SAFER LEWISHAM PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

Overview 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: September 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.

1. Preface

1.1 The incident

1.1.1 This Domestic Homicide Review (hereafter 'the review') examines 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 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.

1.1.3 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.

1.2 Introduction

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 The review will consider agencies' contact/involvement with Miss RH and Elijah from 1st January 2016 to the date of Miss RH's death. Where appropriate, the review will consider agency involvement prior to this time period.

1.2.3 In addition to agency involvement, the review will also examine the past to identify any relevant background or trail of abuse before Miss RH's homicide, including whether support was accessed within the community and whether there were any

[1] Not her real name.

[2] Not his real name.

barriers to accessing support. By taking a holistic approach the review seeks to identify appropriate solutions to make the future safer.

1.2.4 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]

1.2.5 The key purpose for undertaking DHRs is to enable lessons to be learned from homicides where a person is killed in the context of domestic violence and abuse. 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 to reduce the risk of such tragedies happening in the future.

1.2.6 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 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 and the Home Office was notified of the decision in writing in June 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 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]

[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).

[4] The letter is included as Appendix 5. As concerns were identified about the accuracy and appropriateness of the feedback, a response document is included in Appendix 6, detailing what changes have been made to the report.

1.3.3 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 (see Section 1.8).
- 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] (See Section 1.7). This included awaiting the completion of a Serious Incident report (See Section 1.12).
- To enable engagement with family and others (see Section 1.10).

1.4 Confidentiality

1.4.1 The findings of this review are confidential until the Overview Report has been approved for publication by the Home Office Quality Assurance Panel. In the interim information has been available only to participating officers/professionals and their line managers.

1.4.2 This review has been anonymised in accordance with the statutory guidance. Only the independent Chair and Review Panel members are named.

1.4.3 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

[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.

1.4.4 In selecting a pseudonym, the family requested an honorific plus initials be used rather than a personal name. While the Review Panel was mindful of the statutory guidance and its preference for the use of pseudonyms, it felt that it should honour the family's request. Consequently, the initials 'RH' were chosen for the victim and pseudonyms were selected for the other people named in this report. These were chosen by the Chair at the family's request and then agreed upon by the family.

1.5 Equality and Diversity

1.5.1 The Chair and the Review Panel have considered the protected characteristics under the Equality Act 2010 of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex, and sexual orientation during the review process.[6]

1.5.2 Throughout the review, the Review Panel identified that the following protected characteristics required specific consideration:

- *Sex*: Sex should always require special consideration. Analysis of domestic homicide reveals gendered victimisation across both intimate partner and familial homicides with women representing most victims and men representing most perpetrators.[7] In this case, Miss RH was a woman and Elijah was a man. In this context, women are particularly at risk of being killed by an adult male child, including where they are caregivers (this is known as 'matricide').[8]
- *Ethnicity*: Miss RH and Elijah were both Black Caribbean.
- *Age:* As in many familial homicides, Miss RH was Elijah's mother. As a result, there was a 25-year age gap between them.
- *Disability:* Miss RH did not have a disability, while Elijah had an enduring mental health condition which, as it had a long-term effect on his day-to-day life, constituted a disability. Suspects in Adult Family Homicides (AFH) often have a history of mental ill health.[9]

[6] For more information, go to: https://www.equalityhumanrights.com/en/equality-act/protected-characteristics.

[7] Office for National Statistics (2020) Domestic abuse victim characteristics, England, and Wales: year ending March 2020. London: As Author. Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/domesticabusevictimcharacteristicsenglandandwales/yearendingmarch2020 (Accessed: 7th August 2021).

[8] Bracewell, K., Jones, C., Haines-Delmont, A., Craig, E., Duxbury, J. and Chantler, K. (2021) 'Beyond intimate partner relationships: utilising domestic homicide reviews to prevent adult family domestic homicide', *Journal of Gender- Based Violence*, pp. 1–16.

[9] Sharp-Jeffs, N. and Kelly, L. (2016) *Domestic Homicide Review (DHR): Case Analysis*. London: Standing Together Against Domestic Abuse. Available at: https://www.standingtogether.org.uk/dhr (Accessed: 31st January 2022).

- *Gender Reassignment:* Not relevant.
- *Pregnancy and Maternity:* Not relevant.
- *Marriage and Civil Partnership:* Not relevant.
- *Religion or Belief*: No information has been shared with the Review Panel about either Miss RH or Elijah's religion or belief.
- *Sexual Orientation:* Not relevant.

1.5.3 The Review Panel took an intersectional and ecological analysis to better understand the lived experiences of both Miss RH and Elijah. This means the Review Panel tried to think of each characteristic of an individual as inextricably linked with all the other characteristics to fully understand their journey and experience with local services and within their community. As stated by Kimberlé Crenshaw, "*if you don't have a lens that's been trained to look at how various forms of discrimination come together, you're unlikely to develop a set of policies that will be as inclusive as they need to be*."

- 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.[10]
- An intersectional analysis considers the complex ways in which differing aspects of someone's identity and lived experience can combine or intersect in the context of structural discrimination to create heightened and persistent forms of inequality, marginalisation, disadvantage, and powerlessness.[11]

1.5.4 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 identify the barriers someone may have faced in recognising or reporting domestic violence and abuse, their options for safety and protection available, and considers any conscious or unconscious bias or privileging by agencies and or society.

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[10] 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*, available at https://www.endviolenceagainstwomen.org.uk/wp-content/uploads/a_different_world_is_possible_report_email_version.pdf

[11] Intersectionality is a term rooted in Black feminism and Critical Race Theory and coined by Kimberlé Williams Crenshaw in the 1989 landmark essay "Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics, "and furthered in 1992 with "Mapping the Margins: Intersectionality, Identity Politics, and Violence Against Women of Color.". These, amongst her other work can be accessed online for further information regarding this approach to analysis.

1.5.5 To aid in the consideration of these issues, the Review Panel benefited from the involvement of several specialist services. These are described in Section 1.6 below.

1.6 Terms of Reference

1.6.1 The Terms of Reference are included in **Appendix 2**. This review aims to identify the learning from this case, and for action to be taken in response to that learning with a view to preventing homicide and ensuring that individuals and families are better supported.

1.6.2 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.

1.6.3 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.

1.6.4 *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.

- 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.

1.6.5 To address the issues in this case (including in relation to equality and diversity as identified in Section 1.5) the following agencies were invited to be part of the review due to their expertise even though they had not been previously aware of the individuals involved:

- The Athena service, provided by Refuge, supports people in Lewisham who experience gender-based violence.[12]
- Southall Back Sisters (SBS), 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.[13]
- Change Grow Live (CGL), a specialist substance misuse service working in Lewisham.[14]
- A specialist with expertise in AFV, Thien Trang Nguyen Phan, a Doctoral Researcher at Anglia Ruskin University.

1.7 Methodology

1.7.1 The Domestic Abuse Act 2021 created a statutory definition of domestic abuse, emphasising that domestic abuse is not just physical violence, but can also be emotional, controlling, or coercive, and economic abuse. This states that the:

"Behaviour of a person ("A") towards another person ("B") is "domestic abuse" if —

(a) A and B are each aged 16 or over and are personally connected to each other, and

(b) the behaviour is abusive.

Behaviour is "abusive" if it consists of any of the following—

(a) physical or sexual abuse.

[12] For more information, go to: https://www.refuge.org.uk/our-work/our-services/one-stop-shop-services/athena/.

[13] For more information, go to: https://southallblacksisters.org.uk.

[14] For more information, go to: https://www.changegrowlive.org/lewisham/info.

(b) violent or threatening behaviour.

(c) controlling or coercive behaviour.

(d) economic abuse.

(e) psychological, emotional, or other abuse.

and it does not matter whether the behaviour consists of a single incident or a course of conduct."

1.7.2 This definition has been used by the Review Panel.

1.7.3 In using this definition, the Review Panel was mindful that the homicide of Miss RH occurred in a familial relationship and could be understood as AFV.

1.7.4 A total of 17 agencies were contacted to check for involvement with the parties concerned with this review. Of these, 4 had extensive contact and were asked to submit Individual Management Reviews (IMRs) and a chronology. 6 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[15]. 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 SLaM 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.

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

1.7.6 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 the General Practice it was quality assured by the Review Panel representative from South East London Integrated Care System (SEL ICS) Lewisham. [16]

1.7.7 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

[15] 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.

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

review. Where necessary further questions were sent to agencies and responses were received.

1.7.8 There were challenges in securing information from SLaM. This included managing the interface with a Serious Incident Investigation (see Section 1.12 below), 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.

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.

1.7.9 In some cases, IMRs/Short Reports reported changes in practice and policies over time and seven made single agency recommendations of their own (these are described in Section 5).

1.7.10 *Documents Reviewed:* In addition to the above information, the Review Panel and/or Chair reviewed several other documents during the review. Where appropriate, these are referenced in the report.

1.8 Contributors to the Review

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

- Athena service.
- CGL.
- Lewisham Council Children Services.

- London Community Rehabilitation Company (CRC).[17]
- Probation Service.
- Victim Support.

1.8.2 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)[18]	Summary of Engagement
Lewisham Adult Social Care	Short Report and Chronology
Lewisham and Greenwich NHS Trust (LGT)[19]	IMR and Chronology
Lewisham Council Housing Needs Department (including the Single Homeless Intervention and Prevention (SHIP) service)[20],	Short Report and Chronology
London Fire Brigade	Summary of Engagement
MPS	IMR and Chronology
Pinnacle Housing[21]	Short Report and Chronology
SLaM	IMR and Chronology
The General Practice of Miss RH and Elijah[22]	IMR and Chronology

[17] In 2014, the probation sector was separated into a public sector organisation that managed high-risk criminals (the NPS) and 21 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 Probation Service.

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

[19] 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.

[20] 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.

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

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

1.8.3 Additionally, the Safer Lewisham Partnership was asked to produce a thematic report on the scale of, and response to, AFV in the borough.

1.9 The Review Panel Members

1.9.1 The Review Panel members were:

Name	Job Title	Agency
Alison Eley	Lead Nurse for Lewisham District	South London and Maudsley's (SLaM)
Angela Middleton	Patient Safety Lead Mental Health, London	NHS England
Brian Scouler	Service Manager, Safeguarding & Risk	Lewisham Adult Social Care
Helena Brett[23]	Adult Safeguarding Advisor	Lewisham Greenwich Trust (LGT)
Chris Franks	Service Manager	Change Grow Live CGL)
Ellie Eghtedar	Head of Housing Needs	Lewisham Housing
Evelyn Semple	Interim Head of Service	Lewisham Adult Social Care, Approved Mental Health Professional (AMHP) Service
Fiona Mitchell	Nurse Consultant Adult Safeguarding Designate	South East London Integrated Care Board (SE ICB)
Hannana Siddiqui	BME Expert	Southall Black Sisters
Heather Payne	Head of Adult Safeguarding	Kings College Hospital (KCH)
Jannet Hall	Head Of Service	Lewisham Safer Communities
John Barker	Housing Options and Advice Service Manager	Lewisham Housing
Julia Dwyer	Senior Operations Manager	Refuge
Kirsty Addicott	Southwark Head of Service	London Probation

[23] Replaced Caz Brown from February 2022.

Lucien Spencer	Area Manager, London South East Area	London CRC[24]
Dr 1[25]	Adult Safeguarding Lead	The General Practice of Miss RH and Elijah
Dr 2[26]	Children's Safeguarding Lead	The General Practice of Miss RH and Elijah
Dr Maria Fotiadou	Consultant Forensic Psychiatrist	SLaM
Detective Sergeant Michael McInerney[27]	Specialist Crime Review Group	Metropolitan Police Service (MPS)
Rosalyn Davidson	Nominated Representative	Violence against Women and Girls (VAWG) Forum Chair
Sandra Simpson	Project Manager	Pinnacle Housing
Vicky Rapti[28]	VAWG Programme manager	Lewisham Safer Communities
Thien Trang Nguyen Phan	AFV Specialist	Standing Together

1.9.2 *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.

1.9.3 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.

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

[24] Lewisham and Bromley Head of Service, London Probation, post-unification, June 2021

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

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

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

[28] Replaced Terri Gannon on the Review Panel in May 2022, who replaced Charlene Noel on the Review Panel in February 2022.

1.10 Involvement of the Victim's Family, Friends, Work Colleagues, Neighbours and Wider Community

1.10.1 The Review Panel sought to involve the family, friends, work colleagues, neighbours, and the wider community.

Victim's Family

Name[29]	Relationship to Victim	Means of Involvement
Aurora	Sister	Interviewed, contributed to a Pen Portrait, reviewed the draft report
Grace	Sister	
Evelyn	Sister	

1.10.2 Once the decision to conduct the DHR had been confirmed in June 2020, the Safer Lewisham Partnership notified Miss RH's family of this decision in July 2020: a letter was sent by post, along with the Home Office leaflet, information on Advocacy After Fatal Domestic Abuse (AAFDA)[30] and the Victim Support Homicide Service (VSHS).[31] In that same month, the Chair also wrote to Miss RH's family, including additional information on the DHR process.

1.10.3 The family wanted to contribute to the review and the Chair had regular contact with Aurora, Grace, and Evelyn throughout. This included consulting the family around the Terms of Reference (the primary concern was related to the response by SLaM, both in terms of the care of Elijah, but also the support provided to Miss RH). Additionally, the family took part in an interview (they approved a note of this meeting, which is described in Section 4 below) and provided a Pen Portrait (including at the start of this report). During this contact, Miss RH's family were supported by a VSHS caseworker and Hundred Families.[32]

1.10.4 The draft Overview Report was shared with the family in May 2022 and there was a discussion about its content and the learning, and changes were made in response.

[29] Not their real name

[30] AAFDA provide emotional, practical and specialist peer support to those left behind after domestic homicide. For or more information, go to: https://aafda.org.uk.

[31] The Victim Support Homicide Service supports bereaved families to navigate and know what to expect from the criminal justice system and providing someone independent to talk to. For more information, go to: https://www.victimsupport.org.uk/more-us/why-choose-us/specialist-services/homicide-service.

[32] Provides practice information for families affected by mental health homicide. For more information, go to: https://www.hundredfamilies.org.

Thereafter, the family asked for a pause, given the memorial of Miss RH's death was in June. The family received a revised copy of the report and then provided feedback in September 2022. Several changes were made to the final report to reflect family feedback.

1.10.5 The family were offered the opportunity to meet the Review Panel but decided not to. However, the family have expressed their wish to be updated about the progress against recommendations, and the Safer Lewisham Partnership has committed to this.

Victim's Friends, Work Colleagues, Neighbours and Wider Community

Name[33]	Relationship to Victim	Means of Involvement
Friend 1	Friend of Miss RH	Contacted but chose not to participate

1.10.6 Consideration was given to approaching friends, work colleagues, neighbours, and the wider community of Miss RH. Miss RH's family introduced the Chair to Friend 1, a friend of Miss RH. After an initial discussion in May 2021, the Chair sent information about DHRs, as well as sources of support (like AAFDA and VSHS). Unfortunately, Friend 1 was not able to participate.

1.10.7 Information was also sought from Miss RH's employer, a financial services company. In the interests of anonymity (see 1.4), the company is not named, but it was invited to participate in the review. Information from the financial services company is summarised in Section 4.

1.11 Involvement of the Perpetrator and their Friends, Work Colleagues, Neighbours and Wider Community

Perpetrator

1.11.1 As Elijah was detained under a mental health order, the Chair approached him via the Mental Health Trust that was responsible for his care. A letter was sent to Elijah – explaining the review process, and an invitation for him to contribute – via the clinician responsible for his care. Elijah subsequently declined to participate.

[33] Not their real name

1.11.2 Consideration was given to approaching Elijah's friends, neighbours, and the wider community. However, as Elijah chose not to contribute it has not been possible to identify any other people who may have known Elijah, except for his family who were already involved in the review.

1.12 Parallel Reviews

1.12.1 *Criminal Trial:* Elijah was charged with the murder of Miss RH and as mental ill health was identified as a factor in this, Elijah's capacity was assessed. It was established he was fit to enter a plea, but he was diagnosed as having been suffering from Delusional Disorder with persecutory beliefs at the time of the killing.

1.12.2 Elijah later pleaded guilty to Miss RH's manslaughter on the grounds of diminished responsibility (specifically, that he was suffering from a form of psychosis, specifically delusional disorder[34]). The guilty plea to manslaughter was accepted by the prosecution in consultation with Miss RH's family. In January 2021, Elijah was ordered to be detained under Section 37 of the MHA 1983 and Section 41 restriction order without the limit of time.

1.12.3 The Senior Investigation Officer (SIO) was invited to the first meeting of the Review Panel to share information about the criminal investigation and address issues in relation to disclosure.

1.12.4 *The Coroner's Inquest*: The death of Miss RH was referred to the HM Coroner, and an inquest was opened and adjourned in July 2021. As of August 2022, the case remained suspended.

1.12.5 *Serious Incident Investigation*: As Elijah had been in contact with SLaM at the point he killed Miss RH, the Trust conducted a Serious Incident investigation in line with the Serious Incident Framework (2015).[35] The Serious Incident findings were shared with the DHR.

1.12.6 Miss RH's family participated in the Serious Incident process. As part of the DHR, Miss RH's family expressed their frustration with how they had been included in the Serious Incident process, in particular a long period where they reported that they had not been updated or involved. While noting that some of these issues were as a result of restrictions on face-to-face meetings because of Covid-19, SLaM have nonetheless identified learning in respect of their engagement with families. SLaM

[34] For more information, go to: https://www.nhs.uk/mental-health/conditions/psychosis/symptoms/

[35] For more information, see: https://www.england.nhs.uk/patient-safety/serious-incident-framework/

have provided assurances to the Review Panel that they have reviewed how information is shared with families and are also considering employing a family liaison worker. Nonetheless, the Review Panel has made the following recommendation for SLaM and the family support services involved in this case.

Narrative / Learning Point: Family have an important role to play in any review process. As part of that, it is important to ensure there is a consistent support offer.

DHR Recommendation 2: SLaM to work with VSHS and Hundred Families to identify and address any learning with respect to family support in this case.

1.13 Chair of the Review and Author of Overview Report

1.13.1 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 received Domestic Homicide Review Chair's training from Standing Together and has chaired and authored 14 previous DHRs.

1.13.2 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).[36] 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 90 reviews across England and Wales from 2013 until the present day.

1.13.3 *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.

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

1.14 Dissemination

1.14.1 Once finalised by the Review Panel, the Executive Summary and Overview Report will be presented to the Safer Lewisham Partnership for approval and thereafter will be sent to the Home Office for quality assurance.

1.14.2 Once agreed by the Home Office, the Executive Summary and Overview Report will be shared with the wider Safer Lewisham Partnership and published. There will be a range of dissemination events to share learning.

1.14.3 The Executive Summary and Overview Report will also be shared with the Commissioner of the MPS and the Mayor's Office for Policing and Crime (MOPAC) and the Domestic Abuse Commissioner for England and Wales.

1.14.4 The recommendations will be owned by the Safer Lewisham Partnership. The VAWG Programme and Strategy Manager will be responsible for monitoring the recommendations and reporting on progress.

1.15 Previous Case Review Learning Locally

1.15.1 This is the ninth DHR commissioned locally, and the fourth DHR related to AFV. [37] These DHRs are considered in Section 5.

1.15.2 Additionally learning from a Safeguarding Adult Review (SAR) into the death of Tyrone Goodyear was identified as being relevant, given the learning related to joint working between housing and mental health services.[38] This is addressed in Section 5.

[37] Available at: https://lewisham.gov.uk/inmyarea/publicsafety/violence-against-women-and-girls/informationforprofessionals/domestic-homicide-reviews--reviewing-a-death-as-a-result-of-domestic-violence.

[38] Lewisham Safeguarding Adults Board. (2020) *Safeguarding Adult Review: Tyrone Goodyear.* Available at: https://www.safeguardinglewisham.org.uk/assets/2/tg_sar_report_final-1.pdf. (Accessed: 10 November 2021).

2. Background Information (The Facts)

The Principal People Referred to in this report						
Referred to in the report as	**Relationship to the victim**	**Age at date of Miss RH's death**	**Ethnic Origin**	**Faith**	**Nationality & Immigration Status**	**Disability**
Miss RH	Victim	56	Black Caribbean	Christian	British Citizen	No
Elijah	Son	31	Black Caribbean	Christian	British Citizen	Mental Health Condition

2.1 The Homicide

2.1.1 *Homicide*: On a date in early June, Elijah approached police officers outside a police station in South London. He told police officers that he had stabbed his mother and that she was at their home address. As a result of what officers had been told, Elijah was arrested on suspicion of causing grievous bodily harm (GBH) and taken into police custody.

2.1.2 Police officers went to the address where Elijah lived with Miss RH. They discovered Miss RH, who had been stabbed multiple times. Miss RH was breathing and responsive and received treatment from the London Ambulance Service (LAS) and Helicopter Emergency Medical Service (HEMS) who had also been called to the scene. Miss RH, whose injuries were initially assessed as non-life threatening, was then taken to Kings College Hospital (KCH). At KCH, Miss RH was moved to the critical care unit where she was placed into an induced coma. Sadly, just under a week later, Miss RH died of her injuries.

2.1.3 *Post-mortem:* A Post-mortem examination established that Miss RH had stab wounds to her back and an arm, as well as defensive injuries to her hands. The cause of Miss RH's death was an incised wound to her chest.

2.2 Background Information on Victim and Perpetrator

2.2.1 *Background Information Relating to Victim:* Miss RH was 56 when she was killed. She was British, Black Caribbean and had no known disability. Miss RH was a Christian.

2.2.2 Miss RH was one of five sisters. At the time of her death, Miss RH worked for a financial services company.

2.2.3 Miss RH was an owner occupier. In 2000, Miss RH exercised her right to buy the property where she had been a tenant since 1990. While Pinnacle Housing was responsible for managing the building where Miss RH lived, she was the leaseholder, and they had no responsibilities for managing the property itself. Miss RH had taken a career break to care for Elijah, although at the time she died, she had been working for a financial services company.

2.2.4 *Background Information Relating to Perpetrator:* Elijah was 31 when he killed his mother. He is British, Black Caribbean. Miss RH was a Christian.

2.2.5 Agency contact with Elijah relating to his mental health began in 2017. Ultimately, Elijah was diagnosed with psychosis and experienced paranoid delusional beliefs. As his mental ill health was enduring, it would have been considered a disability.

2.2.6 It is likely that Elijah's mental ill health was exacerbated by his substance use (particularly cannabis use, although Elijah is also reported to have been using alcohol and other drugs).

2.2.7 Elijah had lived with Miss RH in the family home since he was a child. In late 2016, Elijah moved into private rented accommodation. It is believed his accommodation was close to the family home and he was visiting Miss RH regularly. Elijah returned to live full-time with Miss RH at some point in 2017 and no later than April 2018.[39] This was after he had a road traffic collision and as a result, needed more support to help recover from the physical injuries. This means Elijah was regularly seeing, and then living with, Miss RH from the point his mental health problems first presented.

2.2.8 Elijah had been in employment previously, including training and working as a carpenter. In 2017, Elijah completed vocational training for the security industry. Elijah was in employment in 2018 although may have had periods when he was not in work. In 2019, Elijah appears to have been in work from February through to sometime later in the year. It is unclear how much Elijah was working through the start of 2020 but from March 2020, he could not find work, in part because of Covid-19 restrictions but also because he started becoming unwell. [40]

[39] The Review Panel has not been able to confirm where Elijah was living prior to moving back in with Miss RH. Elijah did not, for example, disclose where he was living to SLaM during this period, but he did report living elsewhere between January 2017 and October 2017 and then, in April 2018, told staff that he was living with Miss RH again. Given this was three years before Miss RH's death, the Review Panel felt it would not be proportionate to specifically explore this although the issue of Elijah's housing needs more generally has been considered.

[40] Building a picture of Elijah's employment has been difficult. While Elijah made some disclosures to staff at SLaM about his employment, and there were discussions about this and other issues like training, the available information is limited. In the interests of proportionality, the Review Panel has made the decision not to explore Elijah's employment further.

2.2.9 *Synopsis of Relationship with the Perpetrator:* Elijah was the only child of Miss RH. Miss RH had raised Elijah as a single parent, as her partner and Elijah's father had left when he was a young child.

2.2.10 *Members of the Family and the Household:* No one else lived at the property with Miss RH and Elijah. Although there were tensions between Miss RH and Elijah, including over his care in the periods when his mental health declined, the relationship between them was broadly good. Their family described them as "*close."*

3. Chronology

3.1 Summary of Significant Events Prior to the Time Period Under Review

3.1.1 The Review Panel did not examine the time before January 2016, but did note the following significant information:

3.1.2 Between 2002 (when Elijah was 13) and the first half of 2007 (when he turned 18), Elijah came to the attention of the police on 13 occasions. Two of these contacts related to allegations of stealing and theft (Elijah was given a final warning, then a reprimand respectively). Others involved contact with Elijah and other young men for suspicions related to vehicles, drug use (cannabis), as well as an imitation firearm. On one occasion Elijah reported he had been the victim of a crime. Of these contacts, eight were the result of Elijah being stopped and searched.[41] No action was taken because of these stops.

