SAFER LEWISHAM PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

EXECUTIVE SUMMARY

Report into the death of Miss RH

June 2020

Independent Chair and Author of Report: James Rowlands

Associate, Standing Together Against Domestic Abuse

Date of Final Version: May 2024

Our sister was a beautiful person inside and out, brave, intelligent and an honest person. She was a Mother, Daughter, Sister, Aunt, Niece and Friend.

Our sister had an infectious laugh, was a good listener and a very loyal friend. She was a truly caring person and had many friends who valued their friendship with her. She loved going to parties, listening to music, and having a good dance. She loved the cinema and the theatre. She loved life. Our sister had a great memory and would always put us to shame remembering things that we never could. She had a great interest and knowledge of her culture and would always encourage us to do the same. She was very strong on education and would always encourage the younger members of her family to achieve their goals, no matter what and to believe in themselves.

Life will never be the same without her. She is dearly missed by family and friends.

Pen Portrait written by Miss RH's sisters

Executive Summary

1. Preface

1.1 The Review Process

1.1.1 This summary outlines the Domestic Homicide Review (hereafter 'the review') which examined agency responses and support given to Miss RH[1], a resident of Lewisham prior to the point of her death in June 2020. Miss RH was killed by her son, Elijah[2], who lived with her. In 2017, Elijah had first experienced a period of mental ill health. From March 2020 and through to the fatal attack on his mother, his mental health had begun to deteriorate significantly.

1.1.2 In approaching this case, the review will be mindful that Miss RH was killed by her son, so this is a case of Adult Family Violence (AFV). While there is no single definition of AFV, fatal AFV is generally accepted to involve a homicide between family members aged 16 years and older, including the killing of a sibling.[3]

1.1.3 Miss RH and Elijah's family have both described how they were as people, including providing a Pen Portrait of Miss RH, to help better understand them and their lives. These descriptions have emphasised the warmth of both Miss RH and Elijah and the part they both played in family life.

1.1.4 The Review Panel expresses its sympathy to the family of Miss RH for their loss and thanks them for their contributions and support for this process.

1.1.5 The following pseudonyms have been used in this review to protect the identities of the victim, those of their family members, other parties, and the perpetrator:

Name	Relationship to victim
Miss RH	Victim
Elijah	Son
Aurora	Sister
Grace	Sister
Evelyn	Sister
Friend 1	Friend of Miss RH

[1] Not her real name.

[2] Not his real name.

[3] Sharp-Jeffs, N. and Kelly, L. (2016) *Domestic Homicide Review (DHR) case analysis*. London: Standing Together Against Domestic Abuse. Available at: http://www.standingtogether.org.uk/sites/default/files/docs/STADV_DHR_Report_Final.pdf (Accessed: 31st January 2022).

1.1.6 Elijah was charged with the murder of Miss RH and later pleaded guilty to her manslaughter on the grounds of diminished responsibility. In January 2021, Elijah was ordered to be detained under Section 37 of the Mental Health Act (MHA) 1983 and under a Section 41 'restriction order' without the limit of time.

1.1.7 This review was commissioned by the Safer Lewisham Partnership. Having received notification from the Metropolitan Police Service (MPS) in June 2020, also in June 2020 a decision was made to conduct a review in consultation with Standing Together Against Domestic Abuse (hereafter 'Standing Together') and the Home Office was notified of the decision in writing in June 2020.

1.1.8 Standing Together was commissioned to provide an Independent Chair (hereafter 'the Chair') for this review in July 2020. The completed report was handed to the Safer Lewisham Partnership in October 2022. In September 2023, it was tabled at a meeting of the Safer Lewisham Partnership and signed off, before being submitted to the Home Office Quality Assurance Panel in the same month. In February 2024, the completed report was considered by the Home Office Quality Assurance Panel. In April 2024, the Safer Lewisham Partnership received a letter from the Home Office Quality Assurance Panel, approving the report for publication. The letter will be published alongside the completed report.[4]

1.1.9 Home Office guidance states that the review should be completed within six months of the initial decision to establish one. This timeframe was not met due to:

- The timeframe for the first panel meeting, which was set to allow all agencies to participate.
- The impact of the Covid-19 pandemic, which has affected the availability of some agencies. While this affected several agencies and led to the cancellation of one meeting, there have also been specific challenges in engaging with the South London and Maudsley Foundation NHS Trust (SLaM).[5] This included awaiting the completion of a Serious Incident report.
- To enable engagement with family and others.

