

*Disability**

Gender reassignment

Marital status

Pregnancy & maternity

*Race/Ethnicity**

Faith/Religion/Belief

*Sex**

Sexual orientation

3.34 Both H and B were British Turks, as are B's mother and his brothers. B's mother was born in the Sivas region of Turkey. She came to the UK at the age of 13 and thereafter attended school here. B had two brothers, one older and one younger. H, B and B's brothers were all born in the UK. English was their first language and all were educated here. H's funeral was a secular ceremony which at least suggests that the family had no strict religious adherence. B's mother speaks English but during the homicide investigation, as a precaution, all statements were taken with the assistance of a Turkish interpreter. Nothing has emerged in this review to suggest that either suffered any disadvantage as a result of their ethnicity. B suffered from a psychotic mental illness which developed from at least 2016 which coincided with him feeling pressurised by his attendance at BPP University.

4. Overview

4.1 The case history compiled by this review reveals the following key areas of information:

- B's family were aware of his gradually deteriorating behaviour. As a schoolboy he was excluded from school due to his violent behaviour and only allowed to return once he and his mother had agreed to an Acceptable Behaviour Contract (ABC). Once he had left school, B became increasingly violent towards his mother, brother and partner. Despite the seriousness of these assaults, they were regarded as matters to be kept within the family and as such were not reported to police, although it seems likely that B's brother and partner must have sought medical help for their injuries. B spent nights sleeping in parks and even when not physically violent, there is clear evidence that he was in conflict with the family as a whole and especially with his parents. B's mother sought help from her GP but was offered only phone numbers for mental health intervention services and advised to call police in the event of an urgent need. B's mother was fearful of calling police for fear of her son being arrested.
- The MPS was aware of having had a number of encounters with B as a youth and the School Police Officer was involved in the process of B being issued with an ABC. The information was entered on the MERLIN database of vulnerable juveniles thus was immediately available via the MASH. However, the information was not shared with LBE Social Care because it was below the threshold for active dissemination. In June 2016, despite B's call to the MPS and the fact that he was taken by officers to hospital, no MERLIN record was made of this encounter with an obviously vulnerable person.
- BPP University was aware that B had "dropped out" of his legal studies due to mental health problems. There is no record that he sought help from the Learning Support Service of the university. As an independent adult he had a right not to seek help and a lawful expectation that personal information would not be shared without his consent.

- Barnet Enfield & Haringey Mental Health Trust attempted to provide mental health care for B over his several presentations at North Middlesex and Chase Farm Hospitals. It is accepted that the initial assessment of his condition in April 2016 lacked depth. His presentation in July 2016 justified his voluntary admission but the lack of critical beds locally undermined this initial care plan when B left the hospital rather than accepting a bed some miles away in Sussex. It is accepted that once the initial care plan had failed, a new plan should have been developed with immediate information to B's GP and the Crisis Intervention Team.
- B's General Practitioner had limited opportunities to build a relationship with him, albeit in June 2016, B told his GP that he was suffering from mental health problems. Based on this information the GP referred B to secondary mental health care from the BEH Mental Health Trust. The main information about B was, however, provided by his distressed mother, asking for help with her increasingly violent son. The CCG IMR notes that the GP delegated responsibility for managing B to his mother rather than seeking to engage directly with B. The GP received letters from the North Middlesex Hospital Mental Health team discharging B to the GP's care but the GP does not appear to have acted upon the limited information that had been supplied. The GP subsequently raised concerns about B's mental health, offering further appointments. Thereafter, communication between secondary mental health services and the GP became disjointed and delayed.

5. Analysis

5.1 B's first contact with health care was via his GP. B sought advice for routine medical matters and sexual health. It is rare for teenagers and young adults to see their GPs but such appointments are an ideal opportunity to make sure that health professionals can help them with any physical or mental problem. (See Recommendation 1)

5.2 When B's mother sought help and advice from the GP, because B's behaviour was becoming increasingly violent, she was given contact numbers for mental health intervention services and advised to call police in an emergency. The GP thus effectively delegated management of B to his mother without trying to contact B. Despite this *de facto* delegation, there was no carers assessment made then or later to consider the capability of B's carers or the risks to them. B's mother did not apparently disclose the extent of B’s violence (assaulting his brother and partner) during her earlier requests for support, neither is there evidence that on her final visit to the GP, the day before the homicide, that she disclosed the contents of the notes she had found in B’s bedroom indicating that B planned to kill his father. A clear learning point emerging from this case is that GPs should be advised that when a friend or family member has concerns about an individual, some contact between the GP and patient should be attempted (see Recommendation 3), albeit the *source* of the information may need to be protected.