3.1.3 From the second half of 2007 to the end of 2016, Elijah had over 20 contacts with the police. These were all because of Elijah being stopped and searched and were mainly related to drug searches (bar a small number of reports made by Elijah where he said he had been the victim, including of criminal damage and assault). No action was taken because of these stops, except for Elijah being issued with a Penalty Notice for Disorder (PND)[42] in January 2013 and being charged with possession of a Controlled (Class B) Drug (i.e., Cannabis) in September 2015. He subsequently pleaded guilty at court and received a fine.

3.1.4 In February 2011, Miss RH and Elijah both registered at the General Practice. There were no significant contacts with the General Practice until 2016.

3.1.5 The General Practice was aware of incidents in February and May 2016. In these, respectively Elijah had been injured in a road traffic collision and then he may have been assaulted (his accounts were unclear). In both these incidents, Elijah had contact with the police. In the former, he attended the General Practice for advice and in the latter, he received treatment at University Hospital Lewisham (provided by LGT). In June 2016, the General Practice was notified that Elijah had attended Guys & St Thomas' (GSTT) Hospital, again for the management of his injuries. The General Practice had contact with Elijah for the remainder of 2016, largely related to the care of the injuries he had sustained. This included providing 'not fit for work'

[41] A police officer has powers to stop and search you if they have 'reasonable grounds' to suspect someone is carrying: illegal drugs, a weapon, stolen property, something which could be used to commit a crime, such as a crowbar. For more information, go to: https://www.gov.uk/police-powers-to-stop-and-search-your-rights.

[42] An on-the-spot fine issued by the police for minor offences. For more information, go to: https://www.askthe.police.uk/content/Q222.htm.

notes,[43] as Elijah reported being unable to work because of his injuries. All these contacts were related to Elijah's physical health and no mental health issues were identified or disclosed.

3.1.6 Miss RH had two appointments in June 2016, with these related to stress and associated health issues. At the first appointment, Miss RH explained she was stressed because of flooding damage to her home, as well as worries about Elijah's injuries. At the second appointment, Miss RH talked about being stressed as she was looking for work (she later started working with a financial services company). Miss RH did not make any disclosures, nor did the GP identify any wider causes for concern.

3.1.7 Miss RH also had a single contact with Lewisham and Greenwich NHS Trust (LGT), attending an outpatient appointment at University Hospital Lewisham for a physical health issue.

3.1.8 At some point towards the end of this year, Elijah moved out of the family home into private rented accommodation. As noted in Section 2, the picture of Elijah's accommodation is unclear, but he would later tell staff at SLaM that he was visiting Miss RH daily, and he moved back in at some point in 2018.

3.2 Time Period Under Review

2017

3.2.1 On the 20th January, Elijah was involved in a further road traffic collision. Elijah sustained serious injuries and was treated at KCH. (Elijah contacted police officers a few days later about the return of his motor vehicle). The Review Panel considered whether Elijah's physical injuries, for which he had a period of inpatient and then follow-up treatment, might be linked to his changed mental health. While this is possible, as will be discussed below, when his mental health was assessed, Elijah disclosed previous mental health episodes and a range of potential triggers (including issues with work and the end of a relationship, as well as the death of a close family member some years previously).

3.2.2 During this admission, Elijah was seen by SLaM's Psychiatric Liaison Team[44] on the 27th January. He disclosed making suicide attempts and/or occasions when he had harmed himself (including one while he had been in hospital and several previous attempts, including taking tablets or incidents involving vehicles).

[43] Doctors issue fit notes to people to provide evidence of the advice they have given about their fitness for work. For more information, go to: https://www.gov.uk/government/collections/fit-note.

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

3.2.3 On the 27th January, the General Practice received a request from SLaM asking about Elijah's medical history and any previous mental health issues. The Practice responded, indicating there were no known mental health issues.

3.2.4 On the 30th January, Elijah was discharged by the Psychiatric Liaison Team – who noted the possibility of an IAPT (Improving Access to Psychological Therapies)[45] referral and discharge to his General Practice – and referred to SLaM's Assessment and Liaison Team.[46] During his time in hospital, Elijah had been prescribed medication and, on discharge, while his medication was changed, he appears to have responded well and was compliant with it.

3.2.5 Regarding his physical injuries, Elijah was an inpatient at KCH until early February. Thereafter, Elijah had several follow-up outpatient appointments.

3.2.6 On the 9th February, Elijah attended the General Practice after his discharge from KCH. Elijah had an unusually long appointment (it was 45 minutes):

- Miss RH had accompanied him, but Elijah was spoken to alone as he was only willing to have a discussion if Miss RH was not present. Elijah disclosed that he had made three suicide attempts while in hospital by holding his breath (he said these were in response to being "*treated badly*" by the hospital). He also stated he had made various attempts to kill himself since his teenage years. Elijah stated that he lived alone and had one friend who he had talked to about what was going on. Elijah also said that he felt better since being in the hospital, and that he had been referred by the Psychiatric Liaison Team for counselling.
- Elijah was diagnosed with depression and treatment options were discussed, including counselling or medication. Miss RH, who had come back to the appointment to discuss the next steps, was keen for Elijah to access counselling but reluctant for him to start on medication. As Elijah thought he had been referred for counselling, it was agreed that Elijah would self-refer to IAPT. Elijah agreed to try anti-depressants and a 'not fit for work' note was issued.
- After seeing Elijah, the GP tried to contact SLaM, but was unable to speak to anyone at the Psychiatric Liaison Team. As a result, they made an urgent

[45] 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.

[46] 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.

referral to the Community Mental Health Team (CMHT)[47] and then updated Elijah to let him know that the CHMT would be in touch.

3.2.7 The length of this consultation seems to have reflected the concern about Elijah's disclosures. Notably, at this consultation, the GP did not have access to a discharge notification from SLaM's Psychiatric Liaison Team. That is because this had only been received on this same day and was not at that point known to the GP, despite Elijah's having been discharged by the Psychiatric Liaison Team on the 30th January.

3.2.8 Following a referral meeting on the 9th February, on the 10th February Elijah had a telephone consultation with SLaM's Assessment and Liaison Team. A risk assessment was completed, although Elijah did not discuss the details, he disclosed suicidal ideation. It was agreed that Elijah would have follow-up appointments and consider a referral for psychological therapies. Although Miss RH was discussed in this meeting, at this early stage there would have been no specific follow up with Miss RH as this was an initial assessment and Elijah was an adult.

3.2.9 On the 16th February, Elijah attended the General Practice for a review. It was agreed he would continue taking anti-depressants and he confirmed that he had an appointment with SLaM. Elijah and the GP also discussed a physical health issue associated with his previous injuries.[48]

3.2.10 On the 28th February, Elijah had a further review appointment with the General Practice. He reported that his mood was good.

3.2.11 On the 10th March, Elijah had an assessment with SLaM's Assessment and Liaison Team. A full personal and family history was taken. In this assessment, Elijah reported that he tended to lose his temper when upset. He said that this was only after what he felt was a considerable provocation and Elijah gave several examples where he described incidents in which he had reacted using violence, although these were all encounters in public and not with family members. He talked about previous suicide attempts (although he denied any current suicidal ideation), as well as his prior use of cannabis (he said he had stopped using this after his road traffic collision in January). It was decided to discharge Elijah from

[47] Works with people with a range of emotional and behavioural difficulties, and their families. Provides early intervention services in GP surgeries, health centres and schools. For more information, go to: https://www.slam.nhs.uk/patients-and-carers/treatment-and-care/community-mental-health-services/.

[48] Elijah would continue to discuss these issues with his GP, and receive appropriate medical advice, but they are not reported in detail in the following chronology.

SLaM's Assessment and Liaison Team, leaving him in the care of his GP, although a referral was also made for him to IAPT.

3.2.12 On the 20th March, SLaM's Assessment and Liaison Team contacted IAPT about a referral for Elijah. Although the referral was for Elijah's depression, the IAPT team felt they might not be able to work with Elijah due to concerns about his anger management. It was clarified that the SLaM's Assessment and Liaison Team had no concerns about Elijah's anger and the referral was being made in relation to helping him manage depression.

3.2.13 On the same day, the General Practice received a discharge summary from SLaM's Assessment and Liaison Team. This noted evidence of Elijah's prior cannabis use before his road traffic collision and that there was an "*absence of abnormalities in the form and content of his speech and thoughts suggestive of psychosis*." As a result, Elijah had been discharged.

3.2.14 On the 23rd March, Elijah came to the General Practice for a review. Elijah reported his mood was "*ok*" and that he was taking his antidepressant medication. He confirmed that he had been referred to anger management[49] and disclosed that he *"did have one episode when he got angry at a housemate, but not physical."* [This appears to have been a reference to the period when Elijah had lived in private rented accommodation].

3.2.15 On the 3rd April, Elijah came to the General Practice for a review. Elijah was noted to be "*doing well*" and reported that his mood was better. Elijah said he was not taking his antidepressant medication regularly, but he agreed to continue with the medication for six months. At the end of the month, on the 24th, he did not attend a scheduled appointment.

3.2.16 On the 4th May, Elijah came to the General Practice for a review. The GP recorded that Elijah had shown a marked improvement. Although Elijah had run out of antidepressants, he agreed to continue taking them, and a further prescription was issued. Elijah also advised the GP that he had completed the self-referral questionnaire for IAPT and was awaiting an appointment.

3.2.17 On the 8th May, SLaM's IAPT service received a referral for Elijah from the Assessment and Liaison Team. Following a further discussion with the SLaM's Assessment and Liaison Team, the referral was accepted.

[49] This was likely a reference to the referral to IAPT through SLaM following his assessment on the 10th of March.

3.2.18 Elijah agreed to another review with the General Practice in mid-August (i.e., after six months of taking anti-depressants). Later that month, and in early June, Elijah also came into the General Practice for reasons related to his road traffic collision in January. This included a request for an extension of his 'not fit to work' note and some treatment for a minor health issue. On the second appointment, he came with Miss RH. In the first appointment, no issues were noted regarding his mood, and in the second meeting, Elijah appeared well. Miss RH was concerned that Elijah was sleeping a lot, although Elijah denied this.

3.2.19 On 14th June, Miss RH had an appointment with the General Practice, related to work stress.

3.2.20 On 20th June, Elijah was contacted by SLAM's IAPT service for a screening assessment, but the appointment could not be completed (he said he was *"getting ready to go out*") and so it was rebooked.

3.2.21 On the 13th July, at a review meeting with the General Practice, Elijah disclosed that he had not been taking the antidepressants he had been prescribed for three or four weeks and had missed his IAPT appointments (this was presumably a reference to his cancelled rebooked screening assessment). Elijah agreed to re-start the antidepressants for two months. No concerns were identified around his mood during the appointment.

3.2.22 On the 20th July, Elijah had a further screening assessment with SLaM's IAPT service. As part of this assessment, Elijah repeated his previous disclosures in terms of self-harm and suicidal thoughts. Elijah also talked about his previous disclosures about losing his temper in public, as well as his previous use of cannabis. Elijah was subsequently offered psychological therapy. However, this did not go ahead, and a decision was made to reassess Elijah.

3.2.23 On the 23rd July, Elijah was a person of interest in an incident of criminal damage (not domestic abuse related). However, there was no evidence linking Elijah to the allegation, so no further action was taken.

3.2.24 On the 29th July, Elijah was stopped and searched by the police. Nitrous oxide canisters were found, but there was no evidence of an intent to supply. No offences were reported by officers and no further action was taken against Elijah.

3.2.25 On the 7th August, Miss RH went to the Emergency Department at University Hospital Lewisham. She had a minor physical health issue which was diagnosed.

3.2.26 On the 18th August, Elijah contacted the General Practice and spoke with the duty GP. He reported having bad thoughts and that he was thinking of hurting himself

and other people. Elijah agreed to come into the surgery for an appointment. Elijah described feeling in danger from family members (cousins) and wanting to hurt others (gang members). However, assessing him, the duty GP did not feel that Elijah was displaying signs of being mentally unwell, and a plan was made for Elijah to see his usual GP on the 21st August. The duty GP explained to Elijah that the police would be contacted given the disclosures about harming others. Elijah seemed to have accepted this, as he asked the GP to give the police his mobile number.

3.2.27 This led to the MPS' first contact about Elijah's mental health. On the same day, the duty GP shared information about Elijah's presentation and said that, although he had a history of depression, he did not have mental health problems. A report was created, and police officers attended Elijah's home address, but could not locate him. No further action was taken that day. However, on the 20th August, police officers were able to speak to Elijah, who was reportedly calm, he explained that he had been "*having a bad day*" and said that he did not want to hurt anyone. It is not clear if Elijah was spoken to in person or over the phone. Elijah was advised to call the LAS or the MPS if he felt like he wanted to hurt someone. No further action was taken. No MERLIN/Adult Coming to Notice (ACN) report was created.[50]

3.2.28 On the 4th September, Elijah was reassessed by SLaM's IAPT service. Elijah presented with signs of paranoia, although he did not report any violence toward himself or others. He said he was using cannabis. The IAPT service decided that Elijah may have been presenting with early signs of psychosis and made an internal referral to the Oasis Service, a service for people aged 14-35 struggling with unusual experiences like feeling paranoid or hearing voices.

3.2.29 On the 7th September, SLaM's IAPT service contacted the General Practice to discuss Elijah. There was a discussion about Elijah's presentation, which included his expressions of feeling persecuted. As an outcome, it was noted that Elijah was due to come into the General Practice in a few days, and additionally, it was agreed that the IAPT service would make a referral to the Early Intervention Team (EIT).[51] The IAPT service would not normally make referrals in this way but did so because they felt that Elijah was psychotic. The referral was sent the following day.

3.2.30 At a review appointment on the 11th September at the General Practice, Elijah was accompanied by Miss RH. Miss RH is recorded as saying she was: "*concerned*

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

[51] 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.

about [Elijah's] *paranoid thoughts and behaviour. Says that everybody is out to get him- all family members. She has never seen him like this."* In the appointment, Elijah said that he had been having paranoid thoughts for about a year. He also said he thought that his two accidents may have contributed to the break-up of his relationship and that he had started smoking cannabis again. He said he did not intend to harm anybody but admitted to carrying something with him – "*a piece"* – although he would not disclose what it was. At one point, Elijah left the appointment but returned when he was told that if he left, the GP would have to call the police. The General Practice contacted the MPS who attended and provided advice but did not take any further action given the concerns related to Elijah's mental health.

3.2.31 Following a further discussion at the General Practice, Elijah agreed to a same-day mental health assessment at hospital. Elijah's attendance led the General Practice to add a caution alert to his records stating, "*Patient has been known to carry a dangerous weapon when unwell*."

3.2.32 Later that day, Elijah was seen at University Hospital Lewisham, having attended the Emergency Department. Elijah was seen by SLaM's Psychiatric Liaison Team. He was admitted informally to the Ladywell Mental Health Unit (MHU). Although Elijah said he was happy for the staff to speak with his mother,[52] he did not want them to speak to anyone else, as he believed that they wanted to kill him. During this period, a Mental Health Act Assessment (MHAA) was completed, and Elijah was detained while already an inpatient. [53]

3.2.33 On the 14th September, staff at the Ladywell MHU contacted the police to report Elijah missing. This appears to have been the result of Elijah becoming angry when it was suggested that there was a recommendation that he should be sectioned. Shortly after, the staff informed police that Elijah had returned to the unit safe and well. No further police action was taken. As a result of this contact, police records state that Elijah had been diagnosed with Paranoid Schizophrenia. The police thereafter took no further action, but a MERLIN/ACN was completed, which triggered a referral to Lewisham Adult Social Care.

3.2.34 Lewisham Adult Social Care received the referral from the police the next day. The referral was screened and, as Elijah was known to be in their care, it was forwarded

[52] In the context of a MHAA, Miss RH was Elijah's 'nearest relative', meaning she had certain rights to be informed or consulted. For more information, go to: https://slam.nhs.uk/nearest-relative.

[53] 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/.

to SLaM. No further action was taken by Lewisham Adult Social Care, which hereafter had no contact with either Elijah or Miss RH.

3.2.35 On the 18th September, Miss RH had an appointment with the General Practice. The GP noted that Miss RH was "*under a lot of stress*." As she reported sleeping difficulties, Miss RH was prescribed some sleeping tablets to help. In this appointment, Miss RH said one of the reasons for her sleep issues was that her "*son only want*[ed] *to see her*."[54] This was Miss RH's last appointment with the GP until May 2020.

3.2.36 On the 10th October, Elijah was discharged from the Ladywell MHU into the care of the SLaM EIT. He was assessed as being of low risk to himself and others. Elijah was offered a package of Care Programme Approach (CPA) support.[55] In addition to medication, his support was to be managed by a Care Coordinator, with whom he would have regular contact, with the frequency reflecting his level of need and depending on what he and the Care Coordinator felt was required. Elijah was also referred for psychological support and was able to access support around vocational activities. At this time, Elijah continued to be compliant with his medication.

3.2.37 On this same day, Miss RH had her first meeting with Elijah's Care Coordinator. Thereafter, Miss RH would have ongoing contact with Elijah's Care Coordinator(s), including via phone, text/WhatsApp, and email.[56] As part of the planning for his discharge, Miss RH requested that a behaviour contract be drawn up with Elijah, including that he would be tested for drugs. It does not appear that a carer's assessment was either considered or completed.

3.2.38 Elijah had his first CPA review on the 30th October. At this meeting, Elijah reported that his paranoid ideation had decreased since admission, but the thoughts were still present. He said he was not carrying weapons and declined psychological therapies. Hereafter, Elijah attended appointments with the Care Coordinator regularly, including medication reviews (there were ongoing discussions about his dosage, as well as his compliance). Broadly, Elijah was engaged with his Care Coordinator but did not take up offers of various other support (including declining the offer of psychological support made on the 10th October). He continued to have

[54] The GP who saw Miss RH has since left the General Practice and it was not possible to establish any further information about this disclosure.

[55] A package of care for people with mental health problems. For more information, go to: https://www.nhs.uk/conditions/social-care-and-support-guide/help-from-social-services-and-charities/care-for-people-with-mental-health-problems-care-programme-approach/.

[56] The Review Panel has not had sight of the correspondence between Miss RH and Elijah's Care Coordinator(s) but has had access to a summary of this contact as recorded in case notes and described in SLaM's chronology.

paranoid thinking. During this time, Elijah said he was not using cannabis, but the evidence suggested he was doing so at least some of the time.

3.2.39 For the remainder of the year, the General Practice was in contact with SLaM, first being notified that Elijah had been admitted, then being updated about his discharge and follow-up care arranged via a Community Mental Healthcare Coordinator. The General Practice was informed that Elijah had been assessed as not being a safety risk and was also advised about his treatment. This included Elijah having regular contact with this Care Coordinator, attempts to engage him in other support (like vocational activities), and taking antipsychotic medication.

3.2.40 Elijah had several further appointments with the General Practice relating to his physical health. His mental health was also kept under review, and it appeared that Elijah had insight into his condition. It was confirmed he would seek support from his Community Mental Healthcare Coordinator if needed. A further 'not fit for work' note was issued.

2018

3.2.41 On the 5th February 2018, Elijah had an appointment with the General Practice. In this appointment, Elijah appeared well and discussed his family relationships, which he is recorded as saying were "*better*," although he noted a grandparent had recently died. Elijah also confirmed he was having weekly reviews at the Ladywell MHU and was taking his medication. At this point, the General Practice had not received an update from SLaM about Elijah's contact with mental health services, so they followed up with them the following day to get further information. They also asked that the practice be kept informed. A few days later, Elijah attended again and a further 'not fit for work' note was issued.

3.2.42 In March, Miss RH was sent a support and recovery plan by Elijah's Care Coordinator at SLaM, as well as information on relapse. This appears to have been based on the Care Coordinator's work with Elijah and focused on relapse indicators.

3.2.43 In April, Elijah had a CPA review. In contact with his Care Coordinator in this month, Elijah referred to an ex-girlfriend when discussing his belief that family and friends were conspiring against him. He said he believed his ex-girlfriend is trying to lure him back so that he can be kidnapped. As a result of these disclosures, and his continued paranoid beliefs, on the 1st May, Elijah was discussed at an EIT meeting. Following this meeting, on the 10th May Elijah was referred to the AMHP service for a MHAA.

3.2.44 On the 11th May, Elijah's Care Coordinator at SLaM contacted the MPS, sharing information about their concerns. Elijah's Care Coordinator said that Elijah appeared guarded about his past but that she believed that he had been involved with the police previously. Elijah's Care Coordinator also noted that:

- Elijah was becoming paranoid of others, believing people were trying to set him up to be kidnapped, tortured, or killed.
- Elijah had said that, while he did not carry a weapon, he would do so for his protection if he was to go to certain areas locally.
- Elijah had also said that although he had thoughts and potential plans to harm someone else, he would not give any details, and he was aware that his Care Coordinator had a duty to pass on the information.

3.2.45 In response to this request, the MPS created an intelligence record. Notably, in its IMR SLaM described receiving information from MPS as indicating there was no evidence that Elijah carried knives. This appears to have been because the police undertook a 5-year intelligence check and confirmed that no incidents had been reported to them in this period involving Elijah and knives. It is possible that the Care Coordinator took this absence of previous intelligence as confirmation that Elijah was of lower risk in terms of his possible use of weapons.

3.2.46 Thereafter, the police took no further action because, whilst the intelligence from SLaM was recorded, no offences had been disclosed. However, the police did complete a MERLIN/ACN and thereby triggered a referral to Lewisham Adult Social Care. However, there was a considerable delay in sharing this information, with this only being sent on the 18th August. Adult Social Care have no record of this referral being received.

3.2.47 On the 20th and 21st May, Elijah contacted the MPS to report that he had been a victim of a crime involving his car, although this did not lead to any further action.

3.2.48 On the 5th June, Elijah met with his Care Coordinator at SLaM. He stated that he had been carrying a multi-purpose tool to defend himself, although he had no intention of harming himself or others. Given Elijah had said that he did not have any thoughts of harming himself or others, this further disclosure was not reported to the police.

3.2.49 On the 6th June, having been referred in October 2017, and initially declining support, Elijah had an appointment for psychological support from SLaM. However, he only had two sessions and thereafter declined further support.

3.2.50 On the 7th June, Elijah had a MHAA. His Care Coordinator from SLaM, other staff, and Miss RH were present. It was agreed that there were no grounds to detain Elijah and his risk would continue to be managed via SLaM's EIT. However, it was agreed that information could be disclosed to Elijah's family about the potential risk, even if Elijah did not agree (this would not happen until July, as Miss RH subsequently was away on holiday). During this contact, Elijah's Care Coordinator provided support to Miss RH around this process.

3.2.51 Reflecting on this flurry of contact, in June, the General Practice received several updates from SLaM confirming that: Elijah had been assessed as not presenting a risk to others but noting that he continued to have paranoid beliefs against family and friends, was becoming "*increasingly paranoid"* and that he was not taking his medication, but there were no grounds to detain him.

3.2.52 On the 16th July, Elijah met with his Care Coordinator at SLaM. In this meeting:

- Elijah again disclosed carrying a knife with him in the last few months to "*defend*" himself, as it was for his "*protection*." Again, this further disclosure was not reported to the police.
- There was a discussion about his family, as he was seeing his mother and aunt. When asked specifically whether he would harm his mother or aunt, Elijah denied this but stated if he saw them put poison in his food, [57] he could not be sure of his reaction.

3.2.53 Elijah had several further meetings in this month with his Care Coordinator, who encouraged him to adhere to his medication, which Elijah said he was doing. At one of these meetings, Elijah is recorded as saying that he had agreed to take medication as he believed that mental health could be used as a defence if someone came to harm him, and he had to act to defend himself. This disclosure was not reported to the police.

3.2.54 Given the concerns about possible risk, Miss RH was contacted by Elijah's Care Coordinator. (This had been discussed with Elijah and, whilst he was unhappy with the decision, he acknowledged that this was something the Care Coordinator had to do). The Care Coordinator had a discussion with Miss RH about Elijah's disclosures. Miss RH said that she had not seen anything that would concern her.

[57] The Home Office Quality Assurance Panel questioned whether comments about witchcraft and voodoo had been sufficiently explored (see Appendix 5 and response to the letter in Appendix 6). Voodoo or poisoning were noted in the chronology here, with other references at 3.2.55, 3.2.61, 3.2.63, and 3.2.84, and are then discussed in the analysis. While allegations around poison and voodoo are not explicitly explored, this is because these issues, as reported at the time and as analysed in this report, were part of Elijah's wider paranoid beliefs. As such, voodoo or poising are explored as part of Elijah's wider paranoid beliefs and the management of these, including about family members (see, for example, 5.1.9) and in terms of SLaM's response (including overriding its duty of confidentiality to Elijah to share these allegations with family members, see 5.3.46).