1.2 Contributors to the Review

1.2.1 This Review has followed the 2016 statutory guidance for Domestic Homicide Reviews which was issued following the implementation of Section 9 of the Domestic Violence Crime and Victims Act 2004.

1.2.2 The Review Panel was comprised of agencies from Lewisham, as both victim and perpetrator were living in that area at the time of the homicide. Agencies were contacted as soon as possible after the review was established and asked to secure their records.

1.2.3 A total of seventeen agencies were contacted to check for involvement with the parties concerned with this review. Of these, four had extensive contact and were asked to submit

[4] For more information, see the Overview Report.

[5] SLaM provides mental health services for people in the London boroughs of Croydon, Lambeth, Southwark and Lewisham, as well as substance misuse services in Lambeth, Southwark, Bexley, Greenwich and Wandsworth, and specialist services for people across the UK. For more information, go to: https://www.slam.nhs.uk.

Individual Management Reviews (IMRs) and a chronology. Six had more limited contact and submitted a Short Report or Summary of Engagement. One of these agencies was the Approved Mental Health Professional (AMHP) service[6]. During the review, it was identified that the AMHP service needed to provide a stand-alone submission, in addition to information that had already been provided by South London and Maudsley Foundation NHS Trust (SLaM)[7] in its IMR and the Serious Incident Report. Consequently, the AMHP service provided a Short Report as a supplement to the submissions by SLaM. A narrative chronology was also prepared.

1.2.4 The following agencies were contacted, but recorded no involvement with Miss RH or Elijah:

- Athena service.[8]
- Change Grow Live (CGL).
- Lewisham Council Children Services.
- London Community Rehabilitation Company (CRC).[9]
- Probation Service.
- Victim Support.

1.2.5 The following agencies and their contributions to this review are:

Agency	Contribution
Lewisham Adult Social Care, AMHP service	Short Report and Chronology
King's College Hospital NHS Foundation Trust (KCH)[10]	Summary of Engagement
Lewisham Adult Social Care	Short Report and Chronology
Lewisham and Greenwich NHS Trust (LGT)[11]	IMR and Chronology
Lewisham Council Housing Needs Department (including the Single	Short Report and Chronology

[6] The AMHP service is provided by Lewisham Council and is responsible for coordinating and completing assessments under the Mental Health Act 1983 (MHA). SLaM and Lewisham Council operate integrated adult mental health services. This means the AMHP Service operates from the Ladywell Unit, a SLaM hospital site, and uses SLaM IT systems for case recording

[7] SLaM provides mental health services for people in the London boroughs of Croydon, Lambeth, Southwark and Lewisham, as well as substance misuse services in Lambeth, Southwark, Bexley, Greenwich and Wandsworth, and specialist services for people across the UK. For more information, go to: https://www.slam.nhs.uk.

[8] Provided by Refuge and supports people in Lewisham who experience gender-based violence. For more information, go to: https://www.refuge.org.uk/our-work/our-services/one-stop-shop-services/athena/.

[9] In 2014, the probation sector was separated into a public sector organisation that managed high-risk criminals (the NPS) and twenty-one private companies that supervised low- to medium-risk offenders (CRCs). This arrangement has been brought to end, meaning all probation work will, once again, be the responsibility of the NPS. In London, this transfer will happen from June 2021. This means the NPS will be responsible for the implementation of any recommendations for the London CRC.

[10] A major trauma centre in Lambeth. For more information, go to: https://www.kch.nhs.uk.

[11] The Lewisham and Greenwich NHS Trust is an NHS trust which was formed on 1 October 2013 and is responsible for running two acute hospitals, Queen Elizabeth Hospital and University Hospital Lewisham, in addition to community health services in Lewisham. For more information, go to: https://www.lewishamandgreenwich.nhs.uk.

Homeless Intervention and Prevention (SHIP) service)[12],	
London Fire Brigade	Summary of Engagement
MPS	IMR and Chronology
Pinnacle Housing[13]	Short Report and Chronology
SLaM	IMR and Chronology
The General Practice of Miss RH and Elijah[14]	IMR and Chronology

1.2.1 *Independence and Quality of IMRs:* All IMRs were written by authors independent of case management or delivery of the service concerned.

