

Barking & Dagenham

BARKING AND DAGENHAM COMMUNITY SAFETY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

EXECUTIVE SUMMARY

Report into the death of Christine

OCTOBER 2022

Independent Chair and Author of Report: Shabana Kausar

Associate, Standing Together Against Domestic Abuse

November 2024



“LIFE IS JUST NOT AS COLOURFUL WITHOUT YOU. I HOPE THAT I AM MAKING YOU PROUD! YOUR MEMORY WILL NEVER BE LOST, AS LONG AS I AM HERE ON THIS EARTH.”

My mother was a woman of contrasts—vibrant and traditional, East End through and through. She loved the simple pleasures, like fish and chips on a Friday and catching up on her soaps in the evening. But her story was anything but ordinary.

Born in Lagos, she was a trailblazer from a young age, leaving her family behind to pursue her passion for textiles in London. Later, she became a nurse, dedicating over 20 years of her life to the Royal London Hospital. She was known throughout her workplace for her colourful makeup and bold hairstyles, but even more for her warm, lively personality. Wherever she went, she made friends, and her presence is deeply missed by so many.

In 2020, she developed a surprising love for dogs, even though she had been terrified of them for most of her life. It was a delightful transformation that brought us together as a family.

She wasn't just a loving mother of four; she was also a single parent who did it all. Her strength and determination shone through in her role as a successful business entrepreneur. I get my love for fashion and entrepreneurship directly from her—it's something she passed down to me.

As her last-born, I was her “handbag”—I went everywhere with her. We were close, and while we had our moments of clashing, our bond was undeniable. She confided in me often, and I spent so much time with her that it feels like part of me is missing now. I miss our car rides, singing along to Fuji music, or the little things like trips to the supermarket—the everyday moments I once took for granted.

My mum was fiercely independent, always pushing me to stand on my own two feet, something I didn't fully appreciate at the time. But now, in her absence, I see how much strength I inherited from her. She didn't have an easy upbringing, but she made the best of what she had, always giving back to her community in Nigeria and supporting her family and friends.

Food was another thing she was passionate about. While she loved her fish and chips, she also had a deep love for Chinese food and enjoyed cooking and trying new things. I was always making food for her to try, and she was a stickler for not wasting anything—if I couldn't finish something, she was more than happy to eat it herself, laughing as she did. Her favourite Nigerian dish was Ayamase, and, true to her fiery personality, she loved her food as spicy as it could get.

My mother always said she would give her life for her children, and I never quite understood why she would say that. But she truly meant it. She was always there when you really needed her, and she would drop everything if her children needed help, no matter if they were right or wrong. She fought for me until her last breath, which speaks to the lengths she would go to protect us. Taken from us in an untimely and tragic manner, we will remember her for her contagious smile, fashionable looks and the warmth she left behind in her absence.

“CHARITY BEGINS AT HOME.” - Christine

Pen portrait of Christine by her daughter

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1. Preface

1.1 The Incident

1.1.1 This review concerns the circumstances leading to the homicide of 64-year-old Christine, by her son, Daniel, who had a history of mental ill-health. At the time of her murder, Christine lived at her home in Barking & Dagenham with her son and her daughter, Nina.

1.1.2 Christine has been described by her family as someone who had a colourful personality and a great sense of humour. She was described as someone who stood out wherever she went and someone who would always look on the positive side of any situation. She was very independent and has been described as a driven and ambitious person.

1.1.3 On the night of the murder, Daniel first attacked his sister, Nina, stabbing her with a kitchen knife in her bedroom. Christine was alerted to Nina's shouts and entered the room, where upon she was also stabbed by Daniel. Nina was able to dial 999, and Daniel left the home. The police forced entry and found Nina in her bedroom with

serious injuries, which were later pronounced non-life threatening after she was admitted to hospital. Christine was found in her own bedroom and treated for her injuries, but sadly, she passed away at the scene.

- 1.1.4 Daniel left the family home armed with the knife and deposited it in a nearby neighbour's bin. He walked into Dagenham Police Station and told the member of staff that he was handing himself in for a stabbing at his home address. Daniel pleaded guilty to Manslaughter by diminished responsibility of his mother and unlawful wounding of his sister. He was sentenced under Section 37 of the Mental Health Act to be detained in a hospital. If a psychiatrist finds Daniel fit for release, this will need to be approved by the Secretary of State.
- 1.1.5 The Review Panel expresses its sympathy to the family of Christine for their loss and thanks them for their contributions and support for this process.

