Barking & Dagenham

BARKING AND DAGENHAM COMMUNITY SAFETY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

Overview Report into the murder of Christine

October 2022

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STANDING TOGETHER
against domestic abuse

"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

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 the 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 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 This Domestic Homicide Review (hereafter 'the review') examines agency responses and support given to Christine,[1] a resident of Barking & Dagenham, prior to the point of her homicide at her home in October 2022.

1.2.3 The review will consider agencies contact/involvement with Christine and Daniel[2] from August 2020, when Daniel was arrested for attacking Christine with a knife, to October 2022, the date of the homicide.

1.2.4 In addition to agency involvement, the review will also examine the past to identify any relevant background or trail of abuse before the homicide, whether support was accessed within the community and whether there were any barriers to accessing support. By taking a holistic approach, the review seeks to identify appropriate solutions to make the future safer.

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

1.2.6 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 Barking & Dagenham Community Safety Partnership. Having received notification from the Metropolitan Police on 1st November 2022, a decision was made to conduct a review in consultation with the Community Safety Partnership on 8th November 2022. Subsequently, the Home Office was notified of the decision in writing on 30th November 2022.

1.3.2 Standing Together Against Domestic Abuse (hereafter 'Standing Together') was commissioned to provide an Independent Chair (hereafter 'the Chair') for this review on 1st March 2023. The completed report was handed to the Barking and Dagenham Community Safety Partnership on 9 September 2024. It was tabled at a meeting on 2 October 2024 and signed off, before being submitted to the Home Office Quality Assurance Panel in XXX. In XXX, the completed report was considered by the Home Office Quality Assurance Panel. In XXX, the Barking and Dagenham Community

[1] Not their real name.

[2] Not their real name.

Safety Partnership received a letter from the Home Office Quality Assurance Panel [XXX] the report for publication. The letter will be published alongside the completed 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 review took longer than six months as time was needed to liaise with the family, to liaise with the perpetrator, to await conclusion of criminal proceedings, and to manage a number of local DHRs.

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, the 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 2016 statutory guidance.

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

Name	Relationship to victim
Nina	Daughter
Daniel	Son
Ayotunde	Ex-husband

1.4.4 These pseudonyms were agreed 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.

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

- *Sex*: The impact of Christine's sex has been an enduring feature of domestic homicides. An analysis of domestic homicide reviews reveals gendered victimisation across both intimate partner and familial homicides with females

representing the majority of victims and males representing the majority of perpetrators.[3] This characteristic is therefore relevant for this case as the victim was the mother of the male perpetrator. To date, of the three domestic homicides that have occurred in Barking and Dagenham since 2012, two have included the homicide of a woman. This is the first homicide of a mother by her son.

- *Ethnicity*: Both Christine and Daniel were from racially minoritised backgrounds as British Nigerians. Research highlights the additional barriers faced by victim/survivors from Black and racially minoritised communities in accessing services, including institutional racism, culture and religion, issues of professional cultural competence, and lack of diversity within frontline services.[4] The panel gave specific consideration to the potential barriers and challenges facing the victim, whilst undertaking the review. Daniel is Black British, and the panel felt it was also important to consider how his lived experiences and particular cultural context may have affected his help seeking patterns/perceptions or the response of services.

- *Age:* Christine was 64-years old at the time of her murder. Research shows that victims aged 61 and above are more likely to experience abuse from an adult family member than those under 60.[5] Significantly, the same research highlights that, on average, older victims experience abuse for twice as long before seeking help as those aged under 61 and are more likely to be living with the perpetrator after getting support. The panel gave specific consideration to age and the impact it may have had on Christine accessing support.

1.5.3 The following have also been identified as pertinent to the lived experiences of Christine and Daniel:

- *Mental health:* Daniel had a long history of mental health support needs. The panel were clear that mental health issues do not cause domestic abuse but can compound existing behaviours. The panel, therefore, considered how Daniel's mental health needs may have compounded his already abusive behaviours.

[3] "In 2014/15 there were 50 male and 107 female domestic homicide victims (which includes intimate partner homicides and familial homicides) aged 16 and over". Home Office, "*Key Findings From Analysis of Domestic Homicide Reviews*" (December 2016), p.3. and Analysis of the London DHR sample (n=84) reveals gendered victimisation across both types of homicide with women representing 83 per cent (n=70) of victims (including one trans-female) and men ninety per cent of perpetrators (n=76)". Montique ,B. "*Domestic Homicide Review (DHR) Case Analysis and Review of Local Authorities DHR Process*" (November, 2020).

[4] Hulley J, Bailey L, Kirkman G, et al. *Intimate Partner Violence and Barriers to Help-Seeking Among Black, Asian, Minority Ethnic and Immigrant Women: A Qualitative Metasynthesis of Global Research*. Trauma, Violence, & Abuse. February 2022.

[5] *https://safelives.org.uk/spotlight-1-older-people-and-domestic-abuse.*

1.5.4 The Review Panel took an intersectional and ecological analysis approach to better understand the lived experiences of both Christine and Daniel. This means to think of each characteristic of an individual as inextricably linked with all of the other characteristics in order to fully understand an individual's 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 identify 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.[6]
- An intersectional analysis considers the complex ways in which differing aspect 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.[7]

1.5.5 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 abuse, their options for safety and protection available, and considers any conscious or unconscious bias or privileging by agencies and or society.

1.5.6 In light of this, the panel invited a specific expert to the panel as an advisory member (see 1.6.6 for details).

1.6 Terms of Reference

1.6.1 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.

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

[7] 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 this 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.

1.6.2 The Review Panel was comprised of agencies from Barking and Dagenham, as the 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 to inform them of the review, invite their participation and request them to secure their records.

1.6.3 Additionally, it was established that the perpetrator had contact with agencies in the borough of Tower Hamlets and therefore agencies in that area were contacted for information and involved in the review.

1.6.4 At the first meeting, the Review Panel shared information about agency contact with the individuals involved, and as a result, established that the timeframe 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 with Christine or Daniel outside of these dates.

1.6.5 To address specific issues in this case (including in relation to equality and diversity as identified in 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:

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

1.6.6 The full Terms of Reference are included below:

This Domestic Homicide Review ('the review') is being completed to consider agency involvement with Christine and Daniel following the death of Christine on 30.10.2022. This review is being conducted in accordance with Section 9(3) of the Domestic Violence Crime and Victims Act 2004 but will be described as a 'Domestic Abuse-Related Death Review'.

Purpose of the Review

1. To review the involvement of each individual agency, statutory and non-statutory, with Christine and Daniel during the relevant period of time of August 2020 to October 2022. To summarise agency involvement prior to August 2020.
2. To establish what lessons are to be learned 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 abuse and domestic abuse-related deaths and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated 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 Review Panel, Independent Chair and the CSP

8. The Independent Chair of the Review will:

a) Chair the review panel.
b) Co-ordinate 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.

9. The Review Panel:

a) Agree robust terms of reference.
b) Ensure appropriate representation of your agency at the review panel: 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 review panel meeting.
c) Prepare Individual Management Reviews (IMRs) and chronologies through delegation to an appropriate person in the agency.
d) Discuss key findings from the IMRs and invite the author of the IMR (if different) to the IMR meeting.
e) Agree and promptly act on recommendations in the IMR Action Plan.
f) Ensure that the information contributed by your 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 review has been met as set out in the ToR;
    - The report provides an accurate description of the circumstances surrounding the case; and
    - The analysis builds on the work of the IMRs 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 full report to the Safer Barking and Dagenham Partnership.
j) Implement your agency's actions from the Overview Report Action Plan.

Safer Barking and Dagenham 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 Against Domestic Abuse ('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

10. The Overview Report will refer to the terms domestic abuse and coercive control. The Review applies the statutory definition[8] of domestic abusive behaviour as consisting of a single incident or course of conduct between two people who are personally connected, each aged 16 or over, and involving any of the following:

    (a) physical or sexual abuse

    (b) violent or threatening behaviour

    (c) controlling or coercive behaviour

    (d) economic abuse

    (e) psychological, emotional or other abuse

11. Economic abuse is defined as "any behaviour that has a substantial adverse effect on a person's ability to acquire, use, or maintain money or other property or obtain goods or services" (s.3: Domestic Abuse Act 2021).

12. 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."

13. 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."

14. This 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."

15. In Wales, the relevant legislation is section 5 of the Violence against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015 (the Act).

Equality and Diversity

16. The review panel will consider all protected characteristics (as defined by the Equality Act 2010) of both Christine and Daniel (age, disability (including learning disabilities), gender reassignment, marriage and civil partnership, pregnancy and maternity, race,

[8] The Domestic Abuse Act 2021 received Royal Assent on 29 April 2021: https://www.legislation.gov.uk/ukpga/2021/17/part/1/enacted

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).

17. The review panel identified the following protected characteristics of Christine and Daniel as requiring specific consideration for this case:
    - Sex
    - Race
    - Age

18. The following issues have also been identified as particularly pertinent to this death
    - Mental health/impact of trauma
    - Substance use
    - Child to parent abuse
    - Intergenerational violence
    - Spirituality/faith/religion

19. Consideration has been given by the Review Panel as to whether either the victim or the [alleged] perpetrator was an 'Adult at Risk' as defined in in section 126(1) of The Social Services And Well- Being (Wales) Act 2014. This defines an adult at risk as an adult who:
    (a) "Is experiencing or is at risk of abuse or neglect;

    (b) has needs for care and support (whether or not the authority is meeting any of those needs); and

    (c) 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. The conclusion by the panel is that this Christine and Daniel's were not adults at risk.

20. *Expertise:* The review panel will therefore invite a specialist by and for organisation to the panel as an expert/advisory panel member to the independent Chair to ensure they are providing appropriate consideration to the identified characteristics and to help understand crucial aspects of the homicide.

21. If Christine and Daniel 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 review can improve the engagement with those communities.

22. The CSP, the independent chair, and/or other panel member will make the link with relevant interested parties outside the main statutory agencies, where identified.

23. The review panel agrees it is important to have an intersectional framework to review Christine and Daniel'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

24. If there are other investigations or inquests into the death, the panel will agree to either:
    i. Run the review in parallel to the other investigations, or

ii. Conduct a coordinated or jointly commissioned review - where a separate investigation will result in duplication of activities.
iii. It will be the responsibility of the Independent Chair to ensure contact is made with the chair of any parallel process.

Membership

25. It is critical to the effectiveness of the meeting and the review 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.

