Hertfordshire Domestic Abuse Partnership

Welwyn and Hatfield Community Safety Partnership

Domestic Homicide Review

Executive Summary

Into the death of Celeste (pseudonym) on September 2021

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A Tribute to Celeste

The Independent Chair and Domestic Homicide Review Panel offer their sincere condolences to all who have been affected by the death of Celeste , who is remembered for her strong willed personality and sociable character. Celeste was described as being very smart and sharp with her opinions on life by her family.

Celeste enjoyed spending time with her friends and family, and would often celebrate birthdays, Christmases and Easter with her wider family. From which Celeste's family have fond memories of these times. Celeste had worked numerous roles in her life despite her mental illness diagnosis which her family advised did affect her confidence.

Celeste's death is a very sad loss to her family; in particular her mother and her sister who loved her dearly. The Independent Chair and Multi Agency Review Panel thank all who have contributed to the deliberations of this review, for their time, patience, honesty, and cooperation.

A Tribute written by Celeste's Mother

First of all no amount of words will ever convey what an incredible person Celeste was. Anyone who had the privilege to be part of her life knew that she was the most loving, the most giving, the most genuine human being you could ever know, and in spite of having to deal with an unforgiving mental illness, she was the strongest, the most resilient and the most determined to live her life to the full.

She was an excellent cook. Every Sunday evening she would cook dinner for me, Alfred and herself. It started with a soup, the best you had ever tasted. Mr Heinz would have been put to shame. Then a roast, either chicken, lamb or pork with all the trimmings, roast potatoes, roast parsnips, carrot, sprouts, cauliflower cheese, yorkshire pudding, stuffing, gravy. Summer or winter it never changed. She liked to have a routine.

She had many friends some going back to her school days others whom she had met through work or socially. She managed to keep them all over the years. She was clever and autonomous in everything she chose to do. I am so proud to be her Mum.

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1. Preface

1.1 Domestic Homicide Reviews (DHRs) came in to force on the 13th April 2011. They were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004). The Act states that a DHR should be a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by-

a) A person to whom she was related or with whom she was or had been in an intimate personal relationship or
b) A member of the same household as herself; held with a view to identifying the lessons to be learnt from the death.

1.2 There was also a change to the Multi Agency Guidance in December 2016 where Community Safety Partnerships have been encouraged to commission a review where an individual has taken their own life and they were known to agencies as experiencing domestic abuse.

1.3 Throughout the report the term 'domestic abuse' is used in reference to 'domestic violence', as this is the term which has been adopted by the Strategic Partnerships Team in Hertfordshire.

1.4 The purpose of a DHR is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and agencies work individually and together to safeguard victims;
- 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;
- Apply those lessons to service response, including changes to inform national and local policies and procedures as appropriate,
- Prevent domestic abuse and homicide and improve service responses for all domestic violence and abuse victims and their children by developing co-ordinated multi agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;
- Contribute to a better understanding of the nature of domestic violence and abuse;
- Highlight good practice

1.5 The criteria for a Domestic Homicide Review was met in relation to Celeste's death because it is understood by Hertfordshire Constabulary that Celeste's death resulted from violence by her husband, Alfred. This review examines the circumstances surrounding the death of Celeste (pseudonym) in a town in Hertfordshire in September 2021. The principles underpinning the review process have been followed in accordance with the Home Office Multi-Agency Statutory Guidance on the Conduct of Domestic Homicide Reviews- Revised Version-December 2016 and pseudonyms have been used.

2. Introduction

2.1 Celeste was aged 48 at the time of her death. She had lived in Hertfordshire for almost her whole life, her mother and sister also lived in the local areas nearby. She was described by her family and friends as a sociable character who enjoyed spending time with family and friends. Her mother and sister described her as 'a beautiful person inside and out; she was very bright, independent and resilient'. When Celeste was 26 years old she made an attempt on her life by taking an overdose. She received support from a number of different health services at the time and was sectioned under the Mental Health Act at one point. It was thereafter when she was diagnosed with paranoid schizophrenia. Her family advised as part of this review that she coped amazingly well with this mental illness. She learnt over the years to manage her ups and downs relatively well, and she knew when she wasn't feeling well.

2.2 Celeste met Alfred when they were in their late teens/early twenties and had remained in a relationship ever since their first date. The couple married in March 2019. It is unknown why they chose to marry after such a long time together, however Celeste's family have happy memories of this occasion and advised as part of this review that they chose to marry after such a long time because they wanted financial security for the surviving spouse. To this end, Celeste's family knew Alfred well and had known him also for about 30 years. Celeste's family described her daughter's relationship with Alfred as a couple who very much loved and cared for one another, and was 'very normal'. They would occasionally argue but they did not ever feel that the relationship was abusive in any way; not physically, sexually, emotionally or otherwise.

2.3 Alfred was diagnosed in 2013 with a depressive disorder and was therefore known to health agencies on and off for some years after this date; sometimes engaging with services and other times not. Alfred also had a history of drug and alcohol misuse which was reported to have stopped in 2020. In and around this time, Alfred also complained of suffering from chronic abdominal pain and therefore underwent further tests and examinations during this time. It is also understood from agency records and Celeste's family that she too used alcohol as a means to cope and manage her symptoms relating to her mental illnesses including Obsessive Compulsive Disorder.

2.4 Since 2010, Celeste was regularly seen by the Adult Mental Health Community Team, part of Hertfordshire Partnership University NHS Foundation Trust as a result of her mental health diagnosis. During the Covid-19 pandemic, Celeste was seen more frequently by the FACT team (Flexible Assertive Care Team), and then daily from June 2021 until September 2021, often at home. The main reason for Celeste being seen more regularly was to manage whether she was taking the correct dose of medication. It was reported as part of this review that whilst Celeste had some intermittent periods of respite from her mental health symptoms these were short-lived, and she required intensive support for her mental health on an on-going basis. It was noted as part of the review and supported by Celeste's family that Alfred's mental health would often exacerbate Celeste's symptoms and ability to self-manage her illness, which was a challenge for all to witness including family members.