1.2 The Review Process

- 1.2.1 This summary outlines the process undertaken by Barking and Dagenham Community Safety Partnership Domestic Homicide Review (DHR) panel in reviewing the homicide of Christine, who was a resident in their area.
- 1.2.2 The following pseudonyms have been in used in this review for the victim and perpetrator (and other parties as appropriate) to protect their identities and those of their family members:

Name	Relation to victim	Age at time of homicide	Ethnicity
Christine	Victim	64	British Nigerian
Daniel	Perpetrator and victim's son	28	British Nigerian
Nina	Victim's daughter	23	British Nigerian
Ayotunde	Victim's ex-partner	71	British Nigerian

- 1.2.3 *Criminal trial:* Daniel was charged with his mother's murder and the attempted murder of his sister. The trial was held in early November 2022. Daniel was on remand in custody since he was charged. In April 2023, Daniel pleaded guilty to manslaughter by

diminished responsibility for Christine’s death. In June 2023 he also pleaded to the unlawful wounding of his sister Nina.

1.2.4 Daniel was sentenced in August 2023 at the Central Criminal Court to a Section 37 Mental Health Act 1983 hospital order with a Section 41 Mental Health Act 1983 restriction attached. He will be detained at St Bernard’s Hospital. In the event of a psychiatrist determining Daniel as being fit for release, this will require ratification by the Secretary of State.

1.2.5 The process began with an initial meeting of the Community Safety Partnership on 8 November 2022 when the decision to hold a DHR was agreed. All agencies that potentially had contact with Christine and Daniel prior to the point of death were contacted, asked to confirm whether they had involvement with them, and instructed to secure their records.

1.3 Contributors to the Review

1.1.1 This review has followed the 2016 statutory guidance for Domestic Homicide Reviews which was issued following the implementation of Section 9 of the Domestic Violence Crime and Victims Act 2004. The following agencies were contacted, but recorded no involvement with Christine and Daniel:

- Change Grow Live;
- London Borough of Barking and Dagenham Adult Social Care;
- London Borough of Barking and Dagenham MARAC;
- Probation Services;
- Solace Women’s Aid; and
- Westminster Drugs Project (Subwise).

1.3.1 The following agencies and their contributions to this review are below. The chronologies were combined, and a narrative chronology was written by the Chair.

Agency	Contribution
East London NHS Foundation Trust	IMR and Chronology

Daniels' employer (as a non-statutory agency they have chosen to remain anonymous)	IMR and Chronology
London Ambulance Service NHS Trust	Short Report and Chronology
London Borough of Barking and Dagenham Children's Services	Short Report and Chronology
Metropolitan Police Service	IMR and Chronology
Northeast London Integrated Care Board	IMR and Chronology
Northeast London NHS Foundation Trust	IMR and Chronology
Refuge	Panel member
Victim Support	IMR and Chronology

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

1.1.2 *Independence and Quality of IMRs:* All IMRs/Short Reports received were comprehensive and enabled the Review Panel to analyse the contact with Christine and Daniel, and to produce the learning for this review. Where necessary further questions were sent to agencies and responses were received. The exception was Adult Social Care, who did not submit the short report requested. Although answers to specific questions were provided via email to the Chair, the absence of a short report,

and lack of engagement, resulted in limited analysis from Adult Social Care. Recommendations have been made in relation to this omission.

1.4 The Review Panel Members

Name	Job Title	Agency
Chris Ayton	Services Manager	Change, Grow, Live
Dawn Mountier	Safeguarding Officer Quality Directorate	London Ambulance Service NHS Trust
Dolores Connolly	Independent Review Officer, Detective Sergeant, Specialist Crime Review Group	Metropolitan Police Service
Frank McSheffrey	Interim HOS Safeguarding & Quality Assurance	London Borough of Barking and Dagenham Children's Services
Gary Jones	Operational Director Enforcement Regulatory Services and Community Safety	London Borough of Barking and Dagenham Community Safety Partnership
James Thomas	Safeguarding Lead	East London NHS Foundation Trust
Jo Kavanagh	Named Nurse Safeguarding Adults	Barking Havering Redbridge University Trust (BHRUT)
Katie Jones	Community Safety Partnership Manager	London Borough of Barking and Dagenham Community Safety Partnership
Louise Bayston	Senior Operations Manager	Refuge

Michael X	Head of Risk, Compliance and Assurance	Daniel's Employer
Rachel Daniel	Head of Service	Victim Support
Sangita Lall	Assistant Director Adults Services Barking & Dagenham	Northeast London NHS Foundation Trust
Steve Danquah-Kuma ¹	Service Manager of Mental Health Social Care Services (Adult Mental Health and Dementia)	London Borough of Barking and Dagenham
Toks Okeniyi	Head of UK Programmes	Forward
Zahid Iqbal	Designated Professional for Safeguarding Adults	Northeast London Integrated Care Board

- 1.4.1 *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.
- 1.4.2 The Review Panel met a total of 4 times, with the first meeting of the Review Panel on the 9 June 2023. There were subsequent meetings on 6 October 2023, 9 February 2024 and 14 June 2024.
- 1.4.3 The Chair of the Review wishes to thank everyone who contributed their time, patience and cooperation to this review.

¹ Adult Social Care was requested to attend the panel and submit a short report. A short report was not submitted, and Adult Social Care did not attend Panel Meeting 3 which focused on analysing Individual Management Reviews and Short Report submitted by the panel.