Miss RH declined to provide contact details for Elijah's aunt, saying instead that she would notify her. Miss RH was advised to remain in touch with the Care Coordinator and call the police if she had any concerns. Miss RH was also informed that there was going to be a MHAA. In a call the following day, Miss RH said that Elijah was still "*irritable*," but she did not feel at risk from him.

3.2.55 On the 16th July, Elijah went to the Emergency Department at University Hospital Lewisham. He claimed his mother had brought poison back from a trip abroad, he believed in witchcraft and was of the "*fixed firm belief his family wants him dead because of his money*." Elijah said that his aunt had tried to poison him, and in this conversation, Elijah also said that his mother had also brought back "*poison*" and "*voodoo*" from her holiday. He was referred to SLaM's Psychiatric Liaison Team but left before being seen, saying he had an appointment with his Care Coordinator in SLaM's EIT (which he in fact did, and who saw him the same day, having been updated by the Psychiatric Liaison Team).

3.2.56 Elijah's General Practice were informed that he had been to the Emergency Department and, in response, tried to engage with Elijah, on one occasion he did not answer, on another he was with his Care Coordinator and was reluctant to talk. An appointment was booked for the 23rd of July, but Elijah did not attend. Elijah was invited to another appointment on the 6th of August, which he also did not attend.

3.2.57 On the 19th July, Elijah reported to his Care Coordinator for the first time that he was barricading himself into his room at night.

3.2.58 On the 20th July, there was consideration as to whether to undertake a MHAA. However, it was decided not to because Elijah was engaging, regularly seeing his Care Coordinator at SLaM, and he continued to say he was adhering to his medication.

3.2.59 On the 21st July, Elijah went to a police station, initially reporting that his phone was lost. However, it transpired that he wished to report his concerns that family members (maternal and paternal), gang members, as well as his Care Coordinator at SLaM, were all working together and plotting a conspiracy to kill him. Elijah stated that this stemmed back to a period around three or four years ago when he used to deal drugs and they wanted the money he made from selling drugs.

3.2.60 The police thereafter took no further action, but a MERLIN/ACN was completed, which triggered a referral to Lewisham Adult Social Care. However, this MERLIN/ACN was also delayed, and it was only shared on the 16th August. Notably, Adult Social Care have no record of this referral being received.

3.2.61 On the 23rd July, Elijah saw his Care Coordinator at SLaM and repeated his previous disclosures (Elijah was still convinced of his belief that his mother and aunt were trying to poison him. Whilst he denied carrying/sleeping with knives, he said he did have a knife in his car and was planning to dispose of it). It was not documented whether Miss RH or the police were informed of these disclosures but the notes state that the Care Coordinator "*made it clear* [to Elijah] *that he is responsible for his own actions and is liable to face the consequences if he harms another person*."

3.2.62 On the 27th July, Elijah's Care Coordinator spoke with the AMHP service, and it was agreed that a MHAA was not needed as, at the time, Elijah was taking his medication.

3.2.63 On the 6th, the 14th and the 15th of August, Miss RH contacted Elijah's Care Coordinator to share information about Elijah. Miss RH felt that his behaviour had become worse since she had returned from holiday the previous year. She shared that:

- Elijah believed his family was trying to poison him
- Elijah was locking his door barricading himself in his room.
- Other behaviours were worrying her, including leaving the iron on, going out without telling her, and not eating properly. She was also concerned he was smoking cannabis.

3.2.64 The Case Coordinator had extensive conversations with Miss RH about what was happening. The Care Coordinator also asked Miss RH if she felt safe (Miss RH said "*No, he is not making threats but swears a lot. I do feel safe*").

3.2.65 Miss RH said she did not want Elijah to be told about her concerns. Following these disclosures, Miss RH was given carers advice, offered psychoeducation, and was sent information about psychosis titled 'Understanding Psychosis.' It is not clear what, any, advice broader safety Miss RH was given.

3.2.66 At a medical review the next day, Elijah repeated his claims that people wanted to "*rob, kidnap, and murder him*." In parallel, Elijah said that he did not want his family to be told anything about his care.

3.2.67 On the 19th August, Elijah flagged down some police officers, stating that people were trying to kill him, and he wanted to see police. Elijah was taken to the station to discuss what he wanted to say in private. Elijah initially said he wanted to report that his phone had been lost. However, he then reported that his family, and local gangs, were trying to kill him and that his phone was bugged. He felt that everyone

was against him, including his mother and his employer. He stated that he had an extreme distrust of the NHS and his support worker. Elijah said that if either were alerted, he would be in extreme danger.

3.2.68 When speaking to police officers, Elijah disclosed that he had a mental health diagnosis and was taking medication. Elijah was also observed to be behaving unusually and erratically. During this encounter, Elijah was carrying a knife, which he said he wanted to hand to the police. Subsequently, police officers dealt with this as a mental health crisis as opposed to taking any further action (e.g., by way of arrest)

3.2.69 Police officers contacted SLaM, and he was seen at the police station by clinicians from SLaM, although he refused to engage with them. Police officers were advised that Elijah did not need to be sectioned as he had stated numerous times that he was not suicidal and would not harm anyone else unless he was in danger. As a result, he was deemed not to meet the detention criteria for a MHAA. Elijah was taken back to his vehicle by police with advice from the mental health team that they would attend his home address the next day.

3.2.70 The police thereafter took no further action. Additionally, on this occasion, no intelligence checks were completed (with this recorded as being because of the "*extreme work volume and staff shortage*"). However, a MERLIN/ACN was completed, which triggered a referral to Lewisham Adult Social Care. As before, there was a delay in sending this, with it only being sent on the 19th September. Adult Social Care have no record of this referral being received.

3.2.71 On the same day, Elijah presented at KCH reporting paranoid beliefs and was seen by SLaM's Psychiatric Liaison Team. He was offered an informal admission but did not want to wait for a bed, so left saying he would come back. The next day (the 20th August), Elijah came back, and he was informally admitted to SLaM Ladywell MHU, and the General Practice were notified. On this occasion, Elijah said he did not want his family to be notified. During this admission, a decision was made to change Elijah's medication, and increase the dosage. However, Elijah refused the increased dose.

3.2.72 On the 28th August, Miss RH and Elijah were both seen by SLaM. This was for psychological support, including a carer support session.

3.2.73 On the 5th September, Miss RH had an outpatient appointment at University Hospital Lewisham for a physical health issue.

3.2.74 On the 6th September, Elijah return home from the Ladywell MHU to live with Miss RH. In the community, he was being seen regularly by his Care Coordinator from

SLaM. In contact with his Care Coordinator, Elijah reported that he was taking lower doses of his medication and/or missing doses. Elijah was advised that he should take his medication at the higher dose, which he said he would consider. Thereafter, Elijah's compliance was not consistent but, whilst his medication was discussed regularly, Elijah had a legal right not to consent to treatment and so SLaM was not able to compel him to take medication.

3.2.75 On the 19th September, Elijah's Care Coordinator supported him to start a housing application as Elijah said wanted to move out. However, this could not be completed because Elijah was not in receipt of benefits and did not want to claim job seeker's allowance. As a result, he was not able to secure a deposit and decided to stay at the family home.

3.2.76 On the 25th September, Elijah had an appointment at the General Practice. Elijah asked for a letter to his employer saying he was fit to return to work (he said they knew about his recent period of illness, as well as admission). During the appointment, it was recorded that Elijah had a "*good, relaxed demeanour, no evidence of psychosis*" and had insight into his mental health. One issue at this appointment was that the General Practice did not have a discharge summary about his last admission to the Ladywell MHU, including details of his current medication. In contrast, SLaM report that this information had previously been shared with the General Practice via an automatic email notification on the same day that Elijah was discharged from the Ladywell MHU. Regardless of whether this had or had not been sent, the General Practice followed up with SLaM, who provided this information in October, including details of Elijah's medication and ongoing care via the CMHT. SLaM requested that the General Practice continue to monitor Elijah's physical health.

3.2.77 On the 11th October, Elijah opened an online housing register application with Lewisham Council Housing Needs Department. However, as Elijah had not completed the eligibility criteria questions correctly, his application was declined on the 19th November. It is not clear if Elijah discussed this with his Care Coordinator at SLaM.

3.2.78 On the 30th November, police officers came across an incident outside of Elijah's workplace where it was alleged that he had been assaulted by a work colleague. The incident was investigated and later concluded with no further action, although it was subsequently identified that there were significant delays in both the investigation and liaison with Elijah. Following this assault, Elijah attended A&E.

3.2.79 The General Practice was notified on the 3rd December. The General Practice had a telephone consultation with Elijah on the same day, and he was invited to an

appointment on the 11th December. In these contacts, in addition to his physical health, there was a discussion of Elijah's mental health. He reported not taking his antipsychotic medication, but the GP was aware from the A&E discharge notification that his Care Coordinator was aware of this.

3.2.80 On the 19th and 30th December Elijah had contact with the police relating to incidents at his workplace (he was a witness to reported criminal behaviour).

3.2.81 During this year, SLaM has indicated that risk assessments in relation to Elijah's risk to others were completed in September and December 2018. At both these assessments, it was decided that Elijah's risk to others was low.

2019

3.2.82 On the 4th January, Elijah contacted the General Practice and asked that Miss RH be removed as his next of kin. No reason was given.

3.2.83 On the 2nd January, Miss RH had an outpatient appointment at University Hospital Lewisham for a physical health issue.

3.2.84 On the 13th February, Elijah was provided with advice by Lewisham Council Housing Needs Department about what next steps he needed to take to complete an application. Elijah's initial application was incomplete, as he had not completed a medical form, which was needed if he was applying on medical grounds (i.e., due to his mental health). Elijah had also not provided other required information about who else was resident in the property where he was currently living. Elijah was provided with advice about how to update his application on the 21st. Subsequently, he completed his application, and it was accepted. On his application, Elijah included the following statement under medical information: ***"****I don't trust any of my family as they are out to kill me and pass on information to people who dislike me and are also out to kill me. Last year my aunt poisoned me with fry fish."* (Elijah later discussed this application with his Care Coordinator at SLaM).

3.2.85 On the same day, Elijah attended the Emergency Department at University Hospital Lewisham. He complained of a headache following a 12-hour shift as a security guard. He declined pain relief and said he would go home and sleep.

3.2.86 On the 14th February, Elijah saw his Care Coordinator at SLaM. He reported having stopped his medication. He was being seen regularly by his Care Coordinator, with this increasing to three times a week. This was because Elijah reported that he was no longer taking medication but continued to have residual psychotic symptoms.

3.2.87 On the 7th and 18th March, Miss RH had outpatient appointments at University Hospital Lewisham for a physical health issue. These were for a specific health issue unrelated to domestic abuse.

3.2.88 On the 19th March, Elijah and his Care Coordinator at SLaM discussed his housing application. Elijah confirmed he was submitting evidence regarding his mental health needs.

3.2.89 On the 1st May, Elijah contacted the General Practice to say he was working in security, but he was planning to start working for a care-for-hire service. He was advised that his history of psychosis would need to be declared and how to request a private medical report. (Subsequently, it does not appear that this was requested, as there is no record of a private medical report being provided). In this contact, there was no discussion as to Elijah's current mental health.

3.2.90 On the 10th May, Elijah contacted the General Practice after a road traffic collision. He had not been to A&E and was seen and treated. This was the General Practice's last contact with Elijah.

3.2.91 On the 13th May, internally to Lewisham Council Housing, there was a decision that Elijah was adequately housed but advice was requested from the medical advisor. The medical advisor had access to Elijah's mental health history.

3.2.92 On the 15th May, based on medical advice, Elijah was advised by a letter from Lewisham Council Housing Needs Department that he was not considered to be in priority need.[58] Thereafter, Elijah's case was closed.

3.2.93 On the 16th July, Elijah saw his Care Coordinator at SLaM. He said he was doing well and had been "*relaxed*" recently. He reported continuing difficulties with his family and being less motivated to work.

3.2.94 On the 5th September, Elijah had a CPA review. This identified that Elijah was continuing to harbour low grade paranoid persecutory beliefs, as well as beliefs that people are intentionally doing things to upset him. His relationship with Miss RH was reported as being variable, having been strained, seemed to have improved, and then becoming uncertain. At this meeting, Elijah confirmed he was no longer taking any medication and indicated he would refuse to do so. ([This means Elijah was not taking any medication for his mental health from this point until he killed Miss RH). As before, whilst there were regular discussions about his

[58] A local council must provide emergency housing is someone is homeless and has priority need. For more information, go to: https://england.shelter.org.uk/housing_advice/homelessness/priority_need.

medication, Elijah had a legal right not to consent to treatment and so SLaM was not legally able to compel him to take medication.

3.2.95 On the 5th September, the General Practice received an update from SLaM about the outcome of the CPA review. This noted that:

- Elijah was refusing medication, but he would be continued to be offered antipsychotic medication.
- Elijah had stated that he was not using cannabis.
- Elijah had some problems in his relationship with Miss RH, but these were deemed to be "*stable*."
- Elijah was assessed as low risk to himself and others.

3.2.96 The only other contact the General Practice had this year were updates about Elijah, including updates about contacts with other health providers related to physical health needs.

3.2.97 In October, Elijah's Care Coordinator at SLaM changed and there was a joint handover meeting on the 30th October with the old and new Care Coordinators. At this meeting, Elijah openly discussed his circumstances but expressed some anxiety about developing a relationship with a new Care Coordinator. This was discussed and it was agreed that Elijah would focus on relapse prevention work with the new Care Coordinator and that they would have regular meetings. At this meeting, it was noted that Elijah's housing application had not progressed further (the reason is recorded as being because he was not eligible for benefits). Thereafter the new Care Coordinator had regular meetings with Elijah, including in November and December. As part of this contact, Elijah reported that he felt better when he was working, and this also meant that things were easier at home as it meant he and Miss RH were not always crossing paths.

3.2.98 During this year, SLaM has indicated that risk assessments in relation to Miss RH's risk to others were completed in September and December 2019. At both these assessments, it was decided that Elijah's risk to others was low.

2020

3.2.99 In 2020, the General Practice had limited contact with Elijah. This included inviting Elijah to a review in January 2020, with a further follow-up, but Elijah did not attend or respond. The General Practice also received an update about contacts with other health providers related to physical health needs.

3.2.100 On the 4th January, as part of regular contact with Elijah at SLaM, the risk assessment was updated by his Care Coordinator, reflecting reports of incidents at home (Elijah had said he had smashed a wall at home). However, his risk to others remained assessed as low and there is no evidence that the risk of domestic abuse was specifically considered.

3.2.101 On the 8th January, Miss RH contacted Elijah's Care Coordinator. Elijah had been making accusations about her, including that she was trying to harm him, and that she felt he was smoking cannabis again. Elijah had become angry and had "*trashed her house*," and she had stayed away for the night. The following day, a crisis plan was discussed, which included identifying a place of safety if she needed to leave the house (Miss RH said she felt safe and wanted to stay at home) and advice about calling SLaM's Crisis Line[59] or 999. On this same day, Elijah met with his Care Coordinator.

3.2.102 On the 14th January, Elijah met with his Care Coordinator, with this appointment being scheduled earlier than planned because of the concerns raised by Miss RH. He said he was "*feeling good*." However, Elijah confirmed he had been using cannabis regularly since October or November, although he was intending to quit. When asked about how he feels when at home, he said that recently he has stepped back from extended family and that his family is "*not good for my mental health*." Elijah described a complicated relationship with his mother, which causes stress for them both. This related to Miss RH's concerns about his mental health, which he said he found "*overprotective and patronising, and always nagging*." This was explored with Elijah, who said that he understood that this was because Miss RH worried about him. In this discussion, Elijah said that he would never harm Miss RH, but also expressed some paranoia towards her.

3.2.103 At this meeting, the Care Coordinator and Elijah discussed his housing needs. Following this, on the 23rd January, the Care Coordinator spoke with Lewisham Homes. The Care Coordinator was advised that Elijah had been assessed in May 2019 and, because he was living with Miss RH, his application had not been approved. The Care Coordinator was advised that Elijah would have to make an application to Lewisham Council's Housing Needs Department. Subsequently, the Care Coordinator was informed by Lewisham Council's Housing Needs Department that Elijah was not eligible for housing.

[59] Provides support out of hours. For more information, go to: https://www.slam.nhs.uk/patients-and-carers/crisis-support/.

3.2.104 On the 18th March, Elijah told his Care Coordinator he was still working but less frequently and had no issues with his mother.

3.2.105 The Covid-19 lockdown began on the 23rd March 2020, meaning that Elijah began to have contact with his Care Coordinator remotely. It is noticeable that attempts to engage with Elijah were largely unsuccessful from this point on, with Elijah not answering his mobile. Several attempts in April to meet with him in person were also unsuccessful. Elijah also did not attend a CPA review on the 7th April (the General Practice did not receive an update about this CPA review).

3.2.106 However, Miss RH was reporting increased concerns, including worries about how Elijah was spending his time because of the Covid-19 lockdown (not least because he was no longer working). On the 3rd April, she contacted the Care Coordinator to say that Elijah was smoking cannabis again, that his behaviour was erratic, that he was becoming aggressive, and was swearing and shouting. Miss RH also said that Elijah was burning rubbish outside his bedroom window. Nonetheless, when asked on the 17th April, she reported feeling safe at home. Miss RH did however admit she had hit Elijah two weeks previously, but said it was not a serious incident and would not provide further details (in a later call, Miss RH described this as she "*pushed*" Elijah). Miss RH also asked about the plans to re-house Elijah, saying she was reluctant to evict him. Miss RH also said she thought that Elijah needed to change the team he was being supported by, due to difficulties in building rapport and trust. (SLaM have indicated that they have no record of this request).

3.2.107 On the 17th April, the Care Coordinator contacted Lewisham Council's Housing Needs Department and explained the concerns about Elijah ("*His psychosis centres on paranoia/persecutory beliefs about his mother. There is evidence of a deterioration in his mental state currently*"). Lewisham Council Housing have no record of this contact, so it was likely general advice provided by phone. Based on SLaM's records, the Care Coordinator was advised that Elijah was not in priority need and, if he was evicted, he should present to SHIP for assistance. At this point, it does not appear further action was taken to address this issue including, for example, linking Elijah's housing need with his health and the needs of Miss RH. This could have included, for example, using the 'duty to refer.'[60]

3.2.108 On the 28th April, the Care Coordinator spoke with Miss RH about an offer of carer support. This included face-to-face Carer Support Meetings, Family Intervention Meetings, and a Carers Peer Support Group. Miss RH said that she

[60] This is a new duty which means public bodies can make a referral to a housing department if they think any of their users are at risk of homelessness. Consent is required. For more information, see: https://www.gov.uk/government/publications/homelessness-duty-to-refer/a-guide-to-the-duty-to-refer.

would be interested, and she was added to the contact list (she was subsequently invited to a group in May). Miss RH was also contacted to complete a carer's support plan.

3.2.109 In May, the situation continued, with Elijah not engaging, and Miss RH reporting continued concerns, including Elijah burning rubbish and his behaviour. During this month, the Care Coordinator offered regular support to Miss RH, although Miss RH was not always available due to work commitments. This also triggered a review of Elijah's mental health, which ultimately led to a MHAA referral.

3.2.110 On the 11th May, the Care Coordinator had a discussion with Miss RH about the possibility of a MHAA at her home, with police support. Miss RH said she was very reluctant to have a police presence in her home. She described having a "*fear of police*" (which she said was because Elijah was a young Black man) and said she had never called 999 because she wanted to protect Elijah from police, despite the ongoing risks and concerns around his behaviour. Miss RH said she would rather try to "*coax*" Elijah to go to the hospital and request an informal admission. The Care Coordinator offered to support him and her in doing so should Elijah wish to. Attempts to contact and see Elijah were unsuccessful in the next few days.

3.2.111 In a call with the Care Coordinator on the 15th May, a further offer of support was made to Miss RH, who at this point accepted a MHAA was needed because she felt Elijah was deteriorating. There was further contact with Miss RH on the 18th May when she told the Care Coordinator she was "*not scared of him* [Elijah]" and was "*always one step ahead*". A MHAA was requested on the 20th May. At this point, following a review by the AMHP service and in consultation with the EIS, it was agreed the referral did not require an immediate response.

3.2.112 On the same day, following up the discussion about carer support in April, a community support worker contacted Miss RH to offer carers support. This led to contact with Miss RH on the 20th May to complete a carer's support plan, with carer support sessions starting on the 22nd May. This was never completed, however, with a second meeting in June being cancelled by Miss RH.

3.2.113 By the 26th May, Miss RH contacted the Care Coordinator and told her that she had found a petrol container, and Elijah had confronted her and said that "*you are dead"*. Miss RH said she had tried to call the Crisis Line three times over the bank holiday but had not been able to get a response. (Subsequently, it appears that the options offered to callers were not clear).

3.2.114 Miss RH and the Care Coordinator discussed how to manage the situation, including practical steps to assist in a crisis. This included removing clutter from

the corridor to enable easy access for the police if they needed to come into the house, as well as providing information on SLaM's Crisis Line. As Miss RH had tried this previously, the Care Coordinator flagged the issues she had raised with the Crisis Line with a manager. The Crisis Line then contacted Miss RH.

3.2.115 As part of this discussion, the Care Coordinator advised Miss RH to call the police if it seemed at all possible that there might be an immediate risk of harm to her. Miss RH said that she would only do this as a last resort. There is no evidence to indicate other options were discussed with Miss RH given her stated aversion to calling the police, including a place of safety.

3.2.116 Because of Miss RH's disclosures and her concern, a request was made to the AMHP service that Elijah's admission be prioritised. As a result, on the 27th May, the AMHP service booked a court slot to obtain a warrant [61] with HM Court and Tribunal Service (HMCTS). The slot offered was on the 2nd June. Despite being aware of Miss RH's request for a MHAA, and that she had indicated she would only call the police as a last resort, the AMHP service did not seek to secure an earlier date.

3.2.117 Miss RH's last consultation with a GP was on 27th May in relation to knee pain. There is no reference to stress or concerns about home life.

3.2.118 This same day, Miss RH was contacted by SLaM and told that they were prioritising the MHAA for Elijah.

3.2.119 In the last few days of May, the situation appeared to stabilise, with Miss RH reporting a calm weekend to the Care Coordinator. She did however agree to a referral to the London Fire Brigade for a Fire Risk Assessment on the 1st of June because of concerns about fire safety.

3.2.120 At the scheduled hearing date, on the 2nd June, a warrant for the MHAA was secured by the AMHP service. A request was then sent to the MPS for their attendance at the MHAA using an online portal hosted on the MPS website.

3.2.121 Having received the request for police assistance from the AMHP service, an email was sent by EIT to the South East Basic Command Unit (BCU)[62] operations room mailbox to request assistance with the execution of the warrant. The supervising officer covering the operations room, who did not normally work in this role, followed what they thought was the correct procedure and forwarded the email to the Neighbourhood Policing Team (NPT), believing this was the route for EIT to

[61] Under the MHA, a warrant allows the police to enter someone's home, if need be, by force, to enable an assessment.

[62] BCUs were introduced in 2018 and the Southeast BCU covers Bexley, Greenwich, and Lewisham.

liaise with MPS. However, at the NPT, a Community Support Officer read the email and, believing it was for 'information only,' did not action the request.

3.2.122 Additionally, having not received a response from the MPS, no contact was made by the AMHP service with MPS. As a result, the warrant was not served on Elijah, and this was outstanding at the point at which Miss RH was killed.

3.2.123 Additionally:

- At the start of June, the London Fire Brigade received a referral from SLaM relating to Elijah. This related to concerns that Elijah was having barbeques and burning rubbish outside of the property. A Home Fire Safety Visit was arranged for the 5th June 2020. Miss RH subsequently declined this visit. The London Fire Brigade has a record that the reason Miss RH gave was that she was too busy and that she would contact them to rearrange the appointment. SLaM records offer a different explanation: Miss RH told Elijah's Care Coordinator that she wanted to wait until Elijah was in hospital as she was worried a visit might cause tension. Regardless of what Miss RH said, SLaM was informed of the cancellation by the London Fire Brigade, however, this was not received until after Miss RH had been killed.
- With respect to these concerns around fire setting, there is no evidence that consideration was given to liaison with Pinnacle Housing (the building owners), either directly or by encouraging Miss RH to do this.
- Two days before Miss RH was stabbed by Elijah, Pinnacle Housing was contacted by a neighbour. This was the only time Pinnacle Housing ever received a complaint relating to the property. The neighbour emailed to alert Pinnacle Housing to the behaviour of Elijah, who they did not identify by name but described as the son of the owner of Miss RH's flat. The then Housing Officer received emails from the tenant about their fears about Elijah, including their fears about wanting to move because they were worried about their safety and that of their children. Elijah was reportedly setting fires in the back garden, and the tenant was concerned that he might set fire to the house or attack them. The Housing Officer completed a risk assessment. They decided there was a minimal risk, given the tenant did not use the same door to the flats as Elijah and had themselves stopped using the garden. As no further action was taken, the tenant was advised how they could request a move and told them to call the police if they felt threatened.

