BEXLEY COMMUNITY SAFETY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

Overview Report into the Homicide of Linda[1]

In September 2020

Independent Chair and Author of Report: Paula Harding

Associate of Standing Together Against Domestic Abuse

[1] Pseudonym

Acknowledgments

Members of the review panel offer their deepest sympathy to all who have been affected by the homicide of LINDA.

Judge Joseph presided over the criminal case and noted the impact

> *“I have read many moving statements from those to whom [LINDA] was a beloved relative and friend… It is clear that the suffering caused by her death has been profound. It has had a terrible effect on her mother, a lady in her 90s and in ill-health. It has left her sister utterly bereft. It has also taken from those to whom she was and others who regarded her as an aunt, the love and support which she endlessly offered them, and from her friends it has taken someone they held in the highest regard. Most important, it has taken from [pseudonym], her future.” (Judge Joseph’s Sentencing Remarks)*

The Chair would like to thank the panel and contributors for their commitment to the review and to improving services for victims of domestic abuse.

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1. Introduction

1.1 The incident

1.1.1 This review concerns the circumstances leading to the manslaughter of LINDA, a 66-year-old woman, who was killed in her home by her 68-year-old husband, DAVID, in September 2020. The couple had been married for over 40 years.

1.1.2 DAVID was convicted of manslaughter with diminished responsibility following a deterioration in his mental health.

1.2 Aim and purpose of a domestic homicide review

1.2.1 Domestic Homicide Reviews (DHRs) were established under Section 9(3), Domestic Violence, Crime and Victims Act 2004 and should be conducted in accordance with the December 2016 Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (hereafter 'the statutory guidance').

1.2.2 This Domestic Homicide Review (hereafter 'the review') examines agency responses and support given to LINDA a resident of Bexley prior to her homicide at her home on in September 2020

1.2.3 The review considered agencies' contact with LINDA and her husband, from September 2019 until the homicide. In addition to agency involvement, the review also examined the past to identify any relevant background or trail of abuse before the homicide; whether support was accessed within the community and whether there were any barriers to accessing support. By taking a holistic approach the review sought to identify appropriate solutions to make the future safer.

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

1.2.5 This review process does not take the place of the criminal or coroner's courts, nor does it take the form of a disciplinary process.

1.3 Timescales

1.3.1 This review was commissioned by Bexley Community Safety Partnership. Having received notification of the death from the Metropolitan Police Service in September

2020, a decision was made, in consultation with local agencies, to undertake a review. Subsequently, the Home Office was notified of the decision in writing on 14th October 2020.

1.3.2 Standing Together Against Domestic Abuse (hereafter 'Standing Together') was commissioned to provide an Independent Chair (hereafter 'the Chair') for this review in October 2020. Criminal proceedings concluded in June 2021 and the panel met four times.

1.3.3 The completed report was handed to the Bexley Community Safety Partnership in August 2022 and endorsed by them before being submitted to the Home Office Quality Assurance Panel. In March 2023, the completed report was considered by the Home Office Quality Assurance Panel. In May 2023, Bexley received a letter from the Home Office Quality Assurance Panel approving the report for publication.

1.3.4 Home Office guidance states that the review should be completed within six months of the initial decision to establish one. In this case, the review was delayed until criminal proceedings concluded in June 2021. Criminal proceedings had themselves been delayed due to backlogs caused by the ongoing Covid-19 pandemic as well as conflicting psychiatric reports presented in the case.

1.4 Confidentiality and anonymisation

1.4.1 The findings of this review have been confidential until the Overview Report was approved for publication by the Home Office Quality Assurance Panel.

1.4.2 This review has been anonymised in accordance with statutory guidance and only the Independent Chair and review panel members are named.

1.4.3 In order to protect the identities of the victim and her family, the following pseudonyms have been used:[2]

Pseudonym	Relationship to victim
Linda	Victim
David	The perpetrator and the victim's husband

[2] In the absence of pseudonyms being provided by the family, the panel agreed to use the following most popular names in the UK in the year of their births. Available at https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/livebirths/datasets/babynamesenglandandwalestop100babynameshistoricaldata

1.5 Equality and Diversity

1.5.1 The review gave due consideration to each of the nine protected characteristics under Section 149 of the Equality Act 2010,[3] as well as to wider matters of vulnerability for both LINDA and her husband.

1.5.2 The victim was a white British woman, recorded to be of Christian faith.

1.5.3 The review panel considered that the sex of the victim and perpetrator required particular attention. Domestic abuse and domestic homicide are, most commonly, gendered crimes (Stark, 2007). In the ten years before LINDA was killed by her husband, an average of 89% of victims of domestic homicides in England and Wales were female (ONS, 2021).[4] The significance of sex and violence against women should, therefore, always be considered within a domestic homicide review.

1.5.4 LINDA was aged 66 when she was killed and it was determined that her age should also receive particular attention, not least because older women face considerable barriers which result in them being less likely than younger women to be engaging in domestic abuse services (Bows, 2018). The term 'older women' shall be used to refer to women over 60 in keeping with the usual transition to older people's services.

1.5.5 We will see that the rapid deterioration of DAVID's mental health was a significant feature in this tragic case. Indeed, deteriorating mental health is a common feature of domestic homicide and the complex inter-relationship between domestic abuse and mental health was considered with the understanding that mental illness does not usually, in itself, cause or excuse domestic abuse, but can exacerbate or intensify the abuse (Bates, 2021:54; Montique, 2019).

1.5.6 LINDA had multiple sclerosis, a degenerative illness, which in her case was slowly progressing and rarely needing medical intervention. The Equality Act 2010 defines a disability as a "physical or mental impairment which has substantial and long-term adverse effects on your ability to carry out normal day to day activities." In this way, the condition falls short of the definition of disability, but given that there is a significantly higher rate of domestic abuse against disabled people (PHE, 2015), the review required health agencies to consider how the diagnosis impacted upon LINDA's care and the risks she may have faced.

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[3] The nine protected characteristics under the Equality Act 2010 are age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation

[4] Between April 2010 and March 2020, there was an average of 80 women and nine men killed by a partner or ex-partner (ONS, 2021).

1.5.7 Moreover, the impact of the relative affluence of the couple was considered in respect of the options that may have been available, or perceived by the couple, to be available.

1.5.8 The Review Panel took an intersectional and ecological analysis approach to better understand the lived experiences of both victim and perpetrator. This means to think of each characteristic of an individual as inextricably linked with all the other characteristics in order to fully understand an individual's journey and experience with local services and within their community. An ecological analysis considers someone's identity and lived experiences at an individual, relational, community, and societal level. It is about how individuals relate to those around them and to their broader environment.[5]

1.5.9 Taking an ecological and intersectional approach can help identify the factors that create, sustain or exacerbate someone's risks and needs. An ecological and intersectional approach can also help to identify the barriers someone may have faced in recognising or reporting domestic abuse, their options for safety and protection available, and considers any conscious or unconscious bias or privileging by agencies and or society.

1.6 Methodology

1.6.1 The review followed the methodology required by the *Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews* (HM Government, 2016a). All local agencies were notified of the death and were asked to examine their records to establish if they had provided any services to the couple and to secure records if there had been any involvement without delay. Additionally, it was established that the individuals had contact with agencies in other parts of London and therefore agencies in that area were contacted for information and involved in the review.

1.6.2 Arrangements were made to appoint an Independent Domestic Homicide Review Chair and Author and agree on the make-up of the multi-agency review panel. Standing Together Against Domestic Abuse (hereinafter 'Standing Together') was commissioned to administer the review and to provide an Independent Chair and Author.

1.6.3 The panel initially met in advance of the conclusion of criminal proceedings in order to set the terms of reference and identify any immediate concerns for agencies' practice. Once criminal proceedings had concluded, the panel went on to meet a further three times. All panel meetings were minuted and all actions agreed for the panel have been tracked and completed.

1.6.4 The Senior Investigating Officer and Family Liaison Officer from the Metropolitan Police Service attended earlier panel meetings and were able to provide the findings from the

5 Further information on this approach can be found online, such as in EVAW (2011) *A Different World is Possible: A call for long-term and targeted action to prevent violence against women and girls*, https://www.endviolenceagainstwomen.org.uk/wp-content/uploads/a_different_world_is_possible_report_email_version.pdf:

criminal investigation and details of the family who were to be invited to engage with the review.

1.6.5 The terms of reference for the review were drawn up by the Independent Chair together with the panel and incorporated both key lines of enquiry and specific questions for individual agencies where necessary. It was identified that nine agencies were to provide reports and chronologies analysing their involvement for the review.

1.6.6 All reports were written by authors who were independent of the delivery of services provided. Wherever possible, report authors presented their findings to the review panel in person and, where necessary, were asked to respond to further questions. The individual agency reports concluded with recommendations for improving their own agency policy and practice responses in the future and informed the multi-agency and thematic recommendations which followed.

1.6.7 The Independent Chair authored the Overview Report, and each draft was discussed and endorsed by the review panel before consultation with the family and submission to the Community Safety Partnership.

1.7 Definition

1.7.1 During the course of this review, the Domestic Abuse Act 2021 was enacted and introduced a legal definition of domestic abusive behaviour as consisting of a single incident or course of conduct between two people who are personally connected, each aged 16 or over, and involving any of the following:

(a) physical or sexual abuse

(b) violent or threatening behaviour

(c) controlling or coercive behaviour

(d) economic abuse

(e) psychological, emotional or other abuse (s1: Domestic Abuse Act 2021)[6]

1.7.2 Within this definition, controlling behaviour is understood to be “a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour….Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.” (HM Government, 2016a)

[6] https://www.legislation.gov.uk/ukpga/2021/17/part/1/enacted

1.7.3 Economic abuse was considered within this review and is defined as any behaviour that has a substantial adverse effect on a person's ability to acquire, use, or maintain money or other property or obtain goods or services (s.3: Domestic Abuse Act 2021).[7]

1.8 Key Lines of Enquiry

1.8.1 The panel agreed that the review should focus on the year before the homicide, as the perpetrator's mental illness and abusive behaviour were reported to have commenced within this time. However, health agencies were required to analyse their involvement outside of this timeframe with particular regard to any injuries or indicators of domestic abuse that may have been presented in recent years.