1.2.2 The exception was the General Practice of Miss RH and Elijah. Several General Practitioners (GP) and other clinical staff at the General Practice had contact with Miss RH and/or Elijah. As a result, while the IMR was completed by the General Practice it was quality assured by the Review Panel representative from South East London Integrated Care System (SEL ICS) Lewisham. [15]

1.2.3 Most Short Reports/IMRs were of a good standard and enabled the Review Panel to analyse the contact with Miss RH and/or Elijah and to produce the learning for this review. Where necessary further questions were sent to agencies and responses were received.

1.2.4 There were challenges in securing information from SLaM. This included managing the interface with a Serious Incident Investigation,[16] as well provision of timely and robust submissions as part of the DHR process. This has had a considerable impact on this review, both in terms of the time taken but also because of the additional capacity needed to manage the process. The extent of these challenges was such that the Review Panel agreed to make a recommendation.

Narrative / Learning Point: A DHR is dependent on the participation of agencies both in terms of sharing of information, but also its analysis internally but also as part of a dialogue between stakeholders during the review process. It is therefore important that agencies can manage and service these requests in line with the requirements of the statutory guidance.

[12] A housing options service for single people in Lewisham who are homeless or worried they might become homeless. For more information, go to: https://lewisham.gov.uk/organizations/single-homeless-intervention-and-prevention.

[13] A housing provider, who manage properties in Lewisham on behalf of the council. For more information, go to: https://www.pinnaclegroup.co.uk/homes/.

[14] Anonymised to protect confidentiality of Miss RH and Elijah.

[15] Replaced the South East London Clinical Commissioning Group (CCG). For more information, go to: https://www.selondonics.org.

[16] As Elijah had been in contact with SLaM at the point he killed Miss RH, SLaM conducted a Serious Incident investigation in line with the Serious Incident Framework (2015). For more information, see: https://www.england.nhs.uk/patient-safety/serious-incident-framework/

DHR Recommendation 1: SLaM to review its process for managing and servicing its participation in DHRs to ensure **that** its contributions are timely and of a good standard.

1.2.5 Miss RH's family also contributed to the review.

1.3 The Review Panel Members

1.3.1 The Review Panel members were:

Name	Job Title	Agency
Alison Eley	Lead Nurse for Lewisham District	SLaM
Angela Middleton	Patient Safety Lead Mental Health, London	NHS England
Brian Scouler	Service Manager, Safeguarding & Risk	Lewisham Adult Social Care
Helena Brett17	Adult Safeguarding Advisor	LGT
Chris Franks	Service Manager	CGL
Ellie Eghtedar	Head of Housing Needs	Lewisham Housing
Evelyn Semple	Interim Head of Service	Lewisham Adult Social Care, AMHP Service
Fiona Mitchell	Nurse Consultant Adult Safeguarding Designate	SEL ICS
Hannana Siddiqui	BME Expert	SBS[18]
Heather Payne	Head of Adult Safeguarding	KCH
Jannet Hall	Head Of Service	Safer Lewisham Partnership
John Barker	Housing Options and Advice Service Manager	Lewisham Housing
Julia Dwyer	Senior Operations Manager	Refuge

[17] Replaced Caz Brown from February 2022.

[18] A leading UK based organisation addressing the needs of Black (Asian and African-Caribbean) and minority women and working to empower them to escape violence.[18]

Kirsty Addicott	Southwark Head of Service	London Probation
Lucien Spencer	Area Manager, London South East Area	London CRC
Dr 1[19]	Adult Safeguarding Lead	The General Practice of Miss RH and Elijah
Dr 2[20]	Children's Safeguarding Lead	The General Practice of Miss RH and Elijah
Dr Maria Fotiadou	Consultant Forensic Psychiatrist	SLaM
Detective Sergeant Michael McInerney[21]	Specialist Crime Review Group	MPS
Rosalyn Davidson	Nominated Representative	Violence against Women and Girls (VAWG) Forum
Sandra Simpson	Project Manager	Pinnacle Housing[22]
Vicky Rapti [23]	VAWG Programme manager	Safer Lewisham Partnership
Thien Trang Nguyen Phan	AFV Specialist	Standing Together

1.3.2 *Independence and expertise*: Review Panel members were of the appropriate level of expertise and were independent, having no direct line management of anyone involved in the case.