1.5 Chair of the DHR and Author of the Overview Report

- 1.5.1 The Chair and author of this DHR is Shabana Kausar, an Associate of Standing Together. Shabana has received Domestic Homicide Review Chair's training from Standing Together. She has extensive experience in the domestic violence sector, having worked in both statutory and voluntary sector organisations. As a Violence against Women and Girls Strategic Lead, Shabana has commissioned and led reviews on behalf of three Local Authority areas in London. She is currently undertaking a PhD on Violence against Women at the University of London.
- 1.5.2 *Independence:* Shabana Kausar has no connection with the Barking and Dagenham area or any of the agencies involved in this case.

1.6 Terms of Reference for the Review

- 1.6.1 At the first meeting, the Review Panel shared information about agency contact with the individuals involved, and as a result, established that the time period to be reviewed would be from August 2020 to the date of the homicide. This timeframe was chosen because of Daniel's attack of his mother in August which led to his arrest and subsequent detention under Section 136 of the Mental Health Act 1983. Agencies were asked to summarise any relevant contact they had had with Christine or Daniel outside of these dates.
- 1.6.2 *Key Lines of Inquiry:* The Review Panel considered both the "generic issues" as set out in 2016 Guidance and identified and considered the following case specific issues:
- Experiences of mental health and the impact of trauma;
 - Historic experiences of domestic abuse and the impact this had on confidence in accessing services;
 - Christine and Daniel's race;
 - How agencies considered adult child to parent abuse and the risk Daniel posed to his female relatives;
 - How agencies considered domestic abuse outside of a traditional intimate partner relationship set up including whether Christine would have recognised the abuse as domestic abuse; and
 - The impact of the COVID-19 pandemic.

1.6.3 To address specific issues in this case, including in relation to equality and diversity, 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:

- FORWARD (Foundation for Women's Health Research and Development) is the leading African women-led organisation working to end violence against women and girls.

2. Summary of Chronology

2.1 Summary of Information Known to the Agencies and Professionals Involved

- 2.1.1 A range of agencies had contact with Christine. Broadly this contact related to the following services:
- Health services;
 - Police; and
 - Domestic abuse services.

Health services:

- 2.1.1 Christine had contact with a number of health services in relation to her own health as well as Daniel's health needs. Christine was registered with a local GP Practice and visited them a number of times, particularly around her diabetes diagnosis in March 2021. Whilst the medical care provided was appropriate, there were missed opportunities where routine enquiry could have been undertaken to explore Christine's experience of abuse after Daniel threatened her with a knife in August 2020.
- 2.1.2 Although not a direct service user herself, Christine had extensive contact with both ELFT and NELFT in her care for Daniel. Whilst Daniel was being supported by ELFT, there were missed opportunities to understand the risk that Daniel posed to Christine and his sister. This was particularly the case for EFLT in October 2021, when no assessments were undertaken when Daniel moved back in with his mother, despite making threats to harm her only a few months earlier and where Christine had expressed her fear of Daniel earlier that year, in February.
- 2.1.3 There was also a missed opportunity to assess Christine as a carer for Daniel and therefore provide her with additional associated support. When Daniel was transferred to NELFT in January 2022, a care assessment was not undertaken, despite Christine regularly liaising with the care coordinator on Daniel's behalf, for example, on 17 July 2021 when Christine called the care coordinator to apologise for Daniel's behaviour after he declined to attend the home visit.
- 2.1.4 A significant missed opportunity was in late October 2022, two days before the homicide, where the NELFT Care Coordinator visited the home to assess Daniel after Christine raised concerns regarding his behaviour. Christine explained that Daniel was behaving "*funny*" that he was not taking his medication. She explained that he had

attacked someone in the past when he was unwell, and she was worried that he might do it again. A patient risk assessment was not undertaken because Daniel was not home. However, no risk assessment had been undertaken for Christine, who was told to call Mental Health Direct if needed, and that the case would be discussed by the NELFT team on Monday.

Police

- 2.1.1 Christine was threatened by Daniel in August 2020, when he chased her into a garden shed with a knife, kicked down the door and continued to threaten his mother. He was sectioned under Section 2 of the Mental Health Act 1983, after he was examined by a health care professional and deemed not fit to be. The crime was flagged as medium risk before it was signposted to Victim Support. There was a missed opportunity to flag the case as high risk, which would have resulted in it being referred to a MARAC meeting.
- 2.1.2 There was a further missed opportunity, on 17 July 2021, to assess the harm Daniel posed to his family after he was arrested for criminal damage. A MERLIN was not shared with Adult Social Care, meaning that vulnerability was not highlighted, and no onward dissemination of information was shared.
- 2.1.3 A significant missed opportunity was two days before the homicide, when Christine attended Dagenham Police station to report Daniel missing and shared her concerns about his mental health, as he was diagnosed with paranoia and was not taking his medication. The case was designated as a medium risk missing person, but there was a missed opportunity to fully assess the risk Daniel posed to Christine and Nina, considering his history of violence against them, particularly when he was non-compliant with his medication. The officer did not look at Daniel's previous history when risk assessing.