3.2.124 On the day that Elijah stabbed her, Miss RH had contact with the Care Coordinator. Miss RH described some of Elijah's behaviour, including his having changeable

moods. Miss RH had encouraged Elijah to contact his Care Coordinator, but he had said that he needed to manage by himself. The family believe that in contact on this day, Miss RH relayed her fears and concerns for herself, although there is no record of this included in the case notes.

3.2.125 Later that day, Elijah approached police officers and told them he had stabbed Miss RH. After this arrest, he was risk assessed to determine if he was fit to be detained and interviewed. As part of this risk assessment, people are asked 16 questions, of which five relate to mental health, as well as three related to alcohol and drug use. The questions and answers are shown in Figure 1 overleaf.

3.2.126 As a result of Elijah's disclosures, he was placed on a constant watch (i.e., two officers remained with him throughout) because of concerns about possible self-harm.

Figure 1.

Risk Assessment of Elijah When Detained

Do you have any mental health problems?	Yes	A: Psychosis / Schizophrenia / Delusional disorder
Have you had or are you receiving any treatment for this?	Yes	A: Intervention team at PL hospital but refuses meds.
Are you taking or supposed to be taking any medication for this?	Yes	Q "Are you up to date with your medication?" A: Refuses Q: "When are you next due to take it?" A: Refuses – meds Q "Where is your medication at the moment?"
Have you ever tried to harm yourself?	Yes	A: "Being trying since age of 6 – Most recently a year ago". – Mentioned he wanted a padded room. States he is a psychopath and punches walls
How are you feeling now?		A: "How would you feel if you just tried to kill your mum" then shows no emotion.
Have you consumed alcohol/taken any drugs (prescribed or otherwise) or solvents within the last 24 hours?	Yes	Q "What did you take? Bit of alcohol / Cannabis and possibly LSD – Q: "When did you take it?" A: "Past few hours"
Dependent on alcohol?	No	
Dependent on drugs (prescribed or otherwise)?	Yes	A: "Cannabis"

3.2.127 Other agencies were involved with Miss RH after she was attacked by Elijah and before she died. This included KCH, which provided health care and made a safeguarding referral to Lewisham Adult Social Care. Meanwhile, Lewisham Adult Social Care, upon being notified, allocated a social worker to coordinate any decisions about future safeguarding, although sadly this was not necessary because of Miss RH's death.

4. Overview

4.1 Summary of Information from Family about Miss RH and Elijah

4.1.1 Aurora, Grace, and Evelyn described Miss RH as "*vibrant, loveable*" and a "*mum, sister, friend and auntie*." They also said that Miss RH was "*level-headed and would always be the person you went to for advice, she would tell you as it is and didn't beat around the bush, what you saw is what you got*."

4.1.2 Talking about Elijah, Aurora, Grace, and Evelyn described him as "*always smiling,"* "*loving"* and "*family orientated."* They were proud that when he had trained as a carpenter, he was the first Black person to have obtained an apprenticeship with a large building company.

4.1.3 Aurora, Grace, and Evelyn described Miss RH and Elijah as "*close"* and said that they had a good relationship and would talk openly. Elijah had moved back home in early 2017 after a road traffic collision. During that year, Elijah's mental health issues became apparent.

4.1.4 Initially, Aurora, Grace and Evelyn felt that Elijah had been well supported, and he started taking medication. They said: "*at that point, he lived a normal life, and you wouldn't know he was ill if you met him."*

4.1.5 Aurora, Grace, and Evelyn were positive about the support that Elijah received from his first Care Coordinator, who worked with him until October 2019. They felt unhappy with the handover between the Care Coordinators and said that Elijah "*didn't feel confident with them and they didn't have a closeness that he had with* [the first Care Coordinator]." Aurora, Grace, and Evelyn highlighted that Miss RH had asked if Elijah could change his Care Coordinator.[63]

4.1.6 As Elijah became more unwell after March 2020, which Aurora, Grace, and Evelyn recognised happened "*suddenly"*, they said they felt that "*Miss RH was left to care for Elijah without any help"*.

4.1.7 They felt that Elijah was not seen as a risk because "*he was looked after by his mum."* Aurora, Grace, and Evelyn felt that the information that Miss RH was supplying to the Care Coordinator was not being considered.

4.1.8 Aurora, Grace, and Evelyn thought that Miss RH would not have seen herself as a carer, "*she would have said she was a loving mother looking after her son."*

[63] This is referenced in the chronology as being in April 2020.

Nonetheless, they felt that "*without realising* [it]*, Miss RH was a carer for Elijah*." Aurora, Grace, and Evelyn said that they did not think that Miss RH was ever offered a Carer's Assessment.[64]

4.1.9 Talking about agency contact, Aurora, Grace, and Evelyn highlighted concerns about the support for Miss RH and Elijah generally by SLaM in late 2019 and early 2020 and felt more proactive support may have made a difference. They also highlighted the time taken to arrange a MHAA and then the delays that arose as SLaM and the MPS tried to arrange a warrant.

4.1.10 When asked about potential barriers, Aurora, Grace, and Evelyn said that "*Miss RH said on one occasion she didn't think that* [the second Care Coordinator] *was experienced with Black people, particularly men, based on how she was interacting with Elijah*."

4.1.11 Aurora, Grace, and Evelyn also said that the second Care Coordinator "*told Miss RH that Elijah should have been admitted to the hospital but said they couldn't take him because of Covid-19, so he wasn't a priority*".

4.1.12 As a final observation, they said that contact with the General Practice largely stopped once SLaM became involved.

4.2 Summary of Information from Perpetrator

4.2.1 As noted in Section 1, Elijah did not engage in the review, so there is no further information available from him.

4.3 Summary of Information from Friends, Work Colleagues, Neighbours and Wider Community

4.3.1 As noted in Section 1, it was not possible to establish contact with any friends of Miss RH.

4.3.2 However, information was provided by Miss RH's employer, a financial services company. This information was based on interviews conducted by a Human Resources Business Partner. The colleagues spoken to included two managers and two work colleagues.

4.3.3 In summary, Miss RH was a well-liked, but a private colleague.

[64] As detailed in the chronology, Miss RH had been offered carer support over time, and an assessment was begun in May 2020.

4.3.4 In terms of management at the company, there were no concerns about her work performance, or any disclosures made by Miss RH, which might have indicated potential issues around domestic abuse. However, managers were aware that Elijah had been injured in a road traffic collision and that, before joining the company, Miss RH had taken a career break to care for him. When Miss RH did talk about Elijah, she was described as "*talking very fondly of him*."

4.3.5 Colleagues of Miss RH also spoke similarly about her. However, they noted two further issues. First, although Miss RH spoke fondly of Elijah, she did tell one colleague that Elijah could be "*very rude and abrupt to her, which sometimes made her frighten*[ed].' However, at the time, the colleague did not feel Miss RH was at risk but did say to her that she could always talk to them if she needed help. Miss RH also told this and another colleague that sometimes Elijah called her names. Second, both colleagues felt that coming to the office may have been a "*break from home*" which, as an option, was not available once Covid-19 lockdown restrictions came into force.

4.4 Summary of Information Known to the Agencies and Professionals Involved

Contact with Miss RH

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

4.4.2 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 an MHAA), 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.

4.4.3 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.

4.4.4 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.

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

4.4.6 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

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

4.4.8 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.

4.4.9 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/ACNs were either not created in line with force policy or delayed. 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.

4.4.10 SLaM had extensive contact with Elijah since 2017, with contact across a range of services including the Psychiatric Liaison Team, Assessment and Liaison Team, IAPT, as well as periods at the Ladywell MHU. Ultimately, he was supported by the EIT, 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 try and secure a Home Safety Visit from the London Fire Brigade, no other actions were taken (including considering possible liaison with Pinnacle Housing).

4.4.11 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.

4.4.12 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.

4.4.13 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.

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

4.4.15 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.

4.4.16 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.

4.5 Any Other Relevant Facts or Information:

4.5.1 No other relevant facts or information were identified.

5. Analysis

5.1 Domestic Violence and Abuse

5.1.1 Miss RH was the victim of a fatal act of violence, this being perpetrated by her son Elijah. In this context, Miss RH's homicide can be understood as a fatal case of AFV. However, as Miss RH was killed by her son, it is also important to recognise that her death could also be described as a matricide.

5.1.2 Beyond this fatal act, the picture is more complicated. Whilst there were sometimes tensions in the relationship between Miss RH and Elijah, it appears they were close, including after Elijah had moved back to the property. After 2017, when Elijah's mental ill health declined, it appears that Miss RH was trying her best to support him and, in effect, she was acting as his carer. Nonetheless, Miss RH was clearly impacted by Elijah's ill health. During her contact with professionals, Miss RH expressed concerns about Elijah's behaviour. Additionally, while Miss RH talked fondly of Elijah at work, she also disclosed how some of his behaviour could be distressing, hurtful and sometimes frightening.

5.1.3 Miss RH's concerns increased in 2020, particularly from March. To some extent, the decline in Elijah's mental health may have reflected issues like his reluctance to engage with services, including taking medication, as well as his ongoing use of substances (cannabis). Additionally, it may be that this was, in part, related to the impact of Covid-19 restrictions which meant many aspects of Elijah's day-to-day life were curtailed. However, there is no evidence that Covid-19 affected SLaM's ability to have direct contact with Elijah because, although the last time that his Care Coordinator saw him was in March, there were ongoing efforts to contact him in person and by phone. These were not successful because Elijah did not respond to phone calls and texts or would not agree to meet staff when they attended the property.

5.1.4 Covid-19 restrictions also impacted on Miss RH and as will be discussed below, meant that her day-to-day life was also curtailed. For example, she was working from home.

5.1.5 As Elijah became more unwell, he became more erratic, including being aggressive and starting fires. There may have been incidents when Elijah's behaviour led to confrontations between Miss RH and Elijah, with Miss RH reporting she had pushed him away on one occasion. Additionally, there was at least one occasion when Elijah threatened to kill Miss RH (he told her: "*You are dead"*).

5.1.6 From March 2020, Miss RH was providing regular updates to SLaM about Elijah's declining mental health, as well as the circumstances at home. SLaM was also in contact with Miss RH, providing support to her and trying to engage with Elijah. At the same time, SLaM was also trying to respect Miss RH's wishes to avoid involving the MPS, which reflected Miss RH's concern about how Elijah may be treated as a Black Caribbean man (this is explored further in Section 5.4).

5.1.7 Ultimately, Miss RH was concerned enough to agree that a MHAA should be undertaken. Whilst a referral for a MHAA was made from SLAM's EIT to the AMHP service on the 20th May, the MHAA never took place. This was because of a failure of inter-agency communication.

5.1.8 If the delay in the MHAA had not happened, 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. The reasons for this delay are discussed further in the analysis of agency contact below. Miss RH's family felt that likelihood that Miss RH's death could have been prevented should be a central finding of this review. The Review Panel agreed.

5.1.9 Although there was no conclusive evidence of a broader pattern of domestic abuse, the Review Panel did identify several concerns:

- First, the focus appears to have been on Elijah, and his risk to himself, rather than his risk to others in this context. As a result, while the *potential* risk of domestic abuse in a familial context was sometimes recognised, both to Miss RH but also to other family members, this was neither consistently identified, assessed, or responded to. This learning is important because it highlights the extent to which AFV is understood, recognised, and responded to by professionals.
- Second, Elijah had said he carried or had access to weapons over several years, and repeatedly expressed paranoid thoughts about family members. At times, agencies had specific occasions in which this triggered a response (these are discussed in the agency analysis below). However, more broadly, it appears that concerns about weapons became accepted as part of Elijah's profile of risk, particularly by SLaM who were aware of reports in this context from other agencies and by Elijah. This also, of course, forms part of the lack of consideration of potential domestic abuse risk.
- Third, from 2017, Miss RH was acting as a carer for Elijah, and it seems she may have identified as such, for example by describing herself as a carer to work colleagues. Her family also felt she was acting as a carer. However, while

Miss RH appears to have been offered and taken up regular contact with Elijah's Care Coordinator at SLaM, as will be explored below, it seems that the response to her as a carer was limited and late.

5.1.10 These issues – the potential risk of AFV related domestic abuse, the presence of or concern about the possible carrying of knives, and Miss RH as a carer – are discussed further in the analysis below, both in relation to individual agencies in Section 5.3 and then overall in Section 5.4.

5.2 Through the Eyes of the Victim – Ecological and Intersectional Analysis

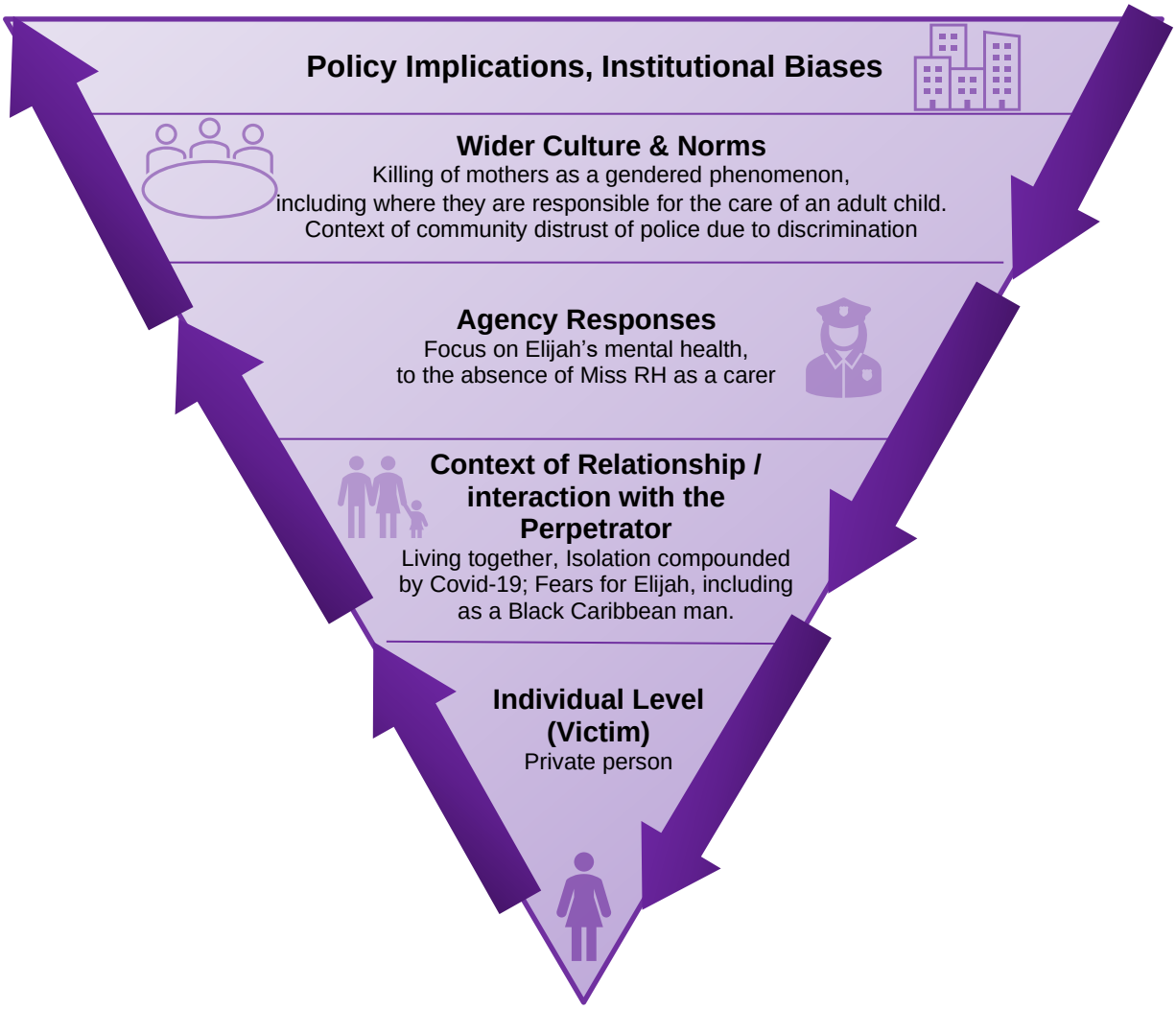
5.2.1 It is difficult to imagine what Miss RH's experiences may have been like. Miss RH was a private person. Whilst she had the support of her family, Miss RH did not readily share details of her life, although her disclosures at work indicate how affected she was in coping with the circumstances in which she found herself. However, it seems reasonable to conclude that, despite the support of her family and sometimes disclosure to others, Miss RH likely felt isolated and conflicted. This isolation was likely exacerbated by Covid-19 restrictions, which meant she and Elijah were largely at home and their daily routines were disrupted. Meanwhile, Miss RH may have felt conflicted because she was both concerned for but sometimes anxious about/fearful of Elijah. Additionally, whilst Miss RH wanted Elijah to access help and support, she was also worried about what this would mean if the MPS became involved during a MHAA. This was because she was concerned about what this might mean for Elijah as a Black British Caribbean man.

5.2.2 Miss RH's sense of isolation and conflict may have been compounded by a sense that she was largely responsible for the care of Elijah. It is noticeable that most agency contact in this review has related to Elijah. This is particularly relevant to SLaM. While SLaM was engaged with Miss RH – as has been touched on above and will be explored in Section 5.3 – her needs as a carer were not fully recognised. This may have compounded her feelings of isolation and conflict because she may have felt responsible for Elijah. In research into AFV, this has been described as 'parental proximity.' This refers to how, in fatal cases of AFV, a victim often carries a heavy burden of responsibility for the care of their child before their death, while

at the same time their own needs (including as carers) are often marginalised. This burden can be gendered, falling, particularly on mothers.[65]

Figure 2.

Through the Eyes of the Victim



[65] Miles, C., Condry, R. and Windsor (2022) 'Parricide, Mental Illness, and Parental Proximity: The Gendered Contexts of Parricide in England and Wales', Violence Against Women, Advance online publication.

5.3 Analysis of Agency Involvement

5.3.1 This section examines how and why events occurred, information that was shared, the decisions that were made, and the actions that were taken or not taken. It is focused on individual agency contact, including: the MPS; health providers (including SLaM, the General Practice, as well as KCH and LGT); Adult Social Care; housing providers (including Lewisham Council Housing, as well as Pinnacle Housing); and the London Fire Brigade. It also summarises contact with Miss RH's employer.

MPS

5.3.2 The police had extensive contact with Elijah, beginning when he was under 18, and carrying on through until the end of 2016. Most of this contact was as the result of stop and search, although Elijah did report being assaulted and criminal damage. From 2017, Elijah continued to have contact with the police, including some stop and searches, as well as for other issues (including road traffic collisions).

5.3.3 The Review Panel has examined these incidents but felt it was beyond the scope and not proportionate for the review to consider them specifically. However, the MPS IMR did identify a specific issue in the police response to a report by Elijah that he had been assaulted at work in November 2018. Specifically, there were delays in the investigation and in updating Elijah about the progress.

5.3.4 In response, the MPS IMR made recommendations. This was accepted by the Review Panel:

Single Agency Recommendation 1: South East BCU Senior Leadership Team (SLT) to remind all staff involved in this incident of their responsibilities to generate a MERLIN PAC where Vulnerable Adults Framework (VAF) identifiers are apparent.

5.3.5 Although it did not consider these incidents in detail, the Review Panel did note:

- It is possible that Elijah was involved in minor criminality, associated with cannabis use and/or dealing. However, he had not been – bar a penalty notice for disorder (PND) and a single charge of possession – subject to any further action by the police. For example, there was nothing known to the MPS to suggest he was involved in gang membership.
- As a young Black man, Elijah's contact with the police because of stop and search was mixed. On one hand, Elijah was sometimes stopped and searched

based on intelligence that identified him specifically. On others, he was stopped during periods of increased police activity. For example, in 2016 police were conducting increased patrols following a rise in violence in Lewisham.

- At the same time, Elijah appears to have been willing to contact the police, both as a victim, and to report crimes. For example, in August 2018, he approached police officers to seek help and disclosed he was carrying a knife.
- Miss RH expressed her concerns about the police, including being reluctant to involve them unless necessary. (For example, Miss RH said on the 11th May 2020, that she wanted to protect Elijah from the police). It may be that this concern reflected this broader issue about confidence in, and perception of, the police.
- These issues are discussed further in Section 5.4 below.

5.3.6 In addition to the above contact, there was significant contact between Elijah and the MPS related to concerns around his mental health. Taken together, these contacts show the level of potential concern about Elijah's well-being, and possible risks to others (given he was reporting his concerns about being set up to be harmed by those close to him and those within the community, and saying he was or would be carrying knives or weapons to protect himself).

5.3.7 The first mental health related contact was in August 2017, when the MPS received a report from the General Practice that Elijah wanted to harm someone (possibly a relative). Police officers appear to have responded to this appropriately, seeking to speak to Elijah and (when he could not be located), following this up. However, in their response to this incident, it does not appear that a MERLIN/ACN was created. The MPS IMR noted that, given concerns about Elijah's behaviour, a MERLIN/ACN should have been created, in line with policy at the time.

5.3.8 In the subsequent incidents on the 14th September 2017, the 11th May 2018, the 21st July 2018, and the 19th August 2019 MERLIN/ACNs were created.

5.3.9 However, there were considerable delays in completing the MERLIN/ACNs in the latter three incidents, meaning that onwards notifications to Lewisham Adult Social Care were delayed. And, in one of these incidents (on the 19th August 2018), no intelligence checks were completed. In 2018, the MPS were undergoing a significant change, with the merging of borough policing areas in BCUs, which may have accounted for these delays.

5.3.10 In response, MPS IMR made recommendations. These were accepted by the Review Panel:

Single Agency Recommendation 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.

Single Agency Recommendation 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.

5.3.11 It appears that these referrals were never received by Lewisham Council Adult Social Care. (This is discussed in relation to that agency below).

5.3.12 In June 2020, the AMHP service applied for and secured a warrant for a MHAA. (The details of this contact with Elijah are addressed in the analysis relating to SLaM). As a result, the AMHP service contacted the MPS to request assistance with the execution of the warrant, with this request being submitted via an online portal for this purpose (see Figure 3).

5.3.13 Requests via this online portal go directly to the relevant BCU mental health team. However, as detailed in the chronology, this request was subsequently sent from the operations room to the local NPT where it was treated as for 'information only.'

5.3.14 The Review Panel felt it was deeply concerning that the process for SLaM to request police support, and for the police to then respond to this, had broken down in this way.

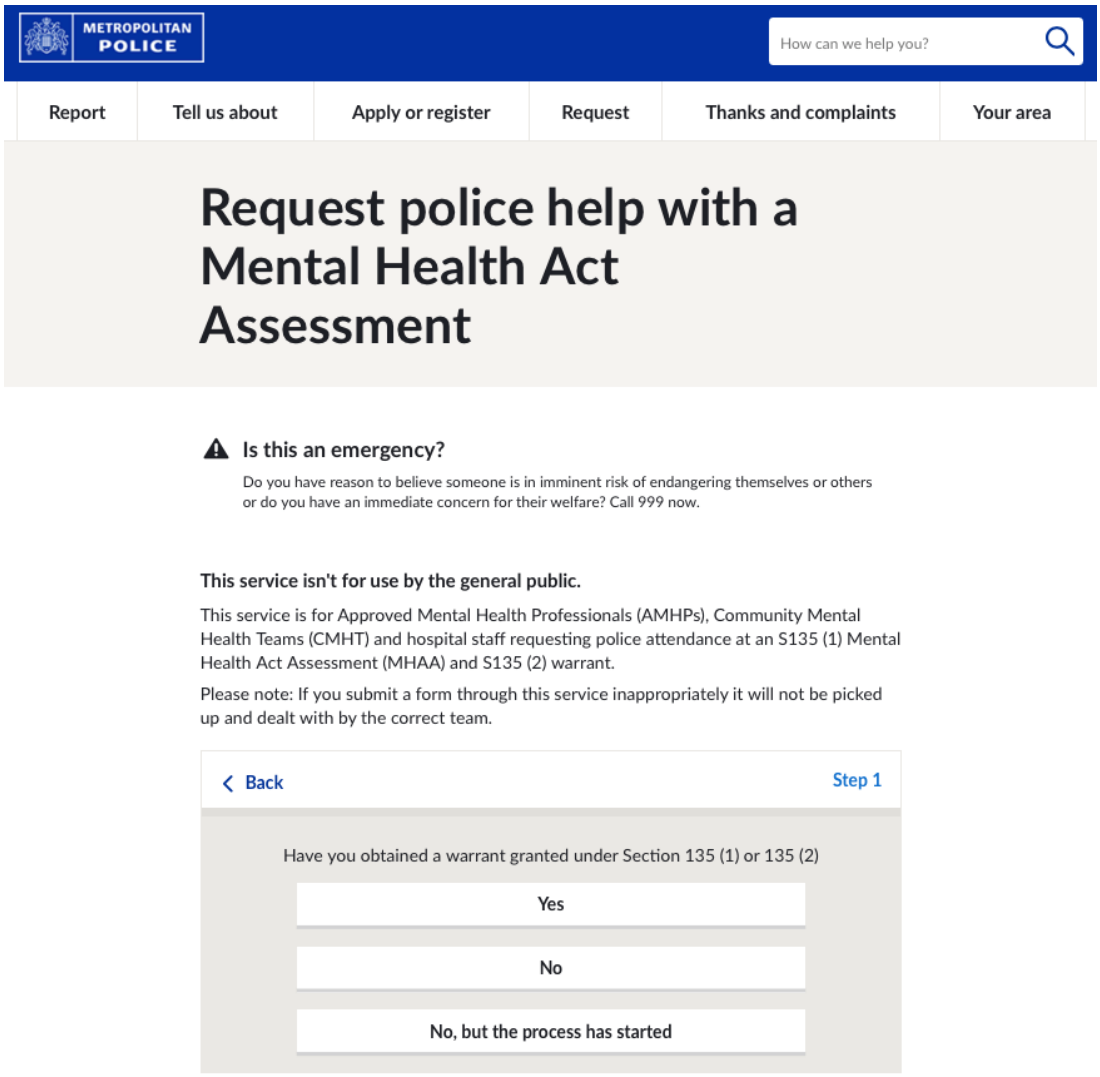
5.3.15 The MPS IMR acknowledged that there was a *"flaw*" in the process as to how information was sent and received between the two agencies.