1.3.3 The Review Panel met a total of four times, with the first meeting of the Review Panel on the 13th October 2020. There were subsequent meetings on the 26th May 2021 (this meeting had been delayed as several agencies had been unable to submit information due to the impact of Covid-19), the 30th November 2020 (delayed until the SLaM Serious Incident report had been completed, see 1.12 below) and 10th February 2022. Thereafter, agencies provided comments and feedback on the revised draft in May 2022, before a final version was circulated for sign-off in August 2022 after further consultation with agencies and the family.

1.3.4 The Chair wishes to thank everyone who contributed their time, patience, and cooperation to this review.

1.4 Chair of the DHR and Author of the Overview Report

1.4.1 The Chair and author of this DHR is James Rowlands, an Associate of Standing Together. James is a qualified Social Worker and Independent Domestic Violence Advisor (IDVA) and has worked in a variety of frontline and strategic roles in the domestic abuse sector since 2004. James has

[19] Anonymised to protect confidentiality of Miss RH and Elijah.

[20] Anonymised to protect confidentiality of Miss RH and Elijah.

[21] Replaced Helen Rendell on the Review Panel in November 2021.

[22] A housing provider, who manage properties in Lewisham on behalf of the council. For more information, go to: https://www.pinnaclegroup.co.uk/homes/.

[23] Replaced Charlene Noel on the Review Panel in February 2022. Replaced Terri Gannon on the Review Panel in June 2022.

received Domestic Homicide Review Chair's training from Standing Together and has chaired and authored fourteen previous DHRs.

1.4.2 Standing Together is a UK charity bringing communities together to end domestic abuse. We aim to see every area in the UK adopt the Coordinated Community Response (CCR).[24] 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 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 ninety reviews across England and Wales from 2013 until the present day.

1.4.3 *Independence:* James has no connection with Lewisham or any of the agencies involved in this case, aside from having chaired one previous DHR in the area.

1.5 Terms of Reference for the Review

1.5.1 At the first meeting, the Review Panel shared information about agency contact with the individuals involved, and as a result, established that the time to be reviewed would be from 1st January 2016 to the date of Miss RH's death. Where appropriate, the review will consider agency involvement prior to this period. This timeframe was chosen to begin from the year before Elijah was believed to have moved in with Miss RH, although, as summarised in Section 2, it was later established that Elijah had largely been living with Miss RH but had moved out for a period between 2016 and 2017.

1.5.2 *Key Lines of Inquiry:* The Review Panel considered both the generic issues as set out in the statutory guidance and identified the following as key lines of enquiry:

- The communication, procedures and discussions, which took place within and between agencies.
- The co-operation between different agencies involved with Miss RH/Elijah [and wider family].
- The opportunity for agencies to identify and assess domestic abuse risk.
- Agency responses to any identification of domestic abuse issues.
- Organisations' access to specialist domestic abuse agencies.
- The policies, procedures and training available to the agencies involved on domestic abuse issues.
- Specific consideration was also given to the following issues:
  - AFV; and
  - Mental Health.

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

1.5.3 Any evidence of help seeking, as well as considering what might have helped or hindered access to help and support. This should include consideration of the impact of the Covid-19 pandemic.

2. Summary of Chronology

Contact with Miss RH

2.1.1 Miss RH had relatively limited contact with most of the agencies who have been part of this DHR, except for SLaM.

2.1.2 SLaM's contact with Miss RH came about because of Elijah's contact with the service for his mental health support. However, while there was regular communication with Miss RH, including during 2020 as Elijah's mental health deteriorated, the DHR has identified a range of learning. Most notably:

- It appears that although Miss RH's potential needs as a carer were noted as early as 2017, and she was offered support from staff, the overall response to her needs in this respect was inconsistent and delayed. For example, it was only in May 2020 that a carer's support plan was initiated.
- While being aware of Elijah's paranoid beliefs about family members, as well as his references and/or carrying of weapons, no specific domestic abuse assessment was completed. This meant that, as Elijah's mental health deteriorated in May 2020, while there was a response to this (including a referral ultimately for a Mental Health Act Assessment, MHAA), [25] the focus was on the risk that Elijah might pose to himself, not Miss RH.
- Additionally, in this same month, Miss RH faced specific barriers in contacting SLaM, including in May 2020. This barrier was because callers could not access the Crisis Line directly, and instead had to select the correct option when placing their call.