26. The following agencies are to be on the Review Panel:

a) Community Health Services (e.g. health visiting)
b) General Practitioner for the victim and alleged perpetrator
c) Hospital
d) Integrated Care Board
e) Local Authority Adult Social Care Services
f) Local Authority Children's Social Care Services
g) Local Authority Community Safety
h) Local Authority Education Services and/or School(s)
i) Local Authority Housing services
j) Local domestic violence specialist service provider e.g. Women's Aid / IDVA
k) Mental Health Trust
l) NHS England
m) NHS Wales
n) Police (Borough Commander or representative, Senior Investigating Officer (for first meeting only) and IMR author)
o) Prison Service
p) Probation Service
q) Substance misuse services
r) Victim Support

27. As set out in paragraph 16 the following will contribute to the review as experts:

a) FORWARD

Role of Standing Together and the Panel

28. Standing Together have been commissioned by the Barking and Dagenham Safer Partnership to independently chair this review. Standing Together have in turn appointed their DHR Associate Shabana Kausar to chair the review. The review team consists of three review coordinators and a review Manager. The review Coordinator will coordinate and have oversight of the review. The manager will quality assure the review process and Overview Report. The contact details for the Standing Together review team will be provided to the panel and you can contact them for advice and support during this review.

Collating evidence

29. Each agency to search all their records outside the identified time periods to ensure no relevant information was omitted and secure all relevant records.
30. Chronologies and Short Reports/Individual Management Review (IMRs) will be completed by the following organisations known to have had contact with Christine and Daniel during the relevant time period:
    (a) Police (IMR)
    (b) ICB (IMR)
    (c) NELFT (IMR)
    (d) Victim Support (IMR)
    (e) Children's Services (short report)
    (f) London Ambulance Service (short report)
    (g) Mental Health Adult Social Care (short report)
31. Further agencies may be asked to completed chronologies and Short Reports/IMRs if their involvement with Christine and Daniel becomes apparent through the information received as part of the review.
32. Each Short/Report IMR will:
    - Set out the facts of their involvement with Christine and Daniel;
    - Critically analyse the service they provided in line with the specific terms of reference;
    - 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 Christine and Daniel in contact with their agency.

Key Lines of Inquiry

34. In order to critically analyse the incident and the agencies' responses to Christine and Daniel, this review 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 Christine and Daniel [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) NA mental health history including impact of trauma;
    h) CA's previous experience of domestic abuse may have impacted her confidence in accessing services;
    i) Victim and perpetrators race;
    j) How agencies considered adult child to parent abuse and the risk NA posed to
    k) his female relatives;
    l) How agencies considered domestic abuse outside of a traditional intimate

m) partner relationship set up including whether CA would have recognised the abuse as domestic abuse.

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 Barking and Dagenham Safer Partnership on their action plans within six months of the Review being completed.
36. The Barking and Dagenham Safer 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 review will sensitively attempt to involve the family of Christine in the review, once it is appropriate to do so in the context of on-going criminal proceedings. The Independent Chair will lead on family engagement with the support of AAFDA.
38. Daniel will be invited to participate in the review, following the completion of the criminal trial.
39. 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.
40. The Review Panel discussed involvement of other informal networks of Christine and Daniel. It was agreed not to involve further networks.

Media handling

41. Any enquiries from the media and family should be forwarded to the Barking and Dagenham Safer Partnership who will liaise with the Independent Chair. Panel members are asked not to comment if requested. The Barking and Dagenham Safer Partnership will make no comment apart from stating that a review is underway and will report in due course.
42. The Barking and Dagenham Safer Partnership is responsible for the final publication of the 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 review 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 review Confidentiality Statement and the specific Terms of Reference.
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 review 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 review.

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 2018 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 reviews (Guidance) outlines data protection issues in relation to reviews (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 review should not normally pose difficulty – this applies to all records relating to the deceased, including those held by solicitors and counsellors’.
    (b) The Guidance and the Explanatory Notes to the Domestic Violence, Crime and Victims Act 2004 paragraph 7 of Section 2, states that the purpose of a review is to safeguard victims (see Section 2, paragraph 7(a)) and to prevent domestic violence and homicide (see Section 2, paragraph 7 (d). Therefore, the legal power to share with the Review is created by Section 7(2) of Part 2 of Schedule 2 of the Data Protection Act 2018.
    (c) 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 domestic homicide reviews 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 agreement on the confidential handling of records or
- partial redaction of record content.

b) 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).

c) 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 review 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 police Disclosure Officer.

53. The Independent Chair, police and CPS will be minded considering the confidentiality of material at all times and to balance that with the interests of justice.

1.7 Methodology

1.7.1 The Review applies the statutory definition[9] of domestic abusive behaviour as consisting of a single incident or course of conduct between two people who are personally connected, each aged 16 or over, and involving any of the following:

(a) physical or sexual abuse

(b) violent or threatening behaviour

(c) controlling or coercive behaviour

[9] The Domestic Abuse Act 2021 received Royal Assent on 29 April 2021: https://www.legislation.gov.uk/ukpga/2021/17/part/1/enacted

(d) economic abuse

(e) psychological, emotional or other abuse

1.7.2 Economic abuse is defined as "*any behaviour that has a substantial adverse effect on a person's ability to acquire, use, or maintain money or other property or obtain goods or services*" (s.1.4: Domestic Abuse Act 2021).

1.7.3 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.*"

1.7.4 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.*"

1.7.5 This 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.*"

1.7.6 **AFV**: In using this definition, the Review Panel was mindful that the homicide of Christine occurred in a familial relationship and could be understood as a particular form of domestic abuse, specifically: 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.[10].

1.7.7 A total of 15 agencies were contacted to check for involvement with the parties concerned with this DHR. Of these, three had only limited contact and submitted a Short Report. However, five had more extensive contact and were asked to submit Individual Management Reviews (IMRs). All eight agencies were asked to provide a chronology, and a narrative chronology was also prepared.

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

1.7.9 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

[10] Sharp-Jeffs, N. and Kelly, L. (2016) *Domestic Homicide Review (DHR) case analysis*. Available at: http://www.standingtogether.org.uk/sites/default/files/docs/STADV_DHR_Report_Final.pdf (Accessed: 28th March 2020).

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.

1.7.10 In some cases, IMRs/Short Reports reported changes in practice and policies over time and all made single agency recommendations of their own (these are described in section 7).

1.7.11 *Documents Reviewed:* In addition to the above information, the Review Panel and/or Chair reviewed a number of 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 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).

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

Agency	Contribution
East London NHS Foundation Trust	IMR and Chronology
Daniel's 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

1.9 The Review Panel Members

1.9.1 The Review Panel members were:

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[11]	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

1.9.2 *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 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.

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

[11] 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.

1.10 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[12]	Relationship to Victim	Means of Involvement
Nina	Daughter	In person interview
Daniel	Son	Declined to be involved

1.10.2 Once the decision to conduct the DHR had been confirmed in November 2022, Barking and Dagenham Community Safety Partnership notified family members of this decision on 29th November 2022: a letter was sent via post, along with the Home Office leaflet, information on Advocacy After Fatal Domestic Abuse (AAFDA)[13] and the Victim Support Homicide Service (VSHS).[14] In September 2023, the Chair also wrote to Nina, including additional information on the DHR process. These letters were sent via the AADFA Advocate once best method of communication was agreed.

1.10.3 In September 2023, the Chair also reached out to Christine's family via the AAFDA Advocate to offer involvement in the review. The Chair highlighted that any participation in the review was voluntary and that they could contribute in the way they found best. Nina was keen to take part and an in-person meeting was arranged to go through the draft Terms of Reference and key lines of enquiry in November

[12] Not their real name

[13] 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.

[14] 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.

2023. The meeting provided a valuable insight into who Christine was and has helped bring her voice to this report.

1.10.4 The draft Overview Report was shared with Nina in September 2024.

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

Perpetrator

1.11.1 In December 2023, the perpetrator 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. The perpetrator 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 nor in the future.

Friends, Work Colleagues, Neighbours and Wider Community

1.11.2 Consideration was given to approaching Daniel's place of employment. They kindly completed an IMR and joined the Review Panel. Their contribution informs the analysis of the review.

1.12 Parallel Reviews

1.12.1 Beyond criminal proceedings, the Review Panel were not made aware of any other parallel proceedings.

1.12.2 *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.

1.12.3 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.

1.12.4 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.

1.12.5 *Judge Sentencing Summary*: "You have caused untold and devastating harm to your family but in my judgment the need for punishment is reduced because your culpability was adversely affected by your mental illness. An issue for the Court to determine was the extent of your own responsibility. I am satisfied that there is a clear association between your illness and your offences, you were clearly suffering from paranoid delusions at the time of the offending."

1.12.6 *The Coroner's Inquest*: The death of Christine was referred to HM Coroner, Waltham Forest and the inquest awaited the completion of this DHR. A pre-inquest hearing was arranged for November 2024, and the coroner's inquest was concluded in March 2026.

1.13 Chair of the Review and Author of Overview Report

1.13.1 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 within London. She is currently undertaking a PhD on Violence against Women at the University of London.

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).[15] 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 125 reviews across England and Wales from 2013 until present day.

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

1.13.3 *Independence:* Shabana Kausar has no connection with the London Borough of Barking and Dagenham, the Barking and Dagenham Community Safety Partnership (CSP), or any of the agencies involved in this case.

1.14 Dissemination

1.14.1 Once finalised by the Review Panel, the Executive Summary and Overview Report will be presented to the Barking and Dagenham CSP 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 Community Safety Partnership membership and be 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, the Mayor's Office for Policing and Crime (MOPAC)/ the Police and Crime Commissioner for Barking and Dagenham, the Domestic Abuse Commissioner's Office, and with the family of Christine.

1.14.4 The recommendations will be owned by the Barking and Dagenham CSP, with the Violence against Women and Girls CSP subgroup being responsible for monitoring the recommendations and reporting on progress.

1.15 Previous Case Review Learning Locally

1.15.1 This is the third DHR commissioned locally.[16]

1.15.2 The Review Panel considered the learning and recommendations from other reviews[17] in the analysis and the development of recommendations for this DHR.

1.15.3 These issues are discussed in the analysis.

[16] To access published DHRs, go to: Domestic homicide review | London Borough of Barking and Dagenham (lbbd.gov.uk)

[17] Safeguarding Adult Reviews included: John SAR and Mrs N and O SAR

2. Background Information (The Facts)

The Principal People Referred to in this report					
Referred to in report as	**Relationship to the victim**	**Age at time of V homicide**	**Ethnic Origin**	**Faith**	**Disability**
Nina	Daughter	23	British Nigerian	Unknown	No
Daniel	Son	28	British Nigerian	Unknown	Yes
Ayotunde	Ex-partner	71	British Nigerian	Unknown	No

2.1 The Homicide

2.1.1 *The homicide:* Daniel killed Christine in the bedroom of their family home, where they resided with Nina, Christine's daughter and Daniel's half-sister. A few days before the murder, Christine informed the police that Daniel was missing. Christine highlighted to the police that Daniel had mental health issues and that she was disturbed by his recent behaviour. It was later discovered that Daniel had travelled to Paris to watch a football match. On the same day of his return, he entered into his sister, Nina's, bedroom with a kitchen knife. He told Nina that he was going to kill her and called her a "*witch*". Daniel then repeatedly stabbed her. Nina used a stool to defend herself.