1.8.2 In addition to the generic issues set out in statutory guidance (Home Office, 2016), the review focussed on the following specific key lines of enquiry:

a) To analyse how the needs of LINDA and DAVID were identified by agencies and how they responded, taking into account the issues equality and vulnerability identified above. To include

- assessment of agency's response to LINDA's degenerative illness
- assessment of agency's response to DAVID's mental health and mental capacity and actions that considerations given where DAVID declined engagement with services and assessments

b) To analyse the opportunities for agencies to identify and assess risks through domestic abuse. If domestic abuse was not known, analyse opportunities for routine or selective enquiry.

c) To identify and assess opportunities to enable the victim to engage with specialist domestic abuse agencies

d) To analyse how agencies worked together to meet the needs and risks faced by LINDA and DAVID.

e) To consider the impact of arrangements over Coronavirus upon agency responses and upon LINDA and DAVID.

f) To consider how well equipped were staff in responding to the needs, threat or risk identified for the couple. Were staff supported to respond to issues of domestic abuse, safeguarding and public protection through

- Robust policies and procedures

[7] ibid

- Strong management and supervision
- Thorough training in the issues and opportunities for personal development
- Having sufficient resources of people and time

g) To consider how public awareness around domestic abuse has been raised in the area amongst older people and disabled people.

1.9 Contributors to the Review

1.9.1 A total of 19 agencies were contacted to check for involvement with the parties concerned with this DHR. Of these, 9 had relevant contact and were asked to submit reports based upon the extent of their involvement. A narrative chronology was also prepared.

1.9.2 Individual agency reports and chronologies were provided by the following organisations:

- Guys & St Thomas' NHS Foundation Trust
- Lewisham and Greenwich NHS Trust
- London Ambulance Service
- Metropolitan Police
- MIND
- Oxleas NHS Foundation Trust
- The GP Practice
- The Blackheath Hospital
- The Hurley Group NHS Partnership

1.9.3 The reports were written by authors who were independent of the case and were sufficiently comprehensive to enable the panel to analyse agency involvement and to produce the learning for this review. Where necessary further questions were sent to agencies and responses were received.

1.9.4 The following agencies were contacted but confirmed that the victim or perpetrator were not known to them, or that their involvement was not relevant to the review:

- Bexley Drug and Alcohol Services
- Bexley MARAC

- Bexley Women's Aid
- Dartford and Gravesham NHS Trust
- King's College Hospital NHS Foundation Trust
- London Borough of Bexley: Adult Social Care, Children's Social Care, Education and Housing Services
- Solace Women's Aid
- South London and Maudsley NHS Foundation Trust
- The Probation Service[8]
- Victim Support

1.10 Members of the Review Panel

1.10.1 Multi-agency membership of this review panel consisted of senior managers and designated professionals from the key statutory and non- statutory agencies. All members of the panel were independent of the case, having no direct involvement or line management of those involved.

[8] At the time the Probation Service was divided into the National Probation Service and Community Rehabilitation Company and neither had contact with the individuals concerned

Name	Job Title	Agency
Dean Morris	Director of Clinical Services	Black Heath Hospital, BMI Healthcare
Deborah Simpson	Domestic Abuse and Sexual Violence Strategy Manager	Bexley Community Safety Partnership
Jacqui Lansley	Head of Housing	Bexley Housing Services
Jennifer Cirone	Deputy Director	Solace Women's Aid
Jennifer Liddington	Named GP for Safeguarding, Bexley	South East London Clinical Commissioning Group
Julie Carpenter	Safeguarding Officer	London Ambulance Service
Klara Sonska	Team Manager, Pier Road Project, Bexley Addictions	South London and Maudsley NHS Foundation Trust
Louise West	MARAC Coordinator	Bexley Community Safety Team
Mala Karusa	Safeguarding Adults Lead at	Guy's and St. Thomas' NHS Foundation Trust
Malcolm Bainsfair	Head of Safeguarding Adults & Principal Social Worker	Bexley Adult Social Care
Matt Beavis	Detective Sergeant, Specialist Crime Review Group	Metropolitan Police Service
Michael Fullerton	Lead Nurse for Safeguarding Adults	Guys & St Thomas' NHS Foundation Trust
Kadiatu Fofanah	Adult Safeguarding Advisor	Lewisham and Greenwich NHS Trust
Philippa Uren	Designated Nurse for Adult Safeguarding	South-East London (Bexley) Clinical Commissioning Group
Samantha Iriving	IAPT Service Lead	MIND Bexley
Sharon Fernandez	Deputy Medical Director, Unscheduled Care	The Hurley Group
Stacy Washington	Safeguarding Adult Lead	Oxleas NHS Foundation Trust
Sue Govier	Named Nurse Safeguarding Children	Dartford and Gravesham NHS Trust

1.10.1 Issues of equality, diversity and vulnerability were considered when agreeing on panel membership. Solace Women's Aid brought particular expertise on domestic abuse and the 'victim's perspective' to the review.

1.11 Involvement of the Victim's Family, Friends and Community

1.11.1 Both the victim and perpetrator came from small families. The victim's sibling was notified about the review in writing by the Chair of Bexley Community Safety Partnership and

provided with Home Office explanatory leaflets as well as leaflets from the support agencies, Advocacy After Fatal Domestic Abuse (AAFDA) and the Victim Support Homicide Service. As a result, they took the opportunity to initially engage with AAFDA, meet virtually with the Independent Chair and comment on the draft terms of reference and were updated as the review progressed. The draft report was shared with the family prior to submission to the Home Office and their comments were responded to in depth. However, the family remained dissatisfied with the review and withdrew from the process. In part, this was because they did not believe that the review would make a difference and this issue is addressed further in the recommendations. They were also dissatisfied that it was not usual for domestic homicide reviews to be able to access full transcripts of the criminal trial, which is not within the powers of this review.

1.11.2 The victim's best friend of over 40 years was also written to, with accompanying explanatory leaflets, but no response was received. The review panel recognised the challenge that families and friends face when being invited to engage with reviews of this nature and made no judgement on any individual's choice not to do so.

1.12 Involvement of the Perpetrator, His Family and Community

1.12.1 In view of the perpetrator's mental illness, letters and details of the review were delivered to the perpetrator through his consultant at the secure psychiatric facility to which he had been assigned. He declined to engage with the review.

1.12.2 Thereafter, letters were written to his close family, who were also reportedly very friendly with the victim and who had been responsible for raising concerns with the police when they were unable to reach LINDA at the time of the killing. However, no response was received, and they were deemed to have declined engagement.

1.12.3 The Chair of the review wrote to the perpetrator's former place of work, a large telecommunications company, inviting their engagement both as an employer and in helping to identify close work colleagues who were friends of ADULT2 and who might share some personal insight into his thoughts and behaviours. Despite sharing the Home Office's *Domestic Homicide Review: Leaflet for Employers and Work Colleagues*[9] and details of the *Employer's Initiative on Domestic Abuse*[10]and inviting to meet with them, The company declined to share personnel information without DAVID's consent. Consideration of the role of private sector employers in domestic homicide reviews is

[9] Available at https://www.gov.uk/government/publications/domestic-homicide-review-leaflet-for-employers-and-colleagues

[10] The Employer's Initiative on Domestic Abuse is a network of large and small businesses which seeks to enable employers to take action on domestic abuse – raising awareness among all employees, supporting those facing domestic abuse, and providing access to services to help perpetrators to stop. More information is available at https://www.eida.org.uk/

therefore referred to later in this report. The company advised that DAVID had no close relationships in the workplace.

1.13 Parallel Reviews

1.13.1 This review was undertaken after the criminal case had concluded. The Senior Investigation Officer for the criminal investigation helpfully attended an early meeting of the Review Panel in order to share information about the criminal investigation and its outcome.

1.13.2 Oxleas NHS Foundation Trust undertook an internal desk-top review investigation, which was incorporated into their Individual Management Review for this review. A decision was reached by South-East London Clinical Commissioning Group that a further review was not required, given the level of contact with the perpetrator.

1.13.3 The death of LINDA was referred to the coroner. An inquest was opened and adjourned until the conclusion of this domestic homicide review

1.14 Chair of the Review and Author of Overview Report

1.14.1 The Independent Chair of the review and author of the report is Paula Harding, an Associate of Standing Together. She has over twenty-five years' experience of working in domestic abuse with both senior local authority management and specialist domestic abuse sector experience. For more than ten of those years she was the local authority strategic and commissioning lead for domestic abuse and violence against women for a large metropolitan area and has been an independent chair and author of domestic homicide and safeguarding adult reviews since 2016. She completed an M.A. (Birmingham) in Equalities and Social Policy in 1997, focusing on domestic abuse and social welfare, and is a regular contributor to conferences, national consultations and academic research. She completed the OCR certificated training funded by the Home Office for *Independent Chairs of Domestic Homicide Reviews* in 2013. She has also completed the on-line training provided by the Home Office, *Conducting a Homicide Review,*[11] received specialist training from Standing Together and undertaken training on the Significant Incident Learning Process and Learning Disability Mortality Reviews.

1.14.2 Standing Together is a UK charity bringing communities together to end domestic abuse. They aim to see every area in the UK adopt the Coordinated Community Response (CCR).[12] The CCR is based on the principle that no single agency or professional has a complete picture of the life of a domestic abuse survivor, but many will have insights that

[11] Available at https://www.gov.uk/guidance/conducting-a-domestic-homicide-review-online-learning

[12] For more information, go to: https://www.standingtogether.org.uk/ccr-network.

are crucial to their safety. It is paramount that agencies work together effectively and systematically to increase survivors' safety, hold perpetrators to account and ultimately prevent domestic homicides. Standing Together has been involved in the Domestic Homicide Review process from its inception, chairing over 90 reviews across England and Wales from 2013 until the present day.