2.1.3 In respect of the General Practice, Miss RH had a small number of appointments in her own right. In these contacts, Miss RH presented with specific physical health needs. There were no disclosures by Miss RH, nor concerns identified by clinicians, about domestic abuse. Additionally, Miss RH accompanied Elijah at a small number of appointments. The General Practice has noted that these contacts – either when Miss RH accompanied Elijah, or when she came on her own – could have been an opportunity to discuss her support needs

2.1.4 Miss RH also had contact with LGT, with scheduled planned outpatient appointments. While there were no disclosures about, nor concerns for, domestic abuse, LGT noted that on the one occasion that Miss RH presented at the Emergency Department, she was not asked about domestic abuse.

2.1.5 Miss RH's employer, the financial services company, did not have any concerns for her safety and, in her contact with staff, was a private person. However, while the company can provide

[25] A MHAA looks in detail at whether some has a mental health condition and whether they need assessment or treatment in the interests of their health, safety and for the protection of others. For more information, go to: https://www.nhs.uk/mental-health/social-care-and-your-rights/mental-health-and-the-law/mental-health-act/.

support via its Employee Assistance Programme, it has identified that it does not have a domestic abuse policy for staff.

2.1.6 Finally, although Miss RH had no significant contact with the MPS, it is notable that she was concerned about involving the police. This appears to have reflected her concerns about the possible experience of a young Black man.

Contact with Elijah

2.1.7 Elijah had extensive contact with a range of services, most significantly the MPS and SLaM.

2.1.8 Concerning the MPS, Elijah had contact with the police because of stop and search (which may have influenced his mother's perspective on the police, see above), as well as occasions he reported being the victim of crime. However, the Review Panel has focused on several significant contacts relating to Elijah's mental health.

2.1.9 When the MPS had contact with Elijah around his mental health, there appears to have been an appropriate recognition of potential concern for his well-being, as well as risk to others. However, there were several issues with responses to these contacts. Earlier incidents up to the end of 2019 included occasions when MERLIN/Adult Coming to Notice (ACN) were either not created in line with force policy or delayed. [26] More significantly when a request was received from the AMHP service for assistance with the execution of the warrant, this request was not actioned. This is discussed further concerning SLaM below.

2.1.10 SLaM had extensive contact with Elijah since 2017, with contact across a range of services including the Psychiatric Liaison Team, [27] Assessment and Liaison Team,[28] Improving Access to Psychological Therapies (IAPT)[29], as well as periods at the Ladywell Mental Health Unit (MHU). Ultimately, he was supported by the Early Intervention Team (EIT)[30], including at the point of the fatal attack on his mother. While Elijah was supported by the EIT, the Review Panel has explored a range of issues, including the response to his cannabis use, housing need, identification of possible domestic abuse, and response to reports about access to weapons and fire safety concerns. There has been learning about each of these issues. Most notably, this includes learning about the insufficiency of the response to Elijah's housing need, as well as limited evidence of specific risk assessment and safety planning around domestic abuse (including an understanding of AFV specifically). The Review Panel has also concluded that concerns about Elijah's use of or claims to have access to weapons were not consistently assessed. Additionally, when Miss RH identified concerns about fire setting, although appropriate actions were taken to

[26] A report created by a police officer detailing any concerns about the welfare and/or safety of a vulnerable adult.

[27] Assesses and treats emergencies in the Emergency Department and inpatient wards who have mental health problems.

[28] Provides expert advice and consultation to help primary and adult social care colleagues look after patients, where possible, without the need for a secondary mental health service.

[29] IAPT provides talking therapies to help with common mental health problems like stress, anxiety and depression. For more information, go to: https://lewishamtalkingtherapies.nhs.uk.

[30] Works with young adults with early onset psychosis. It offers diagnosis and management of persons with psychosis, support to carers, support with accessing education, employment, and psychological therapy.

try and secure a Home Safety Visit from the London Fire Brigade, no other actions were taken (including considering liaison with Pinnacle Housing).