2.5 In June 2020, Celeste attended a local Urgent Care Centre based at the QEII Hospital, part of East and North Hertfordshire NHS Trust with a head injury, stating that she had fallen the night before. It was reported as part of the review that Alfred appeared unhappy that he was asked to stay outside due to Covid-19 regulations. It was also noted that Celeste had some old bruising on her face, arms and top of her back. Celeste was asked whether she was a victim of domestic abuse which she denied, stating that all was well at home when asked if she felt safe. Celeste declined any referrals to specialist domestic abuse services.

2.6 There was a further significant event involving Alfred's mental health in June 2021, when he was brought into the Emergency Department at Lister Hospital, part of East and North Hertfordshire NHS Trust after trying to end his life with a mixed overdose. He was admitted to the critical care unit, and he remained in hospital for 11 days. When assessed as medically fit, he was seen by the Mental Health Liaison Team however he did not want to engage and instead he was signposted to the Acute Mental Health Community Team provided by Hertfordshire Partnership University NHS Foundation Trust.

2.7 Alfred did engage with this service from August 2021 and he was made aware in early September 2021 of the contact numbers to call in case of a crisis for the second time, after a similar conversation in December 2020 also.

2.8 Alfred was also in contact in this same month with Hertfordshire Partnership University NHS Foundation Trust and his GP Practice. This was in relation to a burning feeling in his throat and for some abdominal pain. Following this consultation with his GP he was referred to the Pain Management department at Lister Hospital.

2.9 Also in 2021, it was reported as part of this review by Celeste's family that Alfred started using drugs again in 2021 when he was not feeling well. Celeste was aware and angry with him and often tried to stop him from getting the drugs supplied by a 'friend' known to them.

2.10 **Incident summary:**

2.10.1 In September 2021, Alfred was found lay face down on the floor in a public car park in their hometown. It appeared to police officers upon attendance as if he had jumped from the car park above. CCTV footage confirmed that he was not in the company of anyone else whilst on the top floor of the car park and near to the edge. An old passport type photo of a female was the only item found on him when searched at the scene. This photo was later identified to be an old photograph of Celeste.

2.10.2 A few hours later, on the same day, a call was made to the police by Celeste's family expressing concerns for the welfare of both Celeste and Alfred because they had not been able to get hold of them. Following this call, Celeste and Alfred's family gained access to Celeste and Alfred's family home where they found Celeste laying on the bed unresponsive. Initially owing to numerous empty packets of medication in the drawer beside Celeste it was thought to be an overdose. A suicide note was also found near to Celeste on the bed, believed to have been written by Alfred. A forensic post mortem was conducted of Celeste which resulted in her death being caused by strangulation.

2.10.3 In summary, it would appear that Alfred strangled Celeste to death, and later the same day took his own life by jumping off a multi-storey car park.

2.10.4 The Coroner's Inquest is still outstanding, and likely to take place after the conclusion of both this Domestic Homicide Review and the Mental Health Homicide Review.

2.10.5 The key purpose of this review is to enable lessons to be learned from Celeste's death. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened, and most importantly, what needs to change in order to reduce the risk of such a tragedy happening in the future. It was clear from the information shared by agencies and Celeste's family that the intersectionality of risk factors at play between this couple were complex. Both individuals recognised themselves that they required support with their mental health, both also expressed anxieties to agencies about what would happen to the other person if anything happened to them, and they both openly spoke to health professionals about caring for one another.

2.10.6 The Review considers all contacts/involvement agencies had with Celeste and some contacts with Alfred during the period Summer 2017 to September 2021, as well as any events, prior to 2017, which are relevant to mental health, violence, and abuse.

3. The Terms of Reference

3.1 Specific Terms of Reference for this Review:

3.1.1 To provide an overview report which articulates Celeste's life through her eyes; recognising the reality of her experiences, and how this interfaces with the identification of her as a carer to the alleged perpetrator for his mental health concerns.

Each Agency were asked to:

3.1.2 Comment on the specific areas set out in the key lines of enquiry found below.

3.1.3 Identify the history of the relationship between Celeste and Alfred and provide a detailed chronology of relevant agency contact with them; specifically, Celeste's experience of agencies and her relationship with Alfred, who is the alleged perpetrator of this domestic homicide.

3.1.4 Examine whether there were signs or behaviours exhibited by Celeste as being a victim of domestic abuse or Alfred as the alleged perpetrator, in their contact with services which could have indicated the level of risk.

3.1.5 Report their involvement with Celeste and Alfred to assess whether the services provided offered appropriate interventions, risk assessments, care plans and resources. Assessment should include analysis of any organisational and/or frontline

practice level factors which impacted upon service delivery. Specifically, how Celeste was identified as a carer to Alfred, and what the organisational response was had it been highlighted that she too was a victim of domestic abuse and carer to the perpetrator.

3.1.6 Examine whether there were any indicators or history of domestic abuse and/or coercive control? If so, were these indicators fully realised and how were they responded to? Was the immediate and wider impact of domestic abuse between Celeste and Alfred fully considered by agencies involved? And how was information shared between agencies?

3.1.7 Consider whether there was any collaboration and coordination between agencies in working with Celeste and Alfred; individually and as a couple? What was the nature of this collaboration and coordination, and which agencies were involved with whom and how? Did agencies work effectively in any collaboration?