1.14.3 Beyond this review, the Chair has no connection with Bexley Community Safety Partnerships or its agencies.

1.15 Dissemination

1.15.1 Once finalised by the Review Panel, the Executive Summary and Overview Report was presented to the Bexley Community Safety Partnership for their endorsement and thereafter sent to the Home Office for quality assurance and approval for publication.

1.15.2 The following individuals and organisations will receive copies of this review:

- The victim's family
- Agencies directly affected by this review
- Bexley Community Safety Partnership and its agencies
- Metropolitan Police Commissioner
- Deputy Mayor for Policing and Crime in London
- The Domestic Abuse Commissioner for England and Wales

1.15.3 The recommendations will be owned by Bexley Community Safety Partnership with the Community Safety Team being responsible for monitoring the recommendations and reporting on progress.

2. Background Information

2.1 The Homicide

2.1.1 At 21:18 hrs on the evening in September 2020[13], emergency services were called to LINDA's home address by a close member of the family who had visited the property concerned for the victim's welfare, as they had not been able to contact her by phone. She was found deceased.

2.1.2 A post-mortem later revealed that severe force had been used to inflict multiple serious fractures to the head and face resulting in catastrophic brain injury as well as injuries to the rest of her body. There were also at least four stab wounds to the neck which alone would have led to immediate and profuse bleeding, collapse and a rapid death. The cause of death was recorded as being from head and neck injuries.

2.1.3 DAVID had fled the scene and ordered a drink at a local public house, before being found walking through a local churchyard where he was arrested. He was taken to the police station and assessed by mental health clinicians who found that, whilst there was some evidence of delusional thoughts, no acute psychotic symptoms were detected: he had mental capacity and was fit to be interviewed. DAVID provided a written statement to the police saying he believed that he was, over the course of several months, drugged through his food and drink and through the air and that, in his view, his wife and their handyman were responsible for this. He considered that as a result of the drugging, he felt very unwell and was acting massively out of character.

2.1.4 Some weeks after being charged with the murder and held in custody, DAVID's mental health deteriorated, and he was transferred to a secure mental health facility under section 49 of the Mental Health Act 1983. Following assessment, the court accepted that he had been suffering from an abnormality of mental functioning at the time of the killing with medical opinion stating that he was experiencing

> *"…a chronic psychotic state characterised by morbidly jealous and persecutory delusions. This psychotic state arose from an untreated medical condition, namely delusional disorder together with at least moderate depression. This abnormality of mental functioning substantially impaired his ability to form a rational judgement and to exercise self-control, and provides an explanation for his acts." (Judge Joseph's Sentencing Remarks).*

[13] Precise date redacted

2.1.5 DAVID pleaded guilty to manslaughter on the grounds of diminished responsibility and was sentenced to a Hospital Order to be detained in the secure mental health facility under section 37 of the Mental Health Act 1983 and a Restriction Order section 41 of the Mental Health Act 1983, to be detained without limit of time.

2.2 Background Information

2.2.1 LINDA was aged 66 at the time of her homicide and was enjoying retirement from her career in the financial sector. Her husband, DAVID, was aged 68 at the time of the homicide and had not yet retired. He was very successful professionally, with a senior role in a large telecommunications company, and was described as a 'workaholic'.

2.2.2 The couple had been married for 43 years and had no children. They lived in a large, detached, gated house and enjoyed a financially comfortable lifestyle. Friends, family and neighbours were interviewed for the criminal investigation, and all described the relationship as stable and caring. The couple were close to their small family with LINDA's elderly mother and sister, and DAVID's niece, each living nearby.

2.2.3 LINDA had had a slowly progressive form of multiple sclerosis for several decades but this generally did not require active medical treatment, although a flare of symptoms required her to present to the Emergency Department in 2017.[14]

3. Chronology

3.1.1 The couple had little contact with agencies beyond health matters.

3.1.2 Between 2016 and 2018, LINDA attended the Urgent Treatment Centre of Queen Mary's Hospital on four occasions, three of which related to possible injuries to her right arm, her toe and lastly to pain in one of her fingers after falling down the stairs. Whilst her explanations were consistent with the nature of the injuries, there was no indication in records that routine enquiry was undertaken about domestic abuse. Thereafter, she was seen by the Plastics and Hand Trauma Service of Guys and St Thomas's Hospital for surgery to her hand. This was followed by eleven months of occupational and physiotherapy. During this time, she explained to practitioners that the injury occurred when she had fallen on a marble floor and no further exploration of the possibility of domestic abuse was undertaken.

[14] Darent Valley Hospital. Dartford and Gravesend NHS Trust

3.1.3 It was not until 2019 that a change in DAVID's behaviour was observed by the couple's friends and family. In November 2019, DAVID picked up a text message which his wife had sent to him by mistake. He misconstrued the meaning of the text message, which was meant for their handyman, and wrongly concluded that his wife was having an extra-marital affair.

3.1.4 In March 2020, the nation went into 'lockdown' after the outbreak of the Coronavirus pandemic. The criminal investigation found that, as a result of lockdown, LINDA's family did not see her often but regularly spoke with her on the phone. From these calls, they understood that DAVID was not coping well with lockdown. He was described as being "down and sombre with no energy" and appeared agitated in circumstances that did not merit it. During this time, his morbid jealousy and paranoid beliefs grew. He believed that his wife had been for cheating on him for 19 years: that the handyman used the back staircase to gain access to his wife's bedroom; that she had sabotaged his car; that she was poisoning him; that she was trying to kill him; that she was trying to get the house 'in money' and was swapping his Rolex watches for fakes (Judge Joseph's Sentencing Remarks).

3.1.5 On 5th July 2020, DAVID attended the Urgent Care Centre of Queen Mary's Hospital complaining of various physical ailments, stress from work and relationship difficulties with his wife. He saw a GP and was diagnosed with likely hypertension. Although it was recommended that he attend the Emergency Department because of his high blood pressure, he declined and so was started on medication. His own GP was written to, in order to review his low mood and anxiety symptoms and to monitor his blood pressure and medication. Three days later, DAVID followed these concerns up with his GP and talked about the stress emanating from "issues with his wife" and a general feeling of anxiety.

3.1.6 On 22nd July 2020, DAVID went on to advise the GP of his unintentional weight loss, raising the possibility of an unknown cancer, and he was referred for rapid investigation to the Rapid Access Clinic of Guy's Hospital. It was noted that the threat of cancer raised the perpetrator's anxiety, and he phoned the GP again eight days later to see if the appointment could be brought forward.

3.1.7 On 27th July 2020, DAVID referred himself to Bexley MIND and they had a 30-minute telephone conversation with them three days later. He disclosed that he wanted support to deal with anxiety and to help deal with his wife's affair. He was assessed as suitable for counselling and an appointment was arranged for three months later in October 2020. Within this waiting period, DAVID had access to emergency advice as well as additional support from the Recovery College which offered wellbeing workshops, activities and support, and the Crisis Café, which gave direct access to mental health workers every evening, between 6pm-10pm.

3.1.8 Around 9am on 4th August 2020, their handyman attended the couple's home to carry out pre-planned maintenance work and he was assaulted. DAVID swiped at him with metal grips, causing a minor injury, took his mobile phone and began chasing him. When the doors were locked on DAVID, he began to smash windows with the crowbar tool that he was carrying.

3.1.9 The victim ran out of the front of the house shouting for help, followed by the handyman, by which time other neighbours had come out of their houses and into the street. All parties shouted for the perpetrator to drop the crowbar, which he eventually did and fled the scene. The Police arrived and searched the house and out-buildings but were unable to find him as he appeared to have climbed over the rear fence into the woods.

3.1.10 Although both LINDA and the handyman declined to provide evidential statements or support the prosecution of the perpetrator, LINDA completed a DASH[15] risk assessment with the police where she disclosed her husband's unsubstantiated jealousy about the affair that he thought her to be having, and his declining mental health. She clarified that her husband had never hit her but that he had recently and, on a couple of occasions, restrained her quite hard by holding her wrists and arms. She also said that her husband would call her several times when she was out and that he had also confiscated her car keys, money and bank cards, which was out of character. Her husband had also on more than one occasion accused her of taking alcohol from the garage and he also believed that he had cancer but would not go to the doctors for an assessment. She was offered referrals to domestic abuse services which she declined.

3.1.11 The Police created two crime reports for the two respective victims and undertook intelligence checks, which showed no previous reports of domestic abuse. LINDA was provided with crime prevention advice. She advised the police that she intended to temporarily move in with her mother, who lived nearby, whilst she arranged for her house to be secured by a private contractor. An area search for the perpetrator was undertaken and he was listed as a medium risk outstanding suspect as well as a medium risk missing person due to the concerns put forward about his mental health. At 16.58hrs LINDA contacted the police to advise that her husband had turned up at her mother's address and whilst "he wasn't causing any trouble" she alerted them to the fact that he was a missing person and may need to be sectioned. The call was graded as 'Significant' which requires attendance within one hour. However, officers did

[15] Domestic Abuse, Stalking and Harassment and 'Honour Based Violence' (DASH, 2009) Risk Assessment Checklist

not arrive until 19:16hrs as there was a high demand for prioritised responses at the time.

3.1.12 DAVID was arrested for common assault against the handyman and affray against his wife. However, during the booking in procedure at the custody suite, DAVID became volatile and tried to snap his wrists in the handcuffs that he had been placed in. He informed police that he had mental health issues, had attempted suicide in the previous year and had very high blood pressure. As a result, he was seen by a doctor who assessed that an appropriate adult was not required for interview. DAVID informed the doctor that he was totally at a loss as to how to get through the day without his wife and the doctor recorded that the perpetrator had anxiety and depression, with the possibility of very early cognitive decline.