2.1.11 Additionally, Elijah was subject to MHAA on three occasions, September 2017, June 2018, and May 2020. The most significant of these was in May 2020. On this occasion, when a warrant for an MHAA was secured, a request to the MPS for assistance with its execution was not followed up when no response was received. As a result, the MHAA had not been undertaken 19 days after it was first applied for. If this drift had not occurred, it could potentially have prevented Miss RH's death given that the outcome of the MHAA may have been that Elijah was detained. Although some of the overall delay in securing the MHAA warrant was due to exceptional circumstances, in particular Covid-19, the underlying cause appears to have reflected system delays in the process for making this request, issues with communication between the AMPH service and the MPS, and the capacity of the service itself.

2.1.12 Of the other agencies that had contact with Elijah, these included the General Practice, as well as KCH and LGT. However, the General Practice had the most substantive contact. Broadly, this was appropriate.

2.1.13 The General Practice identified issues with the quality and timeliness of updates from SLaM, including both delays in receiving notifications but also periods when no updates were received at. Additionally, the General Practice has identified that staff awareness of AFV is limited. Finally, the General Practice does not have a stand-alone domestic abuse policy and, locally, it was recognised that there should be further support for general practices to implement such a policy.

2.1.14 Elijah's contact with KCH and LGT was limited to health needs, with no specific concerns or disclosures around domestic abuse having been identified.

2.1.15 For Lewisham Council, there has been learning for both Adult Social Care and the Housing Needs Department. For Adult Social Care, the Review Panel noted with concern that it had no record of the MERLIN/ACNs that the MPS submitted relating to Elijah. This appears to have been a result of historical issues and, since that time, the local MASH has been developed, providing a single front-facing service. The learning about Housing Needs was more substantial. Specifically, Elijah made several approaches to housing. As part of an assessment of his application in May 2019, a medical advisor considered his case, but it does not appear that the systems in place for joint working and information sharing between housing and mental health providers were robust. As a result, Elijah's disclosure at the time, including about his home life and mental health, whilst not enough to mean he would be in priority need, should have triggered further consideration, not least with SLaM.

2.1.16 Pinnacle Housing has also identified learning. While it did not have contact with Elijah, it is of note that a neighbour of Miss RH contacted them with concerns about Elijah's behaviour and expressed their fear of him. However, there was limited exploration with Miss RH's neighbour about their concerns (including a possible safeguarding risk to their child), beyond a reliance on their no longer accessing a communal area, being advised to call the police, and being able to request a move. Moreover, there was no approach to Miss RH. This has been identified as a gap.

3. Conclusions and Lessons to be Learnt

3.1 Conclusions

3.1.1 Miss RH was a much-loved sister and a respected colleague. Miss RH was also a dedicated mother who was doing her best to support her son, including as his mental health declined. Miss RH's death was a tragedy, and the Review Panel extends its sympathy to her family and those who knew her.

3.1.2 The Review Panel has sought to try and understand Miss RH's lived experiences and consider the issues she faced to try and understand the circumstances that led up to her killing by Elijah and identify relevant learning. Elijah's declining mental health played a significant part in Miss RH's death, reflected in the criminal justice outcome. While this decline may have been influenced in part by Elijah's own decisions, including his reluctance to engage with SLaM (particularly in terms of medication) and other behaviour like his reported drug use, there is nonetheless learning for agencies, in particular SLaM, the AMHP service, and the MPS.

3.1.3 In many DHRs, it can be difficult to say with any confidence that a death could have been avoided. That is not the case in this review. If the MHAA had been undertaken, Elijah would have been assessed under the MHA and he may have been detained at the point at which he killed Miss RH. If that had been the case, Miss RH's death would not have occurred.

3.1.4 Broader learning has also been identified during this review concerning how Elijah's potential risk and needs were managed, the recognition of Miss RH's needs (including as a carer), and how agencies work together. It is vital that agencies and local partnerships consider this learning to develop and improve local responses.

3.2 Key Themes and Learning Identified

3.2.1 The learning, in this case, has both been particular to individual agencies but also cut across agencies and the wider local partnership.

3.2.2 The specific learning for individual agencies has been described in detail and has included issues relating to policy and procedure, as well as the response of staff in specific circumstances, both internally and concerning multi-agency working.