2.1.2 Christine was alerted to Nina's shouts and entered the bedroom. Daniel then turned on his mother, stabbing her with the kitchen knife. Both Daniel and Christine left Nina's bedroom during this second attack, whereby Nina dialled 999 and requested the London Ambulance Service (LAS), who in turn contacted the police.

2.1.3 After stabbing his mother, Daniel left the premises armed with the knife, which he deposited in a nearby neighbours' bin before walking into Dagenham Police Station, where he told the member of staff that he was handing himself in for committing a stabbing at his home. When later interviewed with a solicitor and with an appropriate adult present, Daniel admitted to the attack on his mother and sister with a knife,

explaining that he did this because he felt that his family were out to "*get him*". He stated that his sister's "*face was burning*" and that he stabbed her. He admitted to stabbing his mother when she came into the room. He also stated that he suffered with paranoid schizophrenia, which meant he could "*explode*".

2.1.4 Police forced entry into the premises and found Nina in her bedroom with serious injuries. She was treated by the London Ambulance Service and taken to hospital. After treatment, she was deemed to have non-life-threatening injuries. Christine was found in her bedroom and treated for her injuries; however, she was unable to be saved, and she sadly passed away from her injuries approximately 30 minutes after the police arrival.

2.1.5 *Post-mortem*: A Special Post-mortem was held on Christine's body two days after the murder, where a pathologist recorded the cause of death as the result of a fatal wound caused by stabbing to the chest.

2.2 Background Information on Victim and Perpetrator

2.2.1 *Background Information Relating to Victim:* At the time of her death, Christine was 64 years old, a British national, and was of Nigerian heritage. She had previously worked as a nurse before her retirement, 5 years before her murder. She lived in a four-bedroom house which she owned, with her two youngest children, Daniel and Nina.

2.2.2 She was married to Ayotunde, and they had two children before he returned to live in Nigeria for a few years. During this time, Christine had a relationship with another man, who is Daniel's father. Ayotunde returned from Nigeria, whereby Christine had her fourth child, Nina. Ayotunde, therefore, was the father of three of Christine's children and Daniel's stepfather.

2.2.3 Christine experienced domestic abuse from Ayotunde throughout their relationship. They separated in 2007.

2.2.4 *Background Information Relating to Perpetrator:* Daniel was 27 years old when he murdered his mother. He is British Nigerian and had a history of mental health issues. He was accessing mental health specialist support at the time of the murder. He lived with his mother and sister and worked for a security agency.

2.2.5 Daniel had no previous convictions but had a reprimand for assaulting his sister Nina when he was a teenager. He also had a warning signal on police systems regarding his

mental health. He was historically known to services as he had a history of experiencing child abuse from Ayotunde.

2.2.6 *Synopsis of Relationship with the Perpetrator:* Christine was Daniel's mother, and they lived together when the murder took place. After being sectioned in 2020, Daniel was living in a privately rented flat, before moving back in with his mother and sister in October 2021.

2.2.7 *Members of the Family and the Household:* Christine's daughter, and Daniel's half-sister, Nina, lived together with them in their home. She was 22 when she was attacked by her half-brother before he fatally attacked their mother.

3. Chronology

3.1 Overview

3.1.1 The following chronology describes the contact that Christine and Daniel had with agencies. The timeframe period under review is from August 2020, which marks a significant incident between Daniel and his mother, to the date of Christine's death in October 2022. However, there are some significant events prior to the time period under review which have been summarised in 3.2.

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

3.2.1 The family first became known to services when Daniel was seven and ran away from home after an argument with his stepfather, Ayotunde, in 2002. He was returned back home to his mother and deemed safe and well. However, over the subsequent years, Daniel ran away from home a further four occasions from 2002 to 2012. In 2004, Daniel was detained after being caught stealing from a HMV store. He was below the age of responsibility so was placed in police protection and taken home to his parents.

3.2.2 There is a long history of alleged assaults from Ayotunde against Daniel, and on occasion against Nina. In September 2006, Christine called the police to inform them that Ayotunde had assaulted Daniel, and that he only stopped when her eldest son intervened. The family was referred to Children's Services.

3.2.3 When interviewed by a social worker in 2006, Daniel said that his stepfather is "*always saying that I am not his son*", and he expressed that he wanted Ayotunde arrested. At the time, Daniel's older half-sibling told a social worker that Ayotunde was always picking on Daniel and that he had hit him on a number of occasions. The older sibling also shared that her parents' relationship "*is not healthy*".

3.2.4 Christine told the social worker that Ayotunde was hitting the children and that she wanted advice on domestic abuse. The police reported that there was no further action as Christine did not want Ayotunde prosecuted. It was noted from Children's Social Care historic notes that Christine and Ayotunde were referred to couple's counselling and Ayotunde was offered anger management. These interventions are no longer practiced

by Children's Social Care, as they were not appropriate and could have potentially increased the risk to Christine and her children.

3.2.5 Daniel was made subject to a child protection plan under the category of physical abuse by his stepfather. Nina was placed on a Child in Need plan for emotional abuse and for being exposed to domestic abuse. In January 2007, Daniel was again reported missing. He was returned home but went missing again after a day at home. He was in communication with Christine during this time but told the social worker that he would not return home until his "*unhappiness at the situation with his stepfather was listened to*". Daniel was placed in a foster placement between February 2007 to March 2007 before returning home.

3.2.6 In March 2007, Christine confirmed to social services that she had an injunction in place, was receiving support from an Independent Domestic Violence Advocate (IDVA), and that Ayotunde was no longer in the family home. Daniel returned home. In April 2007, the social worker spoke to Christine about her experiences of domestic abuse. The social worker remarked that Christine "*closed down*" and told Nina not to discuss family business.

3.2.7 In June 2007, aged twelve, Daniel came to the attention of statutory services for fighting at school. In August, he reported to the police that he was not getting on with his mother and that she was emotionally abusing him. During this period, Daniel also had an argument with his older half-brother. In September, he was found riding buses in the early hours of the morning after a fight with his half-brother. Later that month, Nina called the police alleging that Daniel had assaulted her. No offenses were noted for any of these incidents.

3.2.8 In 2008, Daniel, along with four other boys, was alleged to have sexually touched a 13-year-old girl whilst at school. This was reported to police and an investigation was undertaken by the school. The victim, in consultation with her parents, declined to make a statement. The case results show no further action was taken.

3.2.9 In 2009, Daniel continued to go missing from the family home. In May, this was because his mother had told him off for hitting his half-sister.

3.2.10 In 2012, police were called to the family home after Daniel's older half-sister locked herself in the bathroom after alleging that they had an argument during which Daniel

assaulted her by hitting her on the chest with a chair, a lamp, and a shoe. However, both had injuries. Daniel was arrested, was referred to the Youth Offending Team who administered a reprimand for common assault.

3.2.11 In 2013, Nina called the police to report that her father, Ayotunde, had hit her. After questioning them, no offences were reported. In April, Nina was caught shoplifting. Nina later disclosed to the police that Christine had slapped her around the face after she was caught shoplifting, and that her relationship with her mother was unfortunately deteriorating. Christine and Nina were seen at school by a Restorative Intervention worker and a number of appointments were offered and attended.

3.2.12 There was no further contact with the family until August 2020, which is the start of the timeframe period under review.

3.3 Time Period Under Review

2020

3.3.1 On 18 August, the police were called to family home by Nina, after Daniel threatened his mother with a knife. Daniel chased his mother into the garden shed while armed with the knife. He kicked down the door and continued to threaten his mother, whereby Nina called the police. Daniel was arrested for criminal damage and affray. Whilst in custody, he was examined by a health care professional and was deemed not fit to be interviewed and was made subject of a mental health assessment whereby he was sectioned under Section 2 of the Mental Health Act 1983.

3.3.2 Christine and Nina were noted to be concerned with Daniel's mental wellbeing and did not want to make statements. No further action was taken in relation to the crime. A Domestic Abuse, Stalking, Harassment (DASH) risk assessment was completed, and the risk was assessed as medium. Nina and Christine did not respond to the DASH questions and therefore the risk was assessed on professional judgement. Non-molestation injunctions were offered but were declined. A special scheme was placed on the home address with a domestic abuse flag.

3.3.3 The following week, the case was referred to the London Victim Support and Witness Service, overseen by Victim Support, where an Independent Victims Advocate (IVA) was assigned.

3.3.4 On 27 August, the IVA made contact with Christine by phone and the services that Victim Support offered was explained. Christine stated that she was okay now as her son was in hospital. She explained that she felt scared when her son threatened her and that she did not want to live with him anymore. The IVA explained that, as Daniel did not have a job at the time, he would have to apply for a homelessness application on his release. Christine was offered home security items and support numbers via a text message. A risk assessment was not completed by Victim Support and there was no referral made to Multi-agency Risk Assessment Conference (MARAC). There was also no follow up support provided by Victim Support.

3.3.5 On 6 November, the Church Elm Lane Medical Practice contacted Christine to arrange for her blood pressure and pre-diabetes check. Christine informed the GP that she would be going away until the next year.

3.3.6 Whilst sectioned, Daniel was supported by Barking and Dagenham Early Intervention Service, provided by Northeast London NHS Foundation Trust (NELFT). During his initial presentation to NELFT, he had made threats to his mother. Christine was notified of his release, but no action was undertaken to mitigate the risk he posed to her upon his release. On his release in November, he was initially housed in Barking but was then moved to a shared flat in Tower Hamlets. As a result, on 12 November, Daniel was referred to the Tower Hamlets Early Intervention Service (THEIS) by East London NHS Foundation Trust (ELFT).

3.3.7 Over November and December, Daniel reported feeling mentally well. When asked by THEIS if he had a carer, he indicated that he did not. THEIS contacted Nina, who reported regular contact with Daniel. Nina also joined a meeting with Daniel and his new Care Coordinator, where she described Daniel as appearing back to his usual self. Daniel was assessed as stable in mental state, without mood or psychotic symptoms. A plan was made to move his ‘traffic lights’ rating to amber (indicating a stable mental state, without acute concerns about risk to himself) which resulted in 2-4 weekly contact with a

Care Coordinator and 3 monthly medical reviews. No other changes to management were made and risk to Christine and Nina were not explored.