3.1.13 A psychiatric liaison nurse in the custody suite[16] went on to speak with DAVID before his interview who explained that during recent weeks, he had started to get shaking movements in his hands and had been prescribed medication for very high blood pressure from Queen Mary's Hospital who, he claimed, also identified that he might be suffering from anxiety and depression. DAVID advised that he had also spoken to his GP a week before as he believed he had bowel cancer and there was a plan for further investigation. He highlighted that he had lost weight: dropping from fourteen to twelve stone and was experiencing problems with concentration and memory. The psychiatric liaison nurse observed that DAVID had capacity, was not acutely unwell and not at immediate risk to himself.

3.1.14 DAVID declined to comment in interview with the police and, due to the judgement that there was insufficient evidence to support a realistic prosecution at court, the matter was reviewed by a Detective Sergeant and closed with no further action taken. This decision was supported and authorised by a Detective Inspector.

3.1.15 LINDA was seen by specialist safeguarding police officers and stated that she did not want her husband to return to their home address but did want him to get some help for his mental health. On being released on 5th August 2020, the perpetrator agreed to stay at a hotel to give his wife some space.

3.1.16 A RARA[17] closing risk assessment was set at ‘standard risk’ by the police who recorded that the threshold was not met for a Domestic Violence Protection Notice (DVPN) and no request was made for a panic alarm or instruction to Treat All Calls as Urgent (TACU). The report recorded that the victim was satisfied with the police action and no further action was taken at her request.

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[16] Clinical services in the custody suites are commissioned by Metropolitan Police Service

[17] Risk Management Model used by the Metropolitan Police in conjunction with the DASH Risk Assessment. RARA stands for remove, avoid, reduce or accept risk.

3.1.17 Later that day, the GP phoned the couple's home to talk with the perpetrator regarding his recent referral to hospital, but LINDA answered the phone and recounted her husband's abusive behaviour and how she had had to throw him out and board up the house. She was clear that she did not want to have him back. The victim declined support and was advised that she could ring back at any time or contact social services for safeguarding.

3.1.18 DAVID went to stay at the hotel for about five weeks, during which time he remained in contact with LINDA, and they occasionally met for a meal, although always in the company of others. These were described as unhappy and fractious occasions, at which DAVID, clearly agitated, would repeat increasingly wild allegations against his wife saying that she was interfering with his car, and with his credit cards, and attempting to poison him with carbon monoxide in his hotel room.

3.1.19 On 11th August 2020, DAVID attended the Urgent Treatment Centre and saw the GP there, firm in his belief that his wife was trying to poison him and asking for a blood test to confirm poisoning. He stated that she would cook the food, serve it and then make an excuse to throw hers away. He claimed to be experiencing increased fatigue, constipation and affected skin in his hands after eating the food that she prepared. He was examined by a GP who diagnosed anxiety with paranoid delusions and was asked to attend the Emergency Department for a same day mental health assessment, which he declined. The doctor told him that there was no facility to undertake a blood test at the centre and wrote to DAVID's GP to ask for an urgent assessment of his mental health.

3.1.20 However, shortly afterwards, DAVID did attend the Emergency Department of the Queen Elizabeth Hospital stating that he was being poisoned by his wife from whom he had separated but who was continuing to bring him meals.[18] He initially expressed concerns that people were watching him and threatening to call the police but denied any mental health concerns, depression, confusion, suicidal or paranoid thoughts but declined a referral to the mental health team and later denied that people were threatening him. A blood test was completed which was normal and there were no other indicators of poisoning. He was diagnosed with kidney stones[19] and was discharged with the invitation to return if he was feeling paranoid, depressed and would like some help from the mental health team.

3.1.21 On the same day, a member of the perpetrator's family contacted the GP by email to voice concerns over the perpetrator's erratic behaviour and alerting them to the

[18] The review was unable to establish whether LINDA was taking him meals or whether this formed part of his delusions, although it appeared unlikely as he was staying in a hotel.

[19] The diagnosis was renal/uretic colic due to a stone

psychiatrist involvement and the need for the perpetrator to be restrained when he was arrested. Mental health services were not made aware of this contact.

3.1.22 On 19th August 2020, DAVID had a telephone consultation with the GP who invited him to discuss his mental health, but the perpetrator denied any mental illness and refused a referral for a psychiatric assessment. The GP did not consider that DAVID was so unwell that he could be sectioned under the Mental Health Act and consequently, DAVID's consent and engagement would have been needed for an effective referral.

3.1.23 On the same day, DAVID attended a consultation at Guys and St Thomas's Hospital under the Rapid Diagnostic Pathway in respect of his unintentional weight loss. Although the consultant observed no obvious signs of underlying symptoms, several tests were undertaken. However, in response to DAVID's disclosures of being poisoned, the consultant suggested that the GP make a referral to mental health services. During the consultation, DAVID advised that he was consuming four units of alcohol per day, which was a recent reduction, and he was intending to continue to reduce his intake.

3.1.24 On 27th August 2020, DAVID contacted the GP again by telephone and agreed to a psychiatric referral being made on his behalf. At the time, DAVID denied delusions, hallucinations, thought disorders or intentions to harm himself or others. Nevertheless, an urgent referral was made for a mental health assessment.

3.1.25 On 28th August 2020, the Older Adults Community Mental Health Team received the referral for DAVID from his GP. The referral was screened that day by a community psychiatric nurse who attempted to contact him by phone a number of times before the bank holiday and before eventual speaking with him on 1st September where he was invited to an initial assessment on the following day.

3.1.26 At the assessment DAVID was initially unsettled and concerned that he would be "locked up". However, the community psychiatric nurse was able to reassure him and conduct the assessment on the condition that the door of the interview room was left open. DAVID went on to explain that his wife had been bullying him during lockdown. He said that she had dropped food on him and made hurtful comments such as wishing that he had cancer. He reiterated his belief that his wife was having a long-standing affair with a builder and advised that he had moved out of their home approximately five weeks earlier. He went on to report that he had become increasingly anxious during lockdown; was finding it difficult to concentrate; felt tired and shaky and had a poor appetite. When asked about suicidal thoughts, DAVID wanted to leave the room but did go on to deny any suicidal thought or intent.

3.1.27 The mental health nurse formed the impression that DAVID was extremely anxious and there was likely development of dementia. The risks that he posed to self and others, and from others, were deemed by the nurse to be low. The plan was to discuss the

assessment with the multi-disciplinary team (MDT) during the next meeting on 9th September and for a care co-ordinator to be allocated at that point.

3.1.28 On 1st September 2020, the Advanced Nurse Practitioner from Guy's Hospital telephoned DAVID to advise him that investigations had revealed diverticulosis rather than cancer and he was given dietary advice. His alcohol reduction was discussed further and DAVID advised that he had seen the psychiatrist, but they had "not helped much". DAVID was discharged from Guys and St Thomas's Rapid Diagnostic Clinic and a discharge letter was sent to the GP recommending psychiatric input. This was received four days late.

3.1.29 Whilst DAVID was in the hotel, LINDA became increasingly concerned about her husband's mental condition which appeared to be deteriorating markedly. He said that he was feeling "very, very low". And he kept forgetting and repeating things. LINDA was concerned that her husband was not eating properly or looking after himself. He began to appear unkempt and was losing weight.

3.1.30 She eventually decided to let him back into the house on 7th September, although it was clear to her family and friends that she was very uneasy about doing so. Indeed, family members had been keen that LINDA did not take DAVID back. When it was clear that this was going to happen, they helped her to install a lock on her bedroom door and gave her an emergency phone to hide in her room. LINDA agreed that she would not cook for DAVID given the accusations he had been making about her trying to poison him.

3.1.31 Following his return, LINDA had told a close friend that her husband had been behaving strangely and that things had been "awful", although she went on to tell a member of the family that things were not too bad. Later that evening family members became concerned when they were unable to contact LINDA and called round to the family home to find her deceased.

4. Overview of Agency Involvement

4.0 This section considers the Individual Management Review and Information Reports completed by individual agencies and the outcomes of discussions with the review panel concerning improvements to services in the future.

4.1 Metropolitan Police

4.1.1 Prior to the killing, the police had only one contact with the couple concerning domestic abuse. This incident was considered by the police to be relatively straightforward and did not proceed through insufficient evidence: neither LINDA nor the handyman wanted DAVID to be prosecuted nor were prepared to provide statements, and the neighbours had not witnessed the assault itself. The incident was investigated by safeguarding officer and both the DASH and RARA risk assessments were completed. However, LINDA made a number of disclosures concerning her husband's concerning recent and escalating behaviour, but it was his deteriorating mental health that appeared to dominate her concerns.

4.1.2 However, LINDA also disclosed that her husband had confiscated her bank cards, money and keys. Although she said that he was acting out of character, opportunities to explore the impact of this economic abuse were not taken up. It was reflected by the police that the relative affluence of the couple and the dominant concerns of the victim about the perpetrator's mental health may have masked the need to do so. Economic abuse being concealed by affluence is an issue which will be picked up for all agencies below.

4.1.3 The police had been alerted by the victim to the perpetrator's worsening mental health and changing behaviours and his anxiety and depression were considered by clinicians prior to his interview. In these circumstances, police procedure would have required that an Adult Merlin report, featuring his mental health concerns, be shared with partner agencies and particularly his GP. A recommendation has been made that:

- Officers in charge and their supervisors in this case should be reminded of their responsibilities under the Vulnerable Adult assessment Framework (VAF) and the criteria for Adult Come to Notice (ACN) Merlin reports.

4.1.4 The police also recognised that there had been a seventeen-day delay in recording the secondary investigation on the domestic abuse crime report and that the risk assessment was not updated before closing the report. Had the risk assessment been updated, this would have given the police the opportunity to discuss any changes in circumstances with LINDA and for the safeguarding measures to be reviewed. A recommendation has been made that:

- Officers in charge and their supervisors should be reminded that reports should be updated within a timely fashion and of secondary risk assessment responsibilities.