5.3 B’s GP appears to have been a relatively passive recipient of information from BEH Mental Health Trust. Whilst it was B’s mother who attended the surgery expressing concerns about B’s mental health due to his aggressive behaviour, B himself only presented at the GP surgery once in relation to mental health and later that same day at North Middlesex Hospital where he was subject to a mental state examination after which it was concluded that “no mental health issue [was] elicited”. Thereafter communication between secondary agencies and the GP was fragmented, slow and incomplete. It is not clear from the perspective of an outsider, where responsibility for B’s mental health care actually sat at any given moment and it is possible that this was a factor in B’s family not disclosing the extent of his violence to his brother and partner. (see Recommendations 4 & 5)

5.4 There is no sense in which B’s family could be “blamed” for not disclosing to either the GP or Police that B had assaulted his brother and partner. Whilst cultural issues *may* have played a part, it is perhaps more likely that when B’s mother sought help from her GP but received no practical assistance, this reinforced her reluctance to deal with police. (See Recommendation 5)

5.5 In June 2016 B was taken to North Middlesex Hospital by police officers but no record MERLIN was made of the encounter with such an obviously vulnerable adult. (See Recommendation 6)

5.6 When B presented at North Middlesex Hospital in July 2016, saying he had attempted suicide he was eventually seen and assessed by the BEH Psychiatric Liaison Team and judged to be in need of a psychiatric bed as a voluntary admission, albeit he was considered to have no real suicidal intent. There is no evidence that he was assessed in terms of the risk he might present to others. Regrettably, no local bed was available but after a five-hour delay, one was found some distance away in Sussex, which B declined. Having declined voluntary admission, B was discharged to the care of his GP with a “plan” that he should contact the BEH Crisis Team if necessary.

5.7 Documentation regarding B's assessment and management in July is somewhat sparse. The assessors were interviewed by BEH investigators and recall that the assessment was of greater depth than is recorded, not least on the subject of the need for a referral to the CRHTT for further assessment and exploration of risks in B's home setting. One of the main areas of concern is that there is a significant change in the management plan from an initial recommendation of informal admission to a discharge with no referral for follow-up from mental health services (i.e. CRHTT) or communication with B's GP. This indicates an apparent lack of consistency in attending to risk assessment and the appropriate mitigation of identified risks. The perceived risks were, however, considered as risks to self rather than to others. (See Recommendation 7)

5.8 A month later (at the start of August), B's mother made her third attempt to gain the assistance of B's GP. She had found notes in B's bedroom suggesting he intended to kill his father, although she apparently did not disclose this to the GP. She was advised to call the Crisis Team and did so but was then advised to call Police. Fearing repercussions, she did not do so. The following day, B killed his father.

5.9 Some months after B's conviction, the Consultant Forensic Psychiatrist responsible for his care expressed the view that, "Hindsight sometimes allows the identification of a trajectory from apparently minor difficulties to murder". However, there can be no certainty that B would have received the treatment he needed even if mental health professionals had been in full possession of all information – when, at the start of July 2016, the initial treatment plan required his voluntary admission, no local bed was available and it is a common occurrence in the overstressed secondary mental health sphere for bed capacity to be almost entirely used up to cater for patients requiring involuntary (i.e. more acute) admission.