3.1.8 Consider what learning if any there is to be identified in the care management of Celeste who was a victim to a domestic homicide, had a mental health condition, and was identified as a carer to the alleged perpetrator of the domestic homicide because of his mental health concerns also. Is there any good or poor practice relating to this case that the Review should learn from? Each agency is asked to examine best practice in their specialist area and determine whether there are any changes to systems or ways of operating that can reduce the risk of a similar fatal incident taking place in future?

3.1.9 Examine whether communication and information sharing between agencies or within agencies was adequate, timely and in line with policies and procedures?

3.1.10 Examine whether there were any equality and diversity issues or other barriers to Celeste or Alfred in seeking help?

3.1.11 Examine whether Celeste or Alfred were assessed or could they have been assessed as an 'adult at risk' as defined with the Care Act 2014. If not were the circumstances such that consideration should have been given to this risk assessment? Were either Celeste or Alfred identified as a carer and what did this look like in terms of carer's support and assessment?

3.1.12 Provide an assessment of whether family, friends, neighbours or key workers were aware of any abusive or concerning behaviour that occurred prior to Celeste's death, and if they were whether they shared this information with any agencies.

3.1.13 Assess whether agencies have domestic abuse policies and procedures in place, whether these were known and understood by staff, are up to date and fit for purpose in assisting staff to practice effectively where domestic abuse is suspected or present.

3.1.14 Examine the level of domestic abuse training undertaken by staff who had contact with Celeste and/or Alfred, and their knowledge of indicators of domestic abuse, both for a victim and for a potential perpetrator of abuse; the application and use of the DASH risk assessment tool; safety planning; referral pathway to Multi Agency Risk Assessment Conference (MARAC), or to appropriate specialist domestic abuse services.

3.2 Key lines of enquiry

The following key lines of enquiry were also explored further with the relevant agencies in the review:

3.2.1 The reasons and motivations for Alfred's change in behaviour to stop misusing drugs and alcohol in 2020.

3.2.2 The support offered to couples where there are known mental health concerns for both parties, and how this interfaces with being identified as a 'carer' and then where there are domestic abuse concerns.

3.2.3 The information sharing of agencies following Celeste's attendance at an Urgent Care setting with a head injury.

3.3 Legal advice and costs

3.3.1 Each statutory agency will be expected and reminded to inform their legal departments that the review is taking place. The costs of their legal advice and involvement of their legal teams are at their discretion.

3.3.2 Should the Independent Chair, Chair of the CSP or the Review Panel require legal advice then this will be sought following discussion with the Panel.

3.4 Media and communication

3.4.1 The management of all media and communication matters will be through the Review Panel, supported by the Strategic Partnerships Team.

3.5 Roles and Responsibilities

Chair of Strategic Partnerships Team

3.5.1 To commission the DHR and seek assurance that the Terms of Reference have been met for the DHR before sending onto Home Office to be quality assured.

Independent Chair

3.5.2 To convene (with administrative support from the Partnership) and Chair the Review Panel meetings.

3.5.3 To liaise with the family/friends of Celeste and Alfred, using the relevant family advocates or Family Liaison Officer.

3.5.4 To determine the brief of, coordinate and request Individual Management Reviews (IMRs)

3.5.5 To review IMRs ensuring that they meet the satisfactory criteria of the Home Office

3.5.6 To write the Overview Report and Executive Summary

3.5.7 To present the findings of the Overview Report to the Strategic Partnerships Team.

4. Involvement of family, friends and wider community

4.1 As per the Home Office guidance a letter together with the Leaflet on 'Domestic Homicide Reviews', was sent to Celeste's family inviting them to contribute and engage in this review, this was sent by the Independent Chair. Her family members responded positively, recognising that this was a learning opportunity for the organisations who supported Celeste and Alfred over the year, and had opportunity to influence the Terms of Reference. One family member is being supported by a Victim Support Case worker who acted as a conduit between the Independent Chair and the family member. The Independent Chair met with Celeste's family on Microsoft Teams twice, however engagement and updates were shared with the family via email which was their preferred method of communication. The final draft Overview Report was shared with the family for comment during November 2023 with comments and suggested amendments received in January 2024.

4.2 Alfred's family members were also contacted by the Independent Chair and the Independent Consultant for the Mental Health Homicide Review inviting contributions, however there was no response to this letter. Colleagues from Hertfordshire and Cambridgeshire Constabulary supported the delivery of these letters.

5. Summary of agencies involved and their contact

5.1 The following agencies listed below were invited to attend the Panel meeting to discuss their involvement:

5.1.1 Hertfordshire Partnership University NHS Foundation Trust is the main provider of mental health services in Hertfordshire, and both Celeste and Alfred accessed these services frequently. They also provide some of the requirements relating to Social Care and Safeguarding under the Care Act 2014 following a formal delegation from the County Council.

The (Adult Community Mental Health Service) ACMHS offers a multi-disciplinary service to adults experiencing severe and enduring mental illness. This service is comprised of a range of professions: specialist medical professionals, nursing, social work, occupational therapy, psychological therapy, art psychotherapy, drama therapy, psychology, support workers and administrative staff. At the time of her death, Celeste was under the Care Programme Approach (CPA) receiving care via Outpatients clinic (Psychiatric), Clozapine monitoring and also the Flexible Assertive Community Team (FACT) who are a subsidiary of the ACMHS, providing an increased level of support for service users who require more regular monitoring and support with medication compliance. At the time of his death, Alfred was under standard care with the ACMHS, receiving support via a Speciality Doctor line managed by Celeste's Consultant Psychiatrist.