Domestic abuse services

- 2.1.4 After Daniel threatened to attack his mother in August 2020, the police referred the case to Victim Support. The referral was received by a London Victim and Witness Service manager and assigned to an Independent Victim Advocate (IVA) in the triage team as it was noted as standard risk. If the case had been triaged to an Independent Domestic Violence Advocate (IDVA) in Victim Support, more specialist support could have been provided to Christine. Instead, the referral was deemed 'standard risk' because Daniel was subsequently sectioned.

2.1.5 When Victim Support received the referral, there is no record of whether a further risk assessment was carried out by the IVA service and there is no detail in the case notes of any further services Christine was signposted to. Christine told the IVA that she was scared of Daniel and did not want to live with him anymore. The IVA had not recorded any safety planning in response to this other than that Daniel was currently in hospital, and they might support him with alternative housing on his release. There was no professional curiosity in relation to why Daniel was in hospital and what caring responsibilities Christine had. There was no plan for support for Christine once Daniel was released, and the case was closed after this one and only interaction.

2.1.6 The following services had contact with Daniel:

- Health services
- Police

Health services

2.1.1 Daniel was known extensively to both ELFT and NELFT. Whilst with ELFT between November 2020 and January 2022, Daniel was provided with a range of support which he positively responded to. In July 2021, however, Daniel was treated with a relapse of psychosis, which was seen to be most likely due to non-compliance with medication. This remained a feature with Daniel, and there were missed opportunities to manage his medication use more effectively. Further, whilst sectioned between July to October 2021, Daniel sent a number of threatening text messages to his mother. He was discharged in October and deemed safe to move home, as his threats were seen in the context of his illness. There was a missed opportunity to understand the risk he posed to others.

2.1.2 NELFT also provided Daniel with a range of support, however Daniel started to withdraw from the service after being transferred from ELFT in January 2022, not turning up to appointments or cancelling at short notice. He did not have a face-to-face appointment for 6 months until July 2022. He also declined psychological support in May 2022 and focused on reducing his medication in order to manage his weight. In June 2022, he denied having been non-adherent to his medication use. On a number of occasions, risk assessments were not undertaken because of Daniel's lack of engagement. There were, therefore, missed opportunities to assess the risk that Daniel posed to others.

Police

- 2.1.1 Daniel was known to police on three separate occasions across August 2020 and October 2022. He was appropriately supported and sectioned whilst in custody. As mentioned above, the case was referred to Victim Support but deemed to be medium. In July 2021, Daniel was arrested for criminal damage, however no risk assessment was undertaken to understand the risk that he may have posed to family or others.
- 2.1.2 On 28 October, when Christine reported Daniel as missing, there was a missed opportunity to review Daniel's previous history of violence and the threats he had previously made to harm his mother and sister. He was designated as a medium risk missing person despite being told that he was not taking his medication and had previously harmed someone when he had last stopped taking his medication.

2.2 Any other relevant facts or information

Daniel's employer:

- 2.2.1 Although not a statutory service, Daniel's private employer submitted information to the panel. It is significant that during the period of this review, Daniel did not disclose anything to his employer regarding his mental health, nor cause any concern in a professional capacity. This will be explored further in the analysis section of this report.

2.3 Summary of Information from Family

- 2.3.1 The Chair interviewed Nina, Christine's daughter, in November 2023. Nina spoke about Christine's experience of services, the barriers Christine faced in accessing support, and the missed opportunities. Nina highlighted that there was no professional consideration of whether Christine was able to support Daniel and be his carer. This was particularly the case after Daniel was released from hospital in October 2021 and moved in with his mother and sister. Nina shared that:

'They asked my mum whether he could return to our house, and she said that would be fine. There was no curiosity or exploration [by professionals] into whether this arrangement would make sense. I told my mum not to allow him to come back but she said, this is my son and my house. She was scared herself, so I don't know why she let him back.'

- 2.3.2 Nina went on to share that she felt that Christine was pressurised by professionals:

'It felt like they were rushing Daniel out of the hospital. Once he was deemed okay, they wanted him out. I remember them saying that there was not enough bedspace for him. They said that he was fine, but I knew him, and I knew that he was not okay. Daniel said that he was fine, but this was because he did not want to be hospitalised. He was trying to be okay, but I could see there was still something wrong, but he was drugged up. I don't think he had enough support, and no one pushed to see whether he was okay. He was headstrong and wanted to get back to his work. They took his word at face value that he was fine.'

- 2.3.3 Nina also felt that Christine had limited understanding of mental health and that it was a taboo subject. Nina shared that she would *'try to explain to her what some of this information meant but there were so many missed opportunities to see whether my mum understood what was being asked of her.'* She went on to explain to the Chair that they were offered family counselling:

'But this never happened. I think the counselling never happened because my mum did not want it. I lived with my mum, so I felt that everything was on me. It was hard because I wanted the support and counselling, and I thought my mum should do it, but she was against it. I couldn't force her to do it. When the second psychotic episode happened, she was more interested, and she was sent links so that she could look it up, but this is where it ended.'