5.3.16 The Review Panel were informed that, when this flaw was identified during the murder enquiry following Miss RH's death, a new information sharing process was implemented between the MPS and the local partners. This requires that if no response is received following an email being sent, it would be followed up by a telephone call from the sending agency to ensure the message has been received and is attended to (this, and other actions to ensure concerns can be escalated promptly, are addressed in following discussion relating to SLaM).

5.3.17 Additionally, it is of note that there is no evidence that SLaM followed up on the request for police assistance when they did not receive a response. (This again is discussed in the analysis related to SLaM).

Figure 3.

Through a Screenshot of the MHAA request page (see: https://www.met.police.uk/partners/partner-services/mha/v1/request-mental-health-act-assessment).



SLaM

5.3.18 The following analysis of SLaM is in two parts. Firstly, an overview of contact with Elijah and Miss RH and then a specific analysis of the application for a MHAA in May 2020 (which incorporates information from the AMHP service)

Overview of contact with Elijah and Miss RH

5.3.19 SLaM had extensive contact with Elijah, as well as Miss RH. A Serious Incident Report was conducted, and the following analysis draws on that report, as well as the IMR completed for this review. In approaching its consideration of SLaM's care of Elijah, the Review Panel recognised the challenge of working with mental ill health, including the balance between a patient's right and the rights of others (including in terms of information sharing). A further issue is the need to employ the least restrictive practice (for example, avoiding detention where possible), as well as working with patients constructively (for example, encouraging compliance to medication where possible and maintaining engagement rather than detaining someone. As a result, Elijah had a legal right not to consent to treatment and so SLaM was not able to compel him to take medication).

5.3.20 Support for Elijah: During his contact with SLaM, Elijah was in contact with the Psychiatric Liaison Team, the Assessment and Liaison Team, the IAPT service, and the EIT (who provided ongoing support under a CPA). On two occasions Elijah was also admitted to the Ladywell MHU.

5.3.21 Broadly, there was evidence of ongoing work to try and meet Elijah's needs. This was particularly challenging regarding his compliance with medication. As described in the chronology, whilst Elijah was initially compliant with his medication, over time his compliance became intermittent and by September 2019 he reported that he was medication free. This was clearly challenging for SLaM, but the Review Panel felt that there was good evidence of attempts to address this. Elijah's medication was regularly reviewed and, as appropriate, changed. As his compliance reduced and then stopped, it is also evident that this was discussed with Elijah and attempts were made to address this, including changes to the frequency of contact. Moreover, ultimately, SLaM had no powers to compel Elijah to take his medication while he was in the community.

5.3.22 Elijah's primary point of contact was with a Care Coordinator from SLAM's EIT, with this individual changing in October 2019. Overall, Elijah and the two Care Coordinators appeared to have good relationships, although at times Elijah's paranoia included reference to his suspicions about the first Care Coordinator. It

was only in May 2020 that the relationship between Elijah and his Care Coordinator broke down, with this linked to the decline in his mental health.

5.3.23 However, Miss RH may have raised a concern relating to Care Coordination. Specifically, Miss RH's family have reported that Miss RH requested a change of Care Coordinator in 2020 after the staff member had changed in October 2019. However, SLaM have no record of this request. From the evidence seen by the Review Panel, it appears that the transfer of the Care Coordinator was appropriately managed. Unfortunately, as the Review Panel has not been able to speak with Elijah, it has not been possible to explore this further. As a result, regretfully, the Review Panel cannot take forward the concerns raised by Miss RH's family.

5.3.24 Aurora, Grace, and Evelyn identified a further concern with Elijah's contact with SLaM, specifically relating to the extent to which they felt the second Care Coordinator was able to work with Elijah as a Black Man.

5.3.25 Having reviewed the case notes, the SLaM representative on the Review Panel stated that there was neither evidence that Elijah was treated less well as a Black Caribbean man nor that the Care Coordinators involved in his case did not have experience working with this community. Unfortunately, as the Review Panel has not been able to speak with Elijah, it has not been possible to explore his perception of his experiences and test these assertions. Nonetheless, whilst the Review Panel agreed that it was therefore not possible to explore the family's concern further, it noted that it is well established that Black people experience a disparity in terms of access to and outcomes in relation to health care, including mental health.[66] In recognition of this, the Review Panel noted that it is positive that SLaM is currently rolling out cultural awareness training as part of its Patient and Carer Race Equality Framework.[67] The issue of Elijah's experiences as a Black Caribbean man are explored generally in Section 5.4 below.

5.3.26 Broadly, Elijah seemed to have been ambivalent about his mental health diagnosis and although he was often engaged (for example, meeting with his Care Coordinator), as described above, he did not always take his medication and stopped entirely from September 2019. Over this time, he was also, at periods, using cannabis and, although he identified this as an issue, was overall either

[66] Kapadia, D., Zhang, J., Salway, S., Nazroo, J., Booth, A., Villarroel-Williams, N., Bécares, L., and Esmail, A. (2022) Ethnic Inequalities in Healthcare: A Rapid Evidence Review. London: NHS Race & Health Observatory. Available at: https://www.nhsrho.org/wp-content/uploads/2022/02/RHO-Rapid-Review-Final-Report_v.7.pdf (Accessed 6th June 2022).

[67] For more information, go to: https://slam.nhs.uk/pcref.

unable or unwilling to address this (he was also potentially taking other drugs too). Collectively, this would have affected his mental health. Additionally, Elijah was also reluctant to access psychological support, although this was offered to him (he attended a few sessions, then did not engage further), with this possibly related to a stigma around mental illness.

5.3.27 While he was in the care of SLaM, Elijah's CPA was reviewed annually (in October 2017, March 2018, and September 2019). A planned CPA review in April 2020 did not happen as Elijah did not attend and this, as well as his broader decline, triggered an MHAA (discussed below). The guidance for a CPA review is that it should happen annually. After each review, the General Practice was notified (although issues around communication with the General Practice are discussed below).

5.3.28 Having considered the Serious Incident report, as well as an IMR and additional information from SLaM, the Review Panel identified five areas of focus:

- Response to Elijah's cannabis use.
- Response to Elijah's housing need.
- Support for Miss RH.
- Identification of possible domestic abuse.
- Response to reports that Elijah had access to weapons, and fire safety concerns.
- Applying for a MHAA in May 2020.

5.3.29 These areas are summarised in turn, before SLaM's IMR recommendations are considered.

5.3.30 In relation to Elijah's cannabis use, this was known to staff at SLaM. Initially, Elijah expressed a wish to give up cannabis because of the problems it caused him in terms of mental health, but later he said he did not want to, and it does appear he continued to use cannabis. Attempts were made to support Elijah around this, including psychological support (as noted above, bar a few sessions, he chose not to continue with this offer), and an attempt was made to refer Elijah to a local drug service (but Elijah did not accept this).[68]

[68] This referral was to a service provided by CGL, which confirmed it had not had any contact with Elijah.

5.3.31 The Serious Incident report concluded that staff could have kept exploring with Elijah how to get help with his cannabis use, although whether he addressed this would have been his decision. SLaM now have dual diagnosis practitioners embedded in teams which, if this case occurred today, may have made such work easier to facilitate.

5.3.32 However, one clinician said that they were not aware of services in Lewisham that could have helped Elijah because they thought the substance misuse services in the borough were focused on opioids rather than cannabis.

5.3.33 The Review Panel were informed that Lewisham Council has recently commissioned a new service provided by Humankind to strengthen the local offer relating to substance misuse specific support.[69] Additionally, as demonstrated by the referral offered to Elijah, CGL can also offer support around cannabis use.

Narrative / Learning Point: It is important that local professionals are aware of services, particularly given that the service provision landscape can change.

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.

5.3.34 Response to housing need: Elijah had moved back in with Miss RH in 2017, and there were attempts to support him with his housing needs in 2019 and 2020.

5.3.35 It appears that whilst SLaM did take some action to address housing needs, there were several weaknesses in the response. Specifically, in the record of contact with Elijah about this issue, there are periods of activity around housing but then prolonged delays. This may, in part, be because SLaM was encouraging Elijah to make decisions for himself, including approaching the council. However, it does not appear that there was a firm grip on his housing needs over time, including potentially a misunderstanding about which agency to contact (given contact was initially made with Lewisham Homes rather than Lewisham Housing Needs).

5.3.36 More problematically, in April 2020, when Elijah was told that he was not in priority need and would need to present as homeless to access accommodation, this was then not considered further. There is no evidence that SLaM tried to escalate this considering Elijah's deteriorating mental health or concerns about Miss RH (although, as discussed below, this would have been challenging given concerns

[69] For more information, go to: https://humankindcharity.org.uk/service/primary-care-recovery-service-pcrs/

about domestic abuse had not been specifically identified). This could have included a new referral to Lewisham Council Housing under the 'duty to refer.'

5.3.37 Finally, there is no evidence that SLaM attempted to liaise with Pinnacle Housing when Miss RH reported concerns about fire setting by Elijah (these specific concerns are discussed further below, alongside a discussion of access to/use of knives).

5.3.38 Although initially no recommendations were made, SLaM have recognised that the response in April 2020 was not sufficient. In response, SLaM suggested that this is a training issue. Following further discussions with the independent chair, SLaM proposed a single agency recommendation:

Single Agency Recommendation 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 thereafter monitor compliance.

5.3.39 An overlapping issue was the response by Lewisham Council Housing, with this being discussed in the later part of this section.

5.3.40 Support for Miss RH: There appears to have been regular communication between the Care Coordinator(s) and Miss RH which, as noted in the chronology, included Miss RH regularly sharing information via phone, text/WhatsApp, and email. This included during 2020 as Elijah's mental health deteriorated.

5.3.41 However, although Miss RH's needs as a carer were noted as early as 2017 – and she was offered support from staff and there were some interventions with Miss RH over the years – it was only in May 2020 that a carer's support plan was initiated. While this specific support plan was not completed in part because Miss RH cancelled a session in June 2020, it is notable that the overall response to Miss RH as a carer was inconsistent and delayed.

5.3.42 Linked to this, when there were discussions of her safety, the Care Coordinator emphasised that Miss RH should call the police if she felt at risk. This advice was given despite Miss RH's stated reluctance to involve the police. This does not appear to have been explored further with Miss RH, including the reasons she

might have been mistrustful. Indeed, it appears that the police were still offered to Miss RH as a support option regardless (for example, in May 2020).

5.3.43 The other source of support offered to Miss RH in a crisis was that she should call SLaM's Crisis Line. When Miss RH reported on the 24th May 2020 that she had tried to contact the Crisis Line over the weekend, she was unable to do so. This was because the technology used on the support line was dependent on callers' selecting the correct option. This has since been changed so that callers can access the Crisis Line directly.

5.3.44 In relation to SLaM's specific response to Miss RH as a carer, SLaM did not initially make a recommendation, noting the trust already has guidelines about carer assessments and the timeframes in which they need to be completed. Following further discussions with the independent chair, SLaM, proposed a single agency recommendation:

Single Agency Recommendation 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 accordance with Trust policy.
- Appoint a 'carer's assessment' lead who will be checking the data to evaluate that Teams are following Trust policy.

The wider issue of support for carers is discussed in Section 5.4 below.

5.3.45 Identification of possible domestic abuse: The Serious Incident Report noted that "*there appeared to be minimal safety planning*." Indeed, at the time, there was no domestic abuse risk assessment within the overarching risk assessment used by SLaM.

5.3.46 Moreover, throughout contact with Elijah from 2017, it was clear that Elijah had paranoid beliefs about family members, and he made regular reference to carrying, having, or accessing weapons (discussed further below). However, the Serious Incident report recognised that decisions to disclose this information should have been made earlier, including – for example – overriding Elijah's confidentiality to share information with Miss RH. The Serious Incident report also suggested that this could have included sharing information with other family members (particularly the aunt he had said was poisoning him), although this would have been challenging as Miss RH had always declined to share Elijah's aunt's contact details, saying she would prefer to tell her information herself.

5.3.47 Furthermore, in May 2020, the deterioration in Elijah's mental health, and the disclosures by Miss RH about his behaviour, should have triggered a fuller consideration of risk. Specifically, whilst there was a response generally (in terms of a referral for a MHAA for example), the focus was on the risk that Elijah might pose to himself, rather than explicit consideration of the potential risk to Miss RH. For example, no direct questions were asked about domestic abuse and staff did not appear to recognise this as a risk.

5.3.48 During May 2020, there could have been:

- Consideration of offering a place of safety to Miss RH while the Mental Health Assessment was pending (particularly given, as discussed above, Elijah's own housing needs had not been addressed).
- An assessment of whether Miss RH's reluctance to involve the police could have been overridden soon given the concerns about Elijah's deteriorating health and his resulting behaviour.

5.3.49 The wider issue of the response to AFV is discussed in Section 5.4 below.

5.3.50 The SLaM Serious Incident report / IMR made 5 recommendations, of which 3 are noted here and were accepted by the Review Panel:

Single Agency Recommendation 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.

Single Agency Recommendation 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).

Single Agency Recommendation 5: The Trust to consider having a dedicated telephone line which goes directly through to the Crisis Line

5.3.51 <u>About reports that Elijah was carrying or had access to knives, and fire safety concerns:</u>

5.3.52 The response to reports that Elijah historically *carried knives and/or talked about carrying them* appears to have been inconsistent.

5.3.53 SLaM was aware of concerns around knives. This was either because of Elijah's contact with other agencies (for example, in September 2017 with this initially

because of disclosure to his General Practice, and in August 2018 when Elijah approached the police). Alternatively, it was because Elijah directly made disclosures about his carrying or access to knives, or thoughts in this regard.

5.3.54 In response to this awareness, there were episodes of good practice. For example, the Care Coordinator contacted the police in May 2018 to share intelligence around this. Similarly, in the MHAA application in May 2020, the AMHP Service was able to flag this as an issue to the MPS, based on information provided by Elijah's Care Coordinator.

5.3.55 However, despite these episodic considerations, no evidence has been supplied to the Review Panel to indicate whether and how concerns about knife use were specifically revisited or risk assessed over time, including in the context of the potential risk to Miss RH. Moreover, no evidence that been supplied to the Review Panel to indicate consideration of whether concerns about knives should – beyond the examples noted above – be shared with the police and/or Miss RH or other family members.

5.3.56 Additionally, the SLaM representative recognised that, in May 2018, when the police confirmed that there was at the time no history of concerns about knives it is important that staff do not understand such a nil return as meaning that these issues should not be revisited.

5.3.57 In effect, it appears that Elijah's reported thoughts and/or carrying of knives and weapons was normalised. SLaM has indicated it does not agree with this finding. To resolve this, on receiving the final draft, Review Panel was asked to reach a conclusion in this respect. Bar SLaM, no other agency indicated its disagreement with this finding. As a result, the Chair agreed to record SLaM's dissent.

5.3.58 It appears that the knives that Elijah was carrying were household knives. SLaM has noted that its staff routinely encounter service users who carry knives and that there is a broader trend in London concerning this issue *and* suggested that there is no legal pathway to address this.

5.3.59 This Review Panel was concerned about this possibility, and the Chair facilitated a discussion between Review Panel representatives from the MPS, SLaM, and the Safer Lewisham Partnership.

5.3.60 The MPS representative reported that there is a pathway in place for concerns to be shared between the AMPH service and the MPS, with these going directly to the police mental health team. However, it was noted that more generally there is no routine sharing of information in terms of concerns raised by professionals around service users accessing community services and carrying weapons or

indeed any real sense of risk assessment in cases where there are concerns raised about individuals.

5.3.61 In response, the SLaM representative felt that, whilst information should be shared, within SLaM there was perhaps a perception that police would not take further action and just refer people back to mental health services.

5.3.62 The contact with Elijah in August 2018 is perhaps illustrative of this issue. The MPS representative suggested that the decision not to criminalise Elijah and respond to his mental health needs was positive, whilst the SLaM representative highlighted that this meant the responsibility to respond was largely left to the trust.

Narrative / Learning Point: It is important that there is a robust local pathway and procedures for the sharing of intelligence about knives, including an understanding between agencies about when and how to share concerns and the implications for single and multi-agency risk assessment.

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.

5.3.63 In addition to knives, possible *fire safety concerns* were also identified in May 2020 because of Miss RH's reports about Elijah's fire setting. In this respect, it was good practice to facilitate a Home Safety Visit from the London Fire Brigade although this was later declined by Miss RH. However, there does not appear to have been any consideration of broader risk, given Elijah's fire setting was happening in and around a public block of flats. Such consideration might have, for example, led to a discussion with Miss RH about whether it would be appropriate to contact Pinnacle Housing given they owned the building. Given a recommendation has already been made around housing, the Review Panel agreed a further recommendation was not necessary.

Applying for a Mental Health Act (MHA) assessment (including information provided by SLaM and the AMHP service)

5.3.64 Elijah was referred to Lewisham AMHP service on three separate occasions, including September 2017 (when he was detained while he was already an inpatient), in June 2018 (when he was not admitted) and in May 2020.

5.3.65 The Review Panel has focused on this last MHAA, which was sought after Elijah's mental health deteriorated in April and May of 2020. It may be that this deterioration was linked to the Covid-19 lockdown (see Section 5.4 for a discussion).

5.3.66 As Elijah's mental health deteriorated, it was recognised by staff that a MHAA was required, leading to a referral being made by SLAM's EIT to the AMHP service on the 20th May 2020. This referral has been described by the AMHP service as "*of high quality*" and included information on Elijah's current needs, as well as his previous history (including that he had carried knives in the past). Following a review, a decision was initially made that an immediate response was not required, with this informed by the general levels of need in the community (see below for a description of the service context at the time) and the view that there was no imminent threat to life based on the information provided by SLaM's EIT. This decision was confirmed with the SLAM's EIT, including during liaison on the 22nd May.

5.3.67 However, on the 26th May, the EIT team reported further concerns and asked that a MHAA be prioritised. The AMHP service responded promptly, booking a slot to obtain a warrant on the 27th May via HMCTS. The slot subsequently provided was on the 2nd June.

5.3.68 This meant there was a delay of 5 working days between the request for a warrant and it being obtained. There is therefore the question of whether steps could have been taken to expedite the warrant:

- The Serious Incident report considered whether a Section 4 MHAA could have been made at this point. This is an emergency application for detention. The Serious Incident report notes "*this would have been against the wishes of Elijah's mother*." However, it appears that the AMHP team did not feel there was an immediate risk to life and limb, despite the escalating concerns about the severity of Elijah's ill health.[70]
- However, the information provided to the Review Panel from the AMHP service suggested that the reported 'unwillingness' of Miss RH to call the police if threatened by Elijah was a red flag which should have been factored into the risk assessment by the AMHP. A request could have been made to the HMCTS for a more urgent response when the slot was offered for 6 days after the request.

5.3.69 On the 2nd June, when the warrant was obtained, this was sent to the MPS via their online portal (along with the other information required for a risk assessment).

[70] The SLAM Review Panel representative made a representation on receipt of the final draft of this report that this paragraph should be removed as it should not have been included in the Serious Incident report. However, given the Serious Incident report has been completed and signed off, the Chair did not feel it was appropriate to do so. Consequently, the Chair agreed to make a record of this issue.

5.3.70 However, no acknowledgement was subsequently received by the AMHP service. Moreover, thereafter, there is no record of further communication between the AMHP service and MPS. It seems that the EIT did not follow the outstanding MHAA up with the AMHP service.

5.3.71 Taken together, this meant that the MHAA still had not been undertaken 19 days after it was first applied for. This clearly led to an unacceptable drift and, if this 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. The Serious Incident report concluded: "*Therefore if the Mental Health Assessment had taken place during that week the incident may not have happened*." As noted in 5.1, the Review Panel agrees.

5.3.72 There appear to be three broad underlying causes, specifically:

- The demand on the AMHP service.
- System delays that are built in the process for requesting and actioning a warrant, with these being exacerbated by Covid-19.
- The broader matter of liaison with the MPS around the execution of warrants, as well as the specific errors that occurred in terms of communication between the AMPH service and MPS in relation to this case.

5.3.73 Demand on the AMHP service: In May 2020, the AMHP service was experiencing exceptional levels of demand. In May, 123 referrals were received of which over half were considered a high priority. When the MHAA referral for Elijah was received, there were already 13 community assessments outstanding and only one community assessment a day could be completed.

5.3.74 This high level of demand was exacerbated by system delays that are built in the process of requesting and actioning a warrant, with these being exacerbated by Covid-19.

5.3.75 These demand and system issues are summarised overleaf, including challenges at the time as identified by the AMHP service Short Report, as well as a summary of the current situation, including some of the actions taken since 2020.

Step	Summary	Challenges	Current Situation
Referral	Referral made, with this then screened by the AMHP service	Covid-19 led to a reduction in face-to-face contacts and a significant number of referrals from community teams did not provide the quality of information required by AMHPs to present to the courts and police, leading to requests for further information and delays in setting up assessments.	Changes to the referral process have increased efficiency and alleviated pressure by reducing the number of repeated assessments. Changes include: the introduction of a standard operating procedure for referrals; revisions to the AMHP referral form to minimise delays caused by seeking further information; pre-referral consultation offered by the AMHP lead to community teams. The introduction of electronic MHA documentation has allowed for forms to be sent digitally which has reduced the number of assessments being passed back and forward between AMHPs and EDT.
Obtaining a warrant	Warrant obtained from the magistrate's court, with this arranged through the HMCTS	Due to Covid-19 HMCTS moved to operating virtually, providing pre-booked slots for warrant applications. This led to longer delays than usual in securing warrants. In addition, the magistrates were applying increasing levels of scrutiny to applications and requiring mental health teams to present evidence of proactive attempts to engage before granting warrants, leading to an increasing number of warrants being refused.	Virtual courts are now well-established and HMCTS is now generally offering the AMHP service next working day slots for warrant applications.
Requesting police support	The completion of an online risk assessment to request police attendance (via the	Unless there was an imminent threat, the MPS require a warrant to be obtained in advance of the AMHP service making a	See below

	online portal noted above) and then liaison with an NPT to secure a date.	request for police attendance via the online portal. There are also several stages, including initial receipt by the BCU mental health team and then liaison with the relevant NPT.	
Arranging additional support	The AMHP books any additional resources (e.g., doctors, ambulance, locksmith etc) for the date offered by the police and that SLaM make a bed available on that date.	There was ongoing severe pressure on bed availability meaning at times MHAA were stood down, to changes in assessment times, or to repeated assessments by different AMHPs who were unable to complete applications due to the lack of beds. This pressure was increased by a surge in demand at the end of the Covid-19 lockdown.	See below

5.3.76 Other actions taken by the AMHP services to improve responsiveness to requests for MHAA include:

- The referrals tracker has been revised to include confirmation of the designated police team responsible for carrying out the assessment.
- Data collection systems have been improved to facilitate the monitoring and analysis of delays at different junctures of the assessment and admission process.
- Recruiting a second full-time permanent AMHP post.

5.3.77 Linked to this, the Review Panel accepted the sixth of the seven single agency recommendations made in the SLaM Serious Incident report / IMR, as this will provide assurance as to MHAAs in future.

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

5.3.78 Whilst this is the first step, and will build a clear picture of the problem, clearly this does not provide assurances that the underlying issue has been addended.

5.3.79 Additionally, a third issue and final issue was the broader matter of liaison with the MPS around the execution of warrants, as well as the specific errors that occurred in terms of communication between the AMPH service and MPS in relation to this case.

5.3.80 Broadly, there have been delays in the time taken for police assistance to be secured in the execution of warrants. Clearly, given the level of risk which has been flagged by the EIT, this should have been picked up and addressed. However, it appears that the delay was accepted as normal and thus did not lead to remedial action.

5.3.81 The underlying cause of this acceptance may be two-fold. The Serious Incident report noted:

- A "*tradition"* of a two-week timeframe had developed locally over time, which may have meant that those involved accepted these system delays. This possibility was acknowledged by the AMHP service, which noted that the lack of communication thereafter may have reflected a culture of acceptance that delays in securing police attendance had become normalised due to pressures on the MPS.