5.1.2 Hertfordshire and West Essex Integrated Care Board is the main commissioner of health services within the Hertfordshire area including Primary Care services; GP. Although Celeste and Alfred were married, lived together and in the same home, they were registered at different GP Practices. It was known by Celeste's GP Practice that she had a mental health diagnosis of schizophrenia and sought support from the Hertfordshire Partnership University NHS Foundation Trust for this. Alfred was registered at a different GP Practice and was well known to this organisation for making contact to review his medication, seek advice on his physical and mental health and ask for a referral to a specialist department at the hospital.

5.1.3 Hertfordshire Constabulary provide the police service to the county of Hertfordshire. Neither Celeste or Alfred were known to this agency. There was just one incident reported to the police in 2017 which was reported by a third party, most likely a neighbour. There was no further engagement with this organisation until the tragic incidents in September 2021.

5.1.4 East and North Hertfordshire NHS Trust is one of the acute hospital trusts operating in Hertfordshire. It was this organisation who recorded domestic abuse concerns relating to Celeste's head injury when she attended an Urgent Care Centre in June 2020, however Celeste denied this. Alfred also frequented the Emergency Departments provided by this Trust several times over the period of review including his overdose in the summer of 2021.

5.2 A chronology was compiled as part of this review given the number of contacts Celeste and Alfred had had with these agencies. A brief summary of this is captured in 'The facts' section of this report.

5.3 As previously advised, other agencies also attended the Panel in order to provide expertise to discussions in relation to the area of Hertfordshire (local authority), domestic abuse (Refuge- specialist domestic abuse service- providing IDVA service across Hertfordshire), and a drug and alcohol misuse support service (CGL).

6. Conclusions

6.1 In reaching their conclusions the Review Panel have focussed on the following questions;

- Has the Panel fulfilled the Terms of Reference for this review by undertaking a variety of lines of enquiry, including discussing the identification of caring responsibilities and working with couples who both present with mental health concerns?
- Will the actions and suggestions for improvement improve the response domestic abuse victims have in the future?
- What are the key themes or learning points from this review?

6.2.1 The Review Panel are satisfied that the Terms of Reference have been fulfilled and that discussions did take place at the Panel meeting to consider what was known prior to Celeste's death in September 2021.

6.2.2 The Panel is of the opinion that the agreed recommendations as listed in Section 19 below appropriately address the points raised throughout the review, particularly in relation to key areas identified in the IMRs and described in the Analysis and Lessons to be learnt sections of this report.

6.4 The main issues identified as part of this review process were; **communication between health services**- many different health services were involved with Celeste and Alfred's care and the review highlighted that some of the practitioners did not always know what and who else was involved. This therefore had an impact on the coordination of their care and the holistic assessment of what else was going on for and around them. Another key issue identified was that of the **MARAC process and thresholds**, neither Celeste nor Alfred were referred to MARAC. However during Panel meetings it was raised that there was potentially a gap in process for those concerns/cases when agencies identify individuals at risk of domestic abuse but there is limited information and the risk is unknown, for example Celeste's attendance at the Urgent Care Centre in June 2020. Another issue was the **identification of those with a caring role-** this was in relation to the stigma attached to the word 'carer' and also that both Celeste and Alfred supported and looked after one another but neither were identified as having a 'caring role'. This meant that there were missed opportunities to offer greater support via a carer's assessment and have a contingency plan in place. Linked to this issue, it was also identified that there were issues and learning from how systems and agencies can **work better with couples who both have mental health concerns.** This was in relation to how services and teams within organisations could work better together to offer support but also that domestic abuse should be more widely understood so that it can be recognised and identified by mental health practitioners working with couples who both have mental health concerns. **Mental health concerns and use of drug and alcohol services** also featured within this review because neither Celeste or Alfred engaged with these specialist services. Lastly, the **impact of the Covid-19 Pandemic** was also identified as a key issue in this review because it was reported as part of the review by family members that both Celeste and Alfred were sociable characters and Celeste enjoyed working for some financial independence, confidence and routine. Therefore, the Panel concluded that the lockdowns and restrictions would have had a significant impact on

their health and wellbeing as individuals and as a couple. This conclusion was also supported by Celeste's family.

7. Lessons to be learnt

Communication between health services

7.1 The Panel discussed this theme several times during the course of the IMR presentations and review. On the one hand, there was some evidence within the agency chronologies that health services did share information with one another in terms of changes to medications, attendances at Emergency Departments and referrals to other secondary care services. This is good practice but also to be expected because as has already been mentioned, Primary Care services provided by the GP Practice should be sighted on all basic aspects of care provided by any other NHS provider. Research undertaken by Dinsdale et al (2019) showed that often letters being received by health services were delayed owing to administrative delay and that medication changes, medication lists and secondary diagnoses were not included. Similar findings were found in this review for Alfred's care because the changes in medication doses were not always known and understood by Primary Care and Secondary Care Mental Health services. Therefore, the Panel also recognised that the communication between health services could have been better; particularly for Alfred who had contact with several different health services who all knew only their information in detail. The Panel noted that there may have been a false sense of risk management by health partners due to the volume of contact had.

7.2 In line with this, the Panel were advised of a new tool being implemented across Hertfordshire NHS services called Shared Care Record, which is intended to help with this issue. A shared care record is a safe and secure way of bringing all separate records from different health and care organisations together digitally into one place. The purpose of this is to join up information based on the individual rather than one organisation. The Panel felt assured by this change programme underway that information from different health organisations would be brought together in a new and innovative way. The Panel discussed the timeframes for this and it was concluded that each organisation were in a different phase of the project at the time of the discussion but that by the end of 2023 it would be in place across the system. Alongside this conversation, panel members also discussed how well Professional Meetings are used to discuss individuals who may have a range of complex needs which may or may not include care and support needs under the Care Act 2014 legislation. There were differing views in relation to this suggestion, and therefore a recommendation was agreed that all practitioners across the sectors should be reminded of the benefits of a Professionals meeting to discuss complex cases. A multi-agency Professionals meeting can be organised and coordinated to discuss cases where there are significant concerns about the likelihood of significant risk of abuse and neglect, or self-neglect. This may be important where there is a concern about potential risk to an adult; or where there is uncertainty amongst professionals about the necessary steps being taken by any of the agencies to protect the adult from risk or abuse. A Professionals meeting can be helpful as an opportunity to reflect on the plans for working with an adult when progress is not being made. Any practitioner can call a Professionals meeting. The Panel felt that this may have been useful in coordinating and risk assessing Alfred's care and needs.