2021

3.3.8 In January, the GP was informed that Christine declined her breast cancer screening. They subsequently sent Christine a letter to encourage her to attend the screening, which she attended in February.

3.3.9 The GP contacted Nina to review the talking therapies that she accessed until 14 January. Nina informed the GP that she has some sessions but that they were not helpful for her. She described her mood as down and that she had some anxiety, which was triggered by her brother's breakdown the previous summer. She stated that she was generally sleeping well and had no suicidal ideation. There is no evidence that the GP explored Nina's trigger in more detail. A follow up call was made in March, where Nina stated she was feeling sluggish for the past few months and felt she had an iron deficiency as she had irregular periods. A routine blood test was requested by the GP, and she is prescribed with iron medication.

3.3.10 Over January and February, the THEIS Care Coordinator continued to meet with Daniel and his family. Nina reported no concerns at a telephone meeting on 2 February. Nina declined psychological input, but family work was offered by the team psychologist, which was accepted on 22 February. On a call to the Care Coordinator, whilst discussing the referral to the family work, Christine informed them that: "*it was scary when he put the knife on me. He behave[s] bad, I don't know why or understand.*" Christine went on to explain that she talked to Daniel every week, but that it was hard to say how he was because "*anyone can talk okay on the phone but when you see them face to face you can judge better*". There is no evidence that Christine's fear was further explored.

3.3.11 Christine was diagnosed with Type 2 diabetes in March. The GP called on 16 March to discuss the diagnosis and new medication arrangement, which Christine is recorded as being happy to start. On 17 March, Christine called the LAS via the 111 non-emergency number, where advice is provided for general illness. The following week, Christine attended the GP to be seen by a podiatrist. Checks were completed and Christine was deemed to be in good health. Two days later, another call was made to the LAS via 111

by Christine. As on the previous occasion, advice was provided for general illness. Christine spoke to her GP about pains in her knees and was provided with knee exercises and referred to a Social Prescriber to support with diet/exercise. In July, she was reported as feeling good and finding the guidance from the Social Prescriber helpful.

3.3.12 On 18 March, a THEIS doctor called Daniel to conduct a medical review. Daniel stated that he had no difficulties with his mental health and reported good compliance with his medication. His 'traffic light' was moved from amber to green. Daniel was appointed a new temporary Care Coordinator, as the previous one left the post, and a handover was conducted. Plans were made to start family work with his mother, which started on 18 April.

3.3.13 The family work session was a reflective session where it was agreed to work on the development of a crisis plan and information sharing. A new permanent Care Coordinator was allocated on 16 July. During the initial introduction session, Daniel presented as mildly anxious on the phone and spoke of the pressures of living in a shared property over the COVID-19 period.

3.3.14 Daniel had incurred rental arrears and also made threats to burn down the shared property. He was given two weeks' notice to end the tenancy because of the threat he posed to other residents.

3.3.15 On 17 July, the Crisis Line received a call from Christine explaining that Daniel sent a text message to his father saying that he will kill him. She stated that she was worried about the safety of Daniel's father's family members, such as his auntie, as Daniel knew where she lives. Christine was advised to call the police and report any threat to life. Christine was not recorded to have contacted the police on this matter. She was also advised to encourage Daniel to call the crisis line for support if required.

3.3.16 On the same day, the police were called by a witness and local resident as Daniel armed himself with a large metal pole and a fire extinguisher and smashed a door to a property and the windows of a number of cars. The incident was captured on CCTV, and Daniel was arrested for Criminal Damage. In custody, there were concerns about his mental health and a Mental Health Act assessment was undertaken which recorded that Daniel made references to "*black magic*" and "*voodoo*". On assessment, he was thought disordered, paranoid, and lacking in insight. He admitted that he had run out of

medication. He was detained under Section 2 of the Mental Health Act on 17 July and admitted to Tower Hamlets Centre for Mental Health. The investigation for the Criminal Damage resulted in no further action.

3.3.17 Between 17 July and 1 October, Daniel was treated for a relapse of psychosis, which was attributed to non-compliance of his medication for a period of some weeks prior to admission. He was recorded as referring to himself as the "*King of Africa*", and that his family were involved in witchcraft. Whilst unwell, Daniel continued to send threatening text-messages to his family, mainly to his mother. These threats were viewed by EFLT within the context of Daniel's ill-health and were not explored further. Once Daniel's mental health improved, Christine became involved in care planning meetings on the ward. Daniel was initially detained under Section 2, then moved onto Section 3 of the Mental Health Act, which he remained on until 15 September 2021, and he remained as an informal patient until the day of discharge on 1 October.

3.3.18 The GP called Daniel to carry out a review following his discharge from hospital on 1 October into the care of Newham Home Treatment Team and he was housed in a non-mental health supported accommodation in Newham. An appointment was arranged with the Home Treatment team for the following day. Over October, Daniel engaged in therapy sessions with THEIS. He was supported in accessing benefits and housing. The THEIS Care Coordinator maintained regular contact with Christine, who did not raise any concerns related to Daniel' mental state.

3.3.19 On 20 October, without informing THEIS, Daniel moved out of the supported accommodation in Newham in order to move back with his mother at her address in Dagenham. The Care Coordinator was made aware of the move shortly after. The reason for his decision to move back home was not explored. On 27 October, Daniel reported feeling okay and that he got along well with family and his sister. On 28 October, Daniel attended a Care Programme Review with his Care Coordinator and a Responsible Clinician. He was recorded as being in a stable state. There were no concerns regarding drugs or alcohol. His move back with his mother was seen as not posing a risk as his previous threats were understood to be made in the context of his illness, which was now managed through medication.

3.3.20 His relationship with his family was seen as positive, with them providing Daniel with support. There was no exploration at this stage of any support that Christine or Nina may need in providing this support for Daniel. Daniel was concerned about his weight gain as a result of his medication, and it was agreed to reduce his medication dosage. He was noted as attending weekly psychology sessions focused on psychoeducation, which he found helpful.

3.3.21 On 14 December, Daniel applied for a job at a security company, and he was offered the role on 21 December. As part of his onboarding, he was asked to complete a medical questionnaire. He did not declare any medical conditions. On 20 December, Daniel attended a face-to-face appointment at the GP surgery and reported feeling well and that he was taking his medication.

3.3.22 Daniel continued to have regular phone and face-to-face contact with his ELFT Care Coordinator.

2022

3.3.23 On 28 January, a face-to-face transfer meeting was held for Daniel moving him from being supported by ELFT to NELFT as he had moved back to Barking and Dagenham to his family home. He was assigned a new Care Coordinator. The transfer included a copy of Daniel's most recent Care Protection Approach (October 2021), his care plan, and risk assessment at the point of transfer.

3.3.24 From February through to June, Daniel had a number of appointments with his GP focusing on reviewing his medication and well-being. He described his mood as stable and that he was taking his medication. In May, he raised concerns about the weight he had gained as a result of his medication and requested a reduction in the dosage. During this time, Daniel also requested for his medication to be dispensed in 4-weekly batches, rather than weekly, as it interfered with his work schedule. It was noted that Daniel claimed being fully adherent with taking Risperidone (medicine that helps with the symptoms of some mental health conditions such as schizophrenia), despite the medical system showing that there was inconsistency in dispensing until 20 May.

3.3.25 After assessment, which included speaking to Christine about Daniel's state of mind, Daniel's medication reduction was granted on 24 June, and the Risperidone dosage was

reduced. He was also informed by NELFT that he could speak to his GP about changing the frequency of his medication supply.

3.3.26 On 14 July, the Care Coordinator arranged a home visit with Daniel and his mother. Daniel declined entry, stating that he had sent a text message to cancel the appointment as he had to go to work. It is recorded that Christine later called the Care Coordinator to apologise for Daniel's behaviour. Christine explained that Daniel did not like people visiting, and that she was able to monitor his behaviour now that he had moved back home. She advised the Care Coordinator that she would speak with Daniel about home visits and her participation in his care. A detailed mental state assessment was not undertaken, but it was noted that Daniel posed a low risk to himself and others.

3.3.27 Over May to August, Christine had five appointments with the GP to discuss her diabetes and concerns about her eyes being affected by cataracts.

3.3.28 On 8 and 25 August, Daniel attended Barking Community Hospital with his Care Coordinator for a mental health review. He reported that he was taking his medication and was noted as appearing stable in his mental health. Risk was assessed as low to himself and others.

3.3.29 On 13 September, the Care Coordinator attempted a home visit but there was no response. On 21 September, the GP sent a reminder text to Daniel that he was due for a medical review. On 27 September, the Care Coordinator attempted to telephone Daniel; however, he did not answer the phone but texted to say that he was at work. Contact was made on 28 September via video call, while Daniel was on a train. He reported that he was doing well and taking his medication. Risk was assessed as low to himself and others.

3.3.30 On 18 October, Daniel's new Care Coordinator called him to introduce herself and arrange a home visit on 20 October. The Care Coordinator was newly qualified, so her visits were to be accompanied by another colleague. On 20 October, the Care Coordinator called Daniel to cancel the appointment as the accompanying colleague was not available. The Care Coordinator recorded risk as low to himself and others. On the same day, the GP was unable to get through to Daniel via telephone to hold a medication review. Daniel initially picked up and told the GP to call back in an hour, but he did not pick up when the GP called back.

3.3.31 On 21 October, the Care Coordinator visited the home as arranged. Christine met them and informed them that Daniel had just left and that she was unable to hold him much longer to wait for their arrival. Christine reported that Daniel was doing okay and was working. On 24 October, there was a further unsuccessful home visit, this time due to traffic and navigation issues. The Care Coordinator called Christine to apologise, who replied that it was fine, and that Daniel was on his way to work.

3.3.32 On 26 October, Daniel texted a work colleague stating: "*I don't think I'll return [to work] for now, just having family problems, have to think about family first.*" On the same day, Christine contacted the Care Coordinator in the afternoon to inform her that Daniel had left home that morning without a bag or his phone and had not yet returned home. She reported that he was behaving "*funny*". She reported that he had called her a few days before from work to inform her that he was not feeling well and as he has not taken his medication, she had to pick him up from work. Christine reported to the Care Coordinator that Daniel had attacked someone in the past when he was unwell, and she was worried that he might do this again. She was advised to call the police if he did not come home or if he behaved violently towards anyone.

3.3.33 On 27 October, the Care Coordinator was unable to contact Daniel via telephone. She contacted Christine who informed her that Daniel had returned home, he seemed fine, but angry. The Care Coordinator asked to speak to Daniel, but Christine informed her that he did not want to talk to anyone because "*everyone is after him*". Christine was informed to contact Mental Health Direct when the need arose. Significantly, his risk was not assessed because the Care Coordinator was unable to make contact directly with Daniel. The Care Coordinator arranged to call back the next day, which was a Friday.