4.1.5 In the intervening time, the need to complete MERLIN reports for suspects in custody had featured in previous domestic homicide reviews involving the Metropolitan Police Service, and actions have been undertaken by the police to ensure that MERLIN Pre-Assessment Checklist reports were being completed in circumstances which would warrant information sharing with partners. As a result, actions from the previous reviews included: updating of the Force's Custody Policy for Vulnerable Adults and Protection for Adults at Risk; training to raise awareness of officers' responsibilities in the application of the Vulnerable Adult Assessment Framework and dip sampling of cases to ensure MERLIN reports for information sharing with partners was being appropriately undertaken. This assurance was noted by the panel.

4.2 The GP Practice

4.2.1 The couple had been known to the GP, who was the safeguarding lead for the practice, for 20 years. LINDA had attended periodically, mainly consulting over the neurological symptoms of her slowly progressive form of multiple sclerosis. The GP had come to know LINDA reasonably well and considered her to be self-confident and always clear about what she wanted from medical consultations. She was usually seen alone and had opportunities to discuss any concerns that she may have had as a result. Prior to the period under consideration, she did not present with any conditions that may have been indicators of domestic abuse and therefore direct questioning around domestic abuse would not have been required.

4.2.2 However, the GP Practice reflected upon the telephone conversation that had taken place with LINDA after her husband had been arrested in August 2020. As the police were already involved and LINDA had already made protective arrangements, it was recognised that assumptions had been made that she was safe. They have recognised that this was a missed opportunity to meaningfully discuss the benefits of a referral to Solace Women's Aid with the victim and for the completion of a DASH assessment to ensure that all safety concerns were being considered.

4.2.3 DAVID rarely attended the surgery prior to the period under consideration. However, when he did attend and disclosed his suspicions of being poisoned, the GP did not identify this suspicion as a potential indicator of domestic abuse as much as an indicator of deteriorating mental health.

4.2.4 The review panel heard the challenge that is posed for professionals when someone with mental health issues declines further assessment. Following the letter being received from a family member, the GP made an assessment of DAVID's capacity to decline further intervention and identified that his condition had not met the threshold for his detention under the Mental Health Act which would be enacted if he required urgent

treatment and was considered to be a risk of harm to himself or others. The GP reflected that the focus was on the well-being of DAVID and his mental health whilst further consideration was needed regarding the impact of DAVID's refusal of help, particularly as previous disclosures of domestic abuse had been made by that time.

4.2.5 As a result, the GP Practice has made recommendations to develop a standalone domestic abuse policy and provide procedures, advice and training for the practice concerning:

- How to use routine enquiry to invite disclosure and raise concerns of domestic abuse
- Implement the use of 'STARE Lanyards' for practice staff, enabling identification of domestic abuse and effective referral to specialist domestic abuse services. The STARE acronym has been developed by Dr Jane Monkton Smith as part of the Domestic Abuse and Stalking Reference Tool (DART) and has been adopted by the London Borough of Bexley Community Safety to support the development of routine safe enquiry into domestic abuse in the local area.
- How to safely enter information into patient's individual notes including the use of the "confidential tab" in the medical records so it would not be visible online access and to ensure it is omitted from disclosure if insurance companies or others ask for a release of medical records, when it would be inappropriate (containing third party information) or potentially dangerous if disclosed
- Introduce "pop up alerts" to case notes enabling future contact to alert another doctor to potential issues
- Training for staff regarding indicators of domestic abuse including allegations of poisoning
- Training for staff on how to address the risk posed to others by a patient's deteriorating mental health
- Introduce the role of domestic abuse champion into the Practice

4.2.6 The GP Practice also considered that misconceptions may also have been held concerning domestic abuse amongst older people and have made recommendations to raise awareness on this issue which is considered further for all agencies below.

4.2.7 The Clinical Commissioning Group considered that the issues and recommendations raised for this particular GP Practice would likely be applicable to the wider practices within the Group and these issues are considered further in the thematic section which follows.

4.3 The Hurley Group GP NHS Partnership

4.3.1 The Hurley Group is an NHS organisation that runs a number of GP practices and Urgent Treatment Centres, and provides walk-in GP services, across London. The victim and her husband attended the Group's Urgent Treatment Centres at Queen Mary's Hospital, Sidcup and Erith District Hospital as well as attending the GP Out of Hours service at the Sidcup hospital.

4.3.2 In response to LINDA's attendances, she was known to suffer from multiple sclerosis, and it was evident that the impact of this diagnosis was taken into account in the responses that followed. However, it was not evidenced that questions about domestic abuse were made on the three occasions when LINDA attended with injuries. It was considered that LINDA's age may have had a bearing on the lack of routine enquiry undertaken.

4.3.3 In respect of DAVID's two attendances in the months before the homicide, DAVID complained each time about "relationship difficulty" and its impact upon his health. By the second presentation in August 2020, these difficulties had escalated to DAVID's fears of being poisoned by his wife and resulted in the doctor recommending that DAVID attend the Emergency Department for a same day mental health assessment. However, the records did not include a statement on mental capacity and risk, should the individual decline to attend, as in this case, and it was not documented how the risks to himself, or others, were explored. DAVID's paranoid beliefs about his wife poisoning him made the need to explore and document risks to others particularly pertinent and are picked up for all agencies in the thematic section which follows.

4.3.4 When DAVID declined, the doctor recorded the need for follow-up on the discharge notes which would be forwarded to DAVID's GP within 48 hours. However, in the circumstances, where a same day mental health assessment was considered to be warranted, it was considered that the need for follow-up should have been highlighted and escalated to DAVID's GP with greater urgency. The follow-up process in mental health cases has since been strengthened to ensure that clinicians will be expected to make contact with the duty doctor either by telephone or secure email and to send a set of clinical notes. Training has been undertaken to embed this change in practice.

4.3.5 As a result of this review, the Hurley Group are undertaking a review of adult safeguarding and domestic abuse policies and procedures. This will include:

- The introduction of policy and procedures on routine/targeted enquiry where indicators of domestic abuse are present
- The introduction of a system prompt if a patient has attended with a previous injury
- The introduction of a standalone domestic abuse policy
- The relationship between mental health and domestic abuse to be included in both safeguarding and domestic abuse policies

- A mandatory question on mental capacity to be added to the clinical assessment of all adult presentations to the unit
- Documentation of domestic abuse in the clinical notes accompanied by quarterly audit of compliance

4.3.6 It was noted as good practice that the Hurley Group have adopted the Bexley Domestic Abuse Champions scheme and the multi-agency training on domestic abuse that accompanies it. The role of the Champions scheme is discussed further in this report

4.4 Oxleas NHS Foundation Trust

4.4.1 Oxleas NHS Foundation Trust provides mental health services in Bexley comprising of community-based assessment and intervention, as well as acute and crisis services. Their Older People's Mental Health Team is a multi-disciplinary team comprising community psychiatric nurses, occupational therapists, psychological therapists and support staff. This team received an urgent referral for DAVID from his GP at the end of August 2020, shortly before the homicide.

4.4.2 DAVID was assessed by the duty community psychiatric nurse quickly after contact had been made, in line with policy timeframes and the urgent nature identified by the GP. Although, the GP had requested an assessment, and there being flags indicating acute mental illness, including the presentation of paranoia, delusional thinking, allegations of abuse and physiological changes including changes to sleep patterns and appetite, the initial assessment had indicated the development of dementia and therefore the need for a psychiatrist review was not indicated.

4.4.3 The nurse found it very difficult to manage the assessment as DAVID was very hesitant to engage and much effort was put into encouraging him to stay and complete the assessment. This challenge framed much of the interaction which followed, including the difficulty in assessing the risks posed and address the safeguarding concerns. It was understood that risk was minimised as DAVID had informed the nurse that he had left the family home a number of weeks earlier. The Trust reflected that the risk assessment did not appear to have taken full account of the significant changes in social circumstances that had recently occurred and the strain upon his physical and mental well-being that could be resulting from recent events of moving out of his home and the disclosures of abuse. Indeed, consideration did not appear to have been given to the risks associated with domestic abuse from separation. Likewise, the brevity of the assessment meant that practitioners did not have the opportunity to explore any further his disclosures about poisoning, bullying and his wife's control of the household finances and there were plans to explore these disclosures further at their next meeting. However, whilst risk factors were recorded in the case notes, the assessment was not documented in line with Trust policy. A recommendation has therefore been made that the Trust's

clinical risk assessment and management policy should be adhered to enabling a detailed formulation of the presenting risk and ensuring that key documentation on risk to self and others is reviewed as part of clinical supervision and in multi-disciplinary discussions.

4.4.4 In response to the domestic abuse which was raised as an issue in the initial assessment, the Trust has recommended that consideration of domestic abuse needs to be undertaken within the initial assessment and information on local domestic abuse services to be provided to service users. It was recognised that this needs to happen even when the brevity of an assessment means that the full experience of domestic abuse had not been possible to achieve, and the domestic abuse pathway enacted.