3.2.3 Before setting out the key themes and learning, it is important to recognise the wider context. This wider context includes Elijah's experiences as a Black Caribbean man (which likely affected Miss RH's sense of her options, because she was concerned about the possibility of discrimination, particularly from the police) and Covid-19 (which affected Miss RH and Elijah because they were confined at home and both in closer proximity and more isolated as a result).

3.2.4 The key themes and learning identified in this review were:

3.2.5 *Recognition and response to carers*: Miss RH was caring for Elijah for over three years. Whilst there was evidence of good practice in SLaM's response to Miss RH, including regular contact between Miss RH and Elijah's Care Coordinator, it is also clear that consideration of Miss RH's

needs specifically as a carer was limited and late. Other agencies too, including the General Practice and the MPS, did not specifically consider whether Miss RH was a carer.

3.2.6 *Assessment of risk:* While there was a recognition of Elijah's increased risk to Miss RH in 2020, in the context of SLaM's whole response, it is evident that domestic abuse was not specifically considered. Moreover, even as Elijah's increased risk was recognised, there was limited evidence of consideration around the kind of specific steps that could have been taken to try and increase Miss RH's safety. This assessment of risk also extends to the consideration of knives which, bar a few incidents when specific steps to flag this as a concern, appear to have been normalised in the context of Elijah's behaviour. Other agencies too have learning about assessment in this context including the General Practice (who did not make connections between regular reports from other agencies and possible risk); Pinnacle Housing (who took no action in response to reports about Elijah's behaviour); and Lewisham Council Housing (who did not assess Elijah's adequately).

3.2.7 *Interagency working:* There were several examples where an issue was identified with inter-agency working, including occasions where referral pathways did not operate as they should (including between the MPS and Lewisham Adult Social Care), or liaison was limited (including between Lewisham Council Housing and SLaM). However, the most significant issue was the failures around the MHAA which included both delays in this process and the fact that there was no escalation of concerns when these occurred. As noted above, the delays around the MHAA almost certainly meant Miss RH was left at a risk that could otherwise have been avoided.

3.2.8 Finally, this review has identified that further work needs to be done to develop the response to AFV locally. While there has been some work around AFV, it is clear much more needs to be done to ensure that there is a robust response to this issue, by both individual agencies and in terms of the wider partnership. It is also clear that the Safer Lewisham Partnership needs to reflect on its conduct of DHRs locally, to ensure that recommendations are addressed and the learning from these reviews is used to its best effect.

3.2.9 A review is an opportunity for agencies to consider their response to domestic abuse, individually and in partnership. Reflecting this, both single and DHR recommendations have been made to address the learning identified. Taken together, the Review Panel hopes that the work of individual agencies and the Safer Lewisham Partnership will be underpinned by a recognition that the response to domestic abuse is a shared responsibility as it is everybody's business to make the future safer for others.

4. Recommendations

4.1 Single Agency Recommendations (Identified by Individual Agencies)

4.1.1 The following single agency recommendations were made by the agencies in their IMRs.

4.1.2 These recommendations should be acted on through the development of an action plan, with each agency reporting on progress to the Safer Lewisham Partnership.

Financial Services Company

4.1.3 1: Miss RH's employer (financial services company) to develop a domestic abuse policy for staff.

The General Practice of Miss RH and Elijah

4.1.4 1. Add an alert to the patient's records if the patient has had an involuntary section history.

4.1.5 2.Code high need mental health patients as 'admissions avoidance' and link household members

4.1.6 3. Deteriorating mental health patients to be brought to the Multi-Disciplinary Team meeting discussions.

4.1.7 4. Review the 'Do Not Attend' policy for patients on the mental health register.

4.1.8 5. Training for staff on issues surrounding AFV and its identification and management.

Lewisham Council Housing Needs Department

4.1.9 1. Medical Officer to be invited to the SLaM / Housing Forum to highlight concerns pertaining to any clients to the Housing SLaM liaison meeting.

LGT

4.1.10 1. Ensure that domestic abuse targeted questions are embedded in the triage questioning in the Emergency Department. This will support finding out if a patient is a victim of abuse and would like access to an IDVA.

4.1.11 2. Ensure trust-wide ongoing improvements in relation to domestic abuse training for clinical staff address to AFV.

MPS

4.1.12 1. South East BCU SLT to remind all staff involved in this incident of their responsibilities to generate an ACN MERLIN PAC where Vulnerable Adults Framework (VAF) identifiers are apparent.