6. Conclusions & Recommendations

6.1 The psychological phenomenon known as "outcome (or hindsight) bias" is a common feature of the way in which those analysing a sequence of events allow their knowledge of the outcome to influence their beliefs about the correctness of decisions prior to a crisis, indeed B's Consultant Forensic Psychiatrist specifically referred to the phenomenon in relation to this case (see para. 5.9). At B's trial it was accepted that B started acting strangely in about January of 2016 and that by the time of the homicide he was suffering from a severe and enduring mental disorder, namely paranoid schizophrenia, and that symptoms of his mental disorder were evident prior to the offence. The question thus arises why was the state of B's mental health not recognised and managed? The conclusion of this review is that whilst the combined knowledge of the various agencies and B's family *might* have resulted in a more probing assessment of what was known about his behaviours and thereby suggested the need for more urgent care, the issues identified at Section 5 (above) militated against this collation of knowledge.

6.2 A second issue is the question of which agency had or should have had the primary responsibility for the management of B. B's mother repeatedly sought help from her the GP - she was variously referred to Police and the Crisis Resolution and Home Treatment Team. B himself sought help from two hospitals and the mental health trust liaison team (which then communicated with the GP). Primacy of responsibility for B is not evident from the history of the case and it seems likely that B's mother was equally unclear from whom she should receive help. This case suggests a structural problem in overall mental health provision which should be addressed to ensure that agencies, practitioners and above all patients (and their families) have a clear understanding of which agency has the prime responsibility for the care and management of a patient (see Recommendation 5).

6.3 It must be acknowledged that an underlying cause of this tragedy is the resource stress under which primary and secondary mental health services operate. As evidenced by the difficulty faced when seeking a bed for B's voluntary admission on 1st July 2016, it is frequently the case that available psychiatric bed capacity is entirely used up catering for acute and involuntary admissions. Similar capacity issues occur throughout the system, resulting in the intervention thresholds being raised in order to "ration" available resources. Additionally, there is an urgent need for additional resources to support the "Right Care, Right Person[8]" policy and for specific co-

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[8] Right Care, Right Person is an approach designed to ensure that people of all ages, who have health and/or social care needs, are responded to by the right person, with the right skills, training, and experience to best meet their needs. Though the approach can be applied more broadly than cases relating to mental health, this document is focused on the interface between policing and mental health services, as one step towards implementing RCRP. At the centre of the RCRP approach is a threshold to assist police in making decisions about when it is appropriate for them to respond to incidents, including those which relate to people with mental health needs. The threshold for a police response to a mental health-related incident is:

- to investigate a crime that has occurred or is occurring; or ordination posts to ensure proper linkage between primary health care and specific mental health facilities. (see Recommendation 8)

6.4 Such an increase in resources would be made more effective if combined with the development of clear structures for the support and management of complex and high-risk cases. Such structures must be explained to the families/friends of sufferers to ensure they understand who/which agency is responsible for the management of the patient – simply delegating management to a family member/friend, offering a series of phone numbers and suggesting that the police service should be called upon as a back-up is demonstrably inadequate as well as being unfair on patients and families. The national policy of “Right Care, Right Person” is now being implemented in Enfield to address this, as well as other issues. Full implementation of the policy should address these structural issues albeit the paucity of resources will remain problematic.

6.5 Clearly there is a need for better information sharing and improved communication between primary and secondary care agencies. Since this tragedy BEH NHS Trust has appointed a Domestic Abuse Co-ordinator who acts as an expert reference point within the BEH safeguarding team in supporting staff to identify and respond to domestic abuse. The Barnet local authority area has a specific Mental Health IDVA but regrettably similar posts in Enfield and Haringey did not attract funding. The Domestic Abuse Policy was updated in 2022 following the introduction of the Domestic Abuse Act (2021). Domestic abuse training is delivered across the North London Mental Health Partnership on a bi-monthly basis and is available to staff of all levels. This training covers identifying domestic abuse, risk assessing and risk management, the importance of a co-ordinated community response including information sharing. Training to individual teams is also available by request. A Domestic Abuse and Harmful Practice Surgery operates on a weekly basis as a forum for staff to bring cases for discussion and guidance.

6.6 There can be no certainty that the tragic death of H could have been prevented, however, the following recommendations may go some way to improving the ability of the Enfield Safer Stronger Communities Board to record and collate information from the widest possible range of sources and make it available to mental health and other professionals in a timely fashion.

- to protect people, when there is a real and immediate risk to the life of a person, or of a person being subject to or at risk of serious harm

Recommendation 1

Primary care professionals should be reminded to utilise all opportunities available to them to engage with adolescent and young adult patients to promote engagement of the adolescent or young person.