4.5 Lewisham and Greenwich NHS Trust

4.5.1 Lewisham and Greenwich NHS Trust provides the Emergency Department of Queen Elizabeth Hospital, which DAVID attended in August 2020 with various paranoid thoughts. Although a blood test was undertaken to rule out the possibility of poisoning, consideration had not been given, in the absence of being party to any other background information, to the possibility that DAVID may himself have been experiencing domestic abuse and no questions of that nature were therefore routinely asked. It was reflected that there may have been barriers to the consideration of the possibility of domestic abuse given DAVID's sex, age and mental health presentation and have committed to raise awareness around male victims of domestic abuse. Although the Trust were able to demonstrate significant recent efforts to support staff in their response to safeguarding and domestic abuse, as well as re-introduce the Independent Domestic Violence Advisor (IDVA) for both of its Emergency Department sites, they have made recommendations for themselves to:

- Develop separate bespoke clinical policies for domestic abuse and for supporting staff experiencing domestic abuse
- Provide specialist standalone domestic abuse training at Level 3 in addition to that which is already provided under Level 3 adult safeguarding training. This training will include identifying and responding to risk of DA from patients with paranoid delusions
- Raise awareness of male victims of domestic abuse
- Audit triage questions to ensure routine enquiry on domestic abuse

4.5.2 The Trust also reflected that once the possibility of poisoning had been ruled out, that advice could have been sought regarding DAVID's mental health from the onsite mental health team. Moreover, there was no evidence that his mental capacity or risk, to self or others, had been assessed which may have supported a referral to mental health or

other agencies. Mental Capacity Act training is mandatory for all clinical staff in the Trust and 90 per cent of staff are compliant with this mandatory training. In order to strengthen the procedure, the Trust has recently introduced a revised mental capacity assessment form within its electronic patient record, whereby all patients will have a mental Capacity Assessment on admission and if identified that they have no, or fluctuating, capacity, it will be repeated as necessary. A Mental Capacity Audit will be completed shortly to provide assurance of compliance with the procedure.

4.5.3 Although there was no record to show that DAVID had been referred to the GP for follow-up of his mental health concerns, the Trust recognised that they routinely send patient's discharge summary and follow up requests to the GP. They have nevertheless added this as a matter for safeguarding assurance.

4.5.4 It was noted as good practice that the Trust were implementing routine enquiry in domestic abuse across the whole assessment process, including Emergency Departments, wards and specialist out-patient environments within their hospitals. This will embed routine enquiry beyond the expectations of routine enquiry only at the front-line of health services. This too will be a matter for safeguarding assurance

4.6 Guys and St Thomas's NHS Foundation Trust

4.6.1 DAVID had one assessment with the Rapid Access Diagnostic Clinic of Guy's Hospital in respect of his unintentional weight loss. His pathway through the service was described as fairly typical, having tests and investigations that were standard for his presentation. However, when the clinician heard DAVID's concerns regarding poisoning, the discharge letter to the GP suggested a referral to mental health services. It was not considered to be standard practice for consultants to telephone GPs over such matters but had the need been considered urgent, then it would have been expected that the patient would have been encouraged to attend the adjacent Emergency Department and walked over if necessary. DAVID's need was not considered imminent on this occasion.

LINDA was treated by the Trust's Plastics and Hand Trauma Service over a period of eleven months for injury to her hand. Her explanation for the injury was taken at face value with no further exploration of the possibility of domestic abuse. However, as specialist health services there is currently no formal expectation around routine enquiry into domestic abuse as there is for front-line health services and this issue discussed further below. However, the Trust was able to demonstrate that all staff had attended mandatory training on the identification of domestic abuse and how to respond, and access to specialist training from MOSAIC Women's Wellbeing Centre who provide the Independent Domestic Violence Advisors who were located on site.

4.7 BMI Blackheath Hospital

4.7.1 LINDA was seen by a consultant at Blackheath Hospital, an acute independent hospital, in 2019 in relation to unrelated health matters. Standard investigations were conducted following questions being asked during pre-assessment screening. Whilst the health matters are not relevant to the review the screening tool included questions on mental health but not routine questions on personal safety.

4.7.2 The BMI has considered that routine questioning around personal safety would be a useful addition to the patient assessment process across all patient admission types and is reviewing standard paperwork for this to be added. This improvement will be made across multiple hospitals within the company and is seen as good practice. Moreover, BMI will henceforth be invited to the Health Sub-group of the local domestic abuse partnership.

4.8 London Ambulance Service

4.8.1 Prior to the fatal event, the Ambulance Service attended only the one incident in relation to the couple in August 2020. The police were already on the scene when the ambulance arrived, and the crew were alerted to the allegations that DAVID had assaulted LINDA and others. However, there was no documentary evidence of the conversations held between ambulance staff and therefore no indicator of whether LINDA met the 'Adult at Risk' criteria and if a safeguarding referral was required. The Service have provided feedback to the crew concerned and reinforced the need for accurate and full documentation.

5. Analysis and Lessons to be Learnt

5.0 Following on from consideration of individual agencies responses, this section explores the thematic, multi-agency and system analysis that arises from the circumstances leading to LINDA's homicide.

5.1 The extent of domestic abuse

5.1.1 A key function of domestic homicide reviews is to contribute to a better understanding of domestic violence and abuse (Section 7, Multi-Agency Statutory Guidance, 2016). Tragically, it will never be possible to know the full extent of LINDA's experiences of abuse. However, we have seen that in recent times LINDA was subject to:

- Physical restraint whereby, her husband had restrained her by holding her wrists
- Emotional abuse whereby her husband repeatedly subjected her to accusations of having an extra-marital affair, allegations of poisoning him and stealing alcohol
- Having her movements monitored whereby her husband contacted her repeatedly when she was out
- Economic abuse whereby her husband had stolen and confiscated her bank cards, money and car keys.

5.1.2 It appeared that DAVID's abusive behaviour was relatively recent, starting in late 2019, and thought, by all concerned at the time, to be connected to his deteriorating mental health. The review found no indication that there had been earlier domestic abuse or coercive control in the couple's relationship.

5.1.3 It was reassuring to see that a domestic abuse risk assessment was undertaken in the only incident reported to the police and, despite the fact that the victim was attributing her husband's recent uncharacteristic behaviour to his declining mental health, that offers to refer to domestic abuse services were nonetheless made. In this way, the victim was provided with an opportunity to consider and define her husband's behaviour as abusive.

5.1.4 Nonetheless, the review considered that there were missed opportunities to explore the nature of this abuse and its impact upon the victim. The panel also sought to understand more about the relationship between mental ill-health and domestic abuse in this case.

5.2 Economic abuse

5.2.1 Opportunities to explore the impact of economic abuse were not taken up when LINDA disclosed to the police that her husband had confiscated her bank cards, money and car keys. Research has found that it has not been unusual for economic abuse to have a relatively low regard for professionals. For example, Sharp-Jeffs and Learmouth (2017) highlighted research which found that police officers consistently ranked economic issues nearly bottom in terms of importance when assessing risk in domestic abuse cases (Robinson et al.2016). This was despite economic abuse featuring in one third of domestic homicides analysed by the Home Office (2016).

5.2.2 In this case, the victim was retired and was seen to be relatively affluent but her access to an independent income and her ability to use the economic resources of the household had not been determined. Economic abuse will often have the effect of creating financial dependency and restricting options for a victim, including preventing an individual from exiting a relationship and gaining support (Postmus, 2016). Withholding money, bank cards and car keys could be seen to have that effect. Although LINDA's progressive illness was not at a level that required active medical intervention, she will have been reliant nonetheless on the use of her car and the withholding of car keys was therefore seen as significant act of coercion: preventing her from leaving and isolating her from the assistance of family and friends at a time when isolation was exacerbated by the Covid pandemic.

5.2.3 In this way, it was reflected that the couple's wealth may have obscured the extent of the abuse. Research has shown that economic abuse, "…rarely takes place in isolation" (Sharp-Jeffs and Learmouth, 2017:4) and it is therefore important to understand the extent and significance of economic abuse to the victim in order for a risk assessment to be effective. The new definition of economic abuse within the Domestic Abuse Act 2021 requires that this attention be given more robustly in the future.

Learning Point: **Economic Abuse**

Practitioners need to be curious about the extent of economic abuse and its impact upon the victim, as a form of coercive control. A household's relative affluence could mask the fact that a victim's access to economic resources may nonetheless be restricted or controlled.

Recommendation 1: **Economic Abuse**

Bexley Community Safety Partnership should promote professional awareness of economic abuse as a method of coercive control within domestic abuse, together with the fact that economic abuse can happen irrespective of income and wealth. They

should seek assurance from its partner agencies that they have enacted the new definition of economic abuse within their policies and practice.

5.3 Separation and domestic abuse

5.3.1 One month before the homicide, the perpetrator was required to leave home and stay in a hotel. Although he was allowed to return a few days before the homicide took place, this separation was still seen as a key factor in the homicide.

5.3.2 Separation is widely known to be a key indicator and trigger of heightened risk of domestic abuse and domestic homicide. Over the past decade, nearly half (43%) of all women who were killed by a current or former partner were killed when they were taking steps to separate from them (Femicide Census, 2020). Typically, a perpetrator will refuse to accept their partner's decision to end the relationship and will be trying to regain their control over them (Stark, 2009). In this case, safety planning was undertaken with LINDA by the police, but it is not known whether the victim was aware of the heightened risk arising from separation. Indeed, separation is often viewed by professionals as a protective factor rather than one which heightens risk.

Learning Point: Separation and domestic abuse

Separation should be treated as a time of heightened risk. Nearly half of all women who are killed through domestic abuse were separating or trying to separate from their abusers. Victims need to be made aware of those risks when they are making plans to separate and rigorous safety planning and safety measures should be put in place at those times.

Recommendation 2: Separation and domestic abuse

Bexley Community Safety Partnership should promote the risks associated with separation in domestic abuse. They should seek assurance from partner agencies that victims are being made aware of those risks and ensuring safety planning and safety measures are being undertaken to mitigate those risks.

5.4 Routine enquiry within health

5.4.1 Health practitioners have a unique and privileged position in identifying domestic abuse. They are trusted professionals and will often be the first or only point of contact for domestic abuse victims seeking support (Home Office, 2021). Whilst it appeared that DAVID's abusive behaviour stemmed from the deterioration in his mental health in 2019, health agencies involved in this review identified that there had been missed opportunities to enquire about domestic abuse when the victim presented with injuries and vague symptoms before this time. There also appeared to have been missed opportunities to consider DAVID's concerns about being poisoned, prior to establishing that these stemmed from his paranoid delusions.