3.3.34 On 27 October, Daniel's work manager sent him an email confirming receipt of Daniel's message and offered access to occupational health support. On 28 October, Daniel left a voicemail on his work manager's phone where he asked to speak to them about a personal matter. Daniel's manager attempted to call Daniel back, but he did not pick up the phone.

3.3.35 The Care Coordinator's call on the morning of 28 October was also unsuccessful so she visited the home in the afternoon to assess Daniel's mental state. He was not home, and Christine informed the Care Coordinator that Daniel had not been taking his medication

and that she was worried about him. Christine was informed by the Care Coordinator that the case would be discussed with the team on Monday. The same guidance was provided to contact Mental Health Direct where needed.

3.3.36 On 28 October, Daniel journeyed to Paris to watch a football match but did not tell Christine.

3.3.37 On 29 October, Christine attended Dagenham police station to report Daniel as missing, having last seen him on 28 October at 9.30am. Christine was concerned about his mental health. She told the police that Daniel said he was going to the gym, but he never returned. She also told the police that he was not taking his medication. Daniel was categorised as a medium risk missing person. Christine also contacted Daniel's work, informing them that Daniel had been missing since the previous day and that he had lost his phone.

3.3.38 In late October Daniel returned home. Christine and Nina were both at home. It was at around 9.00pm that evening that Daniel first went into Nina's room, attacking her with a kitchen knife, before going on to attack his mother.

3.3.39 After stabbing his mother, Daniel left the premises armed with the knife, which he deposited in a nearby neighbours' bin before walking into Dagenham Police Station, where he told a member of staff that he was handing himself in for committing a stabbing in his home.

3.3.40 London Ambulance Service arrived at the home address where both Nina and Christine were treated. Nina was taken to hospital where her wounds were deemed as non-life threatening. Christine sadly passed away from her injuries at the scene of the crime.

4. Overview

4.1 Summary of Information from Family

4.1.1 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.'*

4.1.2 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.'*

4.1.3 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.'

4.1.4 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.'*

4.1.5 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.'

4.1.6 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.'

4.1.7 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.'

4.1.8 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.'

4.1.9 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.'*

4.1.10 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.

4.1.11 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.'

4.1.12 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.'

4.1.13 When asked about missed opportunities, Nina explained that it felt like people were more interested in Daniel' 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' word for it without asking family or friends.'

4.2 Summary of Information from Perpetrator

4.2.1 As mentioned above, the Chair reached out to Daniel via his Forensic Social Worker, inviting him to take part in the review. He initially expressed interest in being involved but later declined.

4.2.2 The Chair informed the Forensic Social Worker that Daniel could be involved at a later stage.

4.3 Summary of Information Known to the Agencies and Professionals Involved

4.3.1 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:

4.3.2 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.

4.3.3 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 to 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.

4.3.4 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.

4.3.5 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.

<u>Police</u>

4.3.6 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 to be fit. 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.

4.3.7 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.

4.3.8 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 both 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

4.3.9 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.

4.3.10 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.

4.3.11 The following services had contact with Daniel:

- Health services
- Police

Health services

4.3.12 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.

4.3.13 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

4.3.14 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.

4.3.15 On 28 October, when Christine reported Daniel as missing, there was a missed opportunity to review Daniel' 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.

4.4 Any other relevant facts or information

Daniel's employer:

4.4.1 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.

5. Analysis

5.1 Domestic Abuse

5.1.1 Taking into account the government definition above, information gathered by the police as part of the murder investigation, information provided by agencies, and accounts shared by Nina, it is clear that Daniel exerted abusive behaviour towards Christine, which was compounded by his mental health issues.

5.1.2 Tragically, it will never be possible to know the full extent of Christine's experiences. However, as a minimum it appears Christine experienced the following:

- ***Physical abuse****: In August 2020, Daniel was arrested for affray after threatening his mother with a knife and damaging property, where he chased Christine into a shed, and kicked the door down after she locked herself inside.*
- ***Coercion, threats and intimidation:*** *On a number of occasions, Daniel had threatened his mother. In August 2020, he threatened Christine with a knife, as described above. While sectioned between July and October 2021, Daniel sent threatening messages to a number of family members, but mainly to his mother. Christine had previously disclosed to Victim Support that she was afraid of Daniel and that she did not want him living with her.*
- ***Emotional abuse and isolation:*** *Although neither Daniel nor agencies saw Christine as his carer, Christine undertook significant caring responsibilities for Daniel. He moved into her home after being released from hospital, despite previously expressing her concerns of his return. She regularly contacted professionals, including his Care Coordinator, apologising for Daniel's behaviour and trying to arrange his appointments. We know from research that if abusive behaviours are, or appear to be, a result of the cared-for person having an illness, then the carer can feel guilty about seeking support as they think the person is not to blame for their behaviour.*[18]

[18] Warburton-Wynn, A. (2023), "Carers and domestic abuse – the elephant in the room?", The Journal of Adult Protection, Vol. 25 No. 1, 14-19.

- ***Economic abuse****: Although no direct evidence was shared with the panel on economic abuse, Daniel struggled with employment and housing. This may have increased his financial and emotional dependence on his mother. Indeed, we see this when Daniel moves in with his mother, despite his threats and her previous expressions of fear.*

5.1.3 Research[19] conducted by Standing Together found that 26% of all domestic homicides involved adult family members, where the vast majority were of adult children killing their parents. Despite this, there is still little known by statutory services about adult child to parent abuse. This is clear in Christine's experience where risk was not appropriately identified by a number of agencies. The Review Panel considered domestic abuse outside of a traditional intimate relationship and the impact this had on how both Christine and agencies viewed Daniel' behaviour and Christine's support needs.

Learning point:
It is important that an understanding of domestic abuse is not just limited to that which takes place in an intimate relationship. The Domestic Abuse Act 2021 created a statutory definition of domestic abuse and recognises abuse between relatives. More needs to be done to broaden understanding to ensure that professionals are able to identify and respond to wider forms of domestic abuse.

Recommendation 1:
Barking and Dagenham Community Safety Partnership to identify how to raise awareness of domestic abuse experienced within a familial context.

5.1.4 The Review Panel also considered Daniel' significant mental health needs and the impact this had on Christine. Although research is clear that domestic abuse is not caused by mental ill health, but can compound already abusive behaviours, the Review Panel considered how Daniel's needs overshadowed his actions towards his mother and sister by agencies. For example, when considering Daniel's move back home with his mother, NELFT recognised that Daniel had made threats to his family, but this was described as being in the context of his illness.

[19] Adult Family Violence (AFV) Briefing Sheet (accessed February 2024)

5.1.5 Research by Against Violence and Abuse,[20] highlights that a perpetrator's mental health is often cited as a cause of their violent or abusive behaviour, which is a belief that plays into a common misperception that people who experience mental ill-health are more likely than people without these experiences to be violent. Although symptoms of mental health problems can exacerbate domestic abusive behaviours, perpetrators who do have a mental health problem are, however, likely to be abusive even when well. Their behaviour should not be addressed as illness-related violence exclusively. For Daniel, this is particularly the case when his behaviour with his mother and sister is juxtaposed with his presentation at work. During his 10-month's employment, there were no concerns raised, aside from the last few messages he sent to his manager prior to the homicide. The Review Panel considered the complex relationship between mental health and domestic abuse and the need for a more nuanced understanding of how they intersect.

Learning point:
Clients experiencing mental ill-health must be provided with the support they need for recovery. Symptoms associated with some mental health diagnoses may mirror behaviours common to many male perpetrators; this can make it difficult for practitioners to understand the motivations for violence and how to respond.[21] However, mental health should not be seen as a causal factor in the abuse and perpetrators need to be held to account for their behaviour whilst being supported with their mental health needs.

Recommendation 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:

[20] https://avaproject.org.uk/wp-content/uploads/2013/05/AVA-Toolkit-2018reprint.pdf pp. 191-194 (accessed February 2024).

[21] https://avaproject.org.uk/wp-content/uploads/2013/05/AVA-Toolkit-2018reprint.pdf pp. 193 (accessed February 2024).

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

5.1.6 The panel also considered the caring role that Christine played in supporting Daniel. Although no carers assessment had been undertaken for Christine, and she was not viewed as a carer by either Daniel or agencies, Christine took extensive care of Daniel and was often the first port of contact with Daniel's Care Coordinators. The panel discussed the gendered expectations on mothers, by both their children and agencies, to provide emotional labour and care for their children. The panel also explored the impact this may have had on Christine in understanding her needs and options for support.

5.1.7 It is also important to consider how stereotypes about Christine's race may have also impacted agency expectations of her. Research has highlighted the widely held problematic beliefs around the "*super strong Black mother image*",[22] which can be debilitating to Black mothers, who can feel pressurised to strive to mirror these unrealistic standards. It can also impact the level of support they are offered by agencies. This can be seen in Christine being described by her daughter as "*someone who you would look at and not understand how she could do it all.*" It can also be seen in the limited support offered to Christine by agencies and how she was not recognised as being Daniel's carer. An expert panel member on this DHR highlighted the taboo around mental health and how this may have created barriers for Christine to reach out for support. In light of this, support needed to be offered in a proactive way to tackle any stigma associated with mental ill-health.

Learning point:
Caring responsibilities are varied, and it is important that professionals recognise the impact on families who are supporting someone with mental ill-health. There is a need to understand the impact of gendered and racialised biases when considering caring responsibilities. Further, the issue of carers as victims of domestic abuse is being

[22] Bush, L. 2000, "Black mothers/Black sons: A critical examination of the social science literature", Western Journal of Black Studies, vol. 24, no. 3, pp. 145-155.

overlooked by statutory organisations because they often do not fit the traditional patterns of abusive relationships, and the complexities of the caring role can make typical safety options unsuitable.[23]

Recommendation 4:
NELFT and ELFLT to review their processes in relation to their responsibility in identifying and supporting carers.

Recommendation 5:
Barking and Dagenham Community Safety Partnership to identify how to raise awareness of domestic abuse experienced by carers.

Recommendation 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.

5.2 Analysis of Agency Involvement / Responding to the Terms of Reference

5.2.1 The following section responds to the lines of enquiry as set out in the Terms of Reference in section 1.6.

The communication, procedures, and discussions, which took place within and between agencies. The co-operation between different agencies involved with victim and/or perp, and wider family.

Health services

5.2.2 Daniel and Christine both had the most contact with health services. There are some specific examples of good practice in health services' individual responses to Christine. For example, after Christine declined her breast cancer screening in January 2021, the GP at Church Elm Lane followed up to encourage Christine to attend, which she did in

[23] Warburton-Wynn, A. (2023), "Carers and domestic abuse – the elephant in the room?", The Journal of Adult Protection, Vol. 25 No. 1, 14-19

February 2021. We also see ELFT offer carers support to Christine and Nina in the form of the Brief Family Intervention work. After the homicide, Church Elm Lane Medical Practice also reached out to Nina to check in on her well-being.