- Staff felt they had to use "*trigger*" words to secure a prompt response from the police. The Serious Incident Report summarised this issue as follows: "*It is the opinion of the investigation team that this is related to how police and services rate risk: what is high risk for Trust staff may be different for the police. Therefore, an understanding of shared language may need to be considered*."

5.3.82 In addition to this acceptance of delays, during the review it has been established that there was no formal escalation protocol in place at that point between the AMHPs (as well as SLaM) and the MPS.

5.3.83 Reflecting these delays, a Care Quality Commission monitoring visit of the Lewisham MHAA assessment and admissions process took place in June 2021. This found the AMHP service to be responsive and operating well, although some issues were identified, including the recognition that there were regular waits between two and three weeks for police assistance to execute warrants obtained under the MHAA. The concern identified by the Care Quality Commission was that these delays increased risks to patients and families in the community as well as causing them distress. Such concerns clearly reflect the issues identified in this review.

5.3.84 An outcome of this monitoring visit was an action plan, intended to address this issue of timeliness of the execution of warrants. This does appear to be having the intended effect: As reported to the Review Panel in January 2022, whilst the average period from referral to MPS to completion of MHAA has fallen, it remains more than 10 days. There is, however, an ongoing commitment to reduce this.

5.3.85 Given the issue of the time taken for the execution of warrants has been identified by the Care Quality Commission and is the subject of an action plan, the Review Panel did not make any further recommendations as it felt this was being addressed through the appropriate channels. This was captured in the seventh recommendation from the SLaM Serious Incident report / IMR:

Single Agency Recommendation 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.

5.3.86 More specifically than the broader issue of the execution of warrants, the Review Panel was concerned about the error within the MPS which meant that the request from the AMHP service made on 2nd June was not actioned. The Review Panel was also concerned that there was then no follow up by the AMHP service when the MPS did not acknowledge receipt of the request. Additionally, the EIT

should have followed up with the AMHP service as to why the MHAA had not been progressed.

5.3.87 In accepting this single agency recommendation, the Review Panel were informed that a regular interface meeting between the AMHP service (which is jointly operated by SLaM and Lewisham Council operated integrated adult mental health services), SLaM and MPS have been established at a senior leadership level to improve channels of communication and escalation processes. Other actions include:

- Regular bi-monthly multi-agency liaison meetings with police and SLaM have been introduced to monitor and seek to reduce delays by identifying and addressing system issues.
- A locally agreed escalation protocol has been introduced by the police to escalate individual higher-risk MHAA requests and in all cases where an assessment date is not provided which is within 10 working days of a referral to the police.
- Local agreement has been reached with the police to allow higher-risk cases to be referred to them in advance of a warrant being secured.
- An escalation protocol has been introduced by SLaM to seek to secure beds in cases of pressing urgency.

5.3.88 The Review Panel welcomed these actions. In addition, the AMHP service Short Report made the following recommendations, which were accepted by the Review Panel:

Single Agency Recommendation 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.

Single Agency Recommendation 2: These targets need to be realistic, and resources need would to be available to services in order to meet them.

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

General Practice of Miss RH and Elijah

5.3.89 As detailed in the chronology, Elijah had extensive contact with the General Practice. Elijah appears to have had a good relationship with the practice, including actively engaging with GPs, including when he was in crisis.

5.3.90 Elijah was seen by multiple GPs during his contact with the General Practice, which raises the issue of continuity of care. It appears there was a good quality of record keeping at the practice, which means that GPs were able to follow up appropriately with Elijah. This also included identifying when he had scheduled appointments, meaning that there were opportunities for follow-up and review. The good quality of record keeping appears to have been supported by using a shared electronic recording system, as well as regular discussions in clinical meetings.

5.3.91 The health care provided by the General Practice to Elijah was appropriate, addressing both his physical and mental health needs. The General Practice regularly reviewed Elijah to May 2019. However, hereafter, their contact with Elijah was limited.

5.3.92 On occasion, there were concerns about the risk Elijah posed to staff or others, and these were responded to appropriately while maintaining a working relationship with Elijah. Concerns about Elijah's risk also led to contact with other agencies, including the MPS, but also different professionals and teams within SLaM. A new Multi-Disciplinary Team meeting, which includes representatives from SLaM, provides opportunities to review these cases further.

5.3.93 However, the General Practice IMR noted that, although Elijah was regularly contacted by the practice, the wording of messages was not always clear. Additionally, when he did miss appointments, this was not always followed up. Reflecting on this learning, the General Practice IMR made the following recommendations which were accepted by the Review Panel:

Single Agency Recommendation 1: Add an alert to the patient's records if the patient has had an involuntary section history.

Single Agency Recommendation 2: Code high need mental health patients as 'admissions avoidance' and link household members

Single Agency Recommendation 3: Deteriorating mental health patients to be brought to the Multi-Disciplinary Team meeting discussions.

Single Agency Recommendation 4: Review the 'Do Not Attend' policy for patients on the mental health register.

5.3.94 Regarding information sharing from other agencies, the General Practice noted that GPs receive a large volume of letters and test results daily and the time available to review and action them is limited. Communications from secondary care, particularly mental health services, are often lengthy and detailed. GPs always read reports where possible or have administrative protocols to pull out key information. However, to avoid key information/action points being missed, it would be very helpful if letters to GPs could include the key information and any actions points on the first page of any letter, for example:

- Diagnosis
- Medication changes and confirmation of who is to prescribe/administer.
- Any recommended referrals with reference to who is to action the referral.
- Discharge/follow-up plans
- Updates on risk profile and any actions necessary to manage the risk.

5.3.95 Looking at the links with SLaM specifically, the General Practice IMR identified issues with the quality and timeliness of updates received, including both delays to receiving notifications but also periods when no updates were received at all. The last update letter the Practice received about Elijah's mental health was on 5th September 2019 from SLaM. The letter references problems with Miss RH but these were deemed to be 'stable.' The SLaM team was aware that Elijah was living with his mother and no concerns are recorded. Elijah was assessed as low risk to self and others. There was no further communication from the mental health teams. While the General Practice does not seem to have followed up with SLaM (something it had done previously), this is because they believed Elijah was low risk.

5.3.96 In relation to Miss RH specifically, Miss RH had a small number of appointments in her own right, including in 2016, 2017 and 2020. 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. However, it is only in the 2016 contacts that there is any record of other issues (stress specifically). It could be there were discussions with Miss RH at these presentations although, if there were, they were not recorded.

5.3.97 In addition, Miss RH accompanied Elijah on a small number of appointments. In these appointments, clinicians thought that Miss RH and Elijah had a good relationship. The General Practice was also aware that Elijah had his own accommodation but often lived with or stayed with Miss RH, and that he had moved in with her after 2017.

5.3.98 The General Practice IMR recognised 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. This could include recognising the specific needs of family carers for patients with chronic mental health problems. Notably, despite it being apparent that Miss RH provided support to Elijah, especially during episodes of physical/mental ill-health, she was not coded as a carer. It is therefore positive that the General Practice has reviewed carer coding for mental health reviews. The wider issue of support for carers is discussed in Section 5.4 below.

5.3.99 Additionally, the General Practice IMR recognised that there could have been more explicit consideration of safety (particularly given the practice was aware of reports that Elijah had carried weapons, had been paranoid about family members, and that Elijah had moved back in with Miss RH).

5.3.100 In this context, the General Practice IMR recognised that skills and knowledge around AFV could be developed. Reflecting this, the General Practice IMR identified one further recommendation, which was accepted by the Review Panel:

Single Agency Recommendation 5: Training for staff on issues surrounding AFV and its identification and management.

5.3.101 The General Practice has previously received IRIS training[71] and is also part of the local Multi-Agency Risk Assessment Conference (MARAC) and practices are able to record domestic abuse on their computer system and this triggers a direct link for a referral to the Athena service. The General Practice does not have a stand-alone domestic abuse policy, but this is part of the Adult Safeguarding Policy.

5.3.102 The Review Panel considered whether it would be best practice for General Practices to have a stand-alone domestic abuse policy. It was felt that this would

[71] Training and support programme IRIS enables GPs to identify patients affected by domestic violence and abuse and refer them to specialist services. For more information, go to: https://irisi.org.

be best practice, in line with existing guidance,[72] but that there needed to be support for General Practices to do so.

Narrative / Learning Point: Primary care has a role to play in the response to domestic abuse, including as a point of disclosure, but also onward referral to a specialist domestic abuse service. It is important that a consistent response is supported by a clear policy framework.

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.

5.3.103 In making this recommendation, the Review Panel noted that the SEL ICS will be able to monitor take up locally, as it intends to include domestic abuse as part of local self-assessment and auditing practice from 2022. Other local activities include commissioning regular training for clinicians relating to domestic abuse.

KCH

5.3.104 KCH had contact with Elijah for several physical health issues, the most notable of which were presentations at the Emergency Department for mental health issues. Following these presentations, Elijah was appropriately referred to SLaM's Psychiatric Liaison Team.

5.3.105 KCH also provided care for Miss RH after she was stabbed by Elijah, but this has not been examined by the Review Panel.

5.3.106 As a result, the KCH IMR identified no learning or recommendations relating to Elijah, with this being accepted by the Review Panel.

5.3.107 For Elijah, when he presented at the Emergency Department, he was appropriately referred to SLaM's Psychiatric Liaison Team. In a single contact in April 2020, Elijah presented with a headache and then left, but made no other disclosures that would have been cause for concern. As a result, the KCH IMR identified no learning or recommendations relating to Elijah, with this being accepted by the Review Panel.

[72] SafeLives (2014) *Responding to domestic abuse: Guidance for General Practices*. Bristol: As Author. Available at: https://safelives.org.uk/sites/default/files/resources/SafeLives%27%20GP%20guidance.pdf (Accessed 31st January 2022).

LGT

5.3.108 Both Miss RH and Elijah had some contact with LGT, with Miss RH mostly attending outpatient appointments, and Elijah presenting at the Emergency Department of University Hospital Lewisham.

5.3.109 It seems that, in these contacts, care was appropriate and other health providers (including the General Practice) were notified.

5.3.110 For Miss RH, these contacts were usually planned, bar one attended at the Emergency Department. In these contacts, there were no disclosures made, or concerns identified, about domestic abuse.

5.3.111 However, the LGT IMR note that when Miss RH presented at the Emergency Department, she was not asked about domestic abuse. In 2019, routine questioning for domestic abuse was due to have been launched at University Hospital Lewisham, supported by a co-located Health IDVA (it is already delivered at LGT's other site, the Queen Elizabeth Hospital). However, the introduction of routine enquiry was delayed due to the Covid-19 pandemic.

5.3.112 This project was postponed during the Covid-19 pandemic due to the demands on the service and the fact that the IDVA service was offered remotely. The Trust is committed to introducing routine enquiry and this has been included as a recommendation in the LGT IMR:

Single Agency Recommendation 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.

Single Agency Recommendation 2: Ensure trust-wide ongoing improvements in relation to domestic abuse training for clinical staff to address AFV

Lewisham Adult Social Care

5.3.113 Lewisham Adult Social Care had a single referral relating to Elijah, in September 2017, when a referral was received from the MPS relating to a report that Elijah had gone missing from the Ladywell MHU. However, this did not lead to any intervention by Lewisham Adult Social Care because, in line with local procedures, the information was passed to SLaM. As a result, Lewisham Adult Social Care did not identify any learning and made no recommendations. This was accepted by the Review Panel.

5.3.114 However, Lewisham Adult Social Care Short Report identified that it had not received the referrals that the MPS describe making following incidents involving Elijah. It has not been possible to resolve this issue i.e., the MPS have stated this information was shared using an established channel, while Adult Social Care have not been able to identify it. This has been discussed in the analysis of MPS contact.

5.3.115 While the Review Panel were concerned about this discrepancy, it noted that this was historical. The Review Panel were informed that an Adult Multi-Agency Safeguarding Hub (MASH) has been developed, providing a single front-facing service. This ensures a consistent approach in terms of receiving information from agencies, including MERLIN/ACNs, and identifying concerns in relation to vulnerable adults, including decision making around domestic abuse concerns. As a result, the Review Panel did not make a recommendation in relation to this issue.

5.3.116 Lewisham Adult Social Care noted that over 60% of MERLIN/ACNs relate to adults in a mental health crisis or indicating a need for support with their mental health If an adult is presently open to SLaM, the MERLIN/ACN is forwarded to their care coordinator or the relevant generic team address. Where the person is not currently open to or known to SLaM, the MERLIN/ACN is forwarded to the GP to review and refer as appropriate.

5.3.117 As a result of these changes, the Review Panel did not make any further recommendations.

Lewisham Council Housing Needs Department

5.3.118 Lewisham Council Housing Needs Department had limited contact with Elijah, but they did have contact with him in October 2018, February 2019, and in May 2019. This related to a housing application, and ultimately Elijah was found not to be in priority need.

5.3.119 Notably, in this contact, Elijah made disclosures about his fears that his family wanted to kill him. He identified a named relative (an aunt) who he said had tried to poison him.

5.3.120 Elijah's application was reviewed by a medical officer employed by the housing department.

5.3.121 Although Elijah's comment was noted, on reviewing his file, the medical officer could see that he had psychosis and was known to SLaM and was being managed under the CPA. Additionally, they decided that, as Elijah did not live with the relative whom he named, there was no risk.

5.3.122 The Lewisham Council Housing Needs Department Short Report recognised that Elijah's statement should have been identified as a concern. Indeed, Elijah's disclosure, while not enough to mean he would be in priority need, should have triggered further consideration, not least with SLaM.

5.3.123 The Review Panel felt that there was clearly learning for the Lewisham Council Housing Needs Department. However, similar issues have already been identified. As noted in Section 1, a SAR published in Lewisham reported issues with joint working and information sharing between housing and mental health providers, as well as the fact that assessment and information gathering processes seemed to involve multiple stages, assessments, and requests for information.

5.3.124 In response, several changes have been implemented locally.

- First, the council is introducing a new housing application and register system which should give applicants more information on the progress of their applications.
- Second, a SLaM / Housing Forum has been introduced. This is a monthly meeting, held online currently, where representatives can bring cases of concern for discussion with senior representatives from both agencies. It is a minuted and actioned meeting intended to lessen the risk that any customer with a housing / mental health need is missed or falls through a gap, and to ensure there is a structured line of communication between the agencies.

5.3.125 The Lewisham Council Housing Needs Department Short Report made a single recommendation to address the learning from this review, as it was identified that the SLaM / Housing Forum is not attended by the medical officer. This was accepted by the Review Panel:

Single Agency Recommendation 1: Medical Officer to be invited to the SLaM / Housing Forum to highlight concerns pertaining to any clients to the Housing SLaM liaison meeting.

Pinnacle Housing

5.3.126 Pinnacle Housing had no recent contact with Miss RH. This was because she had brought her property in 2000. As a result, it had wider management responsibilities for the building but not her property (so, for example, it was not responsible for internal repairs). Additionally, as Miss RH owned her property, she would not have had to notify Pinnacle Housing when Elijah began to live with her.

5.3.127 The only time that Pinnacle Housing were aware that there were any issues was in June 2020, shortly before Elijah attacked Miss RH. A neighbour contacted them

to say they wanted Pinnacle Housing to be aware of the behaviour of the son of the owner of the flat (i.e., Miss RH). Specifically, they were fearful of Elijah. A risk assessment was completed but given the tenant did not use the same door to the flats as Elijah and had themselves stopped using the garden, it was decided there was a minimal risk.

5.3.128 The Review Panel was concerned about the inadequacy of this response, given there seems to have been 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. Such an approach may have been an opportunity to broach Elijah's behaviour with her and, if followed up, potentially to enable exploration of her immediate safety and/or liaison with other agencies (like SLaM) regarding the same.

5.3.129 In discussion with Pinnacle Housing, it was agreed a single agency recommendation would be made, albeit there was a recognition that any obligations for care in this respect would usually remain with other agencies (for example, with respect to Elijah, with SLaM).

Single Agency Recommendation 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.

London Fire Brigade

5.3.130 The London Fire Brigade had a single contact with Miss RH in early June 2020, relating to a referral made by SLaM for a Home Safety Visit. This was related to Elijah having barbeques and burning rubbish outside of the property. An appointment was scheduled but declined by Miss RH, who said she would re-arrange it. The London Fire Brigade also contacted SLaM to inform them the visit had not gone ahead and was advised that this was no longer necessary, so no further action was taken.

5.3.131 Clearly the London Fire Brigade responded promptly to the referral for the Home Safety Visit and liaised with both Miss RH and SLaM as the referrer. However, as the Home Safety Visit was cancelled by Miss RH and then SLaM indicated it was no longer necessary as by that time Ms RH had died, it is appropriate that the London Fire Brigade took no further action. As a result, no learning or recommendations were identified, and this was accepted by the Review Panel.

Financial Services Company

5.3.132 While Miss RH was reported to be a private person, it is noticeable that she did talk to some of her immediate colleagues about Elijah's behaviour. Additionally, as will be explored further in Section 5.4 before, it seems likely that Covid-19 meant that Miss RH could no longer come into the office. However, there is no evidence to indicate that Miss RH's employer had any formal concerns for, or received any disclosures from, Miss RH that could have triggered further enquiry or support.

5.3.133 The financial services company shared that it does not have a domestic abuse policy for staff but is able to provide support to all its employees via its Employee Assistance Programme. Although there is no suggestion from the learning in this case that the financial services company could have intervened, it agreed to consider the development of a domestic abuse policy in its next policy review. This was accepted by the Review Panel, which noted the guidance available in this respect, including a recently reissued toolkit for employers.[73]

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

[73] For more information, see: https://www.bitc.org.uk/toolkit/domestic-abuse-toolkit/.

5.4 Responding to the Lines of Enquiry

5.4.1 The following section addresses the Lines of Enquiry identified in the Terms of Reference. The focus is on cross-cutting themes, given issues with individual agency, and contact have been addressed above.

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 to the following issues:

- **AFV.**

5.4.2 Broadly, these issues have been discussed in relation to specific agencies above.

5.4.3 Specifically in the context of AFV, Elijah's killing of Miss RH shares many features of what is known about family homicides generally. That is, these killings are gendered, with women most often being killed by a man, often a mother being killed by her son. Additionally, the perpetrators in these killings often have serious mental ill health and, in these cases, their caregiver is often the target.[74]

5.4.4 The key issue identified in this review is that, although the potential risk of Elijah to Miss RH (and possibly other family members) was known, this was largely understood in the context of mental health. That is, the focus was on Elijah, rather than any specific consideration of the risk to Miss RH. This was most evident in SLaM's response to this case, as discussed above.

5.4.5 However, the Review Panel felt there was learning in this case in terms of AFV, notably for SLaM but also the General Practice. More broadly, among Review Panel representatives, there was a consensus that there is less awareness of AFV and so professionals may be less able to identify and respond to concerns in this context. Potential issues include the knowledge and skills of staff to assess AFV,

[74] Condry, R. and Miles, C. (2022) 'Who counts: The invisibility of mothers as victims of femicide', *Current Sociology*, Advance online publication.

as well as the extent to which AFV is reflected in policy and procedures, access to specialist support, and how awareness raising should be undertaken in the wider community.

5.4.6 Illustrative of this point, although the borough has produced a Domestic Abuse and Violence against Women and Girls Strategy 2021-2026,[75] it does not explicitly address AFV. The tendency for AFV to be conflated with, and often subsumed under, other forms of domestic abuse has previously been recognised.[76]

5.4.7 The thematic report produced by the Safer Lewisham Partnership noted several issues locally:

- There is no data collected on AFV.
- There is no targeted training specifically with a focus on AFV.

Narrative / Learning Point: The CCR is based on the principle that no single agency or professional can respond to domestic abuse, but all agencies and professionals can offer insights that are crucial to the safety of victims and survivors. In the context of AFV, it is important that their AFV is explicitly addressed.

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.

5.4.8 As noted in Section 1, this is the fourth AFV-related DHR in Lewisham. A range of recommendations have been made in these previous DHRs, largely relating to training and guidance, as well as pathways for care and support (including for carers). Regrettably, the Review Panel was informed that once an action plan has been agreed upon, there is no ongoing auditing of the DHR recommendations from

[75] For more information, go to: https://lewisham.gov.uk/articles/news/domestic-abuse-and-violence-against-women-and-girls-strategy-2021-2026-approved-by-mayor-and-cabinet.

[76] Benbow, S.M., Bhattacharyya, S. And Kingston, P. (2019) 'Older adults and violence: an analysis of Domestic Homicide Reviews in England involving adults over 60 years of age', *Ageing and Society*, 9(6), pp. 1097–1121.

DHRs. As a result, it is not possible to say what the outcomes of these recommendations have been.

Narrative / Learning Point: The CCR is based on the principle that no single agency or professional can respond to domestic abuse, but all agencies and professionals can offer insights that are crucial to the safety of victims and survivors. In the context of AFV, it is important that this specific form of domestic abuse is explicitly addressed.

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.

- **Mental Health**

5.4.9 These issues have been discussed in relation to specific agencies above.

- **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.**

5.4.10 The Review Panel identified three key issues.

5.4.11 First, support for Miss RH as a carer. This is particularly relevant in relation to contact with SLaM (where, as described above, there was an inconsistent and delayed response to Miss RH's needs as a carer, meaning no carer's assessment was ever completed although this had been started in the year she died). Additionally, Miss RH was not coded as a carer by the General Practice. This was also potentially an issue for other agencies, for example when MERLIN/ACN's were completed by the MPS.

5.4.12 The Review Panel noted that a failure to consider the needs of a carer is a consistent theme in adult family homicides. In a recent summary of findings from DHRs, it was noted that often carers had not received a formal assessment despite, under the Care Act 2014, a person supporting another on a regular basis being entitled to one. This meant there were missed opportunities to provide

support, including the identification of domestic abuse and intervention where appropriate.[77]

5.4.13 The Review Panel was informed that a specialist Carers Social Worker has been appointed by Lewisham Council. As part of their role, they are working with SLaM teams to raise awareness of carer's needs and improve both support to carers and updating of assessments. Additionally, there is a Lewisham Carer's Assessment, and this included a question related to domestic abuse (specifically: "*have you ever felt distressed or in danger due to the behaviour of the person you care for? (e.g., accusations, threats, actual harm)*").

Narrative / Learning Point: It is crucial that the needs of carers are identified and assessed.

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).

5.4.14 Second, Elijah's experiences as a Black Caribbean man, means he may have faced personal and/or structural barriers or discrimination in his contact with the police.

5.4.15 This possibility was clearly an issue. As discussed in the analysis of SLaM's contact in the previous section, Miss RH's family shared their concerns that Elijah may have been less well treated because he was a Black Caribbean man, and while the Review Panel has not been able to explore this further, there is generally evidence that Black people experience fewer good outcomes in terms of health care.

5.4.16 More broadly, this issue came together in SLaM's contact work with Miss RH, where a recurring theme was Miss RH's concern about involving the MPS. This appears to have been related to her perception of the police. For example, in the warrant request made to the MPS for a MHAA assessment it was noted: *"Miss RH is reluctant for police to be present… Miss RH has a fear of police and them being heavy handed with her son due to bias based on his cultural background (Black British)."*

[77] Bracewell, K., Jones, C., Haines-Delmont, A., Craig, E., Duxbury, J. and Chantler, K. (2021) 'Beyond intimate partner relationships: utilising domestic homicide reviews to prevent adult family domestic homicide', *Journal of Gender- Based Violence*, pp. 1–16.

5.4.17 Whilst it is not possible to know why Miss RH was so concerned, this may have been a result of community concern generally. Additionally, if Miss RH was aware of them, this may have been based on Elijah's specific experience of being stopped and searched in the past. Taken together, the Review Panel noted the broader context within which Miss RH's concerns could be framed, for example, in relation to the disproportionate use of stop and search relation to Black and other minoritised communities and the impact on confidence in the police.[78]

5.4.18 The Review Panel felt that, given the wider work around policing in this context, including by the Mayor of London,[79] a further recommendation was not necessary. However, it felt it was important to record this issue.

5.4.19 Third, Covid-19 provided an important context to these sad events.[80] Although Elijah's mental health had been a concern for some time, it declined precipitously from March 2020. This likely reflected the direct consequences of Covid-19 restrictions and other impacts on Elijah (he was more isolated and not working or able to undertake his normal activities), as well as Miss RH (including increased contact time at home, and restricted options because she was working from home).

5.4.20 Miss RH's family feel that Covid-19 affected service responses, with this concern supported by the discussion above about the timeframe for securing a warrant being (in part) a result of the impact of Covid-19. However, Miss RH's family also wanted it stated clearly that these pressures were not the sole cause of what happened and many of these concerns about the support provided to Miss RH (in particular as a carer) predate Covid-19.

5.4.21 The Review Panel has recorded these concerns here, but makes no recommendations, although specific agency learning is described in the previous section.