- 2.3.4 Nina felt that the emphasis was always placed on Daniel's health with no consideration given to the impact on her or her mother: *'There was no investigation into whether mum would be able to handle being a carer. He attacked us before, but it was never about us, it was always about whether he took his medication.'*

- 2.3.5 When asked about her mother, Nina shared that Christine:

'Had a colourful personality. She was opinionated and was really funny. She was very smart and always knew what to do if something happened – if something broke in the house she would fix it and she would build wardrobes. She was a landlady and was really driven. She was full of life and wanted to have fun, she loved parties and was confident. She did not care what people said about her and was a strong character. She was someone who you would look at and not understand how she could do it all.'

- 2.3.6 Nina went on to explain that she felt that Christine:

'Had more than her friends in terms of being able to support herself, with a house and a car. Sometimes she could not relate to people because of this and so she would do things herself. She would feel like her friends were jealous of her sometimes or an auntie was jealous because she had a new car. She could be wary of people and did not trust easily while being open at the same time. She was such a unique person; you would not meet anyone like her. She was inspiring to me because she did so much by herself. She would always remind me that my dad had nothing to do with her success.'

2.3.7 Nina also shared that Christine:

'Had been through a lot moving to London and supporting my dad. I feel like she had a lot of trauma and did not have anyone to speak to about this. Because of this she could be quite reactive, and we could have arguments...She had her own mental health journey, but she could be in denial about how she was feeling. It was clear to me that she was depressed with the situation with my brother, but she was not open to seeking help for this. She had a lot of internal hurt and trauma from her childhood and from her experiences with my dad. The situation with my brother was another thing on top of that so it was a lot for her.'

2.3.8 Nina felt that she was not always heard by Christine, sharing that *'sometimes we would clash...because she was old-school Nigerian. She would sometimes feel that I was being disrespectful, it was hard for her to understand that I would not always agree with her and that I was my own person.'* Nina also felt she was unheard by services:

'I was surprised that I had not met any healthcare professionals. I didn't have a number I could call, and I did not feel their presence. They would only meet with my mum and a lot of the time this information wasn't passed on to me. It was hard to get my mum to tell me things...I did not have a voice in the process. As the youngest girl in my family, my voice didn't carry a lot of weight.'

2.3.9 When asked about Christine's friendship groups, Nina shared that her mother went to church but when asked if the church should be approached for involvement in this review, Nina highlighted that *'mum could be going through something, and you wouldn't know. The church would not know. Mum did not even tell my other siblings - it was just me and her who knew.'*

2.3.10 Nina did share that Christine had a friend who she would meet in the local park to speak about Daniel. This friend was White, and Nina shared that she felt her mother could open up to her because she felt she would not be judged. Unfortunately, Nina went on to explain that this friend is no longer on good terms with the family, but that she was glad Christine was able to speak to someone.

2.3.11 Although outside of the scope of this review, Nina also shared the impact of the homicide on her and on her mental health. She explained to the Chair that since the homicide, she has had little support. She shared *'that I've been told there are charities but people who are grieving don't have the energy to reach out. I don't think I'm getting the support I need.'* She went on to share that:

'I was also there; I'm still surviving something that killed my mum. I don't see how people can't see why I'm struggling. Nine [counselling] sessions are not going to help someone like me. I have my friends; I've had such amazing people support me. But no one understands what it was like – I don't feel like I can speak to people. I don't want to be a burden to my friends...I feel like the only way I'll be taken seriously is if I go crazy. I shouldn't need that to get help. It just takes one situation to affect someone's mental health – it is worrying. I don't want to get to a point where my mental health is really bad. There is only so much I can do.'

2.3.12 Nina highlighted that her mother would have wanted her to be involved in the DHR process and have her voice heard. She spoke about how she wanted to raise awareness of adult child to parent abuse:

'I have intentions to create awareness about family domestic abuse. There are so many cases like this. I have a friend whose mum was killed by their stepdad. I reached out and we've spoken. We realised that nothing has changed in 10 years. I know there are big issues that need to be fixed but I think there needs to be new laws for change to come about. I would like my mum's name attached to new domestic abuse policies as a legacy. It is so sad, even looking from the outside. There were so many missed opportunities.'

2.3.13 When asked about missed opportunities, Nina explained that it felt like people were more interested in Daniel's mental health than the family and their general wellbeing. Nina highlighted that *'it isn't like Daniel attacked someone randomly, it was his sister*

and mother.’ She felt that there was little understanding of domestic abuse outside of an intimate relationship:

‘The main thing that is so upsetting is that there was no urgency at all. There was no humanisation either, and no personalisation. This is what confuses me when I look back – there was no urgency, and everyone was so professional, talking about the process. There needs to be more support for people’s families because there was none, especially when you have to be a carer. There should be more support. There was too much of taking Daniel’s word for it without asking family or friends.’