7.3 In addition to the sharing of information between health agencies, it was also found, as already discussed, that a safeguarding adults referral into adult social care from East and North Hertfordshire NHS Trust was lost. Evidence was provided as part of this review that the referral was sent via email and to the correct email address, however it could not be tracked. The Panel discussed the concerns that arose from this, because the process was not failproof. However, assurances were provided to the Panel that a new Portal electronic process came into use in Summer 2021 which should now minimise any referrals being lost in email.

MARAC; the referral process and thresholds

7.4 MARAC stands for Multi Agency Risk Assessment Conference. This process is non-statutory, however exists to gather the information, risk assess, discuss and action plan high risk cases of domestic abuse. High risk is defined as those where there is risk of significant harm or homicide. This process was relevant to the DHR because consideration was given by East and North Hertfordshire NHS Trust in June 2020 when Celeste attended the Urgent Care Centre whether to refer into this process based on professional judgement. However a decision was made not to because the referral criteria was perceived to be very strict and they felt it was unlikely to meet the threshold. A Panel discussion took place to discuss whether this was the right decision, it was agreed that with the limited information known by the Trust at that time it would have unlikely met the criteria for a MARAC discussion. This was because Celeste did not make any disclosure, was asked about her relationship and denied any issues, and apart from a suspicion by the nurses there was no other information or evidence. This further prompted a longer discussion on what actions are available to the Trust when the information they glean from those who attend Urgent Care Centres is often minimal. The Panel agreed that having Independent Domestic Violence Advisers (IDVAs) available in Urgent Care Centres who can meet with these patients when there is an indication that they could be experiencing domestic abuse may enable further detailed conversations to take place, ascertaining more information to support a comprehensive risk assessment and onward referral into services and to MARAC. In addition, where capacity is impaired that IDVAs together with other safeguarding practitioners can follow safeguarding processes instead to protect a person from further harm.

7.5 Furthermore, information was sought from the MARAC Chair to support the Panel discussions on what the process currently is and to learn more about the MARAC review that was being undertaken at the same time as this DHR. The Panel were advised that there are four ways that a case could be referred into MARAC and these are; Visible high risk using the risk assessment, a repeat incident in 12months since being discussed at MARAC, professional judgement and potential escalations- number of attendances or calls increased. Panel members had differing views in relation to professional judgement, however it was accepted that in order to refer a case under professional judgment then a clear rationale on how the case meets the criteria for risk of homicide or serious harm is essential. The Panel were also provided with information that MARAC cases are not rejected from the process but returned asking for further information.

7.6 It was clear to the Independent Chair that there was already work underway to improve the MARAC process in Hertfordshire, with training being delivered to remind MARAC representatives of their responsibilities in engaging with the process, thresholds for MARAC and their role in quality assuring referrals from their organisation before they reach the MARAC team. The aim of this work is to bring some consistency to the application of what is high risk and to improve the quality of referrals.

7.7 In summary, it was found following Panel discussions that there was still potentially a gap in process for cases or individuals who have been identified by an agency as possibly experiencing domestic abuse but the information is limited and the risk is unknown. The conclusion was threefold; firstly all agencies should be reminded of the benefits of signposting or referring those individuals potentially at risk onto Refuge as the local domestic abuse specialist service who can offer support and build a rapport. Secondly, as has already been mentioned 'multi agency professionals meetings' can be organised by any practitioner under the guidance of the Care Act 2014 to share this information and discuss cases of concern where there is risk of abuse or neglect. Lastly, consideration could be given to a domestic abuse triage process that could form part of a Multi Agency Safeguarding Hub or as Safe Lives term a 'One Front Door' approach where those cases not meeting the MARAC high threshold are discussed. Safe Lives (2019) supported a pilot programme of seven locations undertaking the principles of a 'One Front Door' approach, this was concluded and evaluated in 2019 which resulted in a significant impact on early intervention and prevention. Multi- agency work became more collaborative and effective, by bringing together information held by different agencies, the right assessments were being undertaken by the correct agency and there was meaningful analysis to bear from the information available to the agencies. There would be benefits to adopting a similar process in Hertfordshire focussed on prevention and early intervention; bringing information from all agencies together at an earlier point- 'Getting it right first time'. The information held by the Urgent Care Centre in this instance for Celeste could have been shared with the 'One Front Door' where potentially other information about Celeste and her mental health diagnosis, caring responsibilities of both individuals may have come together. This in turn may have enabled further exploration with Celeste about her relationship and signposting to support if required. However these processes which focus on gathering information and risk assessing information known do require support and ownership from a partnership of organisations and equally investment in strong administration. These three summary points were all supported by the Panel as recommendations to support domestic abuse strategy implementation in Hertfordshire.