5.4.2 The National Institute for Health and Clinical Excellence (NICE) provides a list of conditions that are indicators of potential abuse and that should be used as health markers to prompt routine enquiry for key health services (NICE,2016). These form the basis of their Quality Standard for Domestic Abuse providing best practice in identifying, responding and supporting people experiencing domestic abuse (ibid). They align with the expectation that all health and social care agencies are making trained enquiries into domestic abuse to ensure that they are Making Every Contact Count[20] (Public Health England, NHS England & Health Education England, 2016).

Learning Point: Routine enquiry in health settings

Appropriate and sensitive routine enquiry should be standard practice across all front-line health and social care services that women with experience of abuse come in to contact with.

Recommendation 3: Routine enquiry in health settings[21]
Bexley Domestic Abuse Health Sub-Group should seek assurance from health agencies that routine or targeted enquiry into domestic abuse is standard practice across all front-line health services in line with NICE Quality Standard 116 and is accompanied by robust pathways into specialist services.

5.4.3 The review was reassured to find that domestic abuse training for health professionals featured in most of the health agencies' routine training programmes in keeping with

[20] Making Every Contact Count is an undertaking by health agencies to work together to maximise support for population behaviour change, and help individuals and communities significantly reduce their risk of disease. Further information can be found at https://www.england.nhs.uk/wp-content/uploads/2016/04/making-every-contact-count.pdf

[21] This recommendation features also in a soon to published local domestic homicide review which covered events of the same period.

national expectations contained within the Intercollegiate Documents for safeguarding adults and children (Royal College of Nursing, 2018).[22] At its most basic level, all front-line staff need to be trained how to ask about domestic abuse and respond to disclosure (Home Office, 2021)[23]. The review found that in Bexley, multi-agency training is also being provided by the local Partnership, and the local Domestic Abuse and Health Sub-Group was committed to adopting the Pathfinder Toolkit (2020) which aims to improve the capacity of health professionals to respond by establishing comprehensive health practice in relation to domestic abuse.

5.4.4 Most recently, Bexley has introduced a multi-agency Domestic Abuse Champions Network which, at the time of writing, has recruited 200 professionals across the statutory and voluntary sector. Their goal is to have at least two dedicated professionals within each partnership and agency who can act as champions around domestic abuse, offering support and signposting to other professionals. A continued programme of training will be delivered to support the Champions in their role and this approach was seen to be good practice in transforming the prioritisation of responses to domestic abuse across all agencies, including health.

5.4.5 Nonetheless, the panel noted that much domestic abuse training in local health services was included within mandatory safeguarding training. As such, there is a risk that the crucial elements of understanding the dynamics of coercive control and their impact upon risk may be diluted. Health practitioners recognised that as domestic abuse training was not mandated in NHS contracts, it was challenging to be able to organise bespoke training and release staff from their roles to undertake the training necessary to build their core competencies in this area.

Recommendation 4: Domestic Abuse Training in Health

The Home Office considers liaison with the Department of Health and Social Care and the Royal Colleges to provide a framework defining the level of domestic abuse education, awareness, competence correlating to job roles in health and social care, together with the domestic abuse training requirements for those roles.

[22] The Intercollegiate Document identifies the competencies health providers need in order to support individuals to receive personalised and culturally sensitive safeguarding, including domestic abuse. It sets out minimum training requirements along with education and training principles.
[23] This is referred to as Level 1 training for all front-line services within the Intercollegiate Document above

5.5 Domestic abuse of older women

5.5.1 Several agencies considered, on reflection, that assumptions made by professionals concerning the older ages of the couple may have provided barriers to their considering the possibility of domestic abuse and it was most likely this that led to missed opportunities for routine enquiry and exploration of domestic abuse with the victim.

5.5.2 Research before the Covid pandemic determined that ageing per se,[24] for those under 75, was not a significant risk factor but has shown that the assumptions, prejudices and stereotypes about older age, influence how agencies identify and respond to potential risk from domestic abuse (Benbow, 2018:18). Indeed, the All-Parliamentary Group on Domestic Violence and Abuse recognised that abuse amongst older generations can often be minimised or ignored (APPG, 2018). This is reflected in the comparatively low level of referrals that are made nationally to specialist domestic abuse services (SafeLives, 2016). At the same time, research has found that common generational attitudes mean that older women may be less likely to identify their experiences as abuse and less likely to want to discuss it with professionals, combining a "generational invisibility" with a "generational silence" (SafeLives, 2016:)

5.5.3 Research on the impact of Covid pandemic on domestic homicide has suggested that there has been a small but sizeable increase in the number and proportion of older victims and suspects of intimate partner homicide, bringing this concern even more to the fore (Bates et al, 2021). However, it was recognised that Bexley had already made strides to raise awareness of older women's experience of domestic abuse, culminating in a recent multi-agency conference, and therefore a recommendation is made for them to continue with these efforts.

Learning Point: Domestic Abuse and Older Women. A 'generational invisibility' and a 'generational silence.'

Practitioners need to be aware that domestic abuse occurs across the age span and that older women face additional barriers to understanding their experiences as domestic abuse and in accessing help including:

- Less likely to identify their experiences as domestic abuse
- Likely to have lived with abuse for prolonged periods before getting help
- Lack awareness of support services and less likely to want to discuss personal matters with professionals
- Face isolation and fear disrupting family dynamics

[24] Although ageing may be associated with a stronger prevalence of disability which does confer a greater risk from domestic abuse. Statistics on older people's experience of domestic abuse have been limited as the ONS data has not in the past systematically recorded domestic abuse in populations aged over 60.

- More likely to suffer from health problems, reduced mobility or other disabilities which can exacerbate their vulnerability to harm

Recommendation 5: Domestic Abuse and Older Women

Bexley Community Safety Partnership should continue to raise awareness with agencies and the public that domestic abuse occurs across the age span

The Partnership should seek assurance that partner agencies are working to effectively address the barriers that older women face, including challenging prejudice and stereotypes that restrict the options available to them.

5.6 Mental Health, Think Family and Caring Roles

5.6.1 Several thematic reviews into domestic homicide have highlighted the relationship between a perpetrator's mental ill-health and the homicide that they committed (Chantler et al, 2020; Home Office, 2014,2016; Montique, 2019; Neville & McDonagh, 2014; Robinson et al, 2018; Sharp-Jeffs & Kelly, 2016). Indeed, in the largest study of domestic homicide reviews in England and Wales, the perpetrator's mental health was mentioned in 65% of the cases (n=141) (Chantler et al, 2020). However, the degree of severity of mental illness varied considerably within this group, with only 18% of homicides being carried out by individuals experiencing episodes of acute mental illness t the extent a judgement of manslaughter with diminished responsibility could be determined (ibid).

5.6.2 These statistics tell us that, whilst mental ill-health may be a common factor in domestic homicide, mental illness is rarely itself the cause of the homicide or indeed the cause of domestic abuse. In this case, however, the criminal case determined that DAVID's deteriorating mental illness, in terms of his deepening low mood, fixed delusional beliefs and morbid jealousy, was the determining factor in the homicide. In sentencing, the Judge commented:

> *"Not only was this man palpably ill, but everyone knew it. It was apparent before and during the time he killed. It was equally apparent after his arrest and remand in custody when he was quickly admitted onto the healthcare wing at the prison. He was described as "very unwell at the time of admission and almost exclusively pre-occupied with persecutory delusions regarding his wife." (Judge Joseph's sentencing remarks)*

5.6.3 The panel heard how DAVID's mental health presentation was unusual and hard to assess. Whilst his condition deteriorated unusually rapidly, at no time, even after the homicide, was he floridly psychotic and it was several weeks after his arrest and

charge that he was needed to be transferred to a secure psychiatric unit. Nonetheless, there was an escalation of his help-seeking attendances and we have seen that there was a missed opportunity by the police to share information with mental health services and social care for support and follow-up after his arrest; a missed opportunity by the GP to share family's concerns with mental health services and, at times, a lack of urgency on the part of walk-in health services in raising the need for follow-up mental health assessments with the GP. Whilst DAVID's mental health deterioration was rapid, the picture of his increased attendances and help-seeking was not made apparent across agencies.

5.6.4 There also seems to have been little attention given by health agencies, in the few attendances of which they were aware, to the potential risk to LINDA arising from her husband's deteriorating mental health and increasingly paranoid beliefs about being poisoned by her.

5.6.5 It was recognised that the GP offered LINDA support during a telephone conversation a month before the homicide. However, it was not apparent that any other agency considered that LINDA may have had emerging caring responsibilities for her husband. This may well have been because the degree and length of agency involvement, when any caring role could be considered, was short.

Learning Point: Paranoid Delusional Beliefs and Risk to Others

Practitioners always need to be alert to the risk to partners, family members and carers where an individual's mental health is deteriorating, and paranoid delusional beliefs about them are emerging.

Learning Point: Carers

Practitioners need to be alert to the value of a carer's assessment where an opportunity to discuss a carers own needs and concerns as well as caring responsibilities could take place. In the context of domestic abuse, the opportunity for an informed carer's assessment could be vital.

5.7 The impact of the Covid pandemic

5.7.1 It is of significance that this homicide occurred during the unprecedented times of the Covid-19 pandemic: a period which has been described as an escalator and intensifier of domestic abuse (Bates et al, 2018). During the first year of the pandemic, Bexley saw a nine per cent increase in the number of domestic abuse incidents reported to the police and an alarming 39 per cent increase in the number of high-risk cases referred

to MARAC (London Borough of Bexley, 2021).[25] Although DAVID's paranoid delusions and accusations against his wife began some months before this time. There is no doubt that his mental health deteriorated, and his abusive behaviour escalated, following the national lockdown.