[78] Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services (2021) *Disproportionate use of police powers: A spotlight on stop and search and the use of force*. London: As Author. Available at: https://www.justiceinspectorates.gov.uk/hmicfrs/wp-content/uploads/disproportionate-use-of-police-powers-spotlight-on-stop-search-and-use-of-force.pdf (14th April 2022).

[79] Mayor of London. (2020) *Action Plan: Transparency, Accountability and Trust in Policing*. London: Greater London Authority. Available at: https://www.london.gov.uk/sites/default/files/action_plan_-_transparency_accountability_and_trust_in_policing.pdf (Accessed: 14th April 2022).

[80] Wildman, E.K., MacManus, D., Kuipers E. and Onwumere, J. (2021) 'COVID-19, severe mental illness, and family violence', *Psychological Medicine*, 51, pp. 705–706.

6. Conclusions and Lessons to be Learnt

6.1 Conclusions

6.1.1 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.

6.1.2 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.

6.1.3 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.

6.1.4 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.

6.2 Key Themes and Learning Identified

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

6.2.2 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.

6.2.3 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).

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

6.2.5 *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.

6.2.6 *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).

6.2.7 *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.

6.2.8 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.

6.2.9 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.

7. Recommendations

7.1 Single Agency Recommendations (Identified by Individual Agencies)

7.1.1 The following single agency recommendations were made by the agencies in their IMRs. They were described in Section 5 following the analysis of contact by each agency.

7.1.2 These recommendations are also presented by agency in the single agency recommendation action plan template in **Appendix 3**. 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

7.1.3 1: Miss RH's employer (financial services company) to develop a domestic abuse policy for staff.

The General Practice of Miss RH and Elijah

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

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

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

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

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

Lewisham Council Housing Needs Department

7.1.9 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

7.1.10 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.

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

MPS

7.1.12 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.

7.1.13 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.

7.1.14 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

7.1.15 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

7.1.16 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.

7.1.17 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.

7.1.18 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.

7.1.19 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).

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

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

7.1.22 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

7.1.23 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.

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

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

7.2 DHR Recommendations (Developed by the Review Panel)

7.2.1 The Review Panel has made the following recommendations during this review in response to the learning identified. These are described in Section 5 as part of the analysis.

7.2.2 These recommendations are also presented in the multi-agency recommendation action plan template in **Appendix 4**. The Safer Lewisham Partnership is responsible for overseeing the development and monitoring of an action plan.

7.2.3 **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.

7.2.4 **DHR Recommendation 2:** SLaM to work with VSHS and Hundred Families to identify and address any learning with respect to family support in this case.

7.2.5 **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.

7.2.6 **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.

7.2.7 **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.

7.2.8 **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.

7.2.9 **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.

7.2.10 **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).

Appendix 1: Glossary

AAFDA	Advocacy After Fatal Domestic Abuse
ACN	Adult Coming to Notice
AFV	Adult Family Violence
AFH	Adult Family Homicide
AMHP	Approved Mental Health Practitioner
BAMER	Black, Asian, Minority Ethnic and Refugee
BCU	Basic Command Unit
CMHT	Community Mental Health Team
CCG	Clinical Commissioning Group
CCR	Coordinated Community Response
CGL	Change Grow Live
CMHT	Community Mental Health Team
CPA	Care Plan Approach
CRC	Community Rehabilitation Company
DHR	Domestic Homicide Review
EIT	Early Intervention Team
GBH	Grievous Bodily Harm
HEMS	Helicopter Emergency Medical Service
IAPT	Improving Access to Psychological Therapies
IDVA	Independent Domestic Violence Advisor
KCH	Kings College Hospital
GP	General Practitioner
IDVA	Independent Domestic Violence Advisor
IMR	Individual Management Review
KCH	King's College Hospital NHS Foundation Trust
MHU	Mental Health Unit
LAS	London Ambulance Service
LGT	Lewisham and Greenwich NHS Trust
MARAC	Multi Agency Risk Assessment Conference
MASH	Multi Agency Safeguarding Hub
MHA	Mental Health Act 1983
MHAA	Mental Health Act Assessment
MHU	Mental Health Unit
HMCTS	HM Court and Tribunal Service
MARAC	Multi Agency Risk Assessment Conference
MOPAC	Mayor’s Office for Policing and Crime
MOPAC	Mayor’s Office for Policing and Crime
MPS	Metropolitan Police Service
NPT	Neighbourhood Policing Team
PND	Penalty Notice for Disorder
SAR	Safeguarding Adults Review

SBS	Southall Black Sisters
SEL ICS	South East London Integrated Care System
SHIP	Single Homelessness and Prevention Service
SIO	Senior Investigating Officer
SLaM	South London and Maudsley Foundation NHS Trust
SLT	Senior Leadership Team
VAWG	Violence against Women and Girls
VSHS	Victim Support Homicide Service

Appendix 2: Terms of Reference

This Domestic Homicide Review (DHR) is being completed to consider agency involvement with Miss RH and Elijah following the death of Miss RH in June 2020. The DHR is being conducted in accordance with Section 9(3) of the Domestic Violence Crime and Victims Act 2004.

Purpose of DHR

1. To review the involvement of each individual agency, statutory and non-statutory, with Miss RH and [the alleged perpetrator] Elijah during the relevant period of time from 1st January 2016 to the date of death (in June 2020) (inclusive). To summarise agency involvement prior to this time period where relevant.
2. To establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.
3. To identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.
4. To apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate.
5. To prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a coordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity.
6. To contribute to a better understanding of the nature of domestic violence and abuse.
7. To highlight good practice.

Role of the Independent Chair, the Review Panel, and the Safer Lewisham Partnership

8. *The Independent Chair of the DHR will:*
   a) Chair the DHR.
   b) Coordinate the review process.
   c) Quality assure the approach and challenge agencies where necessary.
   d) Produce the Overview Report and Executive Summary by critically analysing each agency involvement in the context of the established Terms of Reference (ToR).
9. *The Review Panel:*
   a) Agree on robust ToR.
   b) Ensure appropriate representation of their agency: panel members must be independent of any line management of staff involved in the case and must be sufficiently senior to have the authority to commit on behalf of their agency to decisions made during a panel meeting.
   c) Where requested, prepare Individual Management Reviews (IMRs)/Short Reports and chronologies through delegation to an appropriate person in the agency.
   d) Discuss key findings from the IMRs/Short Report and invite the author (if different) to the relevant meeting.
   e) Agree and promptly act on recommendations in the IMR/Short Report Action Plan.
   f) Ensure that the information contributed by their organisation is fully and fairly represented in the Overview Report.
   g) Ensure that the Overview Report is of a sufficiently high standard for it to be submitted to the Home Office, for example:
      - The purpose of the DHR has been met as set out in the ToR.
      - The Overview Report provides an accurate description of the circumstances surrounding the case; and

- The analysis builds on the work of the IMRs/Short Reports and the findings can be substantiated.

h) To conduct the process as swiftly as possible, to comply with any disclosure requirements, panel deadlines and timely responses to queries.
i) On completion present the Overview Report to the Safer Lewisham Partnership.
j) Implement their agency's actions from the Overview Report Action Plan.

10. *Safer Lewisham Partnership*:
    a) Translate recommendations from Overview Report into a SMART Action Plan.
    b) Submit the Executive Summary, Overview Report and Action Plan to the Home Office Quality Assurance Panel.
    c) Forward Home Office feedback to the family, Review Panel and Standing Together.
    d) Agree publication date and method of the Executive Summary and Overview Report.
    e) Notify the family, Review Panel and Standing Together of publication.

Definitions: Domestic Violence and Coercive Control

11. The Overview Report will make reference to the terms domestic violence and coercive control. The Review Panel understands and agrees to the use of the cross-government definition (amended March 2013) as a framework for understanding the domestic violence experienced by the victim in this DHR. The cross-government definition states that domestic violence and abuse is:
    "*Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence, or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse: psychological; physical; sexual; financial; and emotional.*

    Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

    Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim."

    This definition, which is not a legal definition, includes so-called 'honour' based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group."

12. In using this definition, the Review Panel will be mindful that this case relates to Adult Family Violence (AFV).

Equality and Diversity

13. The Review Panel will consider all protected characteristics (as defined by the Equality Act 2010) of both Miss RH and the Elijah (age, disability (including learning disabilities), gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex, and sexual orientation) and will also identify any additional vulnerabilities to consider (e.g., armed forces, carer status and looked after child).
14. The Review Panel identified the following protected characteristics of Miss RH and of Elijah as requiring specific consideration for this case:
    - Sex (Miss RH was female; Elijah is male).

- Disability (Miss RH is not known to have had a disability; regarding Elijah, a mental health condition is considered a disability if it has a long-term effect (i.e., if it lasts, or is likely to last, 12 months) on someone's normal day-to-day activity).
- Faith (Miss RH and Elijah was/is believed to have been Christian, although the extent and practice of their faith is unknown at the start of the DHR); and
- Race (Miss RH and Elijah was/is British Black Caribbean).

15. The following issues have also been identified as particularly pertinent to this homicide.
    - AFV (Miss RH was the mother of Elijah); and
    - Mental Health (both Miss RH and Elijah had contact with mental health services).
16. Consideration has been given by the Review Panel as to whether either the victim or the [alleged] perpetrator was an 'Adult at Risk' Definition in Section 42 the Care Act 2014: "An adult who may be vulnerable to abuse or maltreatment is deemed to be someone aged 18 or over, who is in an area and has needs for care and support (whether or not the authority is meeting any of those needs); Is experiencing, or is at risk of, abuse or neglect; and As a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it."
    Abuse is defined widely and includes domestic and financial abuse. These duties apply regardless of whether the adult lacks mental capacity.

    If it is the case that any party is an adult at risk, the Review Panel may require the assistance or advice of additional agencies, such as adult social care, and/or specialists such as a Learning Disability Psychiatrist, an independent advocate or someone with a good understanding of the Mental Capacity Act 2005.

    The Care Act 2014 states; "Safeguarding means protecting an adult's right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, while at the same time making sure that the adult's wellbeing is promoted including, where appropriate, having regard to their views, wishes, feelings and beliefs in deciding on any action. This must recognise that adults sometimes have complex interpersonal relationships and may be ambivalent, unclear, or unrealistic about their personal circumstances."

    The Review Panel will keep this under consideration, including considering whether Miss RH was acting as an (informal) carer.

17. *Expertise:* The Review Panel will secure representation from a Black, Asian, and Minority Ethnic (BAME) organisation to act as an expert/advisory panel member. The Review Panel will also secure representation in relation to AFV and, if appropriate, religion and belief.
18. If Miss RH and Elijah have not come into contact with agencies that they might have been expected to do so, then consideration will be given by the Review Panel on how lessons arising from the DHR can improve the engagement with those communities.
19. The Review Panel agrees it is important to have an intersectional framework to consider Miss RH and Elijah's life experiences. This means to think of each characteristic of an individual as inextricably linked with all of the other characteristics in order to fully understand one's journey and one's experience with local services/agencies and within their community.

Parallel Reviews

20. There is an inquest into the death of Miss RH and the Review Panel will ensure the DHR process dovetails with the Coroner's Inquest.
21. There is a mental health investigation reviewing the care and treatment provided to Elijah led by South London and Maudsley NHS Foundation Trust (SLaM) in line with the Serious Incident Framework, 2015.

22. It will be the responsibility of the Independent Chair to ensure contact is made with any other parallel process if these are identified during the DHR process.

[Criminal trial disclosure dealt with in disclosure paragraph below]

Membership

23. It is critical to the effectiveness of the meeting and the DHR that the correct management representatives attend the panel meetings. Panel members must be independent of any line management of staff involved in the case and must be sufficiently senior to have the authority to commit on behalf of their agency to decisions made during a panel meeting.
24. The following agencies are to be on the Review Panel: [see panel list in Section 1]
25. As set out in paragraph 17 the Review Panel will identify and invite additional members to act as experts in relation to AFV, race and ethnicity, as well as faith and belief.
26. The SLaM representative will be the panel member to ensure good cross communication with mental health investigation (see paragraph 21).

Role of Standing Together Against Domestic Abuse (Standing Together) and the Panel

27. Standing Together have been commissioned by the Safer Lewisham Partnership to independently chair this DHR. Standing Together have in turn appointed their DHR Associate James Rowlands to chair the DHR. The DHR team consists of two Support Officers and a DHR Manager. The DHR Support Officer will be the main point of contact and will coordinate the DHR and the DHR Team Manager Hannah Candee will have oversight of the DHR. The manager will quality assure the DHR process and Overview Report. This may involve their attendance at some panel meetings. The contact details for the Standing Together DHR team will be provided to the panel, and you can contact them for advice and support during this DHR.

Collating evidence

28. Each agency to search all their records outside the identified time periods to ensure no relevant information was omitted and secure all relevant records.
29. Management Review (IMRs) and Chronologies will be completed by the following organisations known to have had contact with Miss RH and Elijah during the relevant time period:
    - [General Practice]
    - Lewisham & Greenwich NHS Trust
    - MPS
    - SLaM
30. Short report & Chronologies will be completed by:
    - Adult Social Care Services (*to be confirmed)*
    - Lewisham Council Housing
    - Pinnacle Housing
31. Further agencies may be asked to complete chronologies and IMRs if their involvement with Miss RH and Elijah becomes apparent through the information received as part of the DHR (including Lewisham Children's Social Care and Education, as well as Kings College Hospital NHS Trust) (*to be confirmed)*.
32. Each IMR will:
    - Set out the facts of their involvement with Miss RH and/or Elijah.
    - Critically analyse the service they provided in line with the specific ToR.
    - Identify any recommendations for practice or policy in relation to their agency.
    - Consider issues of agency activity in other areas and review the impact in this specific case.

33. Agencies that have had no contact should attempt to develop an understanding of why this is the case and how procedures could be changed within the partnership which could have brought Miss RH and Elijah in contact with their agency.

Key Lines of Inquiry

34. In order to critically analyse the incident and the agencies' responses to Miss RH and/or Elijah, this DHR should specifically consider the following points:
    a) Analyse the communication, procedures, and discussions, which took place within and between agencies.
    b) Analyse the co-operation between different agencies involved with Miss RH / Elijah [and wider family].
    c) Analyse the opportunity for agencies to identify and assess domestic abuse risk.
    d) Analyse agency responses to any identification of domestic abuse issues.
    e) Analyse organisations' access to specialist domestic abuse agencies.
    f) Analyse the policies, procedures and training available to the agencies involved on domestic abuse issues.
    g) Specific consideration to the following issues:
        - AFV; and
        - Mental Health.
    h) Analyse 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.

As a result of this analysis, agencies should identify good practice and lessons to be learned. The Review Panel expects that agencies will take action on any learning identified immediately following the internal quality assurance of their IMR.

Development of an action plan

35. Individual agencies to take responsibility for establishing clear action plans for the implementation of any recommendations in their IMRs. The Overview Report will make clear that agencies should report to the Safer Lewisham Partnership on their action plans within six months of the DHR being completed.
36. Safer Lewisham Partnership to establish a multi-agency action plan for the implementation of recommendations arising out of the Overview Report, for submission to the Home Office along with the Overview Report and Executive Summary.

Liaison with the victim's family and [alleged] perpetrator and other informal networks

37. The DHR will sensitively attempt to involve the family of Miss RH once it is appropriate to do so in the context of ongoing criminal proceedings. The Independent Chair will lead on family engagement with the support of the Victim Support Homicide Service and Hundred Families.
38. Family liaison will be coordinated in such a way as to aim to reduce the emotional hurt caused to the family by being contacted by a number of agencies and having to repeat information.
39. The Review Panel discussed the involvement of other informal networks of the Miss RH/Elijah and agreed it was proportionate to seek to identify any relevant persons (neighbour, colleagues, members of church/religious organisation) to be involved in the DHR.
40. Elijah will be invited to participate in the DHR, following the completion of the criminal trial.

Media handling

41. Any enquiries from the media and family should be forwarded to the Safer Lewisham Partnership who will liaise with the Independent Chair. Panel members are asked not to comment if requested. The Safer Lewisham Partnership will make no comment apart from stating that a DHR is underway and will report in due course.
42. The Safer Lewisham Partnership is responsible for the final publication of the Executive Summary and Overview Report and for all feedback to staff, family members and the media.

Confidentiality

43. All information discussed is strictly confidential and must not be disclosed to third parties without the agreement of the responsible agency's representative. That is, no material that states or discusses activity relating to specific agencies can be disclosed without the prior consent of those agencies.
44. All agency representatives are personally responsible for the safe keeping of all documentation that they possess in relation to this DHR and for the secure retention and disposal of that information in a confidential manner.
45. It is recommended that all members of the Review Panel set up a secure email system, e.g., registering for criminal justice secure mail, nhs.net, gsi.gov.uk, pnn or GCSX. Documents will be password protected.
46. If an agency representative does not have a secure email address, then their non-secure address can be used but all confidential information must be sent in a password protected attachment. The password used must be sent in a separate email. Please use the password provided to you by the Standing Together team. They should be reminded that they should remove the password and only share appropriate information to appropriate front-line staff in line with the DHR Confidentiality Statement and the specific ToR.
47. If you are sending password protected document to a non-secure email address, it must be a recognisable work email address for the professional receiving information. Information from DHR should not be sent to a Gmail / Hotmail or other personal email account unless in rare cases when it has been verified as the work address for an individual or charity.
48. No confidential content should be in the body of an email to a non-secure email account. That includes names, DOBs and address of any subjects discussed at DHR.

Disclosure

49. Disclosure of facts or sensitive information will be managed and appropriately so that problems do not arise. The review process will seek to complete its work in a timely fashion in order to safeguard others.
50. The sharing of information by agencies in relation to their contact with the victim and/or the [alleged] perpetrator is guided by the following:
    a) The Data Protection Act 1998 governs the protection of personal data of living persons and places obligations on public authorities to follow 'data protection principles': The 2016 Home Office Multi-Agency Guidance for the Conduct of DHRs (Guidance) outlines data protection issues in relation to DHRs (Par 98). It recognises they tend to emerge in relation to access to records, for example, medical records. It states 'data protection obligations would not normally apply to deceased individuals and so obtaining access to data on deceased victims of domestic abuse for the purposes of a DHR should not normally pose difficulty – this applies to all records relating to the deceased, including those held by solicitors and counsellors.
    b) Data Protection Act and Living Persons: The Guidance notes that in the case of a living person, for example, the [alleged] perpetrator, the obligations do apply. However, it further advises in Par 99 that the Department of Health encourages clinicians and health professionals to cooperate with DHRs and disclose all relevant information about the victim and where appropriate, the individual who caused their death unless exceptional

circumstances apply. Where record holders consider there are reasons why full disclosure of information about a person of interest to a review is not appropriate (e.g., due to confidentiality obligations or other human rights considerations), the following steps should be taken:
    - The review team should be informed about the existence of information relevant to an inquiry in all cases; and
    - The reason for concern about disclosure should be discussed with the review team and attempts made to reach an agreement on the confidential handling of records or
    - partial redaction of record content.

c) Human Rights Act: information shared for the purpose of preventing crime (domestic abuse and domestic homicide), improving public safety, and protecting the rights or freedoms of others (domestic abuse victims).
d) Common Law Duty of Confidentiality outlines that where information is held in confidence, the consent of the individual should normally be sought prior to any information being disclosed, with the exception of the following relevant situations – where they can be demonstrated:
    i) It is needed to prevent serious crime.
    ii) there is a public interest (e.g., prevention of crime, protection of vulnerable persons)

51. If there is a police criminal investigation, the police are bound by law to ensure that there is fair disclosure of material that may be relevant to an investigation, and which does not form part of the prosecution case. Any material gathered in this DHR process could be subject to disclosure to the defence if it is considered to undermine the prosecution case or assisting the case for the accused.
52. The Independent Chair will discuss the issues of disclosure in this case with the MPS Senior Investigating Officer/Disclosure Officer.
53. The chair, police and CPS will be minded to consider the confidentiality of material at all times and to balance that with the interests of justice.

Appendix 3: Single Agency Recommendations – Action Plan Template

Financial Services Company

Recommendation	Scope of recommendation i.e., local, or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
1: Miss RH's employer (financial services company) to develop a domestic abuse policy for staff.		It was not possible to establish contact with RH's employers.				

The General Practice of Miss RH and Elijah

Recommendation	Scope of recommendation i.e., local, or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
1: Add an alert to the patient's records if the patient has had an involuntary section history.	Local	Those coded with a history of involuntary section automatically enter	GP	SMI QOF register review.	Completed	Completed

Recommendation	Scope of recommendation i.e., local, or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
		the Serious Mental Illness Quality Outcome Framework (SMI QOF) register.				
2: Code high need mental health patients as 'admissions avoidance' and link household members	Local	Code high need mental health patients as 'admissions avoidance' and link household members	GP	review of admissions avoidance code	31st March 2023	Under review
3: Deteriorating mental health patients to be brought to the Multi-Disciplinary Team (MDT) meeting discussions.	Local	Discussion at MDT	GP/South London and Maudsley (SLaM)	None	January 2022	Completed
4: Review the 'Do Not Attend' (DNA)policy for patients on the mental health register.	Local	Discussion with local adult safeguarding lead on updating DNA policy	Lewisham Adult Safeguarding Board (LSAB)	None	N/A	Updated guidance has been implemented.

Recommendation	Scope of recommendation i.e., local, or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
5. Training for staff on issues surrounding Adult Family Violence (AFV) and its identification and management.	Local	In house training has been arranged and local training dates have been disseminated.	GP	None	1st September 2022	1st September 2022 In house training has occurred. Staff have been provided with dates for adult safeguarding training

Lewisham Council Housing Needs Department

Recommendation	Scope of recommendation i.e., local, or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
1: Medical Officer to be invited to the SLaM / Housing Forum to highlight concerns pertaining to any clients to the Housing SLaM liaison meeting.	Local	Lewisham Housing implemented changes locally. The Council is introducing a new housing application and register system which should give applicants more	Lewisham Council Housing Needs Department	The Lewisham Housing Register Assessment and Allocations Manager have assigned attendance to two named Housing Medical	On going	Embedded in practice

Recommendation	Scope of recommendation i.e., local, or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
		information on the progress of their applications. A SLaM/Housing Forum has been introduced. This is a monthly meeting, currently held on-line where representatives can bring cases of concern for discussion with Senior leaders from both agencies. It is a minuted and actioned meeting intended to lessen the risk that any resident with a housing/mental health need is missed or falls through a gap and to ensure there is		Advisors.		

Recommendation	Scope of recommendation i.e., local, or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
		a structured line of communication between the agencies. The Lewisham Council Housing Needs Department made a single recommendation for the SLaM/Housing Forum to be attended by the Medical Officer				

LGT

Recommendation	Scope of recommendation i.e., local, or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
1. Ensure that domestic abuse targeted questions are embedded in the triage	Local	To embed the asking of the routine enquiry	Lewisham Greenwich Trust	Routine Enquiry question added to the triage	April 2023	April 2023 IDVA have met with

Recommendation	Scope of recommendation i.e., local, or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
questioning in the Emergency Department. This will support finding out if a patient is a victim of abuse and would like access to an Independent Domestic Violence Advisor (IDVA).		question into the ED triage assessment.	(LGT)	assessment. Training of staff to ask the question and respond appropriate. Monitor impact through the number of DA referrals made.		the Senior Nursing team to agree training plan and implementation. Domestic Abuse (DA) referrals recorded and included in the quarterly data
2. Ensure trust-wide ongoing improvements in relation to domestic abuse training for clinical staff to address AFV.	Local	To review and update DA training	LGT	Review and update DA training as part of the L3 safeguarding training for Trust staff	April 2022	April 2022 As part of the implementation of L3 adult safeguarding training for all clinical staff in response to the revised intercollegiate guidance, the DA part has been updated and refreshed. This will be reviewed

Recommendation	Scope of recommendation i.e., local, or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
						regularly to incorporate AFV

MPS

Recommendation	Scope of recommendation i.e., local, or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
1. South East Basic Command Unit Senior Leadership Team (SE BCU SLT) to remind all staff involved in this incident of their responsibilities to generate an Adult Come to Notice (ACN) MERLIN Pre-Assessment Check (PAC) where Vulnerable Adults Framework (VAF) identifiers are apparent.	Local/BCU		Metropolitan Police Service (MPS)	SLT to advise Staff	November 2021	November 2021 This has been completed. It has also been tasked to Headquarters to be built into future Professional Development Days and BCU wide communications.
2. SE BCU SLT to dip sample (ACN) reports to ensure compliance around appropriate intelligence checks being completed,	Local/BCU		MPS	Dip-Sample	November 2021	November 2021 SLT reminded of the importance of dip sampling these

Recommendation	Scope of recommendation i.e., local, or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
and to ensure compliance with timescales of reports being sent to partner agencies.						reports. Additional dip sample to take place. by the Business Improvement Team in 4 weeks to ensure the process is followed and to identify any potential further learning. A referral to the MPS Leading Responsible Officer for Safeguarding Adults to see if this is something that requires. wider consideration.
1. Central West 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.	Local		MPS	SLT to advise Staff	November 2021	Staff involved have now been debriefed. Completion date 23/11/2021 BCU DCI.