5.2.3 However, there were considerable missed opportunities to provide both Christine and Nina with the support they needed. Whilst Daniel was with ELFT, there were missed opportunities to provide support for his mother and sister. Although Brief Family Intervention work was offered to Christine and Nina, this does not replace the legal right to be offered a carers assessment under the Care Act 2014. There is no recorded information on whether a referral to carers centre was offered, which may have been able to provide more wrap-around support for Christine and Nina. In her interview, Nina highlighted not having a number for ELFT and feeling voiceless in the decisions that professionals made. When Daniel moved out of the supported accommodation in Newham in order to move back with his mother, ELFT did not explore further the reason behind the move at his Care Programme Approach review meeting on 28 October.

5.2.4 There are also missed opportunities around the transfer of information from ELFT to NELFT after Daniel returned to the borough of Barking and Dagenham. At the transfer meeting between ELFT and NELFT in January 2022, it was planned for carers support to be explored with Christine, but this was not completed. This meeting also did not discuss Daniel's move back to the family home. There was also a gap in information sharing between ELFT and NELFT during the transition. Although ELFT shared a recent clinical risk assessment and discharge summary with NELFT, any risk behaviours present during Daniel's second admission to ELFT in 2021 were not transferred over on to the electronic patient record system or documented in the NELFT risk assessment tool.

5.2.5 Furthermore, the ELFT crisis plan was added to their patient record system, however NELFT staff only had limited access to this record, so there was a reliance on emails of crucial documentation pertaining to history and risk. The crisis plan held important information about Daniel's triggers for relapse, including disengaging from mental health services, non-engagement with medication regimes, feeling that people were against him, and talking about him or feeling watched. The crisis plan identified aggressive behaviour towards family as a relapse indicator. These triggers were not documented on

the NELFT crisis plan. And the most recent risk assessment identified no evidence for violence or harm to others.

5.2.6 The Review Panel noted the 'Prevention of Future Deaths' report that was initiated by HM Coroner[24] in March 2023 for a different incident, but which identified significant concerns with managing historical risk and risk formulation within the electronic record. Actions from this has led to NELFT reviewing the clinical risk assessment and management training for clinical staff. The Review Panel also welcomed the news that NELFT is undertaking a review of their risk assessment tools. Therefore, the learning from this separate 'Prevention of Future Deaths' report will support the implantation of learning from this review.

5.2.7 Between August 2020 and October 2022, the timeframe of this review, Daniel had five different Care Coordinators. Although this turnover can be attributed to the transfer between mental health trusts as well as national challenges associated with staff retention, the Review Panel considered the impact this had on internal record keeping. The 'Prevention of Future Deaths' report found that the handover of Daniel's care from the manager to the new care coordinator was focused on current risk, not historical risk. At the point of handover, Daniel was reported to be stable and functioning well.

5.2.8 In addition, when Christine contacted the Care Coordinator a few days prior to her murder, she did so on a Friday. The Care Coordinator informed Christine to call the police in the case of an emergency, and that the case would be picked up by the Team on Monday. Sadly, Christine was killed over the weekend. Instead, due to the level of risk, the case could have been referred to the Home Treatment Team (HTT) in an event of potential relapse or deterioration in mental state. The HTT referral criteria require that the referring team assess the patient's mental state at point of referral. The advice for Christine to call the police in case of an emergency would still be given even if HTT referral was made.

Learning point:
It is important that processes between mental health trusts are robust and appropriately manage risk when transferring cases. Information should be safely

[24] The Coroner has a legal power and duty to write a report following an inquest if it appears there is a risk of other deaths occurring in similar circumstances. This is known as a 'report under regulation 28' or a Preventing Future Deaths report.

shared and used to inform future support plans. Mental health trusts also need to recognise the role of wider family networks when developing support plans. Mental health trusts also need to improve responses to staff turnover in order to understand and respond to risk.

Recommendation 7:
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:
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:
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.

Police

5.2.9 During the timeframe of this review, Daniel came into contact with the police on three occasions, the third being where he handed himself in for the murder in October 2022. The Review Panel noted good practice by the police where, after being arrested, his mental health was quickly assessed, and his vulnerability recognised. The panel also noted that, prior to the timeframe of this review, as a child, Daniel went directly to Dagenham Police station on two occasions seeking support in relation to issues at

home. This demonstrated that Daniel felt safe to reach out to the police. It was also noted that, on the night of the murder, Daniel went directly to the police to hand himself in.

5.2.10 However, the Review Panel identified a number of missed opportunities in Daniel's interactions with the police after the two occasions Daniel was arrested. In August 2020, after Daniel was sectioned, there was a breakdown in communication between the Investigating Officer and the hospital, so that the police were not informed when Daniel was released in October 2020. Furthermore, after Daniel was arrested for criminal damage in July 2021, and detained in hospital, the criminal investigation ceased. This was despite the fact that a number of witnesses were willing to make a statement and followed up with the police requesting updates. A supervisor also tasked the investigation officer to contact the mental health team to ascertain if Daniel was fit for a police interview. However, no follow up was made.

5.2.11 A follow up would have revealed the previous incident of mental health crisis in August 2020 and the risk Daniel posed to his family and the public. Significantly, there was no MERLIN completed by the initial investigating officers in order to ensure the information was shared with adult safeguarding and mental health partners. A MERLIN report would have been shared with partner agencies to ensure a multi-agency approach could be taken to safeguarding.

5.2.12 Another missed opportunity was a few days prior to the homicide when Christine reported Daniel as missing. She informed the police that he was not taking his medication and had been aggressive with her before leaving home. Daniel was marked as medium risk; however, his previous two police interactions were the result of him not taking his medication. An awareness of his history in accessible documentation could have marked him as high risk.

5.2.13 The Review Panel welcomed the update from the police that they are in the process of developing and rolling out a Centralised Vulnerabilities Hub which is a team of specialist officers and staff that are dedicated to changing how the police responds to vulnerability and harm, locating and safeguarding missing people as quickly and safely as possible.

Learning point:

It is important that the police work in partnership with statutory services to ensure that information is appropriately shared. It is also vital that the police do not suspend standard procedures once an individual is transferred to a mental health hospital.

Recommendation 10:
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:
The police to appropriately follow up on investigations that concern offenders who have been sectioned.

Domestic abuse services

5.2.14 Victim Support received a referral from the police in August 2020, which stated that Daniel had threatened his mother with a knife. Christine had run away to the shed, and Daniel had kicked and broken the door down to get to her. The referral to Victim Support was over a weekend and consent was not confirmed until the Monday, which led to a delay in allocation and contact, meaning that Christine wasn't contacted until 5 days after the referral came into Victim Support. The Victim Support Domestic Abuse Operating Procedure stipulates that contact must be made within 2 working days.

5.2.15 During the call to Christine, the IVA demonstrated safe practice by confirming the identity of Christine and checking if it was appropriate to speak. The IVA notes stated that they explained the Victim Support service to Christine. However, there is no record of what Christine was actually told. The IVA recorded that Christine had a "*lack of awareness of support services.*" Therefore, it is significant that there is no detail in the case notes setting out what was offered to Christine.

5.2.16 The IVA asked Christine if she felt afraid and Christine is recorded as saying "*she felt scared when her son threatened her with a knife, she does not want to live with him anymore, she does not want him to come back.*" The IVA did not record if there were any safety planning in response to this other than that Daniel was currently in hospital. There is no professional curiosity in relation to why Daniel was in hospital and what caring responsibilities Christine had for him.

5.2.17 In the IMR submitted by Victim Support, they highlighted the demand on the service at the time. The London Victim Witness Service East London IVA team received 761 crime referrals between 22 August 2020 and 27 August 2020, of which 172 were domestic abuse referrals. The IVA who made contact with Christine had been allocated 44 new referrals during this timeframe, 16 of which were domestic abuse cases. The best practice number should have been 30.

Learning point:
Victim/survivors need to receive prompt and appropriate support which is consistently offered. Support organisations need to ensure that they have robust processes in place to respond to and manage risk. Staff need to be supported but also held to account on their practice.

Recommendation 12:
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:
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. Victim Support to ensure that their staff have manageable workloads and are robustly supported by their managers to ensure they are delivering and offering high-quality support.

Adult Social Care

5.2.18 Adult Social Care was requested to attend this DHR 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. It was important that Adult Social Care were involved in the learning of this review, especially considering the barriers that Christine faced in accessing support around care.

Learning point:
All statutory agencies must be committed to the DHR process to ensure lessons are learnt and victims are better support. Adult Social Care's lack of engagement in the review process had an impact on learning and opportunities to improve practice.

Recommendation 14:
Barking and Dagenham Community Safety Partnership to ensure that Adult Social Care commit to being involved in all future DHRs.

The opportunity for agencies to identify and assess domestic abuse risk and agency responses to any identification of domestic abuse issues.

Health services

5.2.19 Although Daniel had threatened and previously attacked both his sister and mother, his behaviour was seen in the context of his illness. As discussed in section 5.1.5, domestic abuse is not caused by mental ill-health but can be compounded by it. In light of this, the Review Panel considered the lack of risk assessment of domestic abuse across a number of health services.

5.2.20 Over the period of this review, Christine had a number of appointments with Church Elm Lane Medical Practice in relation to her diabetes diagnosis. Despite the recent attack she experienced by Daniel, there was no routine enquiry about domestic abuse during her visits. Further, Nina was discharged from talking therapy in January 2021. Although

her GP demonstrated good practice in following up with a telephone conversation to check in on her well-being, where Nina expressed that she had some anxiety which was triggered by her brother's breakdown the previous summer, the GP did not probe further or demonstrate professional curiosity on Nina's feelings of safety.

5.2.21 Similarly, when Daniel was in the care of ELFT after being sectioned for attacking Christine and Nina in August 2020, they had regular contact with both Christine and Nina who would attend Daniel's Care Programme Approach meetings. Despite this, there is no record of a conversation with either about indicators of domestic abuse and/or the support available to them. There is also no record of a DASH risk assessment being considered or a safeguarding referral for them as carers.

5.2.22 Whilst Daniel was supported by NELFT from January 2022, after being transferred from ELFT, there were also missed opportunities to assess and respond to domestic abuse. As mentioned previously, there was an opportunity to do this during the handover meeting. Significantly, there was also a missed opportunity to do this a few days prior to the murder, when Christine informed the Care Coordinator that Daniel's behaviour was "*funny*" and that he hadn't taken his medication. She had reported to the Care Coordinator that he had attacked someone in the past when he was unwell, and she was worried that he might do it again. Risk was not assessed because Daniel, the patient, was not home, but there was a missed opportunity for Christine and Nina to be risk assessed.