Identification of those with a 'caring role'

7.8 The Panel recognised that the identification of 'carers' or those who have a caring role was a key learning point for Primary Care GP Practice and Hertfordshire Partnership University NHS Foundation Trust as part of this review. The term 'carer' is defined by NHS England as 'anyone, including children and adults who look after a family member, partner or friend who needs help because of their illness, frailty, disability, a mental health problem or an addiction and cannot cope without their support. The care they give is unpaid. Many carers don't see themselves as carers and it can take an average of two years to acknowledge their role as a carer' (NHS England, 2023). It was also found during panel

discussions that there was no consistency in terms of definition and application of what a carer is and the importance and benefits of identifying those who have a 'caring role'. Benefits being that the health and wellbeing of those having a caring responsibility is reviewed, a broader review and use of professional curiosity is used to better understand the dynamics of the relationship between individuals who have caring roles thereby enabling a distinction between domestic abuse and carer's stress to be made. Lastly, by recognising individuals with these additional responsibilities also enables greater support to be offered through signposting, a carer's assessment and care contingency plans should anything happen to the carer themselves as this can cause additional stress, pressure and worry. This was true in Alfred's case, that he often advised professionals that he was worried about what would happen to Celeste 'if anything happened to me' and this was not followed up by way of a carer's assessment or care contingency plan. A carer's assessment being shared with other relevant agencies for example GP Practice would also enable those practitioners to be made aware that their respective patient is a carer for someone else. Therefore, it was agreed that raising the awareness in relation to the identification of those who may have a caring role was deemed important learning from this review for all agencies.

7.9 Secondly, as per the Rapid Review for this case in April 2022, it was highlighted that significant work had been undertaken and was continuing in Hertfordshire to distinguish between domestic abuse and carer's stress defining the following principles. Where harm is intentional in circumstances where there is a caring relationship then it was likely to be deemed domestic abuse. This is because it was understood that control would still feature as the main driver which is true of any domestic abuse situation. Whereas to the contrary, when the harm is unintentional in a set of circumstances where a caring relationship exists, harmful actions of carers may arise as a result of not coping or having unmet needs (ADASS, 2011). The position that Hertfordshire agencies have all agreed upon is that regardless of whether the harm caused by the carer is intentional or not, the impact on the individual affected by the carer's actions, or lack of action, must remain central, and it is important that the nature of the risk posed is understood.

7.10 Furthermore to the above, the Rapid Review also acknowledged through research that the two areas of professional practice; safeguarding adults and specialist domestic abuse services are not as joined up as they could be. For example, those working in the safeguarding adults space rarely ask about abuse and it is widely understood that unless victims are asked specific questions they will be reluctant to disclose unless asked directly or given the space to do so safely. The Panel also agreed that this was most probably the position in Hertfordshire and that more could be done to bring the two areas of professional practice together; joint training on domestic abuse and identification of carers, the responsibilities under the Care Act 2014, the services on offer by each organisation etc.. It was agreed by the Panel that there should be greater alignment between these professional areas which would also most probably enable more and improved multi-agency professionals meetings to be held to discuss complex cases. In turn, when individuals have been correctly identified as having a 'caring role' yet will refuse a carer's assessment then consideration should be given under safeguarding processes when presentations of such a complex nature arise in order that appropriate support and risk management is in place under the safeguarding legal framework to prevent future harm to either persons.

7.11 Since this review, significant work has been undertaken by Hertfordshire Partnership University NHS Foundation Trust to improve the identification, experience and offer made available to carers to Hertfordshire. Owing to the delegation of safeguarding services from the local authority to Hertfordshire Partnership University NHS Foundation Trust, they started this project in January 2023. There were several drivers for this project and programme of work, however pertinent to this review are the following; carers will have their wellbeing prioritised and carers will have contingency plans when needed. In addition, another core purpose has been to ensure that carer safety is promoted, that carers feel safe in their role and have the skills and access to training to help them continue in their role. The intention was to complete this project by September 2023 with a new delivery model in place, where 'Connected Lives' is embedded as the practice model for delivery of carers assessments and that the identification of carers within the system has improved to ensure that they have a streamlined pathway of support. The Panel was presented with a snapshot of this work as part of a panel discussion and felt assured that this project would satisfy the learning from this review in how nor Celeste or Alfred were formally recognised as carers for one another. Being identified as a 'carer' or having a caring role should also be regarded in addition to any relationship of partner, mother, friend, sister etc.. The Panel also concluded that some of this training would be valuable to other organisations working within Hertfordshire in terms of awareness of the programme and the importance of identifying these roles.

7.12 It became clear during conversations with Panel members and family members that stigma still exists in relation to mental health and being identified as a 'carer'. Research undertaken by McAuliffee et al (2008) found that despite the rhetoric of carer inclusion in mental health policy, carers are either still not being involved and engaged as they should and/or stigma prevents individuals wanting to be seen in this role. This was particularly true in this study because the participants involved all cared for someone who had a mental illness, where their physical health needs were able to be met by themselves. There is also the added complexity that where family members are identified as those having a 'caring role' they often do not want to be known as a 'carer' but instead a 'wife, husband, mother'. Carer's Trust also supported this view, advocating that those titles 'wife, husband, partner' are important to both parties, and the fear of being called a 'carer' is often associated with negative reactions hence stigma. Therefore, the Panel concluded that more could be done as a partnership to raise awareness of carers, reducing the stigma of this term and providing assurance that the term 'carer' does not need to replace your other role. Celeste's family further commented on this report advising that they did not feel that the word 'carer' was appropriate. Her family advised as part of this review that Celeste and Alfred looked after each other as any normal loving husband and wife would do. They did not rely on each other to function and they were perfectly autonomous in their own right. Their view is that both Celeste and Alfred refused to be considered 'carers'.