2.4 Summary of Information from Perpetrator

2.4.1 In December 2023, Daniel was sent a letter from the Chair via his Forensic Social Worker, with a Home Office leaflet explaining DHRs and an interview consent form to sign and send back. Daniel sent back the signed consent form and the Chair arranged to meet him in hospital for an interview in February 2024. However, a few days before the meeting, Daniel cancelled the appointment and informed the Chair, via his Forensic Social Worker, that he did not wish to take part in the review now or in the future.

3. Conclusions and Lessons to be Learnt

3.1 Conclusions

- 3.1.1 Christine was tragically murdered by her son, Daniel, after enduring ongoing threats and attempts of violence whilst he was in her care. Daniel had a history of violence against his mother and sister, which was compounded by his mental ill-health.
- 3.1.2 But this tragic incident must not be allowed to overshadow Christine's life. Conversations with Christine's family have shed a light on her colourful character. Despite her own experiences of abuse, Christine has been described as always being the funny one who looked at the positive side of life. She always stood out where she went, and her daughter, Nina, told the Chair that she would have loved to have her mother's confidence. It is this memory of Christine which endures and will be missed.
- 3.1.3 The Review Panel extends its sympathy to all those affected by Christine's death and thanks all those who have participated in the review.
- 3.1.4 There has been significant learning identified during the course of this review, which the Review Panel hopes will prompt individual agencies, as well as the appropriate partnerships, to further develop their response to domestic abuse. This learning is summarised below.

3.2 Key Themes and Learning Identified

- 3.2.1 The most substantive learning of this case has related to four areas: lack of identification and understanding of adult child to parent abuse, limited understanding between mental health and domestic abuse, limited multi-agency working, and limited understanding on what it means to be a carer:

Lack of identification and understanding of adult child to parent abuse

- 3.2.2 Despite Christine being attacked by Daniel two years prior to her murder, and being subjected to ongoing threats of violence, it is clear that agencies did not recognise adult child to parent abuse as domestic abuse. Instead, Daniel's actions were either explained as a result of his mental ill-health or were not considered a risk to Christine.
- 3.2.3 The review has found that agencies had limited awareness of domestic abuse when being perpetrated by an adult child to a parent. It is likely that Christine herself did not recognise her experience as domestic abuse, and it was noted by the Victim Support IVA that she had limited awareness of support available. In light of this, there is a need

for professionals to understand and to raise awareness of the different forms of domestic abuse and the support that is available, especially for those experiencing adult child to parent abuse. Identifying and responding to risk in a broader domestic abuse context can support myth busting and ensure that survivors are able to access the right support at the right time.

- 3.2.4 The Review Panel welcomed learning identified and implemented by ELFT to include domestic abuse and safeguarding prompt questions to their Mental Health Admission checklist. This will ensure that robust processes are in place to flag domestic abuse without being reliant on individuals. The panel also welcomed a focus on delivery of adult child to parent abuse training across the Trust. It is important that this is something that is offered more widely across Barking and Dagenham.
- 3.2.5 Although agencies are recognising the need to respond to domestic abuse, and to have policies and processes in place, this is still mainly limited to intimate partner violence. Agencies need to be confident that their level of awareness is in line with the recent statutory definition of domestic abuse, which includes adult child to parent abuse, as defined in the Domestic Abuse Act 2021. Recommendations have been made in this report to address these points.

Limited understanding between mental health and domestic abuse

- 3.2.6 This review has also found that there was limited professional awareness of the intersection between domestic abuse and mental health. This review does recognise that there is some complexity in the relationship between experiencing mental ill-health and domestic abuse perpetration. However, research illustrates that mental health does not cause domestic abuse, and if an individual is displaying abusive behaviour, then this needs to be seen in the context of domestic abuse.
- 3.2.7 Christine's experience of services was mostly indirectly through their focus on Daniel and in having his needs met. Although this was important, sadly, Christine and Nina's experiences became side-lined, and their needs were not considered as Daniel became the sole focus of agencies' attention. The review found that when Daniel displayed abusive behaviours, the response was to focus on his placement in hospital or his medication dosage.
- 3.2.8 There is a need to strengthen agencies' understanding of how mental health can compound domestic abuse perpetration. It is also vital that wider family's voices do not get lost in the mental health treatment of perpetrators.

Limited multi-agency working

- 3.2.9 A number of different agencies held information on Daniel and Christine, but this information was either not shared, not shared appropriately, or there was no follow up after an onward referral was made. This meant that agencies had a patchy picture of the situation and therefore a limited understanding of risk. This is particularly the case with information sharing between NELFT and ELFT. If information was shared effectively through a broader partnership working approach, agencies could have put the pieces together to build a clearer picture of Christine and her needs.
- 3.2.10 Where good multi-agency practice was identified, for example, when the GP followed up with Nina after they were informed that she was discharged from talking therapy, this was reliant on individual initiative rather than being embedded in processes and procedures. Individual good practice is commendable but can result in inconsistencies and missed opportunities. It is important that Barking and Dagenham take a wider collaborative and multi-agency approach whereby their systems and processes are robust and fit for practice, ensuring join up and appropriate information sharing.
- 3.2.11 We know that no one agency can single handily tackle domestic abuse and that a coordinated community response is needed to provide victims with the support they need. Recommendations have been made to address these points.