Learning point:
Health partners play a vital role in identifying and responding to domestic abuse. It is important that they understand risk and take a holistic approach to responding to the health needs of service users. Professional curiosity needs to be emphasised.

Recommendation 15:
Church Elm Lane Medical Practice to ensure that questions about domestic abuse are routinely asked during appointments and DASH risk assessments are undertaken.

Police

5.2.23 After Daniel was arrested for attacking his mother in August 2020, a DASH Risk Assessment was completed with Christine. Christine did not want to complete the assessment and did not want to pursue a criminal justice route, instead she wanted mental health support for Daniel. As a result of this, the DASH risk assessment completed identified Christine as at medium risk because this was the default risk the police set when a victim does not partake in the assessment. If Christine was identified as at high risk of harm, she would have been referred to a MARAC, where a more robust safety plan would have been developed with her needs at the centre. It is important to note that a DASH risk assessment can be completed on professional judgement and a referral can be made without the consent of the victim. As Daniel had made threats to kill and had attacked Christine with a weapon, a referral to MARAC should have been made. The police also had access to Daniel's record when making their assessment.

5.2.24 However, as the case was deemed to be at medium risk, a referral was made to Victim Support IVA service, which responds to standard risk cases, rather than the IDVA service, which supports victims at greater risk and would have resulted in a referral to MARAC. The impact of this will be discussed more in the next section.

5.2.25 Although Christine was referred to Victim Support, Nina was not. As she was also at the incident, she should have also been referred on to support.

5.2.26 When Daniel was arrested in July 2021, there was also a missed opportunity to assess the risk he posed to his family.

Learning point:
DASH risk assessments must be completed consistently, and staff need to be trained to understand the importance of assessing all parties.

Recommendation 16:
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.

Domestic abuse services

5.2.27 When the domestic abuse referral from the Police was sent through to Victim Support, it was flagged as being standard risk. The following morning, a London Victim and Witness Service manager assigned the case to an IVA in the triage team. There was a missed opportunity to reassess the referral to high risk and refer to an IDVA.

5.2.28 Significantly, when the IVA spoke to Christine, there is no record of whether the IVA attempted to carry out a DASH risk assessment. This is at odds with the Victim Support Operating Procedure. Completing a risk assessment would have marked Christine as at high risk of harm and resulted in a referral to MARAC.

5.2.29 There was a missed opportunity for the IVA to offer ongoing support, such as a complex case IVA or if the risk had been assessed as high, an IDVA. There was also a missed opportunity to determine if anyone else was affected by the attack, and to reach out to Nina for support.

Learning point:
Referrals between the police and Victim Support must be appropriately reviewed. During meetings with service users, it is vital that a needs-led and risk-led approach is adopted so that the right support is offered.

See recommendation 14

Organisations' access to specialist domestic abuse agencies and their consideration of Christine and Daniel' race when offering support.

5.2.30 Christine was known to a number of statutory services, but her involvement with specialist domestic abuse agencies is limited.

5.2.31 This review has found that Christine was reluctant to open up to statutory services and faced barriers to fully accessing support. We know that Christine had experienced historic domestic abuse by Daniel's stepfather, Ayotunde, and that previous interventions offered by Children's Social Services included couples therapy and anger management for Ayotunde - interventions that are known to increase risk. Although Children's Social Services now know that these interventions are not appropriate, they may have had an impact on how Christine viewed the support that was available. Children's services have also updated the panel that the Barking and Dagenham Safeguarding Children's Partnership Executive and the Neglect and Early Help Subgroup (N&EHSG) conducted an end-to-end review of their domestic abuse system, including children as victims of domestic abuse, resulting in updates to their guidance and practitioner toolkits.

5.2.32 From the interview with Nina, the Review Panel was also made aware of Christine being a private person who was worried about external involvement.

5.2.33 The expert panel member of this DHR also highlighted that there can be a strong emphasis on resilience and self-reliance in the face of adversity in some Nigerian communities. For these reasons, Christine could have benefitted from specialist support from a 'by and for' agency who would have been able to adopt a more intersectional approach to understanding Christine's challenges and the support that she needed.

5.2.34 Research[25] undertaken by Imkaan has highlighted some of the barriers that racially minoritised women experience in accessing support, including:

- Fear was the strongest response and linked to several factors including isolation, feeling trapped, and feeling responsible for the violence.
- Not having the space to consider or make connections between their own need for safety and that of their children because of a primary focus on the safety and welfare of the child.
- Not connecting, seeing, or naming their own experiences of violence as indicators of violence prior to engaging with more intensive support interventions.

[25] Imkaan (2013) Beyond the Labels: Women and girls' views on the 2013 mayoral strategy on violence against women and girls. London: MOPAC

5.2.35 The research from Imkaan goes on to highlight the difference specialist 'by and for' services can make in supporting women from racially minoritised backgrounds:

- 52% of women and girls shared that they did not recognise their own experiences as domestic abuse before they accessed specialist support services.[26]
- 99% of women responding to a research study in London said that Black-led women's organisations made them feel safe and protected. Women pointed to the understanding held by specialist workers in regard to the intersecting impact of interpersonal and structural forms of violence, their language, cultural context, racism, and immigration issues.[27]
- 89% of women accessing a Black-led 'by and for' domestic abuse organisation reported improvements in their mental health and well-being.[28]

5.2.36 The Review Panel found that statutory services needed to do more to connect Christine with the specialist support available in Barking and Dagenham.

5.2.37 The Review Panel also considered the barriers Daniel may have faced in engaging with support. Research shows that there can be a reluctance to discuss psychological distress and seek help amongst men of colour due to negative perception of and social stigma against mental health.[29] In light of this, good practice was demonstrated by NELFT in their creation of an Experts by Experience group for Black and racially minoritised service users to share their experiences of racial inequality whilst using mental health services and to work with psychologists to address and change current care provision.

5.2.38 The Experts by Experience group was set up in January 2022 and Daniel was invited to one of the first group meetings in April 2022, which he attended. However, as the group was still in its infancy, it was not in a position to influence care given.

Learning point:

[26] Ibid

[27] Ibid

[28] Imkaan (2012) Vital Statistics 2: Key findings report on Black, Minority Ethnic and Refugee Women's and Children's experiences of gender-based violence. London: Imkaan

[29] Memon A, Taylor K, Mohebati LM, et al (2016) Perceived barriers to accessing mental health services among black and minority ethnic (BME) communities: a qualitative study in Southeast England

Specialist services play an imperative role in supporting victims of domestic abuse, specialist those who are from minoritised backgrounds and face additional barriers in accessing support. Statutory services must engage with the voluntary sector as part of a coordinated community response to domestic abuse. Barking & Dagenham is a very diverse borough, with over 55% of its population being from an ethnic minority background.[30]

Recommendation 17:
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.

The policies, procedures and training available to the agencies involved in domestic abuse issues.

5.2.39 Agencies involved in this review have a range of policy, procedures, and training in place in relation to domestic violence and abuse and these were described in each agency's IMR/short report.

5.2.40 A summary of the agencies with domestic abuse policies and their training is outlined in the table below:

Agency	Domestic Abuse policy and review date at time of this report	Domestic Abuse Training
Northeast London NHS Foundation Trust	Protecting adults, young people, and children at risk of Domestic abuse SOP 2019-2022	Safeguarding Adults level 3 is mandatory training for clinical staff.

[30] https://www.lbbd.gov.uk/council-and-democracy/statistics-and-data/barking-dagenham (accessed May 2024)

	Domestic Abuse Staff Policy expires July 2025	Additional domestic abuse training is available is available as part of the essential to role training and other training facilitated by the NELFT training department
East London NHS Foundation Trust	Domestic Abuse and Harmful Practices Policy which was last reviewed in June 2023.	Domestic abuse awareness training is covered in the mandatory safeguarding adults training, also appearing as a regular item in mandatory quarterly safeguarding supervision. The Trust's Corporate Safeguarding Team regularly offers learning opportunities for all Trust staff.
Church Elm Lane Medical Practice	Domestic Abuse policy in place which was last reviewed in June 2022.	Domestic Abuse training is delivered to ICB staff either through Safeguarding Adults L3 training, or through standalone training that has been requested by a specific team. The IRIS programme was delivered from 2020 but came to an end in March 2022.
London Ambulance Service	Domestic Abuse Policy in place which was last reviewed July 2024.	Level 3 Safeguarding training for all patient facing staff. All clinical staff attend

		Safeguarding Adult and Children Level 3 mandatory training.
Metropolitan Police East Area Borough Command Unit	Domestic Abuse Policy in place, which was last updated in June 2024. MPS uses College of Policing Authorised Professional Practice as the primary source for current policy on domestic abuse.	The Police have the following training offer: One-day Domestic Abuse Matters training Five-day Community Safety Unit course Inclusion of domestic abuse and violence against women and girls awareness in First Line Leaders CPS training for sergeants and inspectors.
Barking & Dagenham Children Services	London Borough of Barking and Dagenham have an employee policy which supports all staff experiencing domestic abuse. Our mantra is “We believe you”. Furthermore we launched a DA Commission in February 2020 which undertook significant engagement work with residents and stakeholders across the system and presented its findings in 2021 which resulted in the creation of a domestic abuse improvement plan over 5 years. We are in year 5 and	Domestic Abuse and Sexual Awareness, 'Honour' Based Abuse, Forced Marriage and FGM, Trauma Informed Practice, Risk Assessment, How to identify a Victim vs. Perpetrator, Children as Victims of Domestic Abuse, Domestic Abuse and Intersectionality, Differences between Parental Conflict and Domestic Abuse, and other bespoke training.

	reflecting on the positive work achieved and exploring opportunities to support our residents.	
Victim Support	Domestic Abuse Operating Procedure, an IDVA Operating Procedure and a Staff and volunteer Domestic Abuse policy in place, which were last reviewed in August 2023.	Staff who come into contact with victim/survivors of domestic abuse are required to complete all mandatory foundation learning including 4-day internal Domestic Abuse, Homicide Timeline, 4-day internal Sexual Abuse and Safeguarding training. All staff working in an IDVA role are required to undertake formal IDVA qualification. All staff in the London Victim and Witness service have to have undertaken the 1-day Risk Assessment course and to attend the Respect 'Working with Perpetrators Presenting as Victims.'

5.2.41 Having a clear and robust domestic abuse policy in place which is regularly reviewed can provide an organisation with the support and guidance to best respond to domestic abuse. It is also important that this policy is accompanied by regular and stand-alone domestic abuse training, which is mandatory for any appropriate professional to attend.