Supporting couples who both have mental health concerns

7.13 Further to the learning points outlined above, the Panel had conversations in relation to how individuals who both have mental health concerns might be supported when they are also in a relationship. This goes further than being identified as a carer, and

reducing the stigma around that title and instead is about how wrap around support might be available to support these situations and prevent escalations in behaviour. The Panel recognised the importance of understanding lived experience and capturing the voice of those with it to strengthen what support could be offered to individuals based on assessed risk and care planning. Panel members agreed that this relied upon those individuals having a trusted relationship with professionals and able to speak openly about their relationship- this links to the care coordinator function as already mentioned. The Panel also highlighted that this should come from a place of supporting individuals on what changes they might like to make or what would work well (strength-based approach). Celeste missed working and would have liked to have been supported to return to work after covid, this was not something that was explored enough with her by professionals on how this could happen. In addition to the above, it also heavily relies upon agencies sharing information with one another as necessary, however also intra-information sharing within organisations- particularly when both individuals are known by one health provider eg. A single GP Practice or a single Mental Health Trust. This has also already been explored. The Panel also identified that a degree of risk assessment is vital to understand when behaviours might be escalating to support couples in this situation- please refer to the Mental Health Homicide Review for further information in relation to the learning on risk assessments for this review. Lastly, the Panel also discussed the need to focus on prevention, education of escalating behaviours and domestic abuse and therefore in turn what strategies might be applicable to these sets of circumstances. For example, the need to raise awareness of domestic abuse, being clear about what is abusive behaviour and what is not through continuous education with these individuals. Furthermore, having contingency plans in place in the event that behaviours do escalate therefore ensuring that there is a strong support network that surrounds each individual in their own right.

7.14 Analysing these points, it became clear that as a result of the learning from this review, the Domestic Abuse Partnership working across Hertfordshire should consider raising the awareness of mental health concerns and domestic abuse. Safe Lives (2019) found following their research that a strong association often exists between having mental health problems and being a victim of domestic abuse. Mental ill health is also a risk factor for abuse perpetration. This research also found that problems with drugs and alcohol use were often also a feature with victims who also had mental health needs.

7.15 Therefore to conclude, in order that couples with mental health concerns can be better supported by organisations and prevention strategies associatied with domestic abuse and other escalating behaviours used, then all practitioners, but particularly mental health practitioners should be trained to respond to domestic abuse. An investment in training this workforce was agreed as essential to enable signs to be identified and referrals to be made to domestic abuse support services for early intervention. Notwithstanding that perpetrators also need to be referred onto appropriate interventions, however with an understanding of the mental health needs of the individual also so that the behaviours can be understood and addressed holistically.

Mental health concerns and use of drug and alcohol services

7.16 The Panel noted within discussions that Celeste and Alfred frequently used alcohol, albeit it was recorded within Alfred's notes by his GP Practice that he had given up drugs and alcohol owing to his physical and mental health concerns. Celeste's family reported as part of this review that they did not consider that either Celeste or Alfred had an addiction to drugs or alcohol but liked to enjoy alcohol socially and perhaps as a coping mechanism when things seemed tough to them.

7.17 There was no evidence in Celeste's records that she was signposted to the specialist drug and alcohol services in Hertfordshire for support, advice and guidance owing to her usage and impact on her health and wellbeing. This was recognised as a possible missed opportunity for a different agency to engage with Celeste and explore her wellbeing and triggers for drinking. The outcome of which might have been some further information about how she was feeling, her need to drink alcohol and potentially her relationship with Alfred. This was also recognised within the Mental Health Homicide Review- focussed on Alfred and his care. Alfred was signposted to these services but refused the service. To note, it was reported as part of this review by Celeste's family that Alfred started using drugs again in 2021 when he was not feeling well. Celeste was aware and angry with him and often tried to stop him from getting the drugs supplied by a 'friend' known to them.

7.18 It was also reported as part of this review, that Celeste's family did seek advice from Hertfordshire Partnership University NHS Foundation Trust about their concerns of Celeste's alcohol consumption and unfortunately this wasn't followed up. Therefore in summary, the Panel felt that drug and alcohol usage was not explored by practitioners in this review as much as it could or should have been. There was a Panel consensus that they would have expected these conversations to feature within the care planning of both Celeste and Alfred by services. A recommendation to capture this learning was that all agencies should be reminded of the impact drug and alcohol use can have on an individual's health, wellbeing and relationship and that specialist services like CGL (Change Grow Live) should be contacted for advice and support.

Impact of Covid-19 pandemic on individuals and couples experiencing mental health issues

7.19 The Covid-19 pandemic began in 2019, and was the transmission of a virus which sadly had deadly results for many people from all walks of life. Patients were first admitted with Covid into acute hospital beds in England during 2020 and the first lockdown came in March 2020, followed by further lockdowns over the rest of that year and into early 2021. These restrictions had a huge impact on all members of society but the Panel identified by agency records and conversations with Celeste's family that this was also significant for Celeste and Alfred. Celeste was furloughed from her job, creating financial dependence on Alfred and the lack of socialisation and routine for Celeste, which was detrimental to her because these things helped her manage her illness. Alfred also expressed to numerous health professionals that he felt anxious about what would happen to Celeste if anything happened to him as a result of the covid 19 infection.

7.20 Services, in particular health services, which are relevant to this review also were affected in terms of their delivery to patients like Alfred and Celeste. There were more

telephone consultations than perhaps there might have been, and therefore less face to face appointments where rapports could be built and body language assessed. It was a reflection of the Panel that Alfred often had contradicting symptoms of his physical and mental health during the time of this review. There was limited evidence that those practitioners who came into contact with him were professionally curious about how he was feeling and what was going on for him other than the chronic pain, caring responsibilities and medication. It is widely supported that individuals should be holistically assessed and supported to access the right help at the right time. However for Celeste her ongoing health contact was only in relation to her mental health illness and she was well known to Hertfordshire Partnership University NHS Foundation Trust. As is mentioned earlier in the report, Celeste was Covid-Rag rated Red owing to the potential impact the virus could have on her because of the medication she was prescribed and taking. As a result of being identified as Red, meant that she was still contacted as frequently as expected with some prioritisation because of her medications.