Limited understanding on what it means to be a carer

- 3.2.12 The review also found that there were significant expectations on Christine to care for Daniel, without due consideration of the strain this placed on her and her subsequent support needs. Despite the substantial caring responsibilities that Christine undertook while looking after Daniel, this was not recognised by agencies meaning that a carers assessment was not undertaken.
- 3.2.13 Carers assessments are important as they discuss how caring affects someone's life, including their physical, mental, and emotional needs. Significantly, they also put a carer in touch with local support groups, so that they have people to talk to and are not isolated. A carers assessment could have supported Christine to articulate her needs and refer her onto support. As Christine was recorded by Victim Support as stating that she did not have awareness of what services were available, this assessment could have put Christine in touch with vital support.
- 3.2.14 This report also recognises that implicit biases may have impacted how agencies understood and recognised Christine's support needs. Racialised and gendered

expectations of Christine may have influenced how her support needs were, or were not, recognised. It is also important that agencies do not offer support based on how someone presents. Christine was described by her daughter and by agencies as “strong”, however this should not result in the absence of support.

- 3.2.15 There is a growing awareness of the relationship between domestic abuse and caring responsibilities. It is vital that agencies better understand this intersection to ensure that victims’ needs are recognised, and appropriate support is offered.

4. Recommendations

4.1 Single Agency Recommendations (identified by individual agencies)

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

NELFT

- 4.1.2 Director of Service to consider Duty of Candor arrangements following engagement with the police around appropriateness of doing so.
- 4.1.3 The Standard Operating Procedure (SOP) system should be reviewed to include that a carers assessment must be offered when service users are re-referred and accepted back into Early Intervention in Psychosis (EIP). The EIP services to audit this demographic of client to provide assurance that this is routinely offered.
- 4.1.4 An indicator to be added to Electronic Patient Record to be completed when the carers wellbeing initiative has been initiated.
- 4.1.5 The EIP local SOP system to be reviewed to include the external pathway process and to provide NELFT teams with an overarching Trust wide policy that is aligned with the quality standards for early intervention in psychosis and NICE guidance.
- 4.1.6 To strengthen in the SOP how salient information pertaining to medical and risk history is captured within the EPR and communicated with the team.
- 4.1.7 A Trust wide communication to be circulated to increase staff awareness of how to access East London Patient Record and clinical portal.
- 4.1.8 A system review of East London Patient Record to be undertaken to explore what improvements can be made with publishing to the clinical portal.
- 4.1.9 Core EIP services to discuss the findings of this case as part of reflective discussion around best practice pertaining to assessment and formulation of current and historical risks following contact or failed contact.
- 4.1.10 An audit of risk formulation to be completed for quality assurance following the reflective session with staff.
- 4.1.11 The EIP SOP to be updated to reflect how medication adherence is monitored in collaboration with GP and pharmacy and how any concerns are reviewed and escalated within zoning meeting.
- 4.1.12 Ensure the EIP SOP is updated to reflect that it is prescriber to prescriber responsibility for communicating the frequency of repeat prescriptions following on from a medical review.

ELFT:

- 4.1.13 Learning lessons event to be held with THEIS and staff from Globe Ward. This will focus on the specific key lessons identified for each service respectively.
- 4.1.14 Trust wide intergenerational abuse session to be held at bi-annual safeguarding conference.
- 4.1.15 Lessons from the IMR and DHR report to be shared via Trust safeguarding newsletter. To be completed when DHR is published.
- 4.1.16 Create domestic abuse checklist and safeguarding prompt questions to be added to Tower Hamlets for Mental Health admission checklist.
- 4.1.17 Carers assessment rights to be included as a topic within next safeguarding supervision for THEIS.
- 4.1.18 Each Neighbourhood Mental Health Team (including THEIS) in Tower Hamlets to have a nominated domestic abuse champion, who has completed the Tower Hamlets VAWG partnership domestic abuse champion training and participates in the domestic abuse champion network.
- 4.1.19 Increase staff awareness of intergenerational abuse the risks to parents supporting adult children with mental health.
- 4.1.20 Service users and carers need support in understanding and identifying domestic abusive behaviour. Increase staff awareness on the importance of completing DASH risk assessments whenever concerns arise, to ensure access to necessary support and protection.
- 4.1.21 Practitioners to be able to identify carers and be mindful that carers also provide emotional support to the cared for person not just practical support. Carers do not have to live in the same home as the cared for person to be identified as a carer.

Northeast London ICB:

- 4.1.22 Delivery of training around identifying domestic abuse and understanding how to support someone who has a history of domestic abuse. Specifically looking at routine enquiry and how best to pose questions to help illicit enough information to help assess risk.