4.1.13 2. South East BCU SLT to dip sample ACN reports to ensure compliance around appropriate intelligence checks being completed, and to ensure compliance with timescales of reports being sent to partner agencies.

4.1.14 3. Central West BCU SLT to conduct a debrief with the investigating officer and supervising officer around the quality of the investigation and supervision as recorded in CRIS 6562000/18.

Pinnacle Housing Group

4.1.15 1. Pinnacle will ensure that going forward, any concerns are raised with the relevant agencies in a timely manner to minimise the risk of harm to residents if a potential concern is raised.

SLaM

4.1.16 1. To ensure that:

- The new training package on domestic abuse has a specific chapter with regards to the assessment of a victim's housing situation
- All staff who attend the training are aware that in such cases the concerns need to be escalated to council housing or the relevant housing provider as it may not be safe for the victim and perpetrator to live together
- To include a relevant question in the assessment following the course and to thereafter monitor compliance

4.1.17 2. The EIT to:

- Complete an audit of new referrals of the last 6 months to see the number of carer's assessments completed within that period and evaluate whether this is in accordance with Trust policy.
- Appoint a 'carer's assessment' lead who will be checking the data to evaluate that Teams are following Trust policy. 3.

4.1.18 3. The Trust to consider the threshold for referrals with support for cannabis misuse for patients where it is a major feature in their illness and risk. Also, the use of outreach to be considered for patients who do not express a wish to stop using cannabis.

4.1.19 4. The Trust to develop domestic abuse guidelines for staff for them to help families to safeguard themselves when there is a possibility of a risk (including in the context of AFV).

4.1.20 5. The Trust to consider having a dedicated telephone line which goes directly through to the Crisis Line

4.1.21 6. All delays of five days or more for MHAAs need to be reported on Datix and documented in the clinical record.

4.1.22 7. Trust senior management to put in place an action plan to address how the delays in MHAAs are going to be addressed with the police.

AMHP service

4.1.23 1. There is a need for clear, agreed and transparent targets and deadlines to be set at a senior level across all agencies for responses to MHAA requests.

4.1.24 2. These targets need to be realistic, and resources need would to be available to services in order to meet them.

4.1.25 3. Mandatory training domestic abuse/AFV training for all professionals working with mental health service-users and carers.

4.2 DHR Recommendations (Developed by the Review Panel)

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

4.2.2 The Safer Lewisham Partnership is responsible for overseeing the development and monitoring of an action plan.

4.2.3 **DHR Recommendation 1:** SLaM to review its process for managing and servicing its participation in DHRs to ensure that its contributions are timely and of a good standard.

4.2.4 **DHR Recommendation 2:** SLaM to work with Victim Support Homicide Service (VSHS) and Hundred Families to identify and address any learning with respect to family support in this case.

4.2.5 **DHR Recommendation 3:** SEL ICS and Lewisham Council to take action to ensure that professionals are aware of the local service officer in relation to drug or alcohol use.

4.2.6 **DHR Recommendation 4:** The Safer Lewisham Partnership to map current pathways and procedures for the sharing of intelligence about knives and take action to address any gaps.

4.2.7 **DHR Recommendation 5:** SEL ICS to develop a template domestic abuse policy for general practice and work with General Practices locally to support its implementation in Lewisham

4.2.8 **DHR Recommendation 6:** The Safer Lewisham Partnership to work with local partners to review the findings from this DHR and further develop the response to AFV locally. This should include:

- Establishing evidence of the local need
- Identifying the actions that agencies can take individually and collectively
- Completing a training needs assessment to identify the skills and training required by professionals to recognise, identify, and respond and ensure such training is available locally.

4.2.9 **DHR Recommendation 7:** The Safer Lewisham Partner to ensure it has a robust DHR framework including the capacity to:

- Monitor the implementation of single and multi-agency recommendations from DHRs
- Identify cross-cutting themes and issues and, where appropriate, develop a thematic response (because of this fourth DHR involving a family death) to AFV.

4.2.10 **DHR Recommendation 8:** The Lewisham Safeguarding Adult Board should review the findings from this DHR and ensure that local procedures, policy and training consistently

support the identification of carers and the consideration of their needs, including in the context of domestic abuse (including AFV).