Recommendation 2

Consideration must be given in primary and secondary care to systems and processes which could be utilised to facilitate information sharing in respect of victims and perpetrators believed to be involved in domestic abuse, to improve the information available across health services.

Recommendation 3

GPs must be reminded of the need to consider direct contact with patients when family or friends have confidentially expressed concerns relating to the patient's poor mental health in order to increase the likelihood of serious deterioration being assessed and appropriate actions to maintain the safety of the patient and others who may be at risk.

Recommendation 4

BEH Mental Health Trust to review and agree a protocol for the timeliness and content of communications between secondary mental health service and primary care, especially in complex cases and those with risks of harm to self and/or others to improve the information available to primary care services.

Recommendation 5

BEH Mental Health Trust should review the information provided on its website to improve public understanding of mental health services and increase the likelihood of sufferers receiving appropriate care.

Recommendation 6

It is recommended that the MPS North Area BCU Senior Leadership Team conduct periodic dip sampling to ensure compliance in the completion of vulnerable adult coming to notice reports on MERLIN in order to share information with partners, reporting results to the LBE Domestic Abuse Co-ordinator.

Recommendation 7

BEH Mental Health Trust should review practice to ensure that:

a) Where a decision is made to change a treatment plan for a patient, there should be evidence of discussion/second opinions and documentation of the reasons for change and the alternative arrangements, including contingency plans.

b) Care to be taken to ensure adequate completion of risk assessment documentation

c) Care to be taken to ensure appropriate information is sent on time to referrers/GPs

d) All North Middlesex Mental Health Liaison Service (NMMHLS) staff to be reminded to use the shared databases of information regarding previous patient admissions and more widely to include the MASH facilities where possible.

This will increase the likelihood of decisions being based on clear and robust assessments and care planning.

Recommendation 8

Financial resources for funding increased bed capacity within the mental health sphere is required to meet demonstrated demand. Additional resources will also be required to adequately fund co-ordination between partner agencies within and beyond the NHS in order to implement the “Right Care, Right Person” policy.

Recommendation 9

The “Right Care, Right Person” policy should be implemented as a matter of urgency, commensurate with the funding available. Particular care will be required to develop suitable communication mechanisms to ensure that Right Care, Right Person can provide the most appropriate interventions.

Action Plan

Recommendation	Scope of recommend-ation e.g. local/ regional	Key actions to take	Lead Agency / Named Officer	Key milestones in enacting the recommendation	Target Date for Completion
Recommendation 1 Health professionals should be reminded to utilise all opportunities available to them to engage with adolescent and young adult patients to promote engagement of the adolescent or young person.	**Local** **CCG**	a) Outcome of DHR 5 to be shared with lead safeguarding GPs in Enfield by end July 2022. b) Lead GPs to cascade this information within their practices by end of September 2022. c) GP practices to consider the establishment or development of young people's participation group or equivalent vehicles such as MDT meetings to improve the management of young people with mental health needs by December 2022.	CCG Named Doctor Safeguarding Adults (Enfield) CCG Designated Professional Safeguarding Adults (Enfield)	a) An increase in 'face to face' type contact with adolescents and young people enabling this patient group to become more engaged with their health and wellbeing. b) All primary care professionals will be aware of the need to pursue engagement with adolescents and young people. C)Robust involvement of adolescents and young people in	**December 2022**

				the governance of the practices.	
Recommendation 2 Consideration must be given in primary and secondary care to systems and processes which could be utilised to facilitate information sharing in respect of victims and perpetrators believed to be involved in domestic abuse, to improve the information available across health services.	**Local** **CCG & BEHMT**	**DA directory has been written.** **Posters and leaflets around the trust.** **DA working group aims to improve the information available across health services.** **Employment of Domestic abuse coordinator for the trust will support with promotion.** **IDVA services have been embedded into the mental health teams across the trust to promote DA and improve access to services.**	**CCG** **&** **BEH MHT**	Employment of a Domestic Abuse Co-ordinator took up the post on 1/08/22	**November 2022**
Recommendation 3 GPs must be reminded of the need to consider direct contact with patients when family or friends have confidentially expressed concerns relating to the	**Local** **CCG**	a) Outcome of DHR 5 to be shared with lead safeguarding GPs in Enfield by end July 2022.	CCG Named Doctor Safeguarding Adults (Enfield)	a,b &c) Notes of the GP forum highlighting this recommendation and follow up	**December 2022**