Learning point:

Domestic abuse policies must be kept up to date and utilised by staff. Staff also need to be regularly trained on all forms of domestic abuse, including parental abuse.

Recommendation 18:
Barking and Dagenham Community Safety Partnership to ensure that their members have policies and training which include detail of adult child to parent abuse.

How agencies considered adult child to parent abuse and the risk Daniel posed.

5.2.42 As discussed at 5.1.3, adult child to parent abuse is an important, though sometimes neglected, aspect of domestic abuse. The Review Panel found that, although a DASH risk was undertaken by the police, no other agency assessed the risk to Christine. It is important to highlight that there is a recognition that DASH is geared towards intimate partner violence rather than adult family violence. Instead, Daniel' abuse was seen in the context of his mental ill-health, which side-lined Christine, and may have had an impact on how she saw her own experience of domestic abuse.

5.2.43 Furthermore, research relevant to this review shows that:

- Adult child to parent abuse most often involves mothers killed by their adult sons.[31]
- Adult children who abuse their parents are more likely to experience some type of mental health issue, however, unless they are a risk to the community, services are not likely to intervene.[32]
- Research on domestic homicide involving people aged over 60, found that older people were almost as likely to be killed by their child as by their partner.[33]

[31] Benbow, S.M., Bhattacharyya, S. and Kingston, P. (2023), "Adult family violence coming out of the shadows", The Journal of Adult Protection, Vol. 25 No. 2, pp. 91-99.

[32] Safe Lives (2016), "Safe later lives older people and domestic abuse" Safe Later Lives - Older people and domestic abuse.pdf (safelives.org.uk) (assessed March 2024)

[33] Bows, H. (2019), "Domestic homicide of older people (2010–15): a comparative analysis of intimate partner homicide and parricide cases in the UK", The British Journal of Social Work, Vol. 49 No. 5, pp. 1234-1253, doi:

- Most deaths of parents by their adult child occurs in the victim's home and a sharp instrument is most frequently involved.[34]
- A recent study identified 'five interlinked precursors' in the perpetration of adult family homicide, namely, mental health and alcohol/substance misuse; criminality; childhood trauma (childhood abuse or death of a parent); "caring" relationships; and economic issues.[35]

5.2.44 Sadly, much of this research speaks directly to Christine's experience of abuse. In particular, a review of ten matricides where the mother-victims were primary carers for their sons, found that mothers were isolated and marginalised in their son's care. They note how the mothers' needs were disregarded and risk to them was not assessed – describing this as a double bind of "*responsibilisation and marginalisation*" in the care of an adult-child with serious mental illness.[36]

5.2.45 Christine's experience of responsibilisation and marginalisation can be seen in the expectations on her as a carer, without the formal title of a carer, and the side-lining of the risk posed to her, even after experiencing an attack by Daniel two years prior to her murder.

Learning point:
It is important that an understanding of domestic abuse is not just limited to that which takes place in an intimate relationship. There is also a need to ensure that professionals understand the relationship between domestic abuse and caring responsibilities to ensure they are offering the right support to victim/survivors.

See recommendations 1, 2, 3, and 4.

The impact of the COVID-19 pandemic

[34] Benbow, S.M., Bhattacharyya, S. and Kingston, P. (2023), "Adult family violence coming out of the shadows", The Journal of Adult Protection, Vol. 25 No. 2, pp. 91-99.
[35] 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, Vol. 6, pp. 535-550
[36] Ibid.

5.2.46 Agencies involved in this DHR were asked to consider the impact of COVID-19 and lockdown on service delivery. Over August 2020 to October 2022, the timeframe of this review, there were national lockdowns between January 2021 to July 2021, and local lockdowns from September 2020 to November 2020.

5.2.47 Further research on the impact of COVID-19 is still very much needed, but initial studies have found that existing mental health difficulties were exacerbated for many people, that there was inadequate access to mental health services, and that new remote ways to access mental health care, including digital solutions, presented substantial barriers to access.[37] Further, people from Black and ethnic minority communities experienced heightened anxiety, stigma and racism associated with the pandemic, further impacting their mental health.

5.2.48 The Review Panel considered the impact of moving to digital solutions, particularly for ELFT and NELFT. It was noted a home visit undertaken by the Care Coordinator in July 2022 was the first one in a 6-month period. This is significant, particularly as Christine was previously noted to have told ELFT, in February 2021, that providers talked to Daniel every week but that it could be "*hard to say how he is because anyone can talk okay on the phone but when you see them face to face you can judge better.*"

5.2.49 Findings have also highlighted the changing patterns of domestic abuse during the Covid-19 lockdown. Abuse by current partners as well as family members increased on average by 8.1% and 17.1% respectively over the lockdown period.[38] Although an important caveat is that this increase was also due to an increase in third party reporting,[39] it is still noted that locking down with a perpetrator increased risk by limiting opportunities for support.

5.2.50 The Review Panel considered this period of heightened risk and how this should have resulted in an increase of awareness of domestic abuse and use of DASH risk assessments.

Learning point:

[37] Gillard, S., Dare, C., Hardy, J. et al. Experiences of living with mental health problems during the COVID-19 pandemic in the UK: a coproduced, participatory qualitative interview study. Soc Psychiatry Psychiatric Epidemiology 56, 1447–1457 (2021)

[38] Ivandic, Ria, Kirchmaier, Thomas and Linton, Ben (2020) Changing patterns of domestic abuse during Covid-19 lockdown. CEP Discussion Papers (1729). London School of Economics and Political Science. Centre for Economic Performance, London, UK.

[39] Ibid.

The COVID pandemic forced a change in how frontline services were delivered. As we return to life beyond the pandemic, it is necessary to review the impact of the lockdown on current service delivery.

Recommendation 19:

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.

6. Conclusions and Lessons to be Learnt

6.1 Conclusions

6.1.1 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.

6.1.2 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.

6.1.3 The Review Panel extends its sympathy to all those affected by Christine's death and thanks all those who have participated in the review.

6.1.4 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.

6.2 Key Themes and Learning Identified

6.2.1 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:

<u>Lack of identification and understanding of adult child to parent abuse</u>

6.2.2 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.

6.2.3 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.

6.2.4 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.

6.2.5 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.

<u>Limited understanding between mental health and domestic abuse</u>

6.2.6 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.

6.2.7 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.

6.2.8 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

6.2.9 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.

6.2.10 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.

6.2.11 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

6.2.12 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.

6.2.13 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.

6.2.14 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.

6.2.15 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.

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.

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 Barking and Dagenham Community Safety Partnership.

NELFT

7.1.3 Director of Service to consider Duty of Candor arrangements following engagement with the police around appropriateness of doing so.

7.1.4 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.

7.1.5 An indicator to be added to Electronic Patient Record to be completed when the carers wellbeing initiative has been initiated.

7.1.6 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.

7.1.7 To strengthen in the SOP how salient information pertaining to medical and risk history is captured within the EPR and communicated with the team.

7.1.8 A Trust wide communication to be circulated to increase staff awareness of how to access East London Patient Record and clinical portal.

7.1.9 A system review of East London Patient Record to be undertaken to explore what improvements can be made with publishing to the clinical portal.

7.1.10 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.

7.1.11 An audit of risk formulation to be completed for quality assurance following the reflective session with staff.

7.1.12 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.

7.1.13 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:

7.1.14 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.

7.1.15 Trust wide intergenerational abuse session to be held at bi-annual safeguarding conference.

7.1.16 Lessons from the IMR and DHR report to be shared via Trust safeguarding newsletter. To be completed when DHR is published.

7.1.17 Create domestic abuse checklist and safeguarding prompt questions to be added to Tower Hamlets for Mental Health admission checklist.

7.1.18 Carers assessment rights to be included as a topic within next safeguarding supervision for THEIS.

7.1.19 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.

7.1.20 Increase staff awareness of intergenerational abuse the risks to parents supporting adult children with mental health.

7.1.21 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.

7.1.22 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:

7.1.23 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

7.1.24 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:

- 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

7.1.25 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.

7.1.26 For the IVA manager to continue to dip sample IVAs cases to check for DASH RA and safety planning.

7.1.27 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.

7.2 Multi Agency Recommendations (Developed by the Review Panel)

7.2.1 The Review Panel has made the following recommendations during this review in response to 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 Barking and Dagenham is responsible for overseeing then development and monitoring of an action plan.

Recommendation 1:

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

Recommendation 2:

7.2.4 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:

7.2.5 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:

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

Recommendation 5:

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

Recommendation 6:

7.2.8 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:

7.2.9 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.

7.2.10 **Recommendation 8:**

7.2.11 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:

7.2.12 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:

7.2.13 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:

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

Recommendation 12:

7.2.15 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:

7.2.16 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:

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

Recommendation 15:

7.2.18 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:

7.2.19 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:

7.2.20 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:

7.2.21 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:

7.2.22 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.

Appendix 1: Glossary

A&E	Accident and Emergency
AAFDA	Advocacy After Fatal Domestic Abuse
AFV	Adult Family Violence
BAMER	Black, Asian, Minority Ethnic and Refugee
CAMHS	Child and Adolescent Mental Health Service
CCG	Clinical Commissioning Group
CCR	Coordinated Community Response
CPS	Crown Prosecution Service
CPV	Child to Parent Violence
CRIS	Crime Recording and Information System
CSP	Community Safety Partnership
CSU	Community Safety Unit
DAHA	Domestic Abuse Housing Alliance
DASH RIC	Domestic Abuse Stalking and Harassment Risk Indicator Checklist
DHR	Domestic Homicide Review
DI	Detective Inspector
FSW	Family Support Worker
FLO	Family Liaison Officer
GP	General Practitioner / Practice
IDVA	Independent Domestic Violence Advisor
IMR	Individual Management Review
IO	Investigating Officer
LAS	London Ambulance Service
LGBT	Lesbian, Gay, Bisexual and Trans
MARAC	Multi Agency Risk Assessment Conference
MASH	Multi Agency Safeguarding Hub
MERLIN PAC	(MPS) report completed by police officer when they encounter a child in circumstances that cause a concern
MOPAC	Mayor's Office for Policing and Crime
MPS	Metropolitan Police Service
SIO	Senior Investigating Officer
SLT	Senior Leadership Team
SPOC	Single Point of Contact
VAWG	Violence against Women and Girls

VSHS	Victim Support Homicide Service

Appendix 2: Single Agency 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

OR CAN USE

Recommendation 1: *(Insert Recommendation and desired outcome)*					
REF	**Action (SMART)**	**Lead Officer**	**Monitoring Arrangements and Key Milestones**	**Target date for completion**	**Completion Date and Outcome**
1.1					
1.2					
1.3					

Appendix 3: Multi Agency 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