7.21 The Panel explored the impact of the pandemic on these individuals, and as organisations they shared their reflections of how services were delivered during this time and what changes or improvements could be made next time. The Panel were reminded that Celeste's family had regular contact even when via phone during the lockdowns which is understood to have been an excellent support for her. When restrictions were lifted she was able to stay with her family for overnight stays, and as a result she reported to agencies that her mood improved and her paranoia decreased when she had time away. It is not known exactly why she felt this way; was it the change of scenery? Was it time away from Alfred? Was it a distraction to be with her family? However, the Panel identified that during lockdowns and times when visiting was restricted this would have had an impact on Celeste's wellbeing because she couldn't do what she wanted to do.

7.22 The final reflection the Panel had in relation to this theme was that Celeste's Family reported as a result of this review that prior to the pandemic Alfred and Celeste were very sociable individuals, they regularly had parties with friends and family coming over to their home. Alfred had built a bar in the garden as an extra place for socialising. Therefore lockdowns were a significant change to the way that they lived their lives; resulting in both of them having to support one another with limited network and socialisation for support and navigating their physical and mental health needs via mostly phone calls. Celeste's family further commented on the drafting of this report by reflecting that even during covid Celeste remained positive, however the restrictions imposed and not being able to see her family and friends were detrimental to her wellbeing. The family also added that Celeste also worried about Alfred's health problems which contributed to her relapse. Nevertheless, the family did comment that they believed it was improving solely once life returned to normality.

8. Recommendations

East and North Hertfordshire NHS Trust

8.1 Increase visibility of IDVA (Independent Domestic Violence Adviser) services within QE2 (Queen Elizabeth 2) urgent care setting

8.2 MARAC (Multi-agency Risk Assessment Conference) referral criteria to be disseminated to the safeguarding team, inclusive of referrals made based on professional judgement

8.3 Awareness raising to services in the Trust in relation to drug and alcohol services and referral criteria

Hertfordshire and West Essex Integrated Care Board

Peartree GP Practice

8.4 Raise awareness of the need to include significant others when making enquiries regarding risk to self and then share that information/seek guidance and expert advice from Mental health services on how to manage (this is linked to recommendation 19.7 below)

8.5 Raise awareness for practice staff to identify patients who have a caring role, but may not identify themselves , as carers and make appropriate referrals

Hall Grove Practice

8.6 Raise awareness to consider the application of safeguarding alerts to electronic patient records following receipt of notification that an 'adult at risk' referral has been completed.

Hertfordshire Partnership University NHS Foundation Trust

8.7 A reflective learning session to be undertaken including Adult Community Mental Health Services (specifically LIT (Low Intensity Team) & FACT (Flexible Assertive Care Team)) and Mental Health Liaison team workers plus inviting service user's GP to consider the learning points raised during this investigation including: the need to identify carers and offer carer assessments and contingency planning where appropriate; ensuring historic risks are properly reflected in updated risk assessments; ensuring information sharing around prescribing; checking individuals presenting in acute settings and not immediately discharged have a follow up within expected time frames; need to check carers are aware professionals have heard their concerns; and the need to allocate a care coordinator when needs change for those managed under the Low Intensity Team Model or those open to FACT.

8.8 The Clinical Risk Assessment and Management for individual Service Users policy V9 should be updated with the wording amended from "…physical, social and psychological factors may be considered …" to "…physical, social and psychological factors **must** be considered …".

8.9 A Risk Assessment refresher session to be delivered to the East and South East Adult Community Mental Health Services to focus on the dynamic assessment of risk including psychological and social factors, medication issues, planning around individuals who have caring responsibilities, and known risk factors and the need to ensure accurate recording of risks, including of historic risk events.

8.10 The learning from this review to inform the development and delivery of risk simulation training to teams across the trust.

8.11 Links to be forged with Refuge; commissioned specialist domestic abuse support service provider in Hertfordshire to ensure that the Trust is aware of all services that this organisation can provide to support awareness raising of domestic abuse, signposting to support and knowledge.

8.12 Comprehensive and essential domestic abuse training to be undertaken across Hertfordshire Partnership University NHS Foundation Trust by all staff to increase awareness of this subject, recognising the links between domestic abuse and mental health

8.13 The 'Connected lives' project now embedded across and within Hertfordshire Partnership University NHS Foundation Trust to be shared across the Integrated Care System for learning and development; an approach to managing dynamic care.

Hertfordshire Domestic Abuse Partnership

8.14 The Partnership should collaborate, design and agree a communications plan which will share the following learning points from this review:

- Strengthened understanding of how to organise and coordinate a Professionals meeting (complex case discussion), as per the Care Act 2014, and the benefits these can have on the coordination of care and support for an individual at risk of harm or self-harm, and any other risk factors that may exist in a household or relationship. This should be in conjunction with the Hertfordshire Safeguarding Adults Board who already have some guidance published called 'Multi-agency guidance for complex cases'.
- Increase the knowledge and understanding of the interdependencies between domestic abuse and mental health concerns across all agencies, and where individuals and family members can be signposted to for support, advice and guidance.
- All agencies to be reminded of the impact drug and alcohol use can have on health, wellbeing, relationships and mindset and that specialist services like CGL (Change Grow Live) should be contacted for advice and support.
- Educate professionals and citizens of Hertfordshire on the benefits associated with being identified as having a 'caring role' to reduce the stigma for individuals and enable those who require support to access it.

The communication plan should include a variety of learning events, webinars and/or roadshows that are to be delivered by members of the Partnership to professionals working in Hertfordshire. The plan should also be supported by a campaign schedule that shares key messages from this review with the general public of Hertfordshire, and specifically the locality where the couple lived.