patient's poor mental health in order to increase the likelihood of serious deterioration being assessed and appropriate actions to maintain the safety of the patient and others.		b) Lead GPs to cascade this information within their practices by end of September 2022. c) GP practices to consider the establishment or development of young peoples participation group or equivalent vehicles such as MDT meetings to improve the management of young people with mental health needs by December 2022.	CCG Designated Professional Safeguarding Adults (Enfield)	meetings to review implementation and impact. Notes of previous GP forum discussions. GP forum case discussion notes evidencing multi professional input	
Recommendation 4 BEH Mental Health Trust to review and agree a protocol for the timeliness and content of communications between secondary mental health service and primary care, especially in complex cases and those with risks of harm to self and/or others to improve the information available to primary care services.	**Local**	**Current policy for communication with primary care re complex cases to be reviewed**	**BEH MHT**	**Policy review scheduled to commence July 2022**	**2022 and beyond**
Recommendation 5 BEH Mental Health Trust should review the information provided on its website to improve public understanding of mental	**Local**	**The Trust has reviewed and revised its website to incorporate simple and highly visible means to seek immediate assistance**	**BEH NHS MHT**	**Completed**	**Completed**

health services and increase the likelihood of sufferers receiving appropriate care.					
Recommendation 6 The MPS North Area BCU Senior Leadership Team conduct periodic dip sampling to ensure compliance in the completion of vulnerable adult coming to notice reports on MERLIN in order to share information with partners, reporting results to the LBE Domestic Abuse Co-ordinator.	**Local**	**Periodic dip sampling now in place.** **Partnership Board to be asked to formally mandate required frequency of checks and mode of reporting**	**MPS** **Safer Enfield Partnership**	**Ongoing**	**Ongoing**
Recommendation 7 BEH Mental Health Trust should review practice to ensure that: a) Where a decision is made to change a treatment plan for a patient, there should be evidence of discussion/second opinions and documentation of the reasons for change and the	**Local**	**The mental health trust is reviewing their Domestic abuse policy. This policy will include direction on :** • Care to be taken to ensure adequate completion of risk assessment documentation including	**BEH NHS MHT**	**The trust now employs a domestic abuse coordinator, appointed August 2022.** **Policy and training content have been developed and the course piloted in Sept 2022.**	**November 2022**

alternative arrangements, including contingency plans. b) Care to be taken to ensure adequate completion of risk assessment documentation c) Care to be taken to ensure appropriate information is sent on time to referrers/GPs d) All NMMHLS staff to be reminded to use the shared databases of information regarding previous patient admissions and more widely to include the MASH facilities where possible. This will increase the likelihood of decisions being based on clear and robust assessments and care planning.		safeguarding risks and mitigation plans. • Liaison with primary care services and other relevant partners. **Trust will ensure that in their Domestic abuse training includes liaison with primary care, risk assessment and documentation.** The Risk Management Policy was updated in November 2021 i.e. since this case.		**Consequential amendments currently in progress for scheduled training commencing Nov 2022**	**Completed**
Recommendation 8 Financial resources for funding increased bed capacity within the mental health sphere is required to meet demonstrated demand. Additional resources will also be required to adequately fund co-	**National**		**Dept. Health & Social Care**		

ordination between partner agencies within and beyond the NHS in order to implement the "Right Care, Right Person" policy.					
Recommendation 9 The "Right Care, Right Person" policy should be implemented as a matter of urgency, commensurate with the funding available.	**Local**		**Enfield Strategic Partnership**		Policy already implemented to a minimum level

Glossary

BEHMHT	Barnet, Enfield & Haringey NHS Mental Health Trust
CCG	Clinical Commissioning Group
CRHTT	Crisis Resolution Home Treatment Team
LBE	London Borough of Enfield
MPS	Metropolitan Police Service
NMUHT	North Middlesex University Hospital NHS Trust