Police

- 4.1.23 East Area Borough Command Unit to issue learning to the officers and supervisors involved in CRIS 4220553/21 to ensure they are reminded of their responsibilities regarding:
 - Five-year Intelligence Checks completion
 - Vulnerability Assessment Framework (VAF) and MERLIN Pre Assessment Check (PAC) completion

- Requirement for secondary investigation
- Consideration for partner agency engagement
- BWV to be secured in compliance with policy – retention for 6 years as a volume crime.

Victim Support

- 4.1.24 East Area Borough Command Unit to issue learning to the officers and supervisors involved in CRIS 4220553/21 to ensure they are reminded of their responsibilities regarding:
- 4.1.25 For the IVA who worked on this case to attend the refresher DASH risk assessment and ISSP training delivered by Senior IDVAs, within the next 8 weeks.
- 4.1.26 For the IVA manager to continue to dip sample IVAs cases to check for DASH RA and safety planning.
- 4.1.27 To ensure that all IVAs have completed the mandatory Homicide timeline - 5 Critical Question training prior to receiving any domestic abuse referrals, this will be an ongoing action for all new starters.

4.2 Multi Agency Recommendations (Developed by the Review Panel)

Recommendation 1:

- 4.2.1 Barking and Dagenham Community Safety Partnership to identify how to raise awareness of domestic abuse experienced within a familial context.

Recommendation 2:

- 4.2.2 ELFT and NELFT to identify ways to increase understanding amongst their staff of the relationship between mental health and domestic abuse and to demystify reasons for perpetration.

Recommendation 3:

- 4.2.3 Non-statutory services to understand the role they play in identifying and responding to domestic abuse as part of a coordinated community response. Daniel's employer to review the need for, and development of, a domestic abuse policy and training.

Recommendation 4:

- 4.2.4 NELFT and ELFLT to review their processes in relation to their responsibility in identifying and supporting carers.

Recommendation 5:

- 4.2.5 Barking and Dagenham Community Safety Partnership to identify how to raise awareness of domestic abuse experienced by carers.

Recommendation 6:

- 4.2.6 Barking and Dagenham Community Safety Partnership to identify the training offer for statutory services to address implicit bias and to adopt an anti-racist approach in partnership practice.

Recommendation 7:

- 2.4.2 ELFT and NELFT to review and improve the way information is transferred when cases are being moved from one trust to another. This needs to include a review of the current handover process between Care Coordinators to ensure these are robust and driven by an understanding of fluctuating risk.

Recommendation 8:

- 2.4.3 ELFT and NELFT to review and improve the current offer of support for the family of service users. ELFT and NELFT to ensure conversations about domestic abuse are regularly had with families of service users and that DASH risk assessments are undertaken.

Recommendation 9:

- 4.2.7 NELFT to ensure they update Barking and Dagenham Community Safety Partnership on the changes implemented as a result of the 'Prevention of Future Deaths' report that was initiated by HM Coroner in March 2023.

Recommendation 10:

- 4.2.8 The police to ensure their multi-agency processes are robust and to provide assurance that MERLINS are being completed and to review their multi-agency processes and information sharing protocols in relation to offenders who are sectioned.

Recommendation 11:

- 4.2.9 The police to appropriately follow up on investigations that concern offenders who have been sectioned.

Recommendation 12:

- 2.4.4 Victim Support to work with the Police to review their triage system which determines the level of risk posed in the referral, ensuring that a process is in place for the assessment to be changed depending on the detail provided. Victim Support to train staff to ensure that all are completing DASH risk assessments and are offering appropriate support to victim and other family members.

Recommendation 13:

- 4.2.10 Victim Support to ensure that their staff are trained to provide consistent and safe support which is needs-led and delivered in a timely way.

Recommendation 14:

- 4.2.11 Barking and Dagenham Community Safety Partnership to ensure that Adult Social Care commit to being involved in all future DHRs.

Recommendation 15:

- 4.2.12 Church Elm Lane Medical Practice to ensure that questions about domestic abuse are routinely asked during appointments and DASH risk assessments are undertaken.

Recommendation 16:

- 4.2.13 The police to ensure that they are compliant with DASH/DARA risk assessment procedures and appropriately assess risk irrespective of whether a victim wishes to partake or not. Professional judgement must be used and referrals to MARAC must be made on assessment outcome, not victim compliance.

Recommendation 17:

- 4.2.14 Barking and Dagenham Community Safety Partnership to review support offered by specialist by and for services in the borough and ensure these are appropriately signposted to. Barking and Dagenham Community Safety Partnership to undertake a need and gap analysis around specialist support offered in the borough and commission specialist services where needed.

Recommendation 18:

- 4.2.15 Barking and Dagenham Community Safety Partnership to ensure that their members have policies and training which include detail of adult child to parent abuse.

Recommendation 19:

- 4.2.16 The Barking and Dagenham Community Safety Partnership to review the impact of lockdown on the work of their partnership and ensure the findings are included in their new ending violence against women and girls strategy.