5.7.2 National reports recognised that access to mental health services was affected by the lockdown arrangements that had been put in place to manage the pandemic (Bates et al, 2021:8). This was not evidenced in this case. However, the bereaved family felt that David had been disadvantaged by not having seen his own GP face-to-face during the month before the homicide and following the concerns they shared with the practice. At this time the GP Practice was following the guidelines set out by the government in relation to the pandemic which involved, wherever possible, undertaking telephone appointments to minimise the spread of the pandemic. The review reflected upon this in detail and found that, during the month of August, David had been seen face-face by clinicians from a number of different agencies and none considered that his mental health had deteriorated to the extent that he should be detained under the Mental Health Act. His access to mental health services therefore depended upon gaining his consent, which once gained, was acted upon swiftly. The review therefore found no indicator that the services that either individual received had been adversely impacted by the pandemic in this case.

5.8 The Employer's Role

5.8.1 It was evident that DAVID had heavily invested in his career and it was therefore a shortcoming of the review not to have been able to engage his employer for this purpose. Indeed, despite the growing awareness of the role of employers in addressing domestic abuse within their workforce, private sector employers are not required by law to engage with domestic homicide reviews. Nonetheless, there are increasing opportunities and guidance being made available for employers to secure and strengthen their response to domestic abuse. Whilst this review is unable to comment upon the role of the employer on this occasion, it would be remiss not to draw attention to the guidance and growing expectations on all employers, given that the workplace had such a dominant place within DAVID's life. The need for this consideration has been made all the greater since the Covid pandemic which has, in many cases, blurred the line between home and the workplace and expectations of homeworking and hybrid working becoming the norm.

5.8.2 At the time of writing, Statutory Guidance for the Domestic Abuse Act 2021 remains in draft form (Home Office, 2021). However, the guidance draws attention to the duty of care that employers have in being able to identify and respond to domestic abuse

[25] Comparing the periods March to December 2020 with the same period in 2019

within its workforce and their role in raising awareness of domestic abuse and signposting those affected to support.

Recommendation 6: Employers Role in Responding to Domestic Abuse

That the Chair of Bexley Community Safety Partnership seeks assurance from the telecommunications company where the perpetrator worker, that it is aware of incoming expectations of employers to identify and respond to domestic abuse within its workforce and raise awareness of domestic abuse and the services that are available for those affected.

Recommendation 7: Employers Role in Responding to Domestic Homicide Review

That the Home Office considers strengthening the expectations of private sector employers to engage with domestic homicide reviews.

6. Conclusion

6.1.1 This review has considered the circumstances leading to the tragic homicide of LINDA and whilst agency involvement was brief, there have nonetheless been lessons to be learnt for all agencies. The review found of most significance: that economic abuse can be obscured by relative affluence; the need to reinforce awareness of the heightened risk of separation; the valuable role of health services in identifying and responding to domestic abuse; the need to identify domestic abuse for older women who face considerable barriers in identifying abuse and help seeking; the need to be alert to the potential risk to partners and carers when an individual's mental health is deteriorating; and the role of employers in preventing in domestic abuse.

6.1.2 The individual and multi-agency recommendations from this review will be monitored till completion by Bexley Community Safety Partnership and fed into the strategic domestic plan for the area in order to strengthen the multi-agency response to domestic abuse and seek to prevent domestic abuse in the future.

7. Recommendations

7.1 Multi Agency Recommendations

7.1.1 The Review Panel has made the following recommendations during this review in response to learning identified.

7.1.2 These recommendations are also presented in the multi-agency recommendation action plans which follow. Bexley Community Safety Partnership is responsible for overseeing then development and monitoring of an action plan.

7.1.3 **Recommendation 1**: **Economic Abuse**

Bexley Community Safety Partnership should promote professional awareness of economic abuse as a method of coercive control within domestic abuse, together with the fact that economic abuse can happen irrespective of income and wealth. They should seek assurance from its partner agencies that they have enacted the new definition of economic abuse within their policies and practice.

7.1.4 **Recommendation 2**: **Separation and domestic abuse**

Bexley Community Safety Partnership should promote the risks associated with separation in domestic abuse. They should seek assurance from partner agencies that victims are being made aware of those risks and ensuring safety planning and safety measures are being undertaken to mitigate those risks.

7.1.5 **Recommendation 3**: **Routine enquiry in health settings**

Bexley Domestic Abuse Health Sub-Group should seek assurance from health agencies that routine or targeted enquiry into domestic abuse is standard practice across all front-line health services in line with NICE Quality Standard 116 and is accompanied by robust pathways into specialist services.

7.1.6 **Recommendation 4: Domestic Abuse Training in Health**

The Home Office considers liaison with the Department of Health and Social Care and the Royal Colleges to provide a framework defining the level of domestic abuse education, awareness, competence correlating to job roles in health and social care, together with the domestic abuse training requirements for those roles.

7.1.7 **Recommendation 5: Domestic Abuse and Older Women**

Bexley Community Safety Partnership should continue to raise awareness with agencies and the public that domestic abuse occurs across the age span. The Partnership should seek assurance that partner agencies are working to effectively address the barriers that

older women face, including challenging prejudice and stereotypes that restrict the options available to them.

7.1.8 **Recommendation 6: Employers Role in Responding to Domestic Abuse**

That the Chair of Bexley Community Safety Partnership seeks assurance from the telecommunications company where the perpetrator worked, that it is aware of incoming expectations of employers to identify and respond to domestic abuse within its workforce and raise awareness of domestic abuse and the services that are available for those affected.

7.1.9 **Recommendation 7: Employers Role in Responding to Domestic Homicide Review**

That the Home Office considers strengthening the expectations of private sector employers to engage with domestic homicide reviews.

7.1.10 **Recommendation 8: Monitoring Outcomes from the Review**

Bexley Community Safety Partnership to provide feedback to the bereaved family in 6 months' time concerning the impact of the recommendations made, and actions undertaken, in this review

7.2 Single Agency Recommendations

7.2.1 The following single agency recommendations were made by the agencies involved and the associated actions for achieving them are featured in the action plans which follow. Agencies are responsible for providing evidence to Bexley Community Safety Partnership that they have progressed and completed the agreed actions within the timeframes specified.

7.2.2 **BMI Blackheath**

- Include routine questions on personal safety and domestic concerns on all assessment paperwork (applying to multiple hospitals)
- All clinical staff complete Safeguarding Vulnerable Adults 3
- All Consultants to complete Safeguarding Vulnerable Adults 3
- IMR to be presented anonymously at local Clinical Governance Meeting and at Regional Safeguarding Meeting

7.2.3 **Hurley Group (NHS Partnership)**

- To undertaking a review of adult safeguarding and domestic abuse policies and procedures, to include:
    - The introduction of policy and procedures on routine/targeted enquiry where indicators of domestic abuse are present
    - The introduction of a system prompt if a patient has attended with a previous injury
    - The introduction of a standalone domestic abuse policy
    - The relationship between mental health and domestic abuse to be included in both safeguarding and domestic abuse policies
    - A mandatory question on mental capacity to be added to the clinical assessment of all adult presentations to the unit
    - Documentation of domestic abuse in the clinical notes accompanied by quarterly audit of compliance

7.2.4 **Lewisham & Greenwich NHS Trust**

- Develop separate bespoke clinical policies for domestic abuse and for supporting staff experiencing domestic abuse
- Provide specialist standalone domestic abuse training at Level 3 in addition to that which is already provided under Level 3 adult safeguarding training
- Raise awareness of male victims of domestic abuse
- Audit triage questions to ensure routine enquiry on domestic abuse
- Consider the need for referrals to GP for follow-up of mental health concerns through safeguarding assurance
- consider recording of mental capacity and risk at safeguarding assurance

7.2.5 **Metropolitan Police**

- Officers in charge and their supervisors in this case should be reminded of their responsibilities under the Vulnerable Adult assessment Framework (VAF) and the criteria for Adult Come to Notice (ACN) Merlin reports.
- Officers in charge and their supervisors in this case should be reminded that reports should be updated within a timely fashion and of secondary risk assessment responsibilities.

7.2.6 **Oxleas NHS Foundation Trust**

- The Trust's Clinical risk assessment and management policy should be adhered to. This would include a detailed formulation of the presenting risk
- Consideration of domestic abuse within the initial assessment and information on local domestic abuse services to be provided to service users
- Ensure the team have access to Domestic Abuse training, including the 15 Domestic Abuse High Risk Indicators.
- Following initial assessments team members should discuss the outcome with a senior colleague to confirm the risks and plans

7.2.7 **The General Practice**

- To develop a standalone domestic abuse policy and provide procedures, advice and training for the practice concerning:
- How to use routine enquiry to invite disclosure and raise concerns of domestic abuse
- How to safely enter information into patient's individual notes including the use of the "confidential tab" in the medical records so it would not be visible online access and to ensure it is omitted from disclosure if insurance companies or others ask for a release of medical records, when it would be inappropriate (containing third party information) or potentially dangerous if disclosed
- Introduce "pop up alerts" to case notes enabling future contact to alert another doctor to potential issues
- Training for staff regarding indicators of domestic abuse including allegations of poisoning
- Training for staff on how to address the risk posed to others by a patient's declining mental health
- Implement the use of Solace Lanyards for practice staff
- Raise awareness of domestic abuse amongst older people
- Introduce the role of domestic abuse champion into the Practice

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Acronyms

AAFDA	Advocacy After Fatal Domestic Abuse
CCG	Clinical Commissioning Group
DART	Domestic Abuse and Stalking Reference Tool
DASH	Domestic Abuse Stalking and Harassment Risk Indicator Checklist
DHR	Domestic homicide review
GP	General Practitioner / Practice
IDVA	Independent Domestic Violence Advisor
IMR	Individual Management Review
LAS	London Ambulance Service
MPS	Metropolitan Police Service

Glossary

DASH Risk Assessment Model identifies three levels of risk that officers can make and determine on submission;

- Standard – Current evidence does not indicate likelihood of causing serious harm.
- Medium – There are identifiable indicators of risk of serious harm. The perpetrator has the potential to cause serious harm but is unlikely to do so unless there is a change in the circumstances.
- High – There are identifiable indicators of risk of serious harm. The potential event could happen at any time and the impact would be serious.