Pinnacle Housing Group

Recommendation	Scope of recommendation i.e., local, or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
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.	Local		Pinnacle Housing	This is an ongoing action and has been embedded in our procedures	On going	Embedded in practice

SLaM

Recommendation	Scope of recommendation i.e., local, or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
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	Local	Action for SLAM: Review of the Trust's Domestic Violence and Abuse policy and training to include information on the assessment of victim's housing situation, and	Housing	Revised Domestic Violence Abuse (DVA) policy and training	October 2023	November 2023 Completed

Recommendation	Scope of recommendation i.e., local, or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
• All staff who attend the training are aware that in such cases the concerns need to be escalated to housing 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.		housing referral and escalation pathways.				
2. The Early Intervention Team (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	Trust Wide	An audit to be undertaken of new referrals to see number of carers' assessments within the 6 months period.	SLAM Lewisham Borough Council	Audit completed SLAM has a Carers lead in Lewisham services	November 2023	November 2023 Completed

Recommendation	Scope of recommendation i.e., local, or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
whether this is 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. 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.	Trust Wide	To develop guidance for staff on the dual diagnoses' pathways and support and resources available to people with dual substance misuse and mental health needs.	SLaM	Cannabis clinic in place Dual Diagnosis nurses in place Additions Consultants Provide Specialised advise Consultant dual diagnosis Nurse in place.	November 2023	November 2023 Completed
4. The Trust to develop domestic abuse guidelines for staff for them to help	Trust Wide	The Trust's existing Domestic Violence and	SLaM	DVA policy reviewed and available to staff	December 2023	November 2023 DA training was

Recommendation	Scope of recommendation i.e., local, or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
families to safeguard themselves when there is a possibility of a risk (including in the context of AFV).		Abuse policy is being reviewed to incorporate learning from DHRs.				updated to include familiar violence, carer abuse, older adults abuse, safety planning and DASH-risk tool Safer Lives
5. The Trust to consider having a dedicated telephone line which goes directly through to the Crisis Line	Trust Wide	The Trust's to review effectiveness/ accessibility of the Crisis Line.	SLaM		December 2023	December 2023 A 24-hour crisis line was established in April 2023. This service supports people across South London (including family members) to access help and support by calling NHS111 number, then pressing 2. Callers can then speak with an experienced call handler who can transfer calls to local services.

Recommendation	Scope of recommendation i.e., local, or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
						All call handlers have received Safeguarding Adult, Children and Domestic Abuse training, including consideration of AFV. There is an additional SLAM specific 24-hour Crisis line, for children, young people, and their families. All staff have been trained in Safeguarding Adult, Children and Domestic Abuse. These staff also receive monthly safeguarding supervision. Information on crisis lines is included as a

Recommendation	Scope of recommendation i.e., local, or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
						matter of routine as part of crisis and contingency plans, and when people are on a waiting list for a service. Information on the lines is publicly accessible on SLAM Website. The Trust has a dedicated page on the Trust Intranet page Maud of Domestic Abuse resources including who the specialist providers are in Lewisham and other Boroughs. A leaflet for carers/families in relation to crisis support. This was

Recommendation	Scope of recommendation i.e., local, or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
						developed in 2023 by Trust wide Carers and Families committee.
6. All delays of five days or more for MHAAs need to be reported on Datix and documented in the clinical record.	Local	The task and finish group (in partnership with Local Authority Approved Mental Health Professionals AMH Service) to review the process for reporting delays in Mental Health Act Assessment (MHAA) of 5 days and more	SLaM	The Trust already records cancellations of MHA assessments, and the reasons for these cancellations.	December 2023	December 2023 On going task. MHAA that are stood down or did not go ahead are dated and recorded on ePJS with a plan on how the team is going to continue managing risks.
7. Trust senior management to put in place an action plan to address about how the delays in MHAAs are going to be addressed with the police.		Local The Trust to work with relevant systems partners, Local Authorities and Met Police on the development of an action plan to address the	SLaM	Comment- The Trust does not manage the AMHP services and not responsible for	December 2023	December 2023 On going. The Local authority has updated and shared the SOP for MHA assessment which include new

Recommendation	Scope of recommendation i.e., local, or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
		delays in MHAA		the capacity within this service to provide AMHPs to undertake the MHAA. The Trust has an existing plan to address delays as result of lack of beds.		weekly forum for escalation involving police, SLaM and AMHP service

AMHP Service

Recommendation	Scope of recommendation i.e., local, or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
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	Local		AMHP Service	Review of Standard Operating Procedure (SOP) for AMHP	May 2023	May 2023 SOP completed May 2022; Reviewed and updated in May 2023

Recommendation	Scope of recommendation i.e., local, or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
to MHAA requests.				service covering all MHAA with target times		and again in April 2024 in the light of 'Right Care, Right Person.
2. These targets need to be realistic, and resources need would to be available to services in order to meet them.	Local		AMHP Service	Completion of guidance with target times for all SLaM /AMH staff around MHA related inter-agency processes including: AMHP referral, court application, police referral and bed allocation.	May 2023	April 2024 May 2023 February 2024 From April 2024 a weekly AMHP / MPS / SLaM forum has been set up to review outstanding MHA.
			AMHP Service	Completion of standard procedure for recall of community patients	May 2023	SOP has been completed and recirculated to the CTO recall patients

Recommendation	Scope of recommendation i.e., local, or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
			AMHP Service AMHP Service	Circulation of police escalation process to SLaM services. IT systems to be set up to facilitate enhanced monitoring of data around target timescales.	May 2023 April 2023	 Process for CTO recall to hospital un Power BI dashboard for managing referrals and monitoring timescales scales has been fully implemented.
3. Mandatory training domestic abuse/AFV training for all professionals working with mental health service-users and carers	Local	All Case Management Officers, Social Workers, and managers to undertake Domestic Abuse e-learning module	Adult Social Care (Adult Mental Health)	Lewisham Council appraisal season – June 2023 Completion of the Skills for Care endorsed Domestic Abuse e-learning module via LBL Learning Academy now included as	June 2023	July 2023 Lewisham Council appraisal season - June 2023 Completion of the Skills for Care endorsed Domestic Abuse e-learning module via LBL Learning Academy now included as requirement in the

Recommendation	Scope of recommendation i.e., local, or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
				requirement in the 2023 appraisal template for AMH staff.		2023 appraisal template for AMH staff

Appendix 4: DHR Recommendations – Action Plan Template

Recommendation	Scope of recommendation i.e., local, or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
Domestic Homicide Review (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.	Local	Key SLaM staff including safeguarding and governance leads for SLaM to participate in DHR training which will assist with managing and servicing its participation in DHRs. A flow chart outlining the internal SLaM process and governance for DHR allocation should be drafted and presented to Safer Lewisham	SLaM	SLaM has drafted and signed off the DHR process/flow chart Flowchart%20for%20the%20management% DHR process is to be presented to the Safer Lewisham Partnership DHR process is embedded in the Safeguarding Adults/Children Training modules	November 2023	November 2023

Recommendation	Scope of recommendation i.e., local, or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
		Partnership.		(Level 1-Level3) SLaM has recruited a DA and Exploitation Lead for the Trust, as part of the ongoing restructuring the Safeguarding team. The candidate is going through the recruitment clearance process and DTA when she commences work with the Trust. The Trust Wide Named Nurse for Children Safeguarding is in the process of		

Recommendation	Scope of recommendation i.e., local, or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
				formulating a DA Staff Knowledge Audit that looks at gaps in knowledge around adult familiar violence, carer abuse, older adults abuse, safety planning and DASH-risk tool Safer Lives. She has consulted with the Lewisham and Lambeth VAWG managers. A questionnaire above tool was designed in SNAP XMP after consultations with the Safeguarding		

Recommendation	Scope of recommendation i.e., local, or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
				Leads. The online questionnaire was sent out Trust wide via Comms and Leads. The tool was made available from 27th November to 8th December. A total of 170 responses were received via the online tool. All 170 responses were downloaded from SNAP XMP to Excel and the data was analysed in Excel to form		

Recommendation	Scope of recommendation i.e., local, or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
				graphs and charts. The report with recommendations from the Leads is also embedded. The Audit will be signed off and the work will be passed on to the new DA and Exploitation Lead to refine and take forward so that the recommendations and action plan is embedded into practice across the Trust SLaM held a CPD Event		

Recommendation	Scope of recommendation i.e., local, or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
				programme Learning from SARs, DHRs and LCSPRs for Consultant on the 27th November 2023 which was well attended SLaM has developed a stand-alone risk assessment within the HCR 20 Risk assessment tool used in the Trust. Trust wide DA 16 days of action events in Nov 2023 The Centralised team are planning a		

Recommendation	Scope of recommendation i.e., local, or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
				Domestic Abuse Conference in the new year 2024.DTA		
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.	Local	SLaM to set a Task and Finish Group with VSHS and Hundred families to examine the support offered to RH' family and establish learning and best practice. Compile and produce an action plan to address. any gaps in the offer and challenges identified and disseminate learning and	SLaM	SLaM: The Trust Wide Named Nurse was introduced to One Hundred Families and the One Hundred Families web link is now uploaded on SLAM safeguarding Intranet Web resource page for easy access by all Staff SLaM Family and Carer Lead, along with SLaM Families and Carers Group	November 2023	Completed

Recommendation	Scope of recommendation i.e., local, or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
		best practice across the partnership and SLaM.		developed, publicised, and circulated a guide for carers and families, addressing delays in Mental Health Act assessments, crisis, and contingency plans, and keeping safe. Safeguarding Leads are promoting this across Adult Mental Health directorates. This guide is in the public domain  Crisis%20support%20for%20carers%20v1		

Recommendation	Scope of recommendation i.e., local, or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
				Hundred Families: Hundred Families informed of separate work at Director level with SLaM colleagues initiatives, with an aim to improve SLaM engagement with affected families as part of a quality improvement programme, including RH' family The Trust has moved from Serious Incidents (SI)		

Recommendation	Scope of recommendation i.e., local, or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
				investigations to Patient Safety Incident Review Framework (PSIRF) and as part of PSIRF, engagement of families after an incident or major incident such as death is an on-going process The DA and Exploitation Lead was recruited and collaboratively with the CAMHs Lead will be raising awareness around interventions for Service users		

Recommendation	Scope of recommendation i.e., local, or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
				who disclose to carry knives.		
DHR Recommendation 3: South East London Integrated Care Service (SEL ICB) and Safer Lewisham Partnership (SLP) to take action to ensure that professionals are aware of the local service officer in relation to drug or alcohol use.	Local	Lewisham council and ICB to liaise with commissioned drug and alcohol services (Change Grow Live) to raise awareness in medical and social care services by rolling out briefing sessions for the partnership.	Integrated Care Board (ICB), SLP & CGL	ICB and SLP approached CGL to arrange an opportunity to deliver training sessions. It is envisaged that within the ICB, this will be delivered at the level 3 Adult and Child Safeguarding briefing sessions, as well as Adult Mental Health and Children and Young People colleagues in Lewisham CGL are currently in the	November 2023	Completed

Recommendation	Scope of recommendation i.e., local, or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
				Process of coordinating the GP's to be able to deliver this training with the nurse consultant for SEL ICB. Training module is in place to be delivered as soon as suitable dates and times have been established. One session delivered to lead GPs in safeguarding 2023 by CGL and one session by Danny Waites Commissioning Manager (Addictions)		

Recommendation	Scope of recommendation i.e., local, or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
				Prevention, Inclusion and Public Health Commissioning Team Community Services on non-intentional management of overdose with Lead GP Novum Health Partnership Dr Davies.		
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.	Local	Safer Lewisham Partnership (SLP) to set a Task and Finish (T&F) group between ICB, Police, Probation, SLaM, Safer Lewisham Partnership, Refuge,	SLP	The Lewisham VAWG Lead initiated conversations about this issue with relevant partners via email in the third quarter on 2022-2023. This exercise indicated that a	November 2023	Ongoing- The T&F Group for this action is incorporated with the DHR Steering Group meetings.

Recommendation	Scope of recommendation i.e., local, or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
		Hourglass, Change Grow Live, Youth Offending service, Violence Reduction Team as well as other partners as necessary. T&F will establish current procedures and pathways around knife carrying and will ensure there are systematic process in place for adequate multiagency risk management. This will take		Task & Finish group is required to ensure a local pathway/procedure is established and followed. Conversations have commenced at the last steering group meeting on 14 November 2024.		

Recommendation	Scope of recommendation i.e., local, or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
		place every 4 weeks.				
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	Local	ICB to develop a clear DA policy and framework as part of the health IGVA co-commissioned service to deliver awareness raising sessions with GP practices in line with the policy	ICB	ICB and Lewisham Council have co-commissioned an Independent Gender Violence Advocate (IGVA), to deliver health focused services on Domestic Abuse which includes AFV. Contract completed August 2023. Ongoing conversations re IDVA locations in Waldren as ongoing estates development 2024 August. IGVA increased	November 2023	The Health focused IGVA project completed in July 2024, reaching over 280 clinical staff. Delivery of monthly briefing sessions of DA to clinical staff is ongoing.

Recommendation	Scope of recommendation i.e., local, or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
				engagement and knowledge within Primary Care. Training has is delivered in monthly sessions via MST. ICB provided SLP with the developed Domestic Abuse Guidance. ICB informed that this was cascaded to other designates within Lewisham but other Southeast London boroughs as well. The ICB DA Staff Policy is currently under development. A		

Recommendation	Scope of recommendation i.e., local, or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
				T&F group meets regularly to review and finalise. This Policy development now with Mental Capacity Act and Safeguarding Development Lead October 2024. High level discussions completed with Exec Board offer as in staff support. SEL ICB.		
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:	Local	SLP to undertake a training needs assessment. SLP to liaise with local	SLP Hourglass	Athena delivered sessions on Familial Abuse. Further sessions are being scheduled.	November 2023	Delivery of briefing sessions around familial abuse is ongoing

Recommendation	Scope of recommendation i.e., local, or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
• 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.		elderly abuse specialist services (Hourglass) to deliver the appropriate training. To ensure this is embedded into corporate memory.		SLP contacted Hourglass (elderly abuse specialist organisation) and briefing dates for practitioners are being scheduled. Hourglass DA specialist for older people delivered to safeguarding leads Primary Care 2023 SEL ICB		
DHR Recommendation 7: The Safer Lewisham Partner to ensure it has a robust DHR framework including the capacity to:	Local	Safer Lewisham Partnership (SLP) to establish a DHR specific task and finish group,	SLP	The VAWG Lead has established the DHR Steering Group, in order to monitor actions' completion and	November 2023	November 2023 Ongoing, the DHR Steering Group meets regularly

Recommendation	Scope of recommendation i.e., local, or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
• 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.		convening every 10 weeks to monitor outstanding actions of DHR Develop a thematic response to Adult Family Violence (AFV). Identify and develop user friendly learning. Consider an online learning event.		discuss and develop thematic responses as appropriate.		
DHR Recommendation 8: The Lewisham Safeguarding Adult Board (LSAB) 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).	Local	LSAB to liaise with SLaM and adult social care to audit their procedures, policies, and training to ascertain whether they	LSAB	LSAB confirmed that there are provisions in place within the legal framework due to carers being defined as a distinct “at risk” group within the	November 2023	November 2023

Recommendation	Scope of recommendation i.e., local, or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
		support the identification of carers and their individual needs. To report back to the Domestic Abuse (DA) & Violence Against Women and Girls (VAWG) board quarterly.		Care Act 2004, however more work needs to be undertaken.		

Appendix 5: Home Office Quality Assurance Panel Letter

Home Office

Interpersonal Abuse Unit
2 Marsham Street
London
SW1P 4DF

Tel: 020 7035 4848
www.homeoffice.gov.uk

Desmond Zephyr
Safer Communities Crime and Violence Reduction Service Manager
Lewisham Council
Holbeach Office, 9 Holbeach Road Catford, London
SE6 4TW

10th April 2024

Dear Desmond,

Thank you for submitting the Domestic Homicide Review (DHR) report (Miss RH) for Lewisham Community Safety Partnership (CSP) to the Home Office Quality Assurance (QA) Panel. The report was considered at the QA Panel meeting on 7th February 2024. I apologise for the delay in responding to you.

The QA Panel felt this was a well written, detailed report which was easy for readers to understand. The report also highlighted the need to build trust with black communities and the police.

Condolences were provided by the Chair and CSP to the family of Miss RH and the family wanted the victim to be known as 'Miss RH.' Other culturally sensitive pseudonyms chosen by the Chair and CSP were also approved by the family. There was positive engagement by the Chair with Miss RH's family (her three sisters) who contributed to DHR process and there was a good sense of who Miss RH was. Miss RH's family provided a very moving and heartfelt tribute to their sister which provided an insight to her as a sister, mother, and friend.

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

Areas for final development:

- Despite signs that Miss RH was under a lot of stress and that Elijah was violent when angry or threatened and he carried weapons, it appears there was insufficient assessment of the risk to Miss RH. The potential for domestic abuse was not considered within the mental health risk assessments that were undertaken regarding the perpetrator.

- There were missed opportunities by agencies (GP/mental health services/police) to consider a referral for a carers assessment for Miss RH under the Care Act (2015). There was also poor information sharing and record keeping.

- There was a lack of 'Think Family/Household' for Miss RH and her son, especially in the context of his deteriorating mental health. The focus was on Elijah and his needs and there was a lack of recognition of potential adult child to mother violence.

- There was a lack of partnership working and information sharing across agencies. This meant that incidents were seen in isolation and not in the broader context.

- Elijah's comments about witchcraft and voodoo appear not to have been explored. He believed Miss RH had brought back poison and voodoo from her holiday, but this was not picked up or addressed within the DHR.

- In section 1.3.2, **'XXX'** is used in place of dates. Please provide appropriate dates before publishing.

- The date on page 1 of Date of Final Version reads **September 2022 in** both the **Executive Summary and Overview report**, but headers throughout the review say **October 2022.** Please correct this before publishing.

- There was a glossary of terms within the appendices, however it would have been helpful to have them at the commencement of the report, as there were a lot of acronyms used.

- Overview, Appendix 2, pg. 104 – the specific date of death is given and should be removed prior to publication.

- A full proofread is required.

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

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

The DHR report including the executive summary and action plan should be converted to a PDF document and be smaller than 20 MB in size; this final Home Office QA Panel feedback letter should be attached to the end of the report as an annex; and the DHR Action Plan should be added to the report as an annex. This should include all implementation updates and note that the action plan is a live document and subject to change as outcomes are delivered.

Please also send a digital copy to the Domestic Abuse Commissioner at **DHR@domesticabusecommissioner.independent.gov.uk**

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

Yours sincerely,

Home Office DHR Quality Assurance Panel

Appendix 6: Response to the Home Office Quality Assurance Panel Letter

Upon receiving the Home Office Quality Assurance Panel Letter, the feedback was reviewed, and several concerns were identified about the accuracy and appropriateness of the feedback.

Representing the Safer Lewisham Partnership, the VAWG Programme Manager and the Chair wrote to the Home Office to request the letter was revised.

In response, the Home Office advised the following: "*As the QA panel have already agreed that this report can be published, we are unable to ask them to look at this again due to the limited capacity we have to review DHRs. If we were to treat this as a resubmission now and ask the panel to look at the amendments again the report would not be seen by the QA panel until September which would ultimately delay the publication of the report.*

As we do not want to delay publication further, we are happy for an annex to be added to reference the changes the CSP, author and panel have made."

Consequently, the following table includes the feedback from the Home Office Quality Assurance Panel, a comment, and a note of any action taken.

Feedback	Comment	Action Taken
1. Despite signs that Miss RH was under a lot of stress and that Elijah was violent when angry or threatened and he carried weapons, it appears there was insufficient assessment of the risk to Miss RH. The potential for domestic abuse was not considered within the mental health risk assessments that were undertaken regarding the perpetrator.	It is unclear whether this is either (a) statement or (b) a suggestion that this is an area that the report has not addressed. If it is the former, it is non-specific, and the ask needs to be clarified. If it is the latter, this is inaccurate: In terms of the overall analysis, this discusses domestic abuse risk identification and assessment, as well as weapons (section 5.1) Regarding SLaM specifically, there is an extensive discussion of contact with Elijah and Miss RH. This is detailed in the chronology and then analysed too in section 5, including a discussion of identification of possible domestic abuse (5.3.45 onwards), reports that Elijah was carrying or had access to knives, and fire safety concerns (5.3.51 onwards). 'Assessment off risk' is identified as an overall lesson to be learnt (6.2.6)	Not actioned

	Recommendations have also been made. For example, in terms of single agency recommendations, SLaM has recommendations around staff training. Regarding DHR recommendations, recommendation 4 explicitly addresses the sharing of intelligence about knives.	
2. There were missed opportunities by agencies (GP/mental health services/police) to consider a referral for a carers assessment for Miss RH under the Care Act (2015). There was also poor information sharing and record keeping.	It is unclear whether this is either (a) statement or (b) a suggestion that this is an area that the report has not addressed. If it is the former, it is non-specific, and the ask needs to be clarified. If it is the latter, this is inaccurate: In terms of the overall analysis, carer status is noted in the overall analysis (section 5.1) and later as an overarching issue in terms of support for carers (5.4.11 onwards). Additionally, carer status (or, more broadly, vulnerability in the context of Elijah / Miss RH) is detailed in the chronology and then discussed in the analysis for agencies like SLaM (5.3.40 onwards) and the GP (5.3.98). While carer status is not discussed explicitly for	Not actioned

	the police, the creation of Merlin/ACNs is discussed. Finally, 'recognition and response to carers' is identified as an overall lesson to be learnt (6.2.5) Concerning information sharing, this is also addressed for individual agencies in the analysis (section 5), with 'interagency working' noted as one of the overall lessons to be learnt (6.2.7). Recommendations have also been made. For example, in terms of single agency recommendations, SLaM has recommendations for carers, the GP around AFV, and the MPS in relation to vulnerable adults. In terms of DHR recommendation, DHR recommendation 8 addresses local procedures, policy, and training around the identification of carers, including in the context of domestic abuse (including AFV).	
3. There was a lack of 'Think Family/Household' for Miss RH and her son, especially in the context of his deteriorating mental health. The focus was on Elijah and his needs and there	'Think Family' is a framework for including a subject and their wider network. While this language is not used in the report, the substantive point is that the potential risk of AFV to Miss RH is. Broadly, this comment repeats comment 1 above.	Not actioned

was a lack of recognition of potential adult child to mother violence.		
4. There was a lack of partnership working and information sharing across agencies. This meant that incidents were seen in isolation and not in the broader context	This comment repeats comment 2 above.	Not actioned
5. Elijah's comments about witchcraft and voodoo appear not to have been explored. He believed Miss RH had brought back poison and voodoo from her holiday, but this was not picked up or addressed within the DHR.	Voodoo or poisoning were noted in the chronology at 3.2.52, 3.2.55, 3.2.61, 3.2.63, and 3.2.84. While allegations around poison and voodoo were not explicitly explored, this is because these issues, as reported at the time and as analysed in the DHR, were part of Elijah's wider paranoid beliefs, including about family members (see, for example, where this is summarised in 5.1.9). This is also addressed specifically for SLaM in terms of its response, including overriding its duty of confidentiality to Elijah to share these allegations with family members (including with his aunt in relation to Elijah's claims she was poisoning him (see 5.3.46).	Footnote inserted to explain the rationale for how poisoning and voodoo have been addressed i.e., within the scope of wider paranoid beliefs and their management.

	In contact with family, their focus was on the reports of paranoia rather than this specific behaviour. Consequently, given the complexity of this DHR, a proportionate decision was made to focus on Elijah's presentation.	
6. In section 1.3.2, **'X_X_X_' _**is used in place of dates. Please provide appropriate dates before publishing	This paragraph includes 'XXX' as a placeholder for procedural dates related to sign-off and submission. These placeholders will be populated for publication.	Completed
The date on page 1 of Date of Final Version reads **September 2022 in** both the **Executive Summary and Overview report**, but headers throughout the review say **October 2022.** Please correct this before publishing	This is a header (not an error), marking the OR and ES up for document control (i.e., 'handed to'). The final header will be revised for publication.	To be revised for final publication.
There was a glossary of terms within the appendices, however it would have been helpful to have them at the commencement of the report, as there were a lot of acronyms used.	This is a stylistic preference and is not a proportionate area for further development. There is no requirement in the statutory guidance template for a glossary, and certainly not one which requires a specific location for a glossary. Practice around glossaries also varies; for example, the Royal Literary Fund notes	Not actioned

	glossaries are usually placed towards the end of a document. Additionally, in text, terms are spelt out in full on first use. It is frankly absurd that the Home Office QA panel feels it should be commenting on what is ultimately a stylistic choice.	
Overview, Appendix 2, pg. 104 – the specific date of death is given and should be removed prior to publication.	This is an error.	Removed
A full proofread is required	The document has already been proofread, and it would be helpful for the feedback to indicate the nature of the errors, e.g., major, or minor. Nonetheless, this can be proofed